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REVISED IMPLEMENTATION PLAN

NIGER - IMPROVING RURAL HEALTH PROJECT

No. 683-0208

USAID/ NIGER

AGENCY FOR INTERNATIONAL DEVELOPMENT

Unclassified

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1. Executive Summary

This Revised Implementation Plan for the Rural Health Improvement Project (RHIP) incorporates the major findings and recommendations of the Joint Project Evaluation done in mid-1981 and the subsequent reactions of both the Ministry of Health and Social Affairs (MOH/SA) of the GON and the USAID/Niamey.

The three person team (Economist, Health Administrator and Health Planner), in preparing the revised plan, coordinated their effort closely with the responsible officials in the MOH/SA and with USAID/Niamey. The Africare representative and in-country staff collaborated in developing the elements of the plan concerning the training of sanitation workers, the training of automotive mechanics and medical equipment maintenance and repair technicians; areas in which Africare has and should continue to furnish technical assistance.

The Revised Plan retains the same goals and objectives of the original project design of 1978. However, a health and management data information system has been added to develop improved health planning, programming and analysis. Other major support areas include: (a) continued health manpower training and development at all levels, emphasis in this respect is, as before, on training and retraining volunteer village health teams and certified nurses at the periphery, but continued training support is given, on a selective basis, to intermediate and central level health workers and officials to provide improved direction and supervision. Special emphasis and added support have been given to the training of sanitation technicians at ENICAS in order to provide more practical "hands-on" field training and practice. (b) Focused support for strengthening the transportation and equipment/maintenance capability at the intermediate department (province) levels with expedited training of automotive mechanics and equipment maintenance/repair technicians.

The administrative arrangements for implementing these inter-related activities have been revised to provide coordination and improved administrative integration. This has been done by creating two new positions: the position of Director of Administration and Finance, responsible for the management and administration of all personnel working in the Project as well as responsibility for the financial aspects of the Project; the second position is that of Technical Director who will have responsibility for managing the technical aspects of the Project activities.

In order to clearly define implementation responsibilities and to simplify management and evaluation of progress towards present quantified targets the revised implementation plan presents these activities in two major implementing modules as follows:

Module 1: Health Planning

- a. A contract with a U.S. School of Public Health charged with

providing services for:

the establishment and development of a health information planning/management system, working in a staff position at the level of Secretary General to provide data and analysis as a basis for health planning and policy decision - making for the Minister. This module is also responsible for manpower development at the higher professional levels (i.e. doctors, planners, degree nurses etc.).

- b. A short-term TA subcontract (6 months) for installation of a micro-computer based data processing and initial orientation training for Nigerian staff - this subcontract must be closely correlated with the follow-up technical assistance services provided under (a) above that will come on-line in January 1983.

Module 2: Contract with Africare responsible for support activities pertaining to:

- training of sanitation technicians at ENICAS in practical field work and practice
- development and testing of simple practical techniques and appropriate technology for the protection of water and the sanitary disposal of human waste
- accelerated training of auto mechanics and medical equipment repair technicians coupled with development of an improved system for vehicle and medical equipment maintenance and repair at department levels.

In both implementing modules the contracting agency is charged with furnishing the technical assistance and recommending the procurement of the essential commodities needed to expedite implementation subject to AID standard procurement regulations.

The position of Chief of Party in the Revised Implementation Plan is placed within Module 1: The University.

It must be fully understood and agreed by all concerned that the Chief of Party is responsible for the overall direction and coordination of all U.S. inputs into the project.

In addition to the above two implementing modules USAID has already hired (personal service contract) a finance officer/accountant to improve the financial administration in the project and to track expenditures in order to provide accountability and financial information needed by USAID.

BACKGROUND AND HISTORY
OF THE PROJECT

Provision has been made for continuous monitoring and evaluation of progress towards well defined targets (see section on Implementation schedule). This is done by quarterly reports from the Chief of Party and quarterly meetings between USAID and MOH/SA to assess progress towards quantified preset targets, identify problems and recommend courses of action needed to advance progress. Evaluation is therefore on a continuous, operational basis. A final joint evaluation, as required for all AID Projects, should be done in the last quarter 1984.

The Revised Implementation Plan is based on an estimation of \$6.8 million remaining in the original budget as of January 1, 1983. The remaining funds have been reallocated to allow original goals to be met or exceeded and to provide the new support services briefly described above. The plan is based on a 30 month extension until June 1985 to correlate with the GON annual training cycle.

Details on the specific types of inputs required, and a comparison of the original budget and estimated spending by December, 1982 with the Revised Implementation Plan Budget can be gained from Section 6 Financial Analysis and accompanying Tables. A quick review of Section 5 Budget and the Implementation bar charts in Section 9 provides more specific details on types of inputs and scheduling of service activities and their relation to outputs.

2. Background History of the Project

2.1. Background

In the late 1960's the concept of Village Health Teams (two securistes with preventive and curative functions and two retrained traditional midwives "matrones") was adopted by the GON. This was reinforced in 1964 by a USAID-financed and WHO-assisted "Ten Year Perspective on the Development of Health Services" which identified the major constraints to improvement in the health delivery system as a lack of qualified personnel and concurrently a lack of fiscal resources. Highest priorities were assigned within this plan to 1) public health and simple curative procedure, called, "Health Care for general population". 2) health education, MOH and 3) personnel training.

The change in government in 1974 resulted in increasing emphasis on the goals in the above noted plan which was codified in 1976 by the Three Year Plan. This Plan emphasized the strengthening of particular health components and the expansion of the geographic coverage and numbers of people covered by the health system. This overall strategy has continued, essentially unchanged, to date.

The current project was formalized in 1978 with its general goal (as expressed in the log frame) being "to improve, at low cost, the quality of life and working capacity of the rural population". The general emphasis of the project followed strategies developed over the 15 prior years in the Ministry with respect to extension of essential health services in the Primary Health Care context.

2.2. Description of the Original Rural Health Improvement Project (RHIP).

As described in the 1978 Project Paper, the Improving Rural Health Project (RHIP) is a major national primary health program for Niger. The project's emphasis is on training 1,500 village health teams (VHTs), a total of 6,000 people and retraining about 13,500 existing village health workers. The Plan, in 1978, was to bring basic health services to 3,500 villages or about 39% of the rural population.

Village health teams are comprised of 2 matrones and 2 secouristes supported by an administrative committee. The VHTs are selected by the communities which they serve and are supervised by dispensary nurses. Secouristes and matrones carry out minor curative care and disease prevention activities. The matrones perform traditional midwifery, enhanced by training in modern medical principles and practices, primarily to provide recognition and early referral of complicated pregnancies, clean safe deliveries, surveillance of the health of mothers and infants and appropriate health education. The secouriste provides simple medical treatment, health education and improvement of village sanitation. Both refer cases beyond their capacity to dispensaries.

The RHIP also expands and strengthens other parts of the health system, particularly support services vital to the success of the VHTs. Generally support includes; upgrading and expanding the number of professional health workers assigned to rural areas, increasing their productivity, improving facilities, and providing sufficient drugs and supplies.

Specifically, this support included:

Training of Personnel

- Academic health training for 25 supervisory level nurses, senior MOH officials, and logistic/maintenance personnel, at a rate of 2 supervisory nurses, 2 MOH personnel, and 1 maintenance supervisor per year of the project.
- 1,100 persons participating in MOH continuing education conferences.
- 40 certified nurses, 20 state nurses, 15 environmental health workers in technical training each year of the project.
- 25 medical equipment technicians and 50 auto mechanics trained by short-term consultants.

Institutional Support

- 200 Mobylettes for dispensary level supervisors and 42 functioning 4 -wheel drive vehicles for supervision at Departmental and Arrondissement level and supply distribution which are expected to lead to 45% more supervisory visits to health centers and dispensaries, and a 10% increase in operational efficiency of all vehicles.
- 2,700 VHTs equipped with drugs, educational materials, and other supplies.
- Sanitation improvements for 250 existing health facilities
- 7 new dispensaries and 2 department health centers in Zinder and Agadez.
- Mobile health units immunizing 100,000 persons per year
- 2 garages and medical repair shops at the department health center
- Sanitary education programs reaching 35% of the rural population

According to the AID Project Paper (March 30, 1978) "in keeping with the AID country strategy, the project focuses on preventive aspects of health care and offers a program which the GON will be able to sustain and operate upon completion of the project". The Project Paper also states (page 94) that: "Objectives contained in this Project Paper are the result of joint planning meetings with the Ministry of Health and reflect the wishes of the government and the professional judgement of an experienced Project Paper team. Unless unforeseen exigencies develop, we expect to carry out the program to full realization."

By 1979 a new GON Five Year Plan was presented which incorporated some of the major goals and objectives of the (RHIP) project agreement but showed few major deviations from prior policy.

