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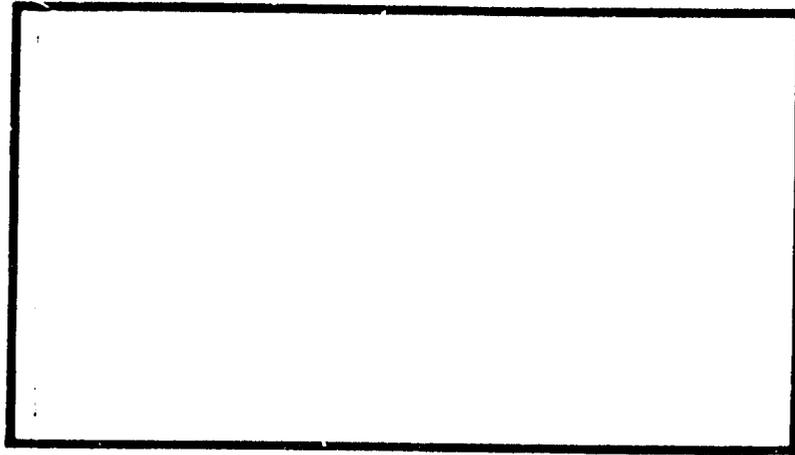
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AMERICAN PUBLIC HEALTH ASSOCIATION

International Health Programs

1015 Eighteenth Street, N.W.

Washington, D.C. 20036

The Sahel Epidemiological and
Environmental Assessments Project

Section I Part C
VOLUME THREE

Health Consultancy in
Republic of Niger

HEALTH CONSULTANCY

IN

REPUBLIC OF NIGER

Studies and Report by:

Eugene R. Boostrom, M.D., Ph.D.
Team Leader

Gladstone Fairweather, M.S.

James Neal, M.B.A.

During the Period:

October 1-6, 1976
Abidjan, Ivory Coast
October 6 - November 27, 1976
Niger

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December 1976

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SECTION I

TRANSMITTAL LETTER FROM AID

DEPARTMENT OF STATE
AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20521

September 8, 1976

Mr. William H. McBeath
Executive Director
American Public Health Association
1015 Eighteenth Street, N.W.
Washington, D.C. 20036

Dear Mr. McBeath:

Pursuant to recent discussions with APHA staff confirming your willingness to participate in any AID-initiated short-term health sector or environmental health assessments during the next year in the Niger River or Lake Chad Basin areas that obviously relate to the longer-term objective of developing an overall Sahelian health plan, we are requesting your services as described below.

The first such short-term task is to assist the RDO Niamey, Mr. Baron, in making such health sector assessments and analyses necessary for preparing a revision of the current Development Assistance Plan (DAP) and a Project Review Paper for a proposed AID sector support grant to the Nigerian Ministry of Health. Dr. Paulson, the AID Regional Health Officer in Abidjan, Ivory Coast, already is in Niamey for 3-4 weeks collecting appropriate background material for this task and a Regional Project Design Officer should be available in October to coordinate the writing of the required papers. We now require the services of the following health technical representatives to assist in assembling these documents:

- Wagner*
- (1) Health Services Administrator/Manpower Planning Specialist *Gaynor*
 - (2) Health Financial Management/Logistics Expert *Farrar*
 - (3) ~~Public Health Physician/Epidemiologist preferably with tropical disease experience.~~

These personnel should be available to start work in Niamey on or about mid-September, and remain for a period from four to six weeks until the appropriate analyses and papers are completed. A knowledge of French, of course, by at least one member of the team will expedite the task.

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Attachment A describes the specific task in more detail but, in general, the study shall emphasize the same areas as are defined in the scope of work for health sector assessments in Appendix "A" of your contract.

May we please have your formal concurrence or non-concurrence in accepting the above task within 5 days as we must make other arrangements as soon as possible if your staff are not available at this time to assist in Niger.

Sincerely yours,


Edward B. Cross, M.D.

Attachment: a/s

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ATTACHMENT A

Niger Health Sector Study

Objective: To carry out a health sector analysis in Niger leading to a ^{assistance in} revision of AID's Development Assistance Plan and the development of a specific project proposal, in the form of a Project Review Paper for increasing the Nigerian capacity to conduct public health programs.

Description:

(a) The Development Assistance Plan (DAP): The DAP is the foundation for AID development efforts in a specific country. It describes existing host country conditions and capabilities and defines areas of common interest existing between AID and the host government.

Using the best available data and analysis, the DAP describes AID program goals and defines AID strategy for helping the host government to meet common development goals.

(b) The Project Review Paper (PRP): The basic purpose of a PRP is to enable AID to make professionally sound judgement concerning the feasibility of a project. The PRP includes discussion and analysis of the project along the following lines:

Priority and relevance, description, beneficiaries, feasibility issues, other donor coordination, financial plan, implementation plan and project development schedule.

A specific format for the DAP and PRP will be provided to the contractor by AID.

(c) Sector Analysis: The analysis required is twofold. First the contractor must evaluate the health problems existing in Niger; the present health infrastructure; the plans and goals of Nigerian and Foreign organizations concerned with health affairs and their ability to implement these plans. Based upon this evaluation the contractor is required to develop alternative program strategies designed to increase the capability of the Nigerian health services to meet national goals. The evaluation and alternative strategies developed by the contractor will serve as the basis for the revision of AID's development assistance plan. The contractor will participate in the discussions leading to the adoption by AID of a revised health sector strategy and assist in the actual revision of the DAP.

The second phase of the contractors responsibilities will be the development of alternative project proposals that will implement the program strategy adopted during the revision of the DAP. With the concurrence and guidance of AID's Regional Development Office Niamey the contractor will refine one of the alternative project proposals into a PRP for submission to AID/Washington

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SECTION II

PROJECT REVIEW PLAN

(available for review upon request to AID)

SECTION III

REPORT ON HEALTH CONSULTANCY

-- Eugene R. Boostrom, M.D.

- A. Objective of Consultancy (From Attachment A to letter of 8 September 1976 from Dr. Edward B. Cross of AID/W to Dr. William H. McBeath of APHA).

"Objective: To carry out a health sector analysis in Niger leading to a revision of AID's Development Assistance Plan and assistance in the development of a specific project proposal, in the form of a Project Review Paper for increasing the Nigerian [sic] capacity to conduct public health programs."

- B. Summary

After briefings in Abidjan with Drs. French (SHDS Project) and Poulsen (RHO, REDSO), consultant Boostrom worked in Niger from 6 October 1976 through 27 November 1976. The other two members of the team, Messrs. Fairweather and Neal, worked in Niger from 11 October 1976 through November 1976 and from 16 October through 27 November 1976, respectively. Within the Ministry of Health, the team's main contact was Dr. John Wright, Secretary General of Health. The team's principal collaborator in RDO/Niamey was Assistant Program Officer Roy A. Harrell, Jr., who also accompanied the team on a field trip to the Departments of Tahona, Agadez and Diffa from 20 October 1976 through 3 November 1976. REDSO contract anthropologist Dr. Dan Aronson wrote a Social Issues Appendix for the PRP while in Niger in early October.

A Project Review Paper was drafted, based on the PID and a preliminary report by Dr. Poulsen, on MOH and WHO documents, on MOH recommendations, on discussions with RDO/Niamey personnel, MOH and on field observations; the PRP was handcarried to AID/W and to APHA on 26 November 1976. The PRP and its appendices contained the results of the "health sector analysis", which RDO/Niamey planned to use in revising the health section of the Niger DAP after the team's departure.

C. RECOMMENDATIONS TO AID

1. The consultant's main recommendations and evaluations regarding health services in Niger and the development of the Improving Rural Health Project are contained in the PRP and its appendices. The rural health services delivery system in Niger, as described in the PRP, is already a good example for other countries attempting to develop rural health services and has great potential for expansion and improvement. It deserves the support which AID is preparing to provide; few programs and projects already actually providing rural health services, including even limited demonstration projects, coincide so well with AID's aims in health and development and with AID's congressional mandates.
2. Continued attention needs to be given to the coordination of AID-sponsored health sector activities in Niger (i.e., the proposed Improving Rural Health Project, Africare, and Strengthening Health Service Delivery Systems). This

is especially important because the mission is seeking ways to help the MOH improve its coordination of donor activities, and Ministry officials feel that AID's own project development activities are uncoordinated.