2.3. The Mid-Project Evaluation

In mid-1981 a mid-project evaluation was carried out by USAID which included an extensive review of project activities up to that time. A five person team generated a report which made specific recommendations which can be categorized as follows:

- I. Organizational arrangement of RHIP within the MOH and the contractual and organizational relationship of Africare to MOH. (Rec. 1.2 - 1.40)
- II. Suggestions for changes in policies and practices with respect to specific health services (malaria, E.P.I., Diarrheal diseases) (Rec. 1.41 - 1.48)
- III. Recommendations for specific changes in rural water supply and sanitation activities (Rec. 1.51 - 1.696)
- IV. A major push in the areas of health planning and statistics in the MOH (Rec. 1.71 - 1.75)

- V. Administrative/Management arrangements for construction and renovation of health facilities (Rec. 1.81 - 1.85)
- VI. Some improvements in development and logistic support activities at all levels (Rec. 1.86 - 1.90)
- VII. Increase in the scope and pace of training initially programmed (Rec. 1.91 - 1.95)

The major operational problem with the RHIP during this time was a very slow rate of expenditure. Technical assistance had also been slow in coming on line and the MOH seemed to be prudently using only those resources that it was capable of absorbing within their own system.

The GON was asked to respond to some sixty four evaluation recommendations with the result that a final combined document reflected the original evaluation recommendations, Government of Niger responses and USAID comments on the responses. A review of these responses by broad category:

- i) In general, the major changes regarding organization have been implemented and both USAID and GON are in agreement with project extension for 30 months. i.e. up to June, 1985 which corresponds to the end of the GON annual training cycle. The GON feels that no major structural change is needed vis-a-vis the line function of the RHIP with personnel changes currently enacted. AID concurs.
- ii) Suggestions for changes in policies with respect to specific health services have been generally rejected by the GON as matters of local policy which should be under Nigerien control. The GON has, however, requested TA from the Communicable Disease Center (CDC) Atlanta Georgia to help with planning the, "cold chain", programming of immunizations and other operational aspects of their on-going immunization program. CDC in responding to this request, called attention to a number of technical defects in the GON on-going program. CDC will furnish assistance only in the context of helping to develop an EPI program that is technically sound, feasible, that targets on effective age groups and that would shift focus to static centers and use mobile operations only where such centers do not exist. Although the design team believes the GON will change their present immunization policy to one consistent with CDC (and WHO) concepts, it is impossible to plan inputs for these activities until this issue is resolved. Attention is also called to section II "Institutional Support" in the original Project Grant Agreement of 1 June, 1978 that states under subsection a, item 6:
 - " A complement of cold chain equipment and supply of vaccines is planned for the second year. Allotment of AID funds for this purpose will be contingent upon development of a detailed, agreed plan for use of the equipment and vaccines."

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ORGANIZATION AND STFUCTURE
OF THE HEALTH SERVICE OF
THE GOVERNMENT OF THE REPUBLIC OF NIGER

- iii) Changes in rural water supply and sanitation activities have been in three areas. The purchase of new supplies has been generally approved while suggestions regarding construction of facilities have deferred to appropriate GON authorities. Suggestions with respect to change of duties for the AFRICARE Sanitary Engineer were approved by the GON.
- iv) Major improvements in health planning and statistics were suggested for the MOH which were agreed upon in principle with an eye to working out specific plans of action.
- v) Arrangements for construction and renovation of facilities were considered as matters for USAID to work out with the Ministry of Public Works, Transport and Urbanism. It was agreed that funds for sanitary improvement of health facilities should be increased.
- vi) Improvements in development and logistic support activities were suggested which were generally agreed to by GON.
- vii) The increases in the scope and pace of training initially programmed under the RHIP were agreed upon at every level.

The implementation team found the GON response to the evaluation team's recommendations to be reasonable and consistent with their prior stated policy of moving within their already decided plan of action (5 year Plan).

With a few minor exceptions, the GON was receptive to the spirit of the suggested changes while insisting upon GON control of overall direction and strategy. The following implementation plan for the proposed 30 month extension is grounded on this general view and on the premise that the evaluation conclusions were appropriate ones.

3. Organization and Structure of the GON Health Services

This section gives a brief summary of the existing health structure and organization - more details are available from the Mid-Term Evaluation Report.

3.1. Overall Pattern of Health Services.

The Health Organizational structure parallels the civil administrative structure - this relationship at central, intermediate and peripheral levels are shown in organigram A on page 8a. In addition to those shown at national level, there are 2 Tuberculosis Centers, 1 Leprosy Center and a National Office of Pharmaceutical and Chemical Products (ONPPC) at Niamey. Mobile medical teams are also assigned to each Department. The Mobile Teams are mainly concerned with immunization programs (BCG, polio, measles, diphtheria, whooping cough, tetanus and meningitis) and are more than less centrally directed, under the Direction of Hygiene and Mobile Medicine (DHMM).

DHMM has, since 1980, had responsibilities in improving rural sanitation. ONPPC (the parastatal drug firm) is well organized and managed and provides a valuable base for the in-country production and packaging of affordable essential drugs.

- 3.2 The Organization of the Ministry of Public Health and Social Affairs at the National level in Niamey.
See Organigramme B page 8b.

Policy decision making in the MOH/SA is highly centralized at the level of the Minister. All major policy decisions are made by the Minister with the advice of his Cabinet. Supervision and coordination of the work of the Ministry is done through the office of the Secretary General.

The 5 major Directions are: (DAF: Administration and Finance; DES: Health Facilities; DAS/PMI/MC: Maternal Child Health; DHMM: Mobile Teams immunizations and environmental sanitation; and DEESN: Training). Each has a varying degree of normative (staff) and executive functions. They are normative in respect to establishing standards; setting modes of health activities, assessing progress, providing information and analysis for policy level decisions and similar staff functions.

The extent of their executive functions varies depending on the personality and influence of the Chief of the respective Directions.

- 3.3 Organization at the Intermediate level (7 Civil/Geographic Departments that cover the country).

Within the guidelines and policies set at the central level, the MD director (DDS) of each of the geographical departments plan, oversee and coordinate all health activities within his area (in Niamey, there are specialized teaching and training institutions e.g.: the National School of Medical Sciences and the National School of Public Health, which by their nature must be more centrally directed).

Contact with the Ministry by the DDS is normally through the responsible officials within the Direction of Health facilities (DES). Sometimes, the DDS may directly contact the Secretary General. Despite this tolerance of a certain degree of flexibility in maintaining the chain of command, health development activities at Central, Intermediate and Peripheral levels are well integrated and have focussed control. This is due mainly to centralized decision-making and continuity of policy. The notable exception are the activities executed vertically by the DHMM: Direction of Hygiene and Mobile Medicine.

The Medical Center (CM), located at the most populous town in the arrondissement consists of a dispensary, a maternity ward of 10-12 beds, a medical treatment ward of 18-20 beds and sometimes a maternal and child health center. French: Protection Maternelle et Infantiles (PMI).

HEALTH AND CIVIL ADMINISTRATION SERVICES

CIVIL GOVERNMENT

MINISTRY OF PUBLIC HEALTH AND SOCIAL AFFAIRS

See Separate Organogram

General Level
and Capital
Niamey

- Secretary General
- (Central Directions
- (2 Maternities
- (8 MCH Centers
- (2 Pharmacies (populaire)
- (2 Training Schools

Intermediate Level

- (a) 7 Departments
(Niamey, Zinder, Agadez,
Dosso, Ullid, Harau
and Tahoua)

7 Prefects

7 Department Directions

- 15 MCH Centers
- 6 Pharmacies (Populaire)
- 8 Maternities
- 7 Hospitals (2 National: Niamey, Zinder
5 Departmental)
- 1 Training School at Zinder

- (b) Arrondissements
(Districts)
and
Communes
(sub-districts)

3- Sub-Prefects
- Communes

38 Health Centers

- 1 MCH Center
- 10 Pharmacies (Populaires)
- 32 Maternities

Peripheral Level

- (a) Canton Civil Administrative
Posts

24 Administrative Posts
one at each Canton

189 Dispensaries
24 Medical Posts

- (b) Villages

8,015 Villages

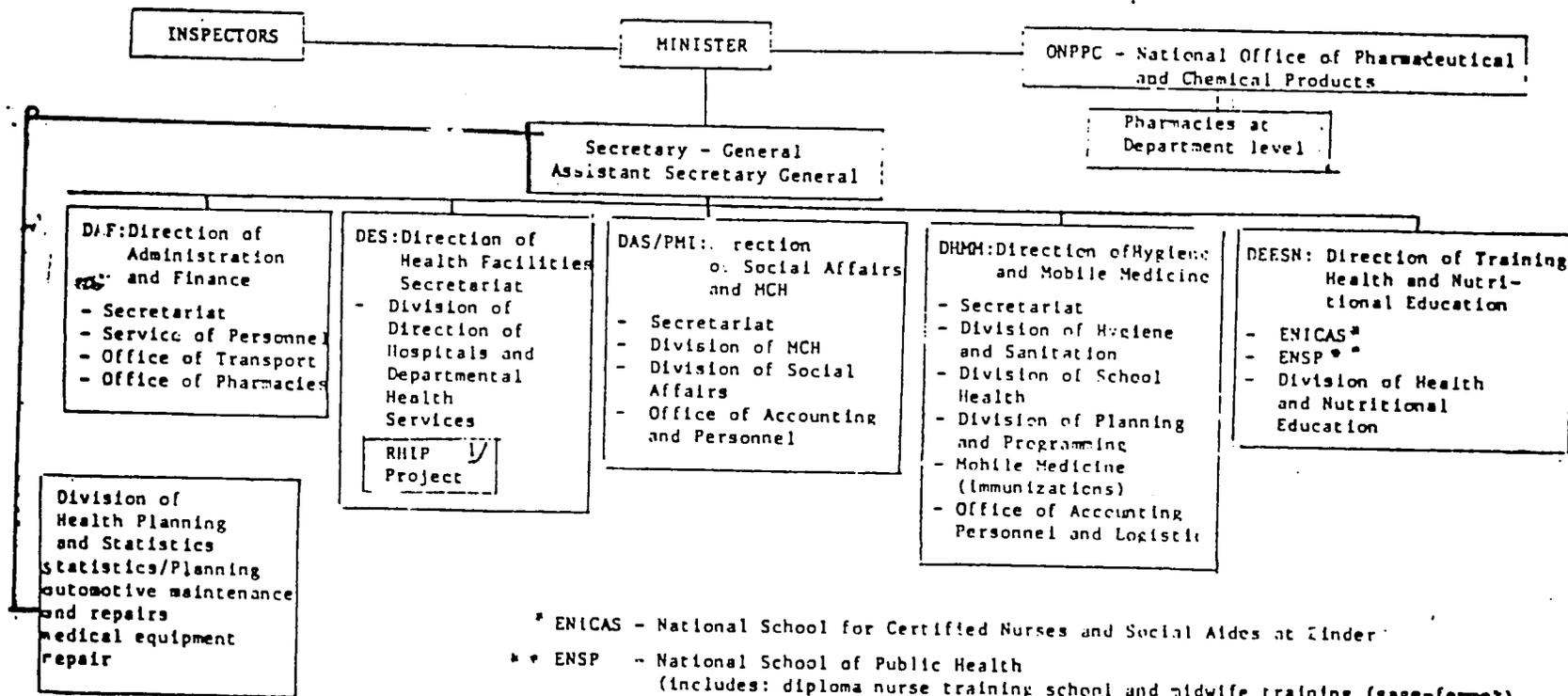
7 Maternities
2,411 Village Health Teams

8A

12a

ORGANIGRAM B.

ORGANIGRAM OF THE MINISTRY OF PUBLIC HEALTH AND SOCIAL AFFAIRS
(CENTRAL LEVEL - NIAMEY)



* ENICAS - National School for Certified Nurses and Social Aides at Zinder

** ENSP - National School of Public Health
(includes: diploma nurse training school and midwife training (sage-femme))

1/ Head of DES also Director of RHIP Project and for these purposes has:

- Administrative Assistant
- Health Training Assistant

There are 38 such CM's in the country distributed among the 7 Departments.

The CM is vital to the rural health system since it trains the village health workers for village health teams, provides referral-services, and carries out systematic supervision of dispensaries. Each CM is directed by a state licensed nurse assisted by 2 - 3 certified nurses, several laborers and one or more drivers. Most CMs have an ambulance for evacuation of serious cases to the hospital at the Department level and some may have another vehicle for supervision visits to the surrounding dispensaries.

The main preventive activities are done through the PMI's (where they exist) which focus on surveillance of pregnant and nursing women and infant growth and development.

Health education activities are aimed mainly at improving nutrition in infants 0 - 2 years. Growth and development of infants is monitored by use of a modified Morley WT/Height Chart.

Immunizations at the CM are dependant upon visits by the Mobile Health Teams from Department level, although the PMI will inject vaccines (without charge) purchased by the family from Peoples Pharmacies (Pharmacies Populaires).. There is ordinarily no electricity or refrigerators for vaccine storage at the CM. The use of kerosene refrigerators has been unsatisfactory, except in the Department of Dosso where the Evaluation Team found the DDS was able to overcome many of the logistics and maintenance problems concerning extension of the "cold chain" for EPI to CM level.

3.4 Organization at the Peripheral level.

Health Services at the peripheral level are executed through dispensaries at the canton level (10,000 population average) and village health teams at the village (500 people average) level. Dispensaries are staffed with 2 certified nurses trained in a 2 year program at ENICAS in Zinder who subsequently supervise the village health teams (VHT), which, according to design, consist of 2 securistes and 2 matrones. Many villages, however have only one securiste and one matrone. The securistes are male and provide simple basic medical care with a short list of essential drugs and perform other preventive health services mainly health education and sanitary improvement. The matrones are the traditional midwives. Their training is aimed at recognition and referral of high risk pregnancies, clean delivery, and subsequent immediate post-partum surveillance of the mother. Other duties concern surveillance of the health and development of the new born through the first year of life. The duties concerning infant care are shared with the securistes. The exact arrangements are somewhat unclear and probably vary in different areas.

The *secouristes* are issued, at the time of their training a box containing the first 6 months of medical supplies. In like fashion *matrones* receive a basic kit for deliveries. Thereafter replenishing of these supplies is through the periodic (planned monthly) visit of the certified nurse from the dispensary or purchased at *Pharmacies Populaire*. Fees are charged for the services of both the *secouriste* and the *matrone* which provide for financing the replenishment of drugs and supplies. Drugs and supplies can be alternatively purchased from *pharmacies populaire* in those areas where such are accessible.

The organization and administration of the VHTs is through village health committees which, according to the design, includes a secretary treasurer to oversee financial transactions: namely drug purchases. In practice, however, the *secouriste* usually collects payments and purchases drugs from either the *pharmacie populaire* or from the dispensary nurse. An exception to this overall system of auto-financing is found in the nomad areas where free services are provided (where available). There are obvious special logistical problems among the nomads. At present GON policy is to deal with these within the standardized system of the rural VHT plans. However, small experimental programs are underway to test methods of more effectively providing simple health services to nomads. There are also seasonal movements of the more fixed populations related to crop cultivation. These are special (and difficult) problems which to date have not been adequately addressed.

3.5 Information/Reporting systems.

Within the last 2 years a special Division of Health Planning and Statistics (DIS) has been established at the central level of the MOH/SA, under the overall direction of the office of the Secretary General. Statistical information reports are regularly compiled at the 7 geographical department levels and are forwarded to the functional Directions at the central level. Info copies, however, are sent to DIS and to other relevant functional Directions. The main health reporting systems are:

- a) Epidemiology and reports on the occurrence of infectious diseases and immunization through the Director of Hygiene and Mobile Medicine.
- b) Hospital and the health facilities service data through DES Direction of Health Facilities.
- c) PMI (MOH) activities through DAS/PMI, Direction of Social Affairs and MOH (PMI).
- d) Training and health manpower development through DEESN (Direction of Training Health and Nutritional Education).

In general a large amount of information and data is collected regularly but analysis and synthesis of these data for decision making, program planning, evaluation etc. is either totally lacking or generally weak.

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3.6 Training Facilities.

- The principle training facilities supported under the RHIP are:
- a) The National School for Certified Nurses and Social Aides at Zinder which trains certified nurses and sanitary technicians.
 - b) The National School of Public Health at Niamey which trains state nurses and midwives who subsequently train the members of the VHTs and supervise the work of the certified nurses at the dispensary and beyond as appropriate.
 - c) On-job-training for auto mechanics and medical equipment maintenance technicians is done at garages and work shops at the Departmental headquarters.

The original project design provided funds for field training studies for medical students at the University Medical School in Niamey but these activities never developed.

4.0. REVISED IMPLEMENTATION PLAN *

4.1. Recapitulation Summary of RHIP

Based on the mid-term evaluation report and other data and information furnished by USAID and MOH/SA officials responsible for the respective activities, the design team reached the following summary conclusions:

Re-training

- a) Academic training for state nurses and midwives at ENSP and Certified Nurses at ENICAS has been essentially on target and the quality is generally satisfactory
- b) The training of sanitation technicians at ENICAS is less satisfactory. The program is behind target and the quality of training is questionable - too much theory and not enough practical work. More hands-on practical field training is required.
- c) Inputs for The National Training Conferences and Department level quarterly seminars have been well utilised and the quality of their outputs is apparently good.
- d) The training of VHTs (Volunteer para-medics and matrones) is essentially on target - quality and relevance of training may be questioned.
- e) On-site training of auto mechanics and equipment maintenance technicians is well behind schedule - this is linked with delays in construction, in the provision of tools and equipment and with fragmentation of responsibilities for inter-related inputs to these types of activities.

Re: Material Support

- a) 7 new dispensaries were built and accepted by the Ministry of Public Works. The faults in design and construction identified by the mid-term evaluation team have been corrected according to the Ministry of Public Works. USAID Engineer needs to verify this by site inspections. If acceptable, USAID should make final payment; if not Engineer should make appropriate recommendations for follow-up

* See Addendum, Annex I.