3. Information Flow from AID/W to RDO/Niamey should be improved with regard to health sector activities. It might have been helpful to RDO/Niamey if during the course of revision of the Africare proposal and the negotiation of the Africare contract more information had been sent to the mission. It would also have been useful for the mission and the APHA team to have had copies of the Africare contract soon after it was signed in late September. At the time of the team's departure, the mission had still not been given copies of the Africare proposal.
4. The number of teams contacting the Ministry of Health in Niger should be kept as small as possible, to reduce what MOH officials perceive to be needless duplication of efforts and unnecessary demands on their own time. The teams should probably also be small.
5. The PP team should have copies of the reports to be provided by the AID/W contract nutrition consultants who were in Niger during the latter part of the PRP team's stay there.
6. Contraception is the fifth of the eight items listed in the GON National Three Year Plan (see Appendix J of PRP) as action to be supported in the health sector. RDO/Niamey should discreetly attempt to determine how and by whom this item came

to be listed, and what it represents in terms of GON attitudes toward contraception and the delivery of contraception information, supplies and services. This is a very sensitive area in Niger, but the listing of contraception in the Three Year Plan warrants careful attention.

7. The eighth and last item listed in the National Three Year Plan as a health sector action to be supported states, under the title "Social Security", that "a system of health insurance will be developed for salaried workers." RDO/Niamey and the PP team should attempt to determine what is meant by this and what implementation actions the GON may be contemplating. Health Insurance for salaried workers would tend to increase their proportional share of health services, and development of such a system therefore has implications as to distribution of health services to rural people most of whom of course are not "salaried workers". Also, if consideration is being given to developing a separate system for providing services to salaried workers, rather than developing a system for paying for MOH services provided to this special group, there is a high risk of wasteful duplication of efforts and services at all levels, eventually at the expense of MOH services.

D. KEY PERSONS CONTACTED IN RELATION TO NIGER ASSIGNMENT

1. In Abidjan

Aronson, Dr. Dan	Contract Anthropologist, REDSO
French, Mr. David	Director, SHDS Project
Larjie, Mr. Panii	Office Manager, SHDS Project
LeMontreer, Mlle. Sylvie	Interpreter/Translator for team
Montague, Mr. Joel	Administrator, SHDS Project
Peterson, Dr. Karen	Contract Social Scientist, SHDS Project
Poulsen, Dr. Niels	Regional Health Officer, REDSO
Satlin, Dr. Gabriel	African Health Training Institutions Project (Yaounde)

2. In Niamey

Ministry of Health Central Offices

Camara, Dr. Issa	Director, Division of Training and Health and Nutrition Education
DuPuis, Madame H.	Director, Division of Social Affairs and MCH (PMI)
Loulou, Mr. Lapuali San	Director, Division of Administration and Finance
Maigi, Dr. Ali	Assistant Secretary General
Ibrahim, Dr. Alfa	Director, Division of Hygiene and Mobile Medicine
Idrissa, Dr. Talfi	Director, Division of Health Care
Sala, Moussa, Chef de Bataillon	Minister of Health
Wright, Dr. John	Secretary General of Health

AID Regional Development Office

Baron, Mr. Albert R.	Regional Development Officer
Harrell, Dr. Roy A., Jr.	Assistant Program Officer
Johnson, Mr. J.P.	Acting Regional Development Officer
Miller, Mr. Herb	Acting Program Officer

Others

Africare Team

AID/W Contract Nutrition Teams

Abdoulaye, Mr. Maiga	Director, National School of Public Health
Gaiba, Mr. Ousseyni	Director Adjoint, National School of Public Health
Kane, Mr. Abdoulaye	WHO Sanitary Engineer
Paviot, Dr. Jean Jacques	WHO Representative to Niger
Sekou, Dr. Hamidou	Chief Administrative Officer, National School of Medical Sciences
Jett, Ms. Joyce	Contract Researcher, REDSO

3. Outside of Niamey - Others

A combined list of names and titles of MOH field personnel and other GON personnel contacted during the field trip was apparently taken to the U.S. by Mr. Fairweather, who may have forwarded it to APHA.

E. HEALTH MANPOWER AND TRAINING APPENDIX TO PRP (written by Boostrom and Poulsen)

1. Health Manpower Policies and Objectives of the MOH

The Ministry of Health (MOH) three year plan 1976-78 (which includes the general objectives and policies pertaining to its personnel) clearly identifies specific areas regarding manpower policies and objectives. The preparation of sufficiently qualified national personnel will have high priority. The training will be carried out within the framework of the reorganization of the present system and will include:

- a. The formation of basic staff at the National School for Certified Nurses and Social Assistants (ENICA) in Zinder.
- b. The formation of middle level personnel at the National School of Public Health (ENSP) in Niamey.
- c. The formation of top level staff at the National School of Health Sciences, in conjunction with the Islamic University.

The Three Year Plan also emphasized that:

- a. Personnel should be enlisted and trained in accordance with the needs and the availability of financial resources.
- b. Expatriate personnel (including foreign doctors) will eventually be replaced by national personnel (Nigerians).
- c. The directors of health of the departments must be Nigerians.
- d. Public health services should be extended within the 9,000 villages by utilizing trained "matrones" (traditional midwives) and "secouristes" (village health workers).
- e. That there should be continuous training, motivation and refresher training of personnel at all levels.

- f. That all training programs and organizations are to be designed and coordinated by all technical departments, using all available means for educating the public and expanding the programs.
- g. That there should be recruitment and/or training of competent technicians in vehicle and equipment maintenance and repair.

2. Health Manpower Availability and Projections

Table One shows the availability of trained Nigerian health personnel as of August 1976. Table Two indicates the numbers of expatriate health personnel working in Niger in 1976.

Table Three indicates MOH estimates of personnel deficits as of 1975, expected training inputs and outputs (for 1975-78) and costs.

Forty-three of the total of 74 physicians available are located in the capital city.

Table Four indicates total numbers of workers expected to complete training in 1975-78 (by categories), yearly salaries, and total salary costs which these workers will represent to the MOH.

The types of health workers assigned to various health facilities, and their responsibilities, are discussed in Appendix E (Background Information); that same Appendix and Appendix G (Report on Village Health Worker Program) discuss the MOH training and use of Village Health Teams. The MOH places high priority on expanding the Village Health Team (VHT) program. There are currently (Nov 76) approximately 1,300 VHT's in Niger, a number which the MOH hopes to increase to 3,000 by late 1980 and to 5,000 by 1982.

TABLE ONE

AVAILABILITY OF TRAINED NIGERIAN HEALTH PERSONNEL, AUGUST, 1975

Qualification	Dept. Niamey	Dept. Dosso	Dept. Tahoua	Dept. Zinder	Dept. Maradi	Dept. Agadez	Dept. Diffa	In Services Practice Assignment	Temp. Detached Services	Susp. from MOH	On Leave	TOTAL
Physician	9	-	1	3	-	1	1	3	3	-	-	21
Dentist	1	-	1	-	1	-	-	-	-	-	-	3
Pharmacists	4	-	-	-	-	-	-	-	1	-	-	5
License in Nursing Care	2	-	-	-	-	-	-	-	-	-	-	2
Health Assistant Technician	17	2	2	5	2	2	1	2	1	-	-	34
State Nurse	104	30	14	30	31	10	14	10	6	-	3	252
Chief Nurse	14	3	-	4	-	-	-	-	-	-	-	21
Certified Nurses	174	48	57	65	35	23	25	-	1	8	2	438
State Midwives	30	3	3	9	4	2	1	1	-	3	-	65
Chief Midwives	-	-	-	-	2	-	-	-	-	-	-	2
Social Assistants	5	-	-	-	1	-	-	1	-	-	-	7
Social Assistance Technician	2	-	-	-	-	-	-	-	-	-	-	2
Social Assistants' Helpers	16	-	2	3	2	2	2	-	-	-	-	27
Extension Supervisor	-	-	-	3	1	-	-	-	-	-	-	4
Extension Auxiliary	1	-	2	-	-	-	-	-	-	-	-	3
Sanitation Technician	1	-	-	1	-	-	-	-	-	-	-	2
Electrical Technician	1	-	-	-	-	-	-	-	-	-	-	1
Health Nurse	-	-	-	6	-	-	-	-	-	-	-	6

Supplied by the World Health Organization (WHO) Representative Niamey, Niger

3. Health Manpower Training Institutions

The MOH Division of Training and Health and Nutrition Education is responsible for the training and retraining of all paramedical personnel and social assistants, and shares with the Ministry of Education the responsibility for the School of Medical Sciences. There are two training institutions for para-medical personnel and social assistants, The National School of Public Health in Niamey provides three-year training programs for state nurses and professional midwives, and the National School for Certified Nurses and Social Assistants provides one year of training for certified nurses, some of whom take an additional year of training in order to become social assistants.