- b) Construction on the two Department Headquarters (Zinder and Agadez) has not begun - pending AID/Washington approval of increased funds in waiver authorization for shelf item purchase. In-country procurement - AID/Washington action.
- c) 15 Ped-o-jets and some spare parts have been furnished. No vaccines have been requested from, or provided through, the RHIP project - adequate vaccines are available from other sources. USAID is withholding further dispersal of funds for the immunization program subject to GON design and adoption of an approved EPI (Expanded Program for Immunization) plan. (Refer to Section 2.3 of this report for previous discussion on this issue).
- d) Of the originally programmed 42 four-wheel drive vehicles, 10 have been delivered to the project; an additional 20 will be purchased and delivered by June 1, 1982. Of the 12 remaining, 2 will be needed for sanitation training at ENICAS, and 10 more will be furnished under this revised implementation plan in 1984 as replacement vehicles.
- e) Of the originally programmed 200 Mobylettes, 91 have been delivered; an additional 85 will be purchased and delivered before June 1982. An additional 100 replacement Mobylettes are programmed for 1984 under this revised implementation plan.

4.2 Overall Concept and Strategy, and Plan of Action.

This Revised Implementation Plan is based on the following fundamental premise:

The capacity of the GON to effectively and efficiently develop and extend health services to rural areas will depend on the Nigerien ability to provide adequate numbers of personnel who will systematically program and manage their own limited resources - human and otherwise.

Consistent with this overall concept, the revised implementation plan, focuses support in the following areas:

- a) Continued original efforts in health manpower development and training (i.e. Human Resources Development) with added emphasis on expanding and improving the quantity and quality of training for Sanitation technicians, auto mechanics and medical equipment maintenance specialists.
- b) A new initiative aimed at establishing and developing a modern health/management information system within the MOH/SA, to improve MOH/SA health planning and programming and management capability.
- c) Expedited infrastructure support for improved transport and equipment maintenance systems.

The sub-sections immediately following expand on the specific outputs expected and the types of support required in each of these broad areas.

The revised implementation plan is based on an assumption that the RHIP will be extended for 30 months i.e. until June of 1985. The June project termination date will correspond to the end of the Nigerien annual Teaching/Training cycle.

4.21 Health Planning Strategy Components

The Minister of Health and Social Affairs, Chef De Bataillon, Moumouni Djermakoye Adamou on April 21, 1982, at a meeting with the Revised Implementation Plan Team and the USAID Director, I. Rosenthal, and in the presence of Dr. Tankari the RHIP Project Director, formally endorsed and approved the concept of USAID including assistance within the RHIP in a Health Planning Component aimed at developing the Nigerien MOH/SA staff self sufficiency in this field. He agreed, in principle, to add United States University based technical assistance in health programming and planning with the objective of providing a planning cell with the staff function of assisting the Minister with health planning. Indicated he wished to explore further the details as they developed.

The current organization of health planning and programming within the GON/MOH is through staff meetings at the ministerial level without data systems to provide more than basic service information and infectious disease attended morbidity. No job title or function exists in the MOH for health statistician or epidemiologist although the ten year plan for training envisions training up to 6 statistical clerks and 2 classically trained infectious disease epidemiologists. The organization of the data collection and processing within the MOH is appropriate (see section on organization) as a staff function of the Secretary General who summarizes information for the Minister. MOH has no current special study mechanisms for collection or analysis except through expatriate assistance.

Development of planning capability within MOH is dependent upon short-term input of human and financial resources capable of:

- a) Design, Implementation and completion of a sample survey based assessment of illness and health care patterns in all of Niger as a foundation for identifying the population most in need of preventive health services;
- b) Providing study design and analysis capability for epidemiological and other special studies as required by planners/decision makers;
- c) Provide a micro-computer based capability for recording, processing and generating descriptive reports of current activity within DIS and DAS/PMI.

The mechanisms for establishing a planning capability within the MOH, as suggested, are as follows: (See Pert charts 1, 2, & 3).

Planning Resource Development:

- a) Observation trip for RHIP Director to U.S. to view capabilities in health planning sector (2 weeks)
- b) Long-term training of 2 MD/Epidemiologists in U.S. University with health planning as focus.

- c) Long-Term technical assistance starting within next 6 months to serve as high level health planner and to aid in development of analyses and organization of studies within the Ministry. Such an individual would be ultimately responsible for developing a planning cell.
- d) Observation trip/short term training for direction of PMI and DIS (2 weeks) to observe U.S. capability.
- e) Locally train 6 - 10 health statistics individuals for mid/level line functions using medium term consultants
- f) Provide micro-computer technology as a mechanism for focussing training of mid-level personnel and a catalyst for MOH involvement.
- g) Develop and implement a community based sample survey mechanism for providing population based health data and training MOH personnel in management of above
- h) Long-term (24 months) Health information systems technical assistance at data processing level.

Rationale and responsibility for suggested steps by broad categories is as follows:

Observation trips short and long term training should be in the United States and should be expected to aid in developing appreciation for and exposure to U.S. capability and technical assistance in public health planning and management.

Long-term technical assistance at senior level is to expose MOH high level personnel to a seasoned U.S. trained professional capable of doing rational health planning by example and directing planning and special study in suggested areas. In combination with junior level data management T.A. the junior level data clerks/statisticians will be on-the-job trained. A University liaison is important in classical french system. Importance of working with local professionals in development of study designs, information systems must be a direct emphasis of T.A. The complete documentation of all activities undertaken within RHIP in planning is a further needed pre-requisite which will assist in institutionalizing planning activity in MOH.

While micro-computer installation will significantly improve processing of internal MOH service records its major contribution will be to increase visibility and interest in data management and processing as an entree to planning. To be effective in such a role micro-computers must be installed with speed so that they can be functional for early stages of pre-testing survey instrument. Since the coordination of University based technical personnel with micro-computer installation and documentation is desirable

it is suggested that this be considered part of the university provided services. Short-term technical expertise for installation of equipment should be provided.

4.22 Management information/planning System (see table 3)

The Evaluation Team proposed a 40 village study that can be expanded to include a random, representative sample of the nation sufficient to address the major questions relevant to health planning in Niger which are:

1. Estimates of infant and child mortality (pregnancy, history, techniques).
2. Prevalence of malnutrition.
3. Coverage of current health service system.
4. Prevalence of specific field assessable morbidity (tracer conditions).
5. Family cost for health services.

A final possible outcome of a well designed study would be an assessment of the effectiveness of Village Health Teams as a strategy for improving health status in Niger. All of the above is useful, even vital, information to any health planning activity however, the design, field work and analysis of such a survey will also serve as a training and sensitization mechanism to the GON/MOH. Such a survey would use the programmed health statisticians/data clerks and the micro-computers to prepare data, involve medical students and public health students in data collection and finally higher level health professionals in the design and analysis. It will serve as a stimulus for public health planning and action throughout the MOH. The implementation should be through a university based sub-contract with African field experience proven, francophone capability and the ability to respond quickly to MOH/AID requests.

If carried out according to plan the final outcome of the proposed implementation plan in the sub-areas of health planning would at the end of 36 months from its inception have:

1. At least one M.D. Epidemiologist with MPH advanced training in health services epidemiology.
2. At least 8 mid-level health data specialists capable of operating line functions in MOH health data system.
3. A micro-computer processing capability for routine service statistics, data entry and editing, report generation and descriptive statistics in special studies.
4. A health survey at a national level appropriate to establish current levels of infant and child mortality, morbidity and health service utilization patterns including resources spent at family level on health care. This survey will be designed, implementation with first round results presented.
5. A documented planning and programming system within the MOH in the DIS with routine report generation to planning committee levels.

6. A protocol for and mechanism for special applied studies to be carried out within the MOH.
7. At least 2 middle level health information system specialists, trained primarily in-country, capable of managing the micro-computer based system.
8. At least 2 senior level MD/Epidemiologists trained in health information systems and health planning in the States.
9. An organization within the MOH specifically designated as having the programming and planning function staffed with fully trained Nigeriens and capable of providing timely and accurate research based documents for national health planning.

4.23 Human Resources Development Component

4.231 Overall Plan

The Revised Human Resources Development component is based on the following overall plan/strategy:

Continue training of all categories of health and maintenance support workers along same lines as in the Original RHIP implementation plan - with adjustments in quantity and quality as noted in the subsequent subsections.

(a) At ENICAS:

- Increase funding support for nurses and Sanitation Technicians in order to attain project training objective of 110 nurses and 35 Sanitation Technicians by 1985.
- Increase time provided for, and emphasis given to "hands-on", practical field training in will defined skills (i.e. competency based training).
- Provide transportation and funds for locally purchased materials to strengthen field training of the Sanitation Technicians.

(b) At the National School of Public Health (ENSP):

- Provide support for the training of state nurses.