TABLE TWO

EXPATRIATE HEALTH PERSONNEL IN NIGER IN 1976

Physicians	59
Pharmacists	1
Dentists	2
Dental Technicians	2
Midwives	3
Nurses (State)	7
Health Assistants	30
Sanitary Engineers	1
Social Aides	23
Medical Assistants	5
Sanitary Auxiliaries	5
Laboratory Technicians	6

TABLE THREE
HEALTH MANPOWER DEFICITS AND TRAINING PROJECTIONS - 1975-1978

Type of Personnel	Deficit 1975	To Begin Training			Expected			Unit Cost	Cost 76	Cost 77	Cost 78	Total
		Oct. 75	Oct. 76	Oct. 77	76	77	78					
1. Physicians	210	25	30	30	10	10	10	820	8,200	8,200	8,200	24,600
2. Dentists	9	3	3	3	-	-	2	820	-	-	1,640	1,640
3. Pharmacists	6	2	2	2	-	3	3	820	-	2,460	2,460	4,920
4. Sanitary Engineer	5	1	1	1	-	-	-	820	-	-	-	-
5. License Nursing Care	4	1	1	1	-	1	1	684	-	684	684	1,368
6. Hospital Nursing Supervisor	9	2	2	2	-	2	2	570	-	1,140	1,140	2,280
7. Training Assistant	24	4	4	4	3	4	4	570	1,170	2,280	2,280	6,270
8. Anesthesists	25	3	3	3	1	3	3	570	570	1,710	1,710	3,990
9. X-Ray Technician	11	2	2	2	1	2	2	570	570	1,140	1,140	2,850
10. Hospital Management	2	2	-	-	6	2	-	570	3,420	1,140	-	4,560
11. Public Health	10	2	2	3	-	2	2	570	-	1,140	1,140	2,280
12. Medical Equipment Technician	7	3	2	2	-	3	2	616	-	1,848	1,232	3,080
13. Laboratory Technician	81	10	10	10	10	13	11	570	5,700	7,410	6,270	19,380
14. Sanitary Technician	19	3	3	3	-	3	3	502	-	1,506	1,506	3,012
15. Dental Technician	9	2	3	2	-	2	3	502	-	1,004	1,506	2,510
16. Physical Therapist	10	2	3	4	-	2	3	570	-	1,140	1,710	2,850
17. Social Action Technician	12	2	2	2	1	-	-	616	616	-	-	616
18. Social Assistant	69	5	5	10	2	5	5	570	1,140	2,850	2,850	6,840
19. Social Assistant Helper	366	10	20	20	10	20	20	272	2,720	5,440	5,440	13,600
20. State Nurse	148	45	45	50	26	24	25	502	13,052	12,048	22,590	47,690
21. Certified Nurse	408	60	50	50	60	50	50	247	14,820	12,350	12,350	39,520
22. Midwife	82	15	15	15	8	16	15	502	4,016	8,032	7,530	19,578
23. Delivery Nurse	97	10	10	10	-	10	10	272	-	2,720	2,720	5,440
24. Director's Secretary	10	3	3	3	-	4	3	684	-	2,736	2,052	4,788
25. Typist	10	3	6	4	-	3	6	247	-	741	1,482	2,223
26. Director of General Office	2	6	-	-	-	-	6	502	-	-	3,012	3,012
27. General Administrative Assistant	5	4	4	-	-	4	4	392	-	1,568	1,568	3,136
28. Administrative Agent	-	15	10	-	-	15	10	272	-	4,080	2,720	6,800
29. Superior Statistician	3	1	1	1	-	-	1	820	-	-	820	820
30. Middle Level Statistician	9	2	2	3	-	2	2	570	-	1,140	1,140	2,280
31. Health Planner	4	1	1	1	-	-	-	820	-	-	-	-
T O T A L									56,534	86,507	98,892	241,933

From Personnel Annex of MOH Three Year Plan , Costs in Thousands of CFA.

TABLE FOUR

PROJECTED SALARY COSTS (THOUSANDS CFA) OF PERSONNEL
COMPLETING TRAINING 1975-1978

<u>Personnel</u>	<u>Number</u>	<u>Yearly Pay</u>	<u>Total</u>
Physicians	30	820	24,600
Dentists	2	820	1,640
Pharmacists	6	820	4,920
License Nursing Sup.	2	684	1,368
Hospital Nursing Sup	4	570	2,280
Hospital Management	8	570	4,560
Teachers	11	570	6,270
Public Health	4	570	2,280
Laboratory Technicians	34	570	19,380
Electro Radiologists	2	616	1,232
Anesthetists	7	570	3,990
Health Technicians	5	616	3,080
Sanitary Technicians	6	502	3,012
Physiotherapists	5	570	2,850
Social Action Technicians	1	616	616
Social Assistants	12	570	6,840
Social Assistant Helpers	50	247	12,350
State Nurses	95	502	47,690
Midwives	39	502	19,578
Certified Nurses	160	247	39,520
Delivery Nurses	20	272	5,440
Director's Secretary	7	684	4,788
Typist	9	247	2,223
Office Chief	6	502	3,012
Gen. Administrative Asst.	8	392	3,136
Administrative Agents	15	272	6,800
Middle Level Statistician	4	570	2,280
	1	820	820
T O T A L	563		236,555

4. The National School of Medical Sciences (NSMS)

The NSMS, located in Niamey, accepted its first students in 1974. Those medical students are now in their third year of a six-year physician training program modeled after the CUSS program in Yaounde, with adjustments to suit the specific needs of Niger. The program is intended to train general practitioners who will function as members of teams and will provide supervision down to the level of village health teams. Thus, the physicians being trained are to be an integral part of the MOH program to provide basic health care for the majority of the national population. The program emphasizes field work and practical experience, with added emphasis to be placed on this now that the first students have entered their third year of medical training. Clinical training will be done by physicians in practice in Niger. Basic science training is assisted by expatriate faculty, including a professor and a studies coordinator supplied by WHO; the director of the school considers basic science training to be one of the school's main problem areas.

Although the school trains only physicians at present, GON and MOH long-term goals include the training of other high level workers (Master's and Doctor's of Health Sciences, pharmacists, dentists, sanitary engineers, social workers) who would enter from the baccalaureate level, or after passing a special University of Niamey examination or meeting other special qualifications.

The school also expects to assume an important role in the MOH programs of continuing education for health workers.

Construction of new buildings for the NSMS is expected to be underway in 1977 and to end in 1978. (more realistically expected to be 1979 or 1980). The construction program includes a multi-disciplinary training unit, a community hospital (to serve a neighborhood near the university), an administrative block, and a public health unit.

WHO estimated four years ago that each student-year of physician training at the school would cost 820,000 CFA (approximately \$3,280 at CFA250/\$1), the school's director judges that the present cost is significantly higher than that (especially with inflation), but emphasizes that training elsewhere might well be even more expensive and take longer in general, and that the physicians trained by the NSMS will be specifically prepared to deal with Niger's health problems and work well within the MOH system immediately after graduation. Detailed cost data for training at the school was not available. There is a potential problem, however, in that of the 32 students admitted in 1974 (a number based on the MOH absorptive capacity in light of salaries) only 20 remained with the class in the second year, 15 in the third (present) year, and about 12 are expected to graduate "on time." Although many of the others were held back to repeat a year rather than lost from the program, a high rate of attrition would drastically increase costs per graduate.

MOH officials, in discussing the NSMS, mentioned that several high level political decisions (assumedly outside of the MOH) were involved in the process that led to the GON training its own physicians, and now to the construction of a hospital to

be used for training. Within that context, the MOH is attempting to use the resources thus acquired in ways which will further the achievement of its own goals and programs.

5. The National School of Public Health (NSPH)

The National School of Public Health (NSPH) located in Niamey, was established in 1965. The WHO assisted in the development and operation of the school during the first ten years of its existence, but the school is now operated by the GON without continuing WHO assistance. To date, the school has graduated:

- 244 State Nurses
- 39 Midwives (since 1971 only)
- 315 Certified Nurses (program now in NSCNSA)
- 47 Social Aides

The current enrollment at the NSPH is shown in Table Five.

The school is now capable of graduating 60-65 "Diplome d'etat" level students (State Nurses and Midwives) per year. Training costs are 480 - 500,000 cfa per year (approximately \$2,000/year) for both State Nurses and Midwives.

The school is well-equipped and contains well-planned laboratories, classrooms, auditorium, library and dormitories.

The NSPH admits students to the "Diplome" programs in two ways. Most students (currently 157 of 187) have completed the first cycle of secondary school before admission. Some, however, (currently 30 of 187) are Certified Nurses (who have less education than the other group of entrants) with four years of work experience, who are selected on the basis of a national

TABLE FIVE
1976-1977 Enrollment at the National School of Public Health

SECTION	FEMALES		COMPETITIVE SELECTION FROM CERT. NURSES		TOTAL
Social Assistants	4	8		12	12
First Year (combined State Nurses & Midwives)	30	40	11	59	70
Second Year Nurses	8	32	8	32	40
Second Year Midwives	24	-	2	22	24
Third Year Nurses	3	25	8	20	28
Third Year Midwives	13	-	1	12	13
			30	157	
T O T A L	82	105			187

SI-III
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Niamey, 18 October 1976

examination. The latter group reportedly does extremely well, both in the school and in later work. This practice illustrates the flexibility which seems to be present in the NSPH.

The NSPH curricula have recently been completely revised in accordance with actual job requirements in the rural areas, in keeping with the overall MOH program. Strong emphasis is placed on public health administration, health education (including teaching and supervision methods), and MOH.

The faculty expects to further revise the curricula in order to place greater emphasis on field work and continuing education and to provide more interaction between graduates and present students (to benefit both). They are now satisfied with the theoretical training provided, however.

The faculty has proposed to the MOH that a retraining program be organized to retrain early graduates and reorient them to the MOH increasing emphasis on prevention and health education. They are also suggesting that the NSPH provides specialized training for nurses (e.g., administration, x-ray, laboratory) and sanitation technicians.

6. The National School for Certified Nurses and Social Assistants (NSCNSA)

In contrast to the NSPH, the NSCNSA in Zinder is still a struggling institution. It was established in 1974 by the transfer of the two training programs to Zinder from the NSPH in Niamey. The Certified Nurse training program has been reduced from two

years to one year, to help meet MOH personnel needs, but there is continuing discussion of reinstating the two-year program. The social assistants students are certified nurses who take one additional year of training.

The NSCNSA is presently located in the old "Grandes Endemies" center and the space is very cramped, with only one classroom large enough to house all 80 students, a few small class and demonstration rooms, a very limited library, and no laboratory. The problem of space will soon be solved by a new and well-planned school building, scheduled to open in 1977. Other problems remain to be solved. The curriculum is being revised, but the revised manual is still not printed, and the school has so far used the old materials from the NSPH two-year training program. The training program is one half theoretical - in the school - and one half practical training in the National Hospital and some limited training in nearby rural dispensaries.

The faculty consists of five "Diplomes d'Etat" who have or will receive additional training in "Cessi" in Yaounde, Dakar or elsewhere bringing them up to Master's level (in public health, administration, nursing education, midwifery or similar fields). The Director mentioned that two members of his staff would be leaving in October for additional training in Yaounde and Dakar - and he still had no replacements.

Training costs for Certified Nurses are 350 - 460,000 cfa (approximately \$1,600) per year. The students receive a salary of 10,000 cfa per month (about \$40) for board per month - usually plus help for housing. Upon entry into the school, the students

must sign a contract with the Fonction Publique (Civil Service) guaranteeing that they will work for the Ministry of Health for at least 10 years.

The students are recruited on a competitive basis by the Fonction Publique (Civil Service). Since there are many times more applicants than openings for students, the applicants with 1-2 years secondary schooling have a better chance of succeeding. As a result of this, the majority of the students have more basic training than the required minimum. The average age of the students is 19 years, and there are presently 59 males and 31 females.

In spite of the crammed curriculum and rather strict requirements for both oral and written graduation examinations, usually only one or two students fail their examinations; those who fail are given no second chance. Upon graduation the nurses are usually assigned to work at least one year in a health center under close supervision of a state nurse, after which they will be in charge of a rural dispensary. Usually, the Certified Nurse will be the only person with some medical training in a canton (cluster of villages) with a population averaging about 10,000, and with responsibility for both curative and preventive services, supervision of village secouristes and matrones, for distribution of flavoquin tablets, for prenatal examinations and nutrition education, etc. The arrondissement state nurse must visit each dispensary once a month - and when called for when there is an emergency, outbreak of serious diseases, etc., but there is no telephone; no transpor-

tation other than by camel or horseback, so communication between arrondissement center and rural dispensary is difficult and slow. The Certified Nurses in rural dispensaries, then, must function relatively independently.

F. PACKAGE OF DOCUMENTS SUBMITTED TO THE MINISTRY OF HEALTH ON 18th NOVEMBER 76 AT THE REQUEST OF THE SECRETARY GENERAL OF HEALTH

1. Questions Relatives aux Systèmes de Planification, de Gestion, et Financiers du Ministère de la Santé
2. Resume du Voyage en Brousse de l'Equipe de l'Avant-Projet de l'USAID pour Observer les Services de Sante dans les Departements de Tahoua, Agadez et Diffa
3. Projet: Amélioration de la Santé Rurale
4. Ebauches de l'Avant-Projet de l'USAID

Questions relatives aux systèmes de planification, de gestion, et financiers
du Ministère de la Santé

1. Planification

Nous avons vu des copies du Plan Triennal 1975-78 et le Programme Triennal du Ministère de la Santé pour 1975-78. Nous avons étudié le budget 1975.

Question : Est-ce qu'il existe maintenant un plan global pour le Ministère de la Santé autre que ce qui est exprimé dans ces documents? Pour 1976? 1977? etc? Si oui, pouvons-nous le voir ou en avoir un exemplaire pour notre usage personnel? Comment l'information financière du document de deux pages décrivant l'emploi et le programme suggérés pour l'assistance proposée par l'USAID (daté du 14 et du 15 octobre 1975) est-elle reliée au Plan Triennal 1975-78 et aux prévisions de budget du Ministère de la Santé pour 1978-80, années dans lesquelles l'assistance sera fournie? Quelles proportions des montants de la colonne II proviennent des fonds du Gouvernement du Niger?

2. Budget

Question : Est-ce que nous pourrions obtenir des répartitions budgétaires sur lesquelles nous pourrions voir la répartition des budgets alloués par départements? Par arrondissements? Pour le personnel? Pour les fournitures pharmaceutiques et médicales? Pour les trois dernières années? Pour les trois prochaines années? Est-ce que les répartitions des dépenses correspondant aux allocations ci-dessus sont disponibles pour 1975 et 1976? Pouvons-nous avoir ces informations?

3. Organisation

Nous avons étudié les chartres d'organisation existant pour le Ministère de la Santé.

Question : Est-ce que des chartres d'organisation plus détaillées sont disponibles? Par fonction, par activité ou par personnel? Y-a-t'il eu d'autres changements organisationnels récemment? Est-ce que des changements dans l'organisation sont envisagés pour l'année prochaine? dans les deux ans? dans les trois ans?

4. Systèmes d'information pour la gestion

Nous avons étudié les propositions d'AFRICARE concernant la fourniture d'une aide pour développer un système d'enregistrement de statistiques.

Question :

Le Ministère de la Santé a-t'il pris en considération également le développement d'un système d'information pour la gestion? Si oui, qu'est-ce qui est prévu? Si non, quels sont les besoins pour développer un plan?

5. Logistique

Nous avons vu les conditions des routes, quelques-uns des garages existants, des générateurs et des réfrigérateurs, et nous notons qu'il existe une assistance extérieure et des propositions d'assistance de fourniture de mécanique.

Question: A-t'on pris en considération le développement d'un programme de formation approprié pour l'entretien pour les chauffeurs? pour le personnel de gestion? (en plus de la mécanique)

A-t'on pris en considération le développement de techniciens pour la réparation des réfrigérateurs? d'autres techniciens?

A-t'on pris en considération le développement de programmes ou de systèmes pour mettre en oeuvre ces objectifs, avec l'assistance d'AFRICARE, du RSPSS ^(Projet du Dr. F. Smith) d'autres donateurs?

6. Gestion

Nous avons noté que nombre d'assistants DDS départementaux ont été formés en gestion à l'étranger. Nous avons compris qu'il y en a d'autres.

Question: Quel rôle leur prévoit-on dans le secteur de la santé? Est-ce que des assistants supplémentaires seront formés dans les trois prochaines années?

Si oui, combien?

7. Coordination

On a estimé que plus de 50% des cas de maladies sont dus à des maladies transmises par l'eau. Il y a des programmes extensifs de forages de puits, et d'autres programmes existent ou sont en cours de développement.

Question: Comment le Ministère de la Santé coordonne-t'il ses travaux avec ces programmes?

Résumé des discussions entre le Ministère de la Santé Publique et des Affaires Sociales du Niger, les représentants de l'USAID à Niamey, et l'équipe de l'Avant-Projet.

Le 12 Octobre - 16 h.00

Le Chef de Bataillon Moussa Sala, Ministre de la Santé, le Secrétaire Général de la Santé : le Docteur John Wright, ont reçu les représentants de l'USAID à Niamey (M. Albert Baron et M. Roy Harrell) et l'équipe de l'Avant-Projet (Dr Eugène Boostrom, M. Glaston Fairweather, et l'interprète, Mlle S. Le Montréar) dans les bureaux du Ministère de la Santé.