(c) VHW training and retraining:

- Provide support for the training of an additional 2000 VHWs (para-medics and matrones equally divided) beginning 1982 - 83.
- Provide support to retrain 15,606 VHWs beginning 1982 - 83.

(d) National Conference/Workshops:

- Provide funds for 3 National Conference/Workshops; one each year 1983 - 84 - 85.

(e) Provide support for 70 quarterly departmental operational planning seminars.

- (f) Provide support for 30 students one year each, third-country training for 3 years, 1982 - 85.

- (g) Long-term training in the U.S. for 4 students. 3 years each beginning 1982 - 83 school year.
- (h) Decrease amount previously allocated for field studies for Medical Students at ESS. (to date funds have not been used). Provide limited (about \$25,000 distributed over three years) funding for medical student participation in special studies generated by the newly developed health information/management system to familiarize students with data collection/processing, methodology and statistical analysis for planning and managing health services.

4.232. Training of Sanitation Agents (Technicians) at ENICAS

The Evaluation Team's Report and reports from the Africare Sanitary Engineer at Zinder identified substantial problems with the sanitation training program at ENICAS. The responsible officials in the Direction of Training (DEESN) at the MOH/SA are fully aware of the problems, talk frankly about them and apparently would like help in solving them. The following steps will accomplish this:

Incorporate the technical assistance (Sanitary Engineer) into the school at ENICAS and free him from other duties so he can concentrate his efforts on expanding practical "hands-on" field training and practice for the sanitation trainees and eventually for sanitation field training observation/ practice for the certified nurses. In order to do this the following actions and support are needed:

- a) TA in environmental sanitation at ENICAS, Zinder is extended for 30 additional months i.e. till June 1985.
- b) Furnish as soon as possible two four-wheel drive vehicles (one Landrover transportation for small groups 5 - 6 people and a small truck for carrying supplies).
- c) Provide funds for training materials for field site training/demonstration work in rural villages.
- d) Shift emphasis of TA away from more complicated sanitary engineering towards simple practical technology suitable to rural Nigerien milieu.
- e) Reach agreement about standard approaches and appropriate technology for water protection and human solid waste disposal for rural areas.
- f) Based on agreements on appropriate technology (derived from e) adjust curriculum, course content and scheduling to increase time and emphasis on practical field work.

- g) Periodically field test methods and interventions as to their suitability and acceptance by the village people and modify methodology accordingly.

In order to accomplish the above the Sanitary Engineer (Africare) would have to be freed from his present load of class room teaching responsibilities particularly in respect to general education and, general sciences and other subject area teaching not related to objectives.

Africare in consultation with relevant MOH/SA officials in DEESN (training) Niamey, and at ENICAS Zinder should by December 1, 1982 recommend specific plans to accomplish the above.

4.24 Support for Improved Vehicle and Medical Equipment Maintenance (tables 4,5,6)

4.241 Automotive and Medical Equipment / Maintenance - Training

The training of auto mechanics and automotive maintenance are well behind expectations. The main problems associated with this lack of progress appear to be:

- a. lack of clear definition of responsibilities
- b. lack of defined mechanism for procurement
- c. delays in garage/repair shop construction
- d. confusion about whether funds provided for repairs authorized (or not) may be used for vehicles other than the Scouts procured from U.S. by USAID
- e. No inventory of status of vehicles nor spare parts
- f. no training plan or schedule of work
- g. no vehicle for mechanic trainees

The Biomedical Technician equipment maintenance and repair activities currently operating under Africare and the accompanying training of Nigerien BMETS are similarly behind schedule. Most of the associated problems are the same as those impeding automotive maintenance, Nigerien mechanic training.

The Revised Implementation Plan for these activities are as follows:

a) Re BMET Equipment Maintenance

There are in country at present two Africare BMET trainers in-country; one at Niamey and the second at Zinder. Will provide TA at these sites for the full thirty six months of the project.

Once the garage/medical equipment workshops are built at Agadez (projected end of 82 a third BMET will be assigned there (through Africare), subject to availability of funds and MOH/SA assignment of counterparts and trainees.

Each of the BMET will be assigned a Scout from those already in-country. This will provide transportation for following

activities in each respective department.

- Inventory of types and status of medical equipment
- Develop equipment repair list and identify spare parts needed; order spare parts needed and procure.
- identify needed equipment list by department, order and procure.
- prepare maintenance schedules and maintenance check lists for major items.

Subsequently maintenance schedule will operate throughout the life of project,

The activities associated with training of BMETS are the following:

- i) identify and procure appropriate manuals, catalogues, and other reference training material
- ii) Design training program
- iii) MOH/SA assign at least 2 trainees each year to each of the repair shops at Niamey and Zinder (i.e. 6 in-training each year x 3 years = 18 trained at end of project, June 1985.
- iv) Use maintenance schedule for on-going repairs and on-job-training for life of project.

The timing of these activities are graphically shown on Chart 4 Supplemental notes are attached to Chart 6 which includes schedule of reports and brief explanatory comments.

- b) Re Automotive Maintenance and Repair/Mechanics Training:
- The three Africare furnished mechanic trainers, one at Tahoua another at Diffa and another at Zinder, will provide continuous TA through the life of the project. A fourth Africare furnished mechanic trainer may possibly be assigned to a fourth site (Agadez) in June of 1983, subject to availability of funds and MOH/SA assignment of counterparts and trainees.
 - Each mechanic/trainer will be assigned a Scout (from those already in country) or other equivalent 4-wheel drive vehicle.

The following specific activities related to motor vehicle maintenance and repair will be carried out in each respective department:

- Prepare annual list of tools and equipment needs, requisition and procure.
 - Inventory of Department vehicle and designate those in use, those dead-lined but repairable, those that must be salvaged for parts.
 - Establish parts inventory, identify spare parts needed, requisition and procure.
 - Prepare and maintain maintenance schedule department vehicles
- c) Re Mechanics Training
- Identify and procure; need vehicle operational manuals,

reference materials and other training materials

- Design training program
- MOH/SA assign at least 2 trainees each year to each automotive repair shop at Tahoua and Zinder (i.e. 4 in-training each year x 3 years = 12 mechanics trained at end of project, June 1985).
- Use maintenance schedule for on-going repairs and on-job-training through life of project.

Scheduling of these activities with supplemental notes and identification and timing of reports are graphically shown on Chart 5.

Again, supplemental notes provide explanation concerning reports and other relevant comments pertaining to these activities.

4.25 Construction

4.251 Dispensaries.

The original Project Agreement Committed USAID/Niamey to provide funds for the construction of new dispensaries. At the time of the joint evaluation in mid 1981, the construction of these dispensaries had just been undertaken by the ministry of Public Works. However, many construction defects, including the water and sewage disposal facilities, were considered inadequate by the Evaluation Team last year. According to Public Works, these defects have been remedied but this has not been confirmed by USAID/Niamey. The following steps are needed to complete the action:

- a. USAID Engineer should complete field site inspections by July 1, 1982.
- b. If USAID/Engineer determines that dispensary construction work has been satisfactorily completed, he should accept them and give final approval where upon final payment can be made
- c. If not then USAID/Engineer should recommend course of Action needed. He and the Health Development Officer should coordinate in executing this follow-up action.

4.252 Department Headquarters

- The original Project Agreement provided funds for the construction of two department level headquarters complexes, one each ZINDER and AGADFZ. These include an administrative section, a motor vehicle maintenance/repair shop and a medical equipment maintenance/repair shop.
- Sites are selected and construction plans have been drawn up and approved, however, construction has not started because AID/W has not yet approved a waiver to increase funds available for purchase of local materials.

The steps needed to complete this action are :

1. AID/W approves increased funds for local procurement waiver hopefully by June 1, 1982.
2. USAID DIRECTOR reviews and approves construction contracts June 15, 1982.
3. Contractor provides USAID Engineer through HDO construction schedule and specifications; USAID Engineer approves specs.
4. Contractor begins construction estimated AUG-SEPT 1982.

5. USAID Engineer and GON PUBLIC WORKS establish construction inspection schedule.
6. Construction completed estimated Jan - Feb, 1983.
7. USAID Engineer inspects construction and approves; if not recommends subsequent course of action - estimated March 1983.
8. USAID makes final payment April - May 1983.

4.253. RHIP Supply / equipment warehouse at Niamey.

The MOH/SA has no warehouse to store and distribute equipment spare parts and other such materials purchased under this project. Although this was not identified as a problem by the Evaluation Team last year, it would appear to be within the scope of the revised Project Implementation plan. Support for this item has been included in this revised plan.

The steps needed to complete this action are :

1. Design for extension to completed by GON Publics Works estimated - Oct. 1982.
2. Design and Specifications reviewed and approval by USAID Engineer - estimated Dec. 1982.
3. Contractor selected - estimated February 1983.
4. Construction begins March / April 1983.
5. Construction completed - estimated July 1983.
6. USAID Engineer inspects and approves; if not recommends subsequent course of action - estimated Sept 1983.
7. USAID makes final payment - estimated October 1983.

The implementation schedule for construction of the above facilities are shown graphically on Chart 8.