Le Ministre de la Santé a souhaité la bienvenue à l'équipe et a commenté les points suivants :

1) le Ministère de la Santé depuis 1971, a activement coordonné toutes les assistances internationales dans le Secteur Santé, contrairement aux affirmations concernant le "manque de coordination" dans les documents que l'USAID de Niamey a envoyés au Ministère.

2) La réponse du Ministre aux documents relatifs au Projet proposé pour l'amélioration de la Santé Rurale (traductions en français des "fiches de synthèse" et du rapport résumé fait par le Dr Niels Poulsen, basé sur ses observations au Niger en Septembre 1976), sera discutée avec le groupe par le Dr Wright et son équipe de cadres techniques (les directeurs de chaque division du Ministère). Le Dr Wright devrait être le principal contact de l'équipe au Ministère de la Santé, et avec l'équipe, devrait revoir et modifier l'itinéraire suggéré et le plan de Travail pour le développement de l'Avant Projet.

3) Le Ministre a exprimé son propre intérêt, que le Ministère de la Santé et que le Chef de l'Etat en voyant le projet proposé, s'est vite tourné vers les phases de développement de l'Avant-Projet et du Dossier, et a commencé à fournir assistance au Ministère de la Santé pour l'implantation de son programme de Santé Rurale.

Le groupe quitta le bureau du Ministère et revint dans le bureau du Dr Wright où ils avaient été présentés aux membres de l'équipe de direction du Ministère de la Santé.

Les points suivants furent discutés :

1) Le Dr Wright expliqua au groupe que le Ministre de la Santé prend la pleine responsabilité pour la coordination de l'assistance internationale pour le Secteur Santé et l'apparent manque de coordination par certains donneurs (spécialement l'USAID) parmi leurs projets est ennuyeux. Il mentionna par exemple le semblant manque de coordination des activités relatives à l'Assistance proposée par AFRICARE au Ministère de la Santé, le projet proposé pour l'Amélioration de la Santé Rurale et le travail du Corps de la Paix. Les Américains présents ont expliqué que l'USAID souhaiterait améliorer la coordination et l'échange de renseignements parmi ces diverses activités assistées par l'Amérique, en donnant comme exemple les récentes réunions des membres de l'équipe avec les représentants de l'AFRICARE à Washington et à Niamey et les discussions du Dr Boastrom avec les Docteurs French et Foulson à Abidjan.

2) Le Docteur Wright a indiqué le souci que lui causent les nombreux équipes et visiteurs américains qui accaparent son temps et son travail ainsi que ceux de son personnel.

3) Le Docteur Wright s'est déclaré surpris de ce que l'équipe de l'Avant-Projet ne comprenne pas le Docteur David French qu'il attendait, d'après les discussions de septembre. Il a expliqué qu'il avait de nombreux problèmes techniques avec le programme du Docteur French, mais cela pourra faire l'objet de discussions lorsque le Docteur French viendra à Niamey. Il a été également surpris du fait qu'un des membres de l'équipe (F. Gaynor) nesoit pas venu, et qu'un participant dont l'arrivée n'avait pas été annoncée (J. Neal) n'arrive que plusieurs jours plus tard.

4) Le Docteur Wright a déclaré que le Ministère de la Santé était en désaccord avec la Fiche de Synthèse et le rapport résumé soumis par le Docteur Poulsen et a suggéré que plutôt que de les utiliser comme base de travail, l'équipe devrait les laisser de côté et tout reprendre. Tous ont été d'accord sur ce point, car quelques problèmes avaient soulevé des difficultés lors de la traduction des documents en français.

5) Le Ministère de la Santé a demandé que le départ de l'équipe pour le voyage sur le terrain, initialement prévu pour le 14 octobre 1976, soit retardé afin de permettre d'autres discussions avant le voyage. Un deuxième entretien a été prévu pour le 15 octobre; à cette date, l'équipe de l'Avant-Projet devrait présenter une esquisse de l'Avant-Projet au Docteur Wright et à ses collaborateurs et en discuter avec eux; cette esquisse devrait comprendre des questions et des commentaires afin d'informer le Ministère de la Santé du type d'information dont l'équipe de l'Avant-Projet aurait besoin, et du degré d'approfondissement ~~xxxx~~ nécessaire. Les plans du voyage et de travail de l'équipe seraient également discutés à ce moment-là.

4

Vendredi 15 octobre 1976, 16 heures.

Le Docteur Wright et les membres de la Direction du Ministère ont rencontré Monsieur Harroll de l'USAID et les membres de l'équipe de l'Avant-Projet, le Docteur Boostrom et Monsieur Fairweather (avec une interprète) dans le bureau du Docteur Wright.

1) L'équipe de l'Avant-Projet a donné au Docteur Wright et à ses collaborateurs des exemplaires en français de l'esquisse de l'Avant-Projet et une note expliquant brièvement les objectifs et les résultats attendus. Le groupe les a discutés et s'est mis d'accord sur le fait de les rediscuter lors d'une troisième réunion, qui devrait se tenir le mardi 19 octobre, date à laquelle le Ministère devrait également recevoir des matériaux supplémentaires (sous la forme de brouillons de sections de l'Avant-Projet) à étudier lors de la réunion et à discuter après le retour de l'équipe de son voyage.

2) Le Docteur Wright a donné à l'équipe des exemplaires d'un document financier suggérant un programme et montrant l'utilisation de l'assistance proposée par l'USAID au Ministère de la Santé sur une période de cinq ans, et indiquant les montants de cette assistance qui pourraient être utilisés dans chacun des différents domaines du budget (en comparaison avec les investissements prévus par le Ministère dans le Plan Triennal 1976-78) pendant les trois premières années, avec moins de détails pour les deux dernières années (en raison du cycle de planification triennal du Gouvernement du Niger). Ce document avait été développé depuis le précédent entretien. Il a également donné à l'équipe des exemplaires d'un document développé antérieurement montrant les déficits en personnel de santé du Ministère de la Santé pour 1976, et a proposé un programme de formation (avec les coûts) pour 1976-78 afin de réduire ces déficits. Le groupe a discuté ces documents.

3) Le groupe a discuté de l'itinéraire proposé pour le voyage de l'équipe, et a ajouté une visite à Tahoua, sur la proposition du Docteur Wright. Il a été décidé, en raison de la distance et de l'exigence du Gouvernement du Niger que seules des caravanes d'au moins cinq voitures tentent le voyage à Bilma, que l'équipe ne pourrait pas visiter Bilma, ainsi que l'avait proposé le Docteur Wright.

4) Le Docteur Wright a assuré à l'équipe que des télégrammes annonçant la composition de l'équipe, son but et son itinéraire avaient été envoyés à tous les fonctionnaires du Gouvernement du Niger des zones à visiter pour lesquels cela était nécessaire, et qu'aucun Ordre de Mission ne serait donc envoyé avec l'équipe. Ces dispositions avaient été prises par le Ministère de l'Intérieur.

Mardi 19 octobre 1976, 16h30.

1) Le Docteur Wright exprime sa surprise devant le fait qu'une personne qui n'avait pas été mentionnée dans les discussions des précédentes réunions (Mme Neal) était présente à la réunion, et qu'il était proposé qu'elle accompagne l'équipe dans son voyage sur le terrain. Il a indiqué que cela causerait des problèmes, particulièrement puisque la note diplomatique concernant le voyage (comprenant les noms des voyageurs) avait déjà été envoyée aux autres Ministères, et que le Ministère de l'Intérieur avait déjà envoyé les télégrammes sur la base de cette note, sur la recommandation du Ministère de la Santé. Il a ajouté qu'il essaierait d'informer les autres Ministères concernés, mais qu'il ne pouvait pas prévoir le résultat.

2) L'équipe a donné au Docteur Wright et à ses collaborateurs des exemplaires des ébauches des sections de l'Avant-Projet rédigées depuis la dernière réunion. Le groupe a alors discuté à la fois de ces sections et de l'ébauche antérieure de l'Avant-Projet. Des points particuliers de la discussion ont touché ce qui suit :

a) le Ministère avait auparavant discuté longuement de la possibilité (mentionnée dans le brouillon de section "issues possibles") d'utiliser des individus sélectionnés parmi les meilleurs membres de l'équipe de santé du village comme ^Fsurveillants rémunérés, mais en avait rejeté l'idée.

b) Monsieur Harrell a déclaré que le Docteur Poulsen et lui-même avaient trouvé que la plupart des infirmières rencontrées au cours de leur voyage sur le terrain avaient mentionné une insuffisance d'essence et d'argent, et ont demandé comment l'équipement et l'argent parviennent du centre à la périphérie. Le Docteur Wright a répondu que pour le moment au Niger, comme ailleurs, personne n'avait assez d'argent ou d'essence. Il a dit que les

crédits d'essence étaient envoyés aux départements. Les crédits de financement sont adressés aux Préfets et aux DOS tous les six mois pour financer leurs services médicaux, et des crédits sont envoyés tous les trimestres pour aider les hôpitaux.

c) Le Docteur Wright a mentionné qu'il attend qu'AFRICARE envoie quatre techniciens pour assister le Ministère : un statisticien, un éducateur pour la santé et la nutrition, un technicien pour la réparation et l'entretien des véhicules et un technicien pour travailler avec les appareils électriques et mécaniques.

d) Le Docteur Wright a dit que le Ministère n'acceptait pas la suggestion de l'OMS d'un "club des donateurs" pour coordonner les aides au secteur de la santé, et il a encore indiqué que depuis 1974, le Ministère effectuait une telle coordination. Monsieur Harrell a répété la suggestion antérieure de Monsieur Baron, que le Ministère de la Santé pourrait vouloir utiliser une partie des fonds du projet en cours de planification pour améliorer une telle coordination.

BEST AVAILABLE COPY

RECAPITULÉ DU VOYAGE EN DISCUSSÉ DE L'ÉQUIPE DE L'AVANT-PROJET DE L'USAID
POUR OBSERVER LES SERVICES DE SANTÉ DANS LES DÉPARTEMENTS DE TAHOUA, AGADEZ ET DIFFA

L'équipe faisant partie de ce voyage comprenait :

- Docteur Eugene Flostrom (Responsable de l'équipe)
- Monsieur James Neal (Analyse fiscale/ Systèmes de gestion de la santé)
- Monsieur Gladstone Fairweather (Ressources humaines et formation pour la Santé)
- Monsieur Roy Harrell (Représentant USAID/Niamey)
- Mademoiselle Sylvie Le Montréor (Interprète)
- Madame Rubi Neal (Accompagnant Monsieur Neal)
- Deux chauffeurs de l'USAID.

L'itinéraire du voyage du groupe, en accord préalable avec le Ministère de la Santé, a été exactement suivi et les règles du Gouvernement du Niger concernant les contacts avec les autorités locales furent observées durant tout le voyage, et tous les Préfets et Sous-préfets locaux ont été d'une grande aide pour ce qui concernait les facilités de logement et de repas pour le groupe, sans compter les arrangements pour les contacts avec les autorités officielles du Ministère de la Santé, et en fournissant l'information au sujet de cette zone de juridiction.

Avant le premier entretien (Tahoua) avec les autorités départementales de la Santé, l'équipe s'était mise d'accord sur une ébauche de base des thèmes de discussion, qui a été utilisée durant toutes les entrevues. Ces thèmes comprenaient :

- (a) Les principaux problèmes de la santé, les principaux problèmes des services sanitaires, et n'importe quel programme spécial à la région.
- (b) Les hôpitaux et/ou les autres installations et services de santé,
- (c) Les services fournis par les installations sanitaires.
- (d) L'assainissement et la distribution d'eau.
- (e) La formation des équipes de santé des villages et leur emploi (y compris la supervision)
- (f) L'entretien des véhicules et de l'équipement.
- (g) Les systèmes d'approvisionnement (y compris les médicaments) et la disponibilité de ces approvisionnements.
- (h) La coordination des Grandes Endémies avec les autres services de santé.

- Mercredi 20 Octobre :** Vol de Niamey à Tahoua, rencontre des chauffeurs et des véhicules de l'USAID à Tahoua. Visite de l'hôpital de Tahoua et rencontres avec le Directeur départemental de la santé et son équipe
- Jeudi 21 Octobre :** Tahoua/Agadès : Hôpital - rencontre avec l'équipe de santé dans la soirée.
- Vendredi 22 Octobre :** 1 véhicule (JN, RN, GF) : Agadès/Arlit
1 véhicule (EB, RH, SL) : Agadès/Iferouane
- Samedi 23 Octobre :** Rencontre avec le Dr Dreisbach (Missionnaire travaillant au dispensaire d'Iferouane)
- Dimanche 24 Octobre :** Interview du Dr Dreisbach et rencontre avec son équipe. Visite du dispensaire médical du Ministère de la Santé et interview de l'infirmière d'état
- Lundi 25 Octobre :** Iferouane/Arlit (deuxième véhicule) - Visite du centre médical à 16 h.00 - rencontre avec l'équipe médicale à 21 h.
- Mardi 26 Octobre :** Arlit/Agadès
- Mercredi 27 Octobre :** Agadès/Zinder
- Jeudi 28 Octobre :** Zinder/Gouré : Visite du centre médical et du dispensaire à Gouré.
- Vendredi 29 Octobre :** Gouré/Diffa - Direction Départementale de la Santé -
Visite de l'hôpital - interviews de l'équipe et du directeur -
Visite du centre médical et du dispensaire à l'ainé-Goroua -
- Samedi 30 Octobre :** Diffa/N'Guigmi/Diffa : Visite au sous-préfet de N'Guigmi et au centre médical avec le directeur départemental de la Santé. Interview de l'infirmière d'état
- Dimanche 31 Octobre :** Dernière réunion le matin avec le préfet, le sous-préfet, le directeur départemental de la santé, et d'autres responsables locaux. Réunion avec l'équipe l'après-midi.
- Lundi 1er Novembre :** Diffa/Zinder
- Mardi 2 Novembre :** Zinder/Maradi
- Mercredi 3 Novembre :** Maradi/Niamey (arrêt à Galmi - hôpital privé - interview de l'équipe de santé).

Notes sur les discussions avec le personnel du Ministère de la Santé
au cours du voyage sur le terrain.

(Les notes suivantes ont pour objet d'éclairer des sujets sélectionnés qui sont d'une importance particulière pour l'extension et le fonctionnement du système du Ministère pour les services de santé rurale.)

TAHOUA

Généralités

Le département de Tahoua a environ un million d'habitants et une superficie de 145.000 km². Les installations des services de santé comprennent :

- 1 centre hospitalier départemental (Tahoua, 183 lits)
- 1 hôpital privé (à Galmi)
- 7 maternités (dans les 7 centres d'arrondissements)
- 25 postes sanitaires ou dispensaires
- 1 centre anti-tuberculeux (à l'hôpital départemental)
- 1 service PMI (à Tahoua)

Il y a une équipe de médecine mobile et d'hygiène pour le département. Les activités PMI ont lieu dans les installations de santé de l'arrondissement, mais il n'y a pas d'installations séparées de PMI pour l'arrondissement.

La République Fédérale d'Allemagne a fourni une aide au service de santé du Département de Tahoua depuis 1953.

Problèmes de Santé

(Voir le tableau ci-joint. La DDS a déclaré que les chiffres du tableau sont à peu près les mêmes que pour 1974 et 1975, sauf pour le paludisme qui est en augmentation dans tout le Département.)

Problèmes des Services de Santé

- 1) Insuffisance de personnel
- 2) Manque de médicaments (bien que le Département reçoive des médicaments supplémentaires de l'UNICEF, etc...)
- 3) Administration des fonds au niveau du Département

Le DOS pense qu'une responsabilité plus importante pour l'administration des fonds et pour l'administration en général pourrait être accordée au niveau départemental. Le Directeur-Adjoint des services de santé a reçu une formation administrative en France.

4) L'équipement, les véhicules et l'entretien posent moins de problèmes dans le Département de Tahoua qu'ailleurs, car la RFA fournit et entretient l'équipement et les véhicules. Cependant, ce projet doit se terminer en 1977 et il n'existe pas de techniciens nigériens qualifiés pour prendre la suite pour les réparations et l'entretien.

Salubrité et fourniture d'eau

De l'eau potable est fournie à Tahoua et à Koni par un système administré par le Directeur des Eaux et Forêts et dirigé par la Nigelec à Niamey. Il y a également de l'eau potable dans chaque centre d'arrondissement. Un programme d'approvisionnement des villages en eau existe, mais il n'a pas encore touché tous les villages. Pour essayer de sensibiliser la population aux problèmes d'eau impure, le Docteur Nargoungou a récemment entrepris un programme d'éducation sanitaire, dans lequel ^{les infirmiers ruraux} rencontrent périodiquement la population pour des discussions sur

- (a) l'hygiène de base (hygiène de l'alimentation, hygiène personnelle)
- (b) purification de l'eau
- (c) animaux - comment les tuer et conserver la viande

La réaction de la population a été bonne dans la région de Tahoua, et le programme doit être étendu en 1977 aux autres régions du Département.