4.3 Evaluation Plan

4.3.1. MONTHLY REUNIONS:

On a monthly basis meetings will be held at the Ministry of Public Health and Social Affairs in the Offices of the Rural Health Improvement Project under the direction of the Director of the Rural Health Improvement Project or his delegate in case of absence of the Director. Participating in this meeting will be representatives of the RHIP Directorate which includes the Director of the Project, the Director of Administration and Finance and The Technical Director, each of the MSP/AS Division Directors or their representatives, and the USAID Health Development Officer.

The Purpose of this meeting will be to evaluate and assess the progress or lack thereof of the project in light of the revised Implementation Plan. A written report of the meeting will be prepared by the Director of Administration and Finance after each meeting.

4.3.2. QUARTERLY REUNIONS:

A functional review of the Project will take place quarterly in order to determine the major problems or obstacles to achieving the targets as outlined in the eight Tables or PERT Charts.

Participating in this meeting will be the three Directors in the RHIP, each MSP/AS Division Director, the USAID Health Development Office and the AFRICARE Representative.

Each Division Director and the AFRICARE Representative will prepare a quarterly report to the Project Director which will be presented to the participants of this meeting. They will note the progress or lack thereof within each Division and AFRICARE in carrying out the activities planned by the Project. They will identify problems and make recommendations for solving identified and perceived problems.

A written report of the meeting will be prepared by the Director of Administration and Finance after each meeting and provided to the Minister of Health, the Director of USAID and the Minister of Plan.

4.33 Final Evaluation of the Project

- a. Final joint evaluation of this Project will be conducted during the second half of 1984. The team evaluation should consist of a representative from USAID/Niamey, one or more representatives from the MOH/SA and 3 independent outside consultants.* The purpose of this final evaluation should be to assess the overall progress of the Project in attaining its planned targets and objectives, as set forth in this Revised Implementation Plan. To the extent that it is feasible, the health and socio economic benefits and impact of the project should also be evaluated, the established Health management information system should provide relevant information, particularly if proper studies are designed with this end in mind.

* The independent consultants will be chosen in collaboration with MOH/SA.

23A

PROJECT BUDGET 1978-1982
BY LINE ITEM

RHIP BUDGET 1978 - 1982
 (\$000)
 EXPENDITURES & ACCRUALS FROM 6/78 TO 6/30/82

ESTIMATED EXPENDITURES AND ACCRUALS
 TO 12/31/82

	OBLIG/ DISB	ACCRUALS	TOTAL	LOCAL	USA	TOTAL
1-01 Personnel-Long Term	453.1	909.9	1363.1		132.0	132.0
1-02 Personnel-Short Term	20.1		20.1			
1-03 Personnel-Local Office	8.4	1.4	9.8			
2-01 Training USA	81.0		81.0			
2-02 Training-3rd Countries		250.0	250.0	34.6		34.6
2-03 Training-Medical Schools	63.6		63.6	79.8		79.8
2-04 Training-ENICAS	124.7	169.2	293.9	36.0		36.0
2-05 Training-ENSP	55.3	40.0	95.3			
2-06 Training-E.S.V.	444.3	281.6	725.9	224.1		224.1
2-07 Workshop-Seminars	77.9		77.9	92.3		92.3
2-08 Immunization						
3-01 Construction-D.D.S.	17.3		17.3	615.4		615.4
3-02 Construction-Dispensaries	674.5	216.5	891.0			
3-03 Construction-Warehouse				126.2		126.2
4-01 Commodities-Vehicles	272.4	287.6	560.0			
4-02 Commodities-Mobylettes	39.9	40.4	80.3			
4-03 Commodities-Garage Tools	53.3		53.3	46.1	170.0	216.1
4-04 Commodities-Equip. Medic.	46.0		46.0			
4-05 Commodities-Dispensaries	254.5		254.5	315.1	70.0	385.1
4-06 Commodities-Others	15.8		15.8	42.6	10.0	52.6
5-01 Other Costs-Sanit. Env.	58.6		58.6	197.4		197.4
5-02 Other Costs-Local Off.Op.	26.2		26.2	55.5		55.5
5-03 Other Costs-Vehicles Op.	100.0		100.0	7.3		7.3
5-04 Devel. Educ. Nutrition						
5-05 Program Sanit. Education						
5-06 Special Study & Eval		2.8	2.8	24.0		24.0
	2886.9	2199.4	5086.3	1896.4	382.0	2278.4

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YEAR BY YEAR BUDGET
FOR REVISED PLAN
BY FUNCTION

5.

BUDGET

The budget for the revised implementation plan is shown by function in Table B1. The specifics behind each of the line items are explained in the notes following the table.

The are five functional categories of expenditure: the short-term contract for computer installation; the University contract to provide technical assistance in management information and health planning; training carried out under the MOH; and other miscellaneous activities.

All cost estimates should be subject to periodic revision in light of experience during the course of the extended project life.

The training costs were calculated from current costs provided by MOH personnel, inflated by 10 percent annually. Current VHW supervision costs were calculated by adding the component supervisory costs provided by the MOH and dividing by the number of VHWs in place at present. The resulting figure differs substantially from the flat cost of supervision provided by the MOH. Subsequent discussions may result in some adjustment in this item.

TABLE B1

YEAR BY YEAR BUDGET FOR REVISED PLAN BY FUNCTION

CHART 2*	1982	1983	1984	1985	AID Total	GON TOTAL
<u>Micro-Computer Installation</u>						
1. Computer Specialist	36	0	0	0	36	
2. Statistician-Programmer	36	0	0	0	36	
3. Computers and Equipment	35	0	0	0	35	
4. Overhead	25	0	0	0	25	
Sub-total Computers	132	0	0	0	132	
<u>CHART 3</u>						
<u>University Contract - Long Term (MIS)</u>						
1. Chief of party	0	130	70	53	253	
2. Computer Expert (Epidemiology)	0	85	45	33	163	
3. Computer Expert (Nutrition)	0	85	45	33	163	
4. Trainer of Trainers	0	60	60	43	163	
5. Administrative Assistant	0	10	5	5	20	
6. Secretary/Typist	0	6	3	3	12	
7. Short-Term Consultants	0	62	36	27	125	
8. Baseline Data Study	0	125	75	0	200	
9. Overhead	0	80	65	30	175	
Sub-total University	0	583	404	227	1,274	4.5

* Chart 1 visualizes project Director's trip to U.S. in addition to other short term trips for selected Ministry personnel.

CHART 4.5.6.	1982	1983	1984	1985	AID Total	GON Total
<u>Africare Technical Assistance</u>						
1. Auto-Mechanics	0	210	110	82	402	
2. Biomedical Equipment Repair	0	210	110	82	402	
3. Specialists						
3. Sanitary Engineer	0	80	45	34	159	
4. Administrative Assistant	0	80	45	34	159	
5. Secretary/Typist	0	4	4	2	10	
6. Overhead	0	150	98	70	318	
Sub-Total Africare	0	734	412	304	1450	6.0

CHART 7

Training - Human Resource Development	82/83	83/84	84/85	AID Total	GON Total
1. Certified Nurse Training	165	220	290	675	213.8
2. State Nurse Training	108	144	150	402	199.5
3. U.S. Long-Term	-	72	80	152	57.0
4. Sanitation Technicians	24.7	33	36	93.7	-
5. Third-country Training	103.8	225	266	594.8	57.0
6. National Seminars	100	100	25	225	394.5
7. Special Studies	8	8	-	16	20
8. VHW Training	160	160	130	450	-
9. VHW Retraining	125	125	75	325	743.6
10. VHW Supervision	90	90	50	230	-
11. Department Quarterly Seminars	20	20	10	50	100
12. Environmental Sanitation	32.5	-	-	32.5	240
Sub-Total Training	937	1,197	1,122	3,246	2025.4

CHART 8

Miscellaneous	1983	1984	1985	AID Total	GON Total
1. Local Office Support	20	20	10	50	64
2. Replacement Vehicles	20	100	-	120	324
3. Garage Materiel	25	50	25	100	95.4
4. Bio-Medical Equipment	10	20	-	30	18.5
5. Immunization Activities	60	60	30	150	523
6. Education Aides to Schools	10	10	10	30	-
7. Vehicle Operating Costs	60	75	25	160	42
8. Personnel, Local Office	10	10	5	25	81
9. Contract Carbonel	34	-	-	-	-
10. Other	12	12	5	29	49
Sub-Total Training	261	357	110	694	1,196.9
TOTALS	2,515	2,385	1,764	6,664	3,232

6.0 ADMINISTRATIVE ARRANGEMENTS

BACKGROUND

In the 1981 evaluation of the Rural Health Improvement Project (683 0208) the evaluators noted that many problems which were encountered by the project arose out of an organizational failure to recognize the multi-divisional nature of the RHIP and failure to position it properly within the administrative structure of the Ministry of Public Health and Social Affairs (MSP/AS).