Formation

La formation des secouristes a commencé ici en 1972, sur l'initiative des responsables de centres médicaux intéressés. Le mouvement a très bien réussi au niveau du village, et s'est étendu au cours des deux années suivantes. Le DOS propose d'essayer de former deux secouristes par village, par des cours de douze jours. Tous seront recyclés pendant au moins cinq jours tous les deux ans.

La formation des matrones a commencé en 1974 et a réussi malgré une acceptation moins générale que celle rencontrée pour le programme des secouristes. La formation des matrones est plus élaborée et plus intensive que celle des secouristes. Le Département a développé ses propres cours de formation

et ses propres formes de rapports (comprenant un inventaire mensuel des médicaments) pour à la fois les secouristes et les matrones.

Le tableau suivant indique les disponibilités passées et futures de secouristes et de matrones formés pour le Département :

	* 1974 *	* 1976 *	* 1978 *
Matrones	* 30 *	* 264 *	* 544 *
Secouristes	* (dispersés * * par la * * sécheresse) *	* 170 *	* 250 *

Seize "matrones de quartier" (qui ne pratiquent pas d'accouchement, mais envoient les patientes à la Maternité) travaillent également dans la ville de Tahoua.

Coordination de l'Equipe de Médecine Mobile et d'Hygiène

La fonction principale de l'Equipe de Médecine Mobile et d'Hygiène est l'immunisation (et la lutte contre les épidémies), mais elle fournit également les soins de base quand ils sont dans les villages. Ils couvrent l'ensemble du Département au cours d'un cycle de deux ou trois ans. Le Responsable du Centre Médical local est informé de toutes les activités prévues et effectuées.

AGADEZ

Généralités

Le Département d'Agadez est le plus grand du Niger, il a un terrain extrêmement difficile, des problèmes de transport énormes et une forte proportion de nomades.

Les installations des services de santé comprennent :

- 1 centre hospitalier départemental (Agadez avec environ 100 lits, bien équipé par le Ministère de la Santé)
- 2 Hôpitaux privés
- 3 centres médicaux (dont le personnel est composé d'infirmiers d'Etat)
- 8 Dispensaires du Ministère de la Santé (dont le personnel est composé d'infirmiers certifiés)
- 3 Dispensaires privés

Trois dispensaires du Ministère de la Santé seront ajoutés en plus. Les installations privées, gérées par les consortiums des mines et par des missionnaires coopèrent avec les installations du Ministère de la Santé.

Problèmes de Santé

- 1) Haute fréquence de tuberculose
- 2) Malnutrition
- 3) Traumatismes (blessures par couteau)
- 4) Problèmes liés à la naissance

Problèmes des services de Santé

1) Les patients viennent à l'hôpital seulement lorsqu'ils sont très malades et partent avant la fin du traitement.

2) De nombreux cas (souvent 20 par mois dans certains dispensaires) doivent être évacués des dispensaires vers l'hôpital, sur de mauvaises routes, et les moyens de transport (véhicules et entretien) sont inadéquats. Les Land Rover doivent être remplacées tous les deux ans; il n'y a pas de mécanicien. Une seule des six Land Rover disponibles est en assez bonne condition pour aller jusqu'à Bilma. Il est souvent nécessaire d'utiliser un avion pour évacuer les patients, soit à l'intérieur du Département, soit vers Niamey; les frais impliqués (15.000 francs CFA de l'heure) sont prohibitifs.

3) Il est difficile de fournir des services de santé à la vaste population nomade.

Formation

Les secouristes et les matrones reçoivent ensemble huit jours de formation commune, après quoi les matrones seules reçoivent quatre jours de formation complémentaire. La formation est limitée par le manque de ressources financières pour la formation (en collaboration avec l'Animation Rurale, le Département dépense 1,6 million CFA pour former huit matrones et quatorze secouristes à Bilma).

Le tableau suivant montre les nombres de secouristes et de matrones par arrondissement et les nombres de villages qu'ils desservent :

	*Agadez	* Arlit	* Bilma	*
Secouristes	* 15	* 20	* 8	*
Matrones	* 6	* 8	* 14	*
Villages desservis	* 17	* 17	* 12	*

Salubrité et eau

Plus de 100 puits qui fonctionnaient en 1975 ne sont pas utilisés actuellement. 53 puits supplémentaires ont été contaminés ou ne sont plus productifs. Comme l'eau est abondante en brousse, les gens doivent faire de longs trajets. Cependant, quand le Ministère des Travaux Publics s'est préoccupé de savoir où creuser les puits, la population est généralement venue et les puits ont été bien utilisés. Des puits supplémentaires (110 pour 1976) sont en cours de forage dans le Département.

Coordination de l'Equipe de Médecine Mobile et d'Hygiène

Cette coordination est actuellement meilleure qu'elle ne le fût dans le passé. La DDS dirige la dite coordination, et les deux services (général et mobile) marchent bien ensemble. La taille du Département, le mauvais état des routes et la grande proportion de nomades limite la couverture de la population par l'équipe mobile.

Généralités

La capitale du Département est la ville de Diffa qui est située entre deux plus grandes villes : Niamey et Niakhar. AFRICARE a fourni une assistance aux programmes de santé de Niakhar jusqu'en 1974, et a récemment signé un accord avec l'AID à Washington pour fournir une assistance ultérieure, cette fois-ci concentrée sur tout le Département et comprenant la collaboration du Ministère de la Santé au niveau national. Il reste à développer des plans particuliers pour cette assistance, de la part d'AFRICARE et du Ministère de la Santé.

Personnel de Santé

Le personnel comprend

- 4 médecins (DMS et 3 français)
- 11 infirmiers d'Etat
- 1 Sage-femme (bien qu'il y ait trois Maternités dans le Département).

Problèmes de Santé

- 1) Paludisme
- 2) Amibiase
- 3) Schistosomiase (Bilharziose)
- 4) Maladies vénériennes
- 5) Conjonctivites

On note peu de tuberculose et peu de malnutrition dans le Département.

Problèmes des Services de Santé

1) La DMS et le Préfet ont discuté la liste ci-jointe des besoins pour les services de santé du Département avec l'équipe lors de leur dernière rencontre.

2) L'hôpital de 110 lits à Niakhar fonctionne comme Centre Médical, alors que le Centre Hospitalier Départemental de 44 lits à Diffa manque de l'équipement et des bâtiments nécessaires.

3) Il est nécessaire d'avoir du personnel médical et paramédical supplémentaire (par exemple : un chirurgien qui pourrait travailler dans un ou plus des trois blocs opératoires actuellement inutilisés; des techniciens de laboratoire et pour les rayons X; des sage-femmes).

4) Il est difficile de fournir des services aux nomades.

5) Les moyens de transport sont inadéquats, peu de véhicules sont disponibles, et aucun entretien n'est fourni dans le Département. (Bien qu'il existe un garage bien équipé à l'installation de santé de Mainé-Soroca, il n'y a pas de mécaniciens.)

6) Des fonds pour la formation sont nécessaires pour continuer la formation des équipes de santé des villages.

7) Il est nécessaire d'avoir des dispensaires supplémentaires.

8) La réparation et l'entretien de l'équipement sont inadéquats.

Formation

110 des 500 villages ont été couverts par le programme qui forme des secouristes, hygiénistes et matrones. Les secouristes et les hygiénistes reçoivent quinze jours de formation ensemble. Les matrones reçoivent quinze jours de formation à la Maternité. La DDS voudrait former 50 matrones, 50 secouristes et 50 hygiénistes chaque année pour chacun des trois arrondissements (soit au total 450 personnes formées par an), mais a besoin de fonds supplémentaires pour la formation pour pouvoir le faire.

Coordination de l'Equipe de Médecine Mobile et d'Hygiène

L'Equipe de Médecine Mobile et d'Hygiène travaille en coordination avec les services de médecine générale et conserve des contacts avec la DDS.