The GON rejected a recommendation to place the RHIP at an organizationally higher level in the MSP/AS in order to establish one central project office and to enhance coordination and project implementation among ministry bureaus. The MSP/AS preferred to maintain the project within the Bureau of Health Facilities. The Project Director is authorized by the Ministry of Health to oversee project implementation. That authorization is respected by the other Bureau Directors and enables the Project Director to effectively monitor project implementation throughout all relevant MSP/AS Bureaus.

The MSP/AS has revised and strengthened its top level administrative and managerial capacity to assure successful implementation of the project during the proposed extension period. In addition to a new Project Director, the Assistant Project Director has been replaced by the former Director of Training, who has already had a leadership role in the MSP/AS and demonstrated managerial skills. Having ministerial responsibilities in addition to RHIP responsibilities, the Project Director, in his companion role as Director of Health Facilities, has also been provided with a full-time assistant for non-RHIP activities. Furthermore, the MSP/AS financial management capability has been strengthened by providing the technical assistance of a full-time American accountant.

In summary, the GON has named a new Project Director and Assistant Director to administer the proposed RHIP extension.

To strengthen project management and implementation, the revised implementation plan offers two distinct technical assistance packages, each having within them clear lines of responsibility for Project implementation. In the first package, AFRICARE will continue as before, to recruit technical personnel and to provide administrative support and periodic monitoring to assure provision of effective technical assistance in automobile mechanics, biomedical technology and sanitary engineering. In the second package a University contractor will be added to include a health project planning expert and two computer specialists - the first with a background in statistics and epidemiology, and the second with a background in nutrition epidemiology.

The revised implementation plan also takes into account former difficulties encountered in the first implementation plan, namely a lack of clearly defined responsibilities and channels of communication. Within the scope of the revised implementation plan, there will be quarterly reviews with the USAID, MSP/AS, University and AFRICARE principals involved. In order to keep fully informed, the Project Directors, the USAID health officer and the persons responsible for project implementation will meet on a monthly basis to assess the project's progress against the time table established in the revised implementation plan. There will be, therefore, more frequent and periodic project monitoring.

Project commodity procurement will be timely to allow implementation of project activities. Technical assistance personnel, in collaboration with their respective Nigerian counterparts, will be required to establish a list of the necessary commodities for the project. These lists will be cleared at the departmental level by the Department Health Officer (DDS) and sent to the MSP/AS Secretary General and to the Project Director for clearance before transmission to USAID. Copies of the commodity lists prepared by the technicians will be sent directly to the Project Director. To assist the Ministry, USAID will procure off-shore commodities. MSP/AS will procure local commodities. AFRICARE has established a specific budget approved by USAID and GON which will allow them to purchase local and off-shore commodities to meet the professional support requirements of AFRICARE technical personnel.

PROJECT PARTICIPANTSMSP/AS1. Project Director:

The Project Director is responsible for monitoring project implementation. The Project Director is also responsible for coordination with GON ministries concerned with project activities. Within the MSP/AS, the Project Director will be responsible for coordinating and implementing project activities at all levels - at the central level in MSP/AS offices and at the levels of department, arrondissements, cantons and villages. The Project Director will be responsible for insuring that Departmental Health Directors (DDS) follow the project objectives agreed on at the central level.

2. Administrative and Financial Director:

The Administrative and Financial Director is responsible for management of Nigerien and foreign project personnel. He will undertake visits to project sites to check on working conditions of all project technicians and will be in direct contact with the Chief of Party at the university and the AFRICARE representative to Niger.

3. Department Director for Health (DDS)

Each DDS will be responsible to the project Director for overseeing effective and timely implementation of project activities in their departments. They will administer and support biomedical technicians, vehicle mechanics and sanitary engineering technicians providing assistance in their departments. The DDS is also responsible for the coordination with the Ministry of Public Works of construction of garages and the

U.S. UNIVERSITY CONTRACTUniversity Chief of Party:

An American university will provide a party of experts. The Chief of Party will act in a technical capacity and will follow the technical implementation of the project. In this respect he will be in direct contact with division directors. He will also make field visits to check on the status of the different project activities and will make a report to the Project Director. The University Chief of Party will also administer and monitor the technical assistance provided by the university in collaboration with the DAF.

AFRICARECountry Representative:

The AFRICARE country representative will be responsible for the timely recruitment of qualified vehicle mechanics, sanitary engineers and bio-medical equipment repair specialists. AFRICARE will provide these technicians administrative support with respect to their in-country settling-in, housing, daily maintenance needs and departure arrangements. Administrative support visits and periodic monitoring will be provided by AFRICARE at a minimum of every 2 to 3 months at the technician's work and living sites. A monthly report to the Project Director with copies to USAID will indicate technician progress and problems. The AFRICARE representative will collaborate closely with the Director of Administration and Finance of the Project. The AFRICARE Representative will attend the tri-monthly reviews along with the Project Director, Chief of Party, and USAID Health Development Officer.

USAID

1. The USAID/Niger Mission Director has ultimate responsibilities for overseeing the implementation of project activities to ensure attainment of project goals.
2. The General Development Officer (GDO) is responsible for periodic monitoring of project implementation. Through quarterly reviews with the Project Director, Project Chief of Party and AFRICARE, the GDO will ensure timely project implementation. The GDO will monitor project activities through site consultations, the reporting of the USAID Health Officer and review of quarterly Project reports, and will intervene as required or requested by any participating agency.
3. The USAID Health Officer will be responsible for the day-to-day project management. The Health Officer will maintain frequent contact with and relate directly to the Project Director, Chief of Party and the AFRICARE country Representative. Monthly project reviews will be conducted with the participating agencies and the MSP/AS to insure appropriate and timely Project achievement of planned activities.

RECURRENT COST ANALYSIS

7 RECURRENT COSTS OF RHIP REVISED PLAN

The recurrent costs arising from the RHIP were handled extensively in the original Project Paper. The revised plan for implementation has changed some of the emphasis of the original project and has attempted to streamline procedures to improve its operation. At the same time, the government revenue outlook for Niger has changed from very bright to dim. The following paragraphs extract the salient points from the PP review of recurrent costs, update them based on the revised plan, and conclude that the recurrent cost burden will not be too great for the MOH.

The recurrent cost section of the original PP made the following observations:

1. RHIP increases in nursing staff would not increase personnel costs "by large sum of money".
2. The VHT teams trained would not "add a financial burden...except for training and retraining costs."
3. Total additional personnel costs engendered by RHIP would mean a 30 percent increase in the personnel budget.
4. The expenditures on transport for supervision of the rural-based system would "greatly increase both the size and proportion of the total MOH budget going for transport."
5. Other donor support in the health sector was seen as likely to continue.
6. It would be expected that "the MOH can manage the additional recurrent costs generated by this project." This statement was made with the caveats: "...given a continuation of the present boom in uranium revenues, "and the external assistance will continue to be required at the end of the project to expand and improve health services.

These points will be addressed below with respect to how they have been affected by the Revised Plan.

1. The revised implementation plan calls for additional nurse training at both the certified and state level, beyond that called for in the PP. During project extension an additional 160 nurses will be trained. By the end of the project in FY85 a total of 440 nurses will have been trained with project funds resulting in an annual increase in salary costs to the GON by 250,000,000 CFA. In addition, by the end of the project 45 environmental health workers, 5 vehicle mechanics and 4 bio-medical equipment repair technicians will be trained.

The GON salary costs for these 54 trained specialists will be approximately 25,154,000 by FY85. Together, all personnel trained by the project will increase GON-MOH salary expenditures by 275,380,000 CFA by 1985. It is estimated that this will represent less than a 10% increase in MOH personnel costs over the MOH 1981 personnel costs.

2. The revised implementation plan calls for the training of 3,280 additional VHWs or 820 VHTs. The recurrent are supervision and retraining costs, but no salary costs because VHTs are supported by user contributions. By the end of the project in FY 1985 there will be 16,000 VHWs in place, 50 percent of whom must be retrained each year. In 1985 dollars the recurrent retraining cost of VHWs will be 160,000,000 CFA, the supervision cost will be 56,000,000 CFA. The additional VHWs trained under the revised plan will account for 20,000,000 CFA of the retraining costs and 8,000,000 CFA of the supervision costs.
3. The health planning component of the Revised Plan calls for the training of 6-10 health statistics people for mid-level line functions. As these people are already MOH employees there will not be a subsequent increase in MOH personnel costs as a result of the training activity.
4. The costs of project vehicle operation (fuel and maintenance) will have to be assumed by the MOH at the end of the project. These costs, which do not include vehicle depreciation, are estimated to be 23,100,000 CFA by 1985, less than 7% of 1985 MOH total vehicle operation costs.

Of the originally planned 42 four-wheel drive vehicles, 32 will be delivered before the revised plan goes into effect. The plan calls for two of the remaining vehicles to be used for training at ENICAS: the remaining eight are to be used as replacement vehicles in 1984. Thus, the revised plan reduces the recurrent cost burden in transport that would have taken place under the original plan by using eight of the vehicles as replacements, rather than expanding the MOH fleet by the entire 41 vehicles.

5. The vehicle and equipment maintenance components will have a recurrent cost-reducing effect not mentioned in the PP: longer and more efficient use of equipment and vehicles. Extended useful lifetimes for equipment lower costs, as improved efficiency reduces fuel and other operating costs.
6. The extended project will assist the MOH to develop a capability to provide in-service education to dispensary nurses in VHW supervision techniques and concepts. Annual MOH costs for in-service education for about 170 dispensary nurses are expected to be 2,263,000 CFA.

7. During the extended life of the project two Department level Public Health office/garage complexes will be constructed. Annual maintenance costs were estimated as one percent of construction costs. By 1985, including a 10% annual rate of inflation, the building maintenance costs are estimated to be 6,600,000 CFA annually.
8. Other donor support in the health sector still seems likely to continue.

In summary, the RHIP project is expected to increase GON - MOH recurrent costs by approximately 523,063,000 CFA annually at the time of project termination in 1985. This amount represents 15 percent of the 1981 GON recurrent budget for health. The three year extension of the project will contribute to 32.6 percent of the estimated increase in recurrent costs as a result of project activities.

Nearly 52 percent of project generated recurrent costs will be attributed to an increase in MOH personnel costs. Aware that a decentralization of health services to rural areas to the village level requires rural based skilled health personnel to support village health workers, the MOH has concentrated on the training of medical personnel. Between 1977 and 1981 expenditures for personnel doubled and were absorbed by the MOH recurrent costs budget. The MOH, therefore, has already assumed the salary costs of medical personnel whose training was financed by the RHIP prior to 1981. The GON continues to support the training of these personnel and one can fully expect, on the basis of the last five year's experience, that the GON will continue to assume the salary costs of newly trained medical personnel. By 1985 an additional 109,000,000 CFA will be added to the 166,000,000 CFA recurrent personnel cost generated by the project since 1978. This added amount is estimated to represent less than 5 percent of 1985 expenditures for personnel.

Of significance is the projected 177,950,000 CFA recurrent cost for supervision (mobile expenses, retraining of VHWs and the in-service training of dispensary nurses. These costs represent nearly 43 percent of project generated recurrent costs, but is estimated to represent less than 5 percent of the MOH recurrent cost budget by 1985. It is expected that the MOH can assume these costs by 1985 because these expenditures will represent a small percentage (less than five percent) of the projected 1985 budget.

The GON has consistently budgeted 7 percent of national expenditures to the health sector since 1977 which is a level higher than in most other African countries. Despite reduced contributions to the (FNI) from uranium revenues, the GON has not reduced FNI allocations to the health sector. For addition, the nearly 18 year commitment of the GON to rural health is reflected in the high proportion of the MOH budget allocated to rural health care. The GON has demonstrated a strong commitment to the delivery of rural health services.

The personnel salary costs, supervision, VHW retraining, and dispensary nurse in-service training costs comprise 95% of the project generated recurrent costs. These expenditures together represent less than 15 percent of the 1981 MOH recurrent budget. Because of the historical and continued GON commitment to rural health and recent evidence of absorbing newly trained medical personnel funded by the project, the MOH would be expected to be able to manage the additional recurrent costs generated by the revised plan.

Finally, the establishment of the management information system and health planning unit under the revised plan will contribute to the MOH efforts to economize and reduce recurrent costs.

RHIP - ANNUAL RECURRENT COST PROJECTIONS
(000 CFA)

	Planned Target FY 78-82	LOP FY78-FY82 (Actual)		Project Extention FY83-FY85		Revised LOP FY78-FY85	
	#	#	Cost	#	Cost	#	Cost
<u>Salaries:</u>							
A. Trained Diploma Nurses 700,000 CFA/Yr. plus 10% Inflation/yr.	50	80	56,000	60	55,900	140	130,436
B. Trained Practical Nurses 300,000 CFA/yr. plus 10% Inflation/yr.	200	200	60,000	100	39,930	300	119,790
C. Environmental Health Workers 300,000 CFA/yr. plus 10% Inflation/ yr.	75	30	9,000	15	5,990	45	17,969
D. Auto mechanics 600,000 CFA/yr. plus 10% Inflation/yr.				5	3,990	5	3,990
E. Bio-Med. Equipment Tech.				4	3,195	4	3,195
SUBTOTAL							275,380

RHIP - ANNUAL RECURRENT COST PROJECTIONS
(000 CFA)

	Planned Target FY 78-82	LOP FY78-FY82 (Actual)		Project Extention FY83-FY85		Revised LOP FY78-FY85	
	#	#	Cost	#	Cost	#	Cost
<u>Supervision:</u>							
Village Health Workers 3500 CFA/VHW	19,500	14,000	49,250	2,000	7,000	16,000	56,000
<u>Retraining/In-Service Education:</u>							
A. VHW Retraining 15,000 CFA/VHW plus 10% Inflation/yr.	9,750	7,000	105,000	1,000	19,965	8,000	159,720
B. Dispensary Nurse In-Service Education 10,000 CFA/Nurse/yr. plus 10% Inflation/yr.				170	2,263	170	2,263
<u>Vehicle Operations:</u>							
Average Cost/yr.			11,770		23,100		23,100
<u>Building Maintenance:</u>							
Two Departmental Health Offices and Garages (1% /yr. of construction costs)					6,600		6,600
TOTAL (CFA)							523,063,000

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SUMMARY
OF
CHARTS

SUMMARY OF CHARTS

The eight charts in this Plan may be briefly summarized as follows:

Chart 1 : Planning Resource Development

Visualizes:

1. Proposed visit of Project Director to U.S. to assess proposed computer technology for use in MOH thru the Project.
2. Long term training in epidemiology for two Nigeriens.
3. Up to three Nigeriens to make additional observation visits to U.S.

Chart 2 : Short Term Contract

Visualizes:

1. Timing of actions to be taken to write an IQC contract to identify purchase and install micro-computer in the MOH.
2. The provision of consultants to provide the adjunct technical assistance and on-the-job training of Nigeriens over six months.

Chart 3 : Management Information Planning System (MIS)

Visualizes:

1. Timing of actions requisite to enter into a long term contract with a University School of Public Health to implement the health and planning components of the revised plan.
2. Provision of required long term technical assistance and related training for Nigeriens nominated to assume planning and epidemiological functions at end of project.
3. The identification and selection of a survey design consultant to develop a protocol for a proposed sampling survey to be undertaken after January, 1983.
4. Follow-up and carrying out of proposed sampling survey noted in 3.

Chart 4 : Africare Technical Assistance

Visualizes:

- 1. Inputs to project by Africare, namely biomedical technicians mechanic and a sanitary engineer.

Chart 5 : Transportation Vehicule Maintenance

Visualizes:

- 1 A follow through of the mechanic component of the AFRICARE T.A. Contract setting out specific objectives for equipment purchase, inventories established systematic maintenance program developed and Nigeriens to be trained.

Chart 6 : BMET Equipment Maintenance / Repair

Visualizes:

- 1 A follow through of bio-medical technical assistance component of the AFRICARE contract, It details specific objectives from preparing tool and equipment inventories, to establishing a repair and maintenance program, preparing training manuals, designing and carrying out a training program.

Chart 7 : Human Resources Development

Visualizes:

- 1 All remaining training which the Project proposes to support namely State nurses, certified nurses, laboratory technicians, Sanitation technicians and Village Health Workers.
- 2 Additionally third country and U.S. training is depicted.
- 3 Seminars, workshops and special studies allied with the above training are also shown.

Chart 8 : Construction

Visualizes:

Plan for construction of DDS and proposed RHIP warehouse.

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ADDENDUM

ANNEX I

Note: In discussions with the Minister of Health and the Director of the Project subsequent to their review of this revised plan, the following items were further agreed to and are hereby included as part of this Revised Plan:

1. -- The MOH will furnish USAID sufficient information to insure that nursing and sanitation workers whose training was financed by the Project are assigned to rural health service facilities to include only rural health centers and dispensaries.
2. -- The MOH assured USAID that sanitation technician graduates will now begin to be assigned to rural health centers to do rural sanitation as of the next graduating class.
3. -- The MOH agreed to provide a minimum of 2 to 3 trainees per year to each project auto mechanic and bio-medical equipment repair specialist to insure a transfer of skills and technology.
4. -- USAID agreed to send each vehicle repair trainee to Lome, Togo for one year of training after the project vehicle repair mechanics have determined their suitability training.
5. -- The MOH will reduce the number of village health teams trained to 820 over the extended life of the project. (3280 VHWs)
6. -- The MOH agreed that resources that would have been used for VHT training will now be used for retraining VHWs and in-service training of dispensary nurses in supervision of VHWs.
7. -- The MSP/AS agreed in principle to the USAID offer to add an additional project technician to the project to provide technical assistance to develop in-service training for dispensary nurses and a health education for rural health workers.
8. -- USAID agreed to accept as Project Director the Director of Health Facilities in the MOH.