Projet : Amélioration de la Santé Rurale

1. La Mission de l'USAID au Niger et les experts-conseils de l'Association Américaine de Santé Publique partagent et apprécient l'intérêt du Ministre de la Santé, du Secrétaire Général de la Santé et des autres hauts fonctionnaires du Ministère de la Santé pour le développement rapide du Projet proposé d'Amélioration de la Santé Rurale. Le développement du Projet progressera grâce à l'accord fondamental qui existe entre les philosophies et les politiques en matière de soins du Gouvernement du Niger et de l'USAID; le Gouvernement du Niger et l'AID, qui sont également en accord avec l'approche du développement des services de santé adoptée par l'OMS et par un nombre croissant de pays confrontés aux problèmes du développement national et de l'amélioration de la santé et de la qualité de vie de leur peuple.
2. Les experts-conseils et l'USAID accueillent favorablement la suggestion du Secrétaire Général de la Santé que les experts-conseils, l'USAID et les représentants du Ministère de la Santé discutent et précisent les objectifs, les besoins d'information, et les plans de travail de l'équipe d'experts-conseils.
3. Les experts-conseils pour le développement du Projet travailleront avec le Ministère de la Santé à développer un Avant-Projet et à revoir et moderniser les documents de base de l'AID qui décrivent les problèmes et les programmes de la Santé au Niger et qui seront un appui pour l'Avant-Projet et plus tard le Dossier (Projet Paper) lors du processus d'approbation à Washington. Le but principal de l'équipe est de développer l'Avant-Projet, et la révision des autres documents sera effectuée en utilisant l'information rassemblée pour l'Avant-Projet.

4. Une bonne partie de l'information dont l'équipe aura besoin est disponible dans les documents que le Ministère de la Santé a fournis à l'USAID et aux experts-conseils précédents. Ces documents expliquent les problèmes de santé au Niger, les ressources, les objectifs et l'important progrès qui a déjà été accompli par la mise en oeuvre d'un programme pour les trois prochaines années pour le secteur de la Santé. On espère que ce qui suit permettra au Ministère de la Santé et aux experts-conseils de définir plus précisément les besoins en informations requis par l'Avant-Projet. Cette information peut être obtenue par des documents supplémentaires, d'autres discussions avec le personnel du Ministère de la Santé à Hamay, et des observations sur place dans les départements de Tahoua, Agadez et Diffa.

5. Le premier document ci-joint consiste en un exposé des normes de l'AID pour les Avant-Projets, comprenant les questions et les commentaires permettant de spécifier l'information requise pour le Projet d'Assistance au Secteur de la Santé au Niger.

6. La seconde série de documents présente les sections de l'Avant-Projet qui ont déjà été préparées sous forme d'ébauche.

7. La dernière page indique un essai de programme de travail pour l'équipe. Tous ces documents sont présentés pour être discutés et révisés.

Projet : d'Amélioration de la Santé Rurale

Normes AID pour un Avant-Projet

1. Priorités

Un exposé des buts et objectifs du Gouvernement du Niger dans le secteur de la santé, et de la manière dont.. le Projet d'Assistance au Secteur de la Santé au Niger aidera le Gouvernement du Niger à les atteindre.

2. Description du Projet

2.1 Qu'est ce qui sera financé par le Projet?

2.2 Comment seront utilisées les ressources financières fournies par le projet?

2.3 Qui organisera et exécutera les activités du Projet? Quels autres groupes y participeront?

2.4 A la fin du Projet, et à la fin de chaque année du Projet, comment le progrès dans l'approche des objectifs sera-t'il mesuré?

2.5 Comment les différents aspects du Projet (discutés dans 2.1 à 2.4) se relient-ils les uns aux autres? (cela sera expliqué à l'aide de la Matrice Cadre Logique de l'AID)

3. Expériences avec d'autres Projets au Niger et ailleurs qui fourniraient des informations utiles pour ce projet.

4. Bénéficiaires

4.1 Qui bénéficiera du Projet?

4.2 Comment les bénéficiaires ont-ils été choisis?

4.3 Comment et quand recevront-ils les avantages?

4.4 Est-ce que le Projet répond aux besoins exprimés des bénéficiaires?

5. Issues possibles

- 5.1 Quels seront les effets du Projet sur les revenus et sur l'emploi?
- 5.2 Est-ce que les méthodes à employer dans les services de santé sont appropriées aux situations physiques et sociales dans lesquelles les services seront dispensés?
- 5.3 Est-ce que les services de Santé développés sont à la mesure des moyens financiers de la population, et est-ce que le Gouvernement national sera capable de continuer à les supporter financièrement?

6. Coordination avec les autres donneurs

Quelles sont les relations entre le Projet et les projets d'autres donneurs contribuant au programme du Ministère de la Santé?

7. Plan financier

- 7.1 Combien d'argent l'USAID devra-t-elle fournir pour ce Projet?
- 7.2 Combien d'argent le Gouvernement du Niger fournira-t'il chaque année à partir de ses propres sources, pour financer les activités du plan triennal?
- 7.3 Combien d'argent les autres donneurs fourniront-ils dans leur contribution pour le plan triennal?
- 7.4 Combien d'argent fourni/1^{er} par USAID sera utilisé pour supporter chacune des activités de divers types dans le Plan Triennal?
- 7.5 Sous quels termes l'assistance financière de l'AID sera-t'elle fournie? (Don)

8. Plan de Mise en Oeuvre

- 8.1 Quel service du Gouvernement du Niger sera responsable de mettre en application les activités financées par ce projet?
- 8.2 Quelle autre assistance pourrait être fournie au Gouvernement du Niger avant et au cours de ce Projet pour améliorer ses capacités de mettre à exécution les activités que ce projet aidera à soutenir?

(par exemple par le Docteur French et les experts-conseils du Projet OMS/AID. Renforcement du système de Prestation de service de Santé Publique en Afrique Centrale et Occidentale, en ce qui concerne la planification, la gestion, la formation, la surveillance des maladies)

8.4: Quels arrangements spécifiques pour la mise en oeuvre du Projet sont encore à mener à bien au cours de la préparation du Dossier?

9. Programme de Développement du Projet

9.1 Quels projets d'information, plans et accords non contenus dans l'Avant-Projet devront être inclus dans le Dossier?

9.2 Qui aura besoin de participer à/d^eveloppement (9.1)?
Comment et quand chacun sera-t'il préparé?

9.3 Quelles actions spécifiques de l'AID seront nécessaires pour le développement du Dossier? quand? Qui sera responsable de les régler?

EBAUCHES DE L'AVANT-PROJET DE L'USAID

1. Priorités et points associés

Le Projet proposé "Amélioration de la Santé Rurale" aidera le Gouvernement du Niger à réaliser son objectif concernant le secteur Santé, qui est exposé ainsi dans le Résumé du Plan Triennal 1975-1978 du Ministère de la Santé :

"Améliorer à moindres frais l'espérance de vie et les possibilités de travail de tout Nigérien, compte tenu de la situation sanitaire"
(Premier objectif général du plan).

Le Ministère de la Santé a décidé quel type de système de soins lui permettra d'atteindre plus efficacement ce but :

"Au Niger, doit se pratiquer une médecine globale, préventive, éducative et curative, pour les communautés rurales et urbaines, avec leur participation, grâce à un personnel compétent et motivé, agissant dans le cadre de structures soigneusement entretenues, améliorées et adaptées, et utilisant des moyens choisis rationnellement."
("Options" du Plan)

La politique globale de la Santé soutenant cette approche des soins a été énoncée dans un décret du Ministère le 22 octobre 1974.

2. Description du Projet

Le nouveau gouvernement du Niger, qui est venu au pouvoir en avril 1974, a augmenté le budget national de la Santé d'environ 75 % entre l'année 1974 et l'année 1975. Même cette augmentation majeure du soutien laisse cependant le Ministère de la Santé incapable de fournir la totalité de l'appui financier pour son programme de développement des services de Santé de base.

Le Projet proposé dans ce document augmentera la capacité du Ministère de la Santé à mettre à exécution le programme de développement des services de santé (esquissé dans le Plan Triennal et autres documents) en fournissant un appui budgétaire au Ministère de la Santé pour quatre ans.

Cette aide sera utilisée dans le cadre des Programmes Triennaux actuel et ultérieurs et permettra au Gouvernement du Niger de mettre à exécution son programme d'extension de la couverture sanitaire et d'amélioration des services élémentaires plus rapidement qu'il serait possible autrement.

En ce qui concerne le développement des services de Santé, le Gouvernement du Niger met l'accent sur la mise à la disposition de la plus grande partie possible de la population de services de santé, à moindres frais. Ces services utiliseront du personnel élémentaire bien instruit et supervisé (y compris les praticiens traditionnels) qui portera d'abord son attention au niveau du village.

En regard de cette accentuation, l'ultime critère de progrès dans la mise à exécution des activités soutenues par ce Projet sera la dimension de la couverture cumulative des villages par les services de santé élémentaires et adéquats.

Les conceptions du Ministère de la Santé en ce qui concerne la couverture des villages par de tels services sont exposées ci-dessous :

ANNEE FISCALE (OCT-SEP)

1974 1975 1976 1977 1978 1979 1980

Avec 20 %
d'augmentation
du budget

Sans les 20 %
d'augmentation
du budget

En résumé, il y a deux objectifs généraux :

- aider le Ministère de la Santé à fortifier son organisation existante,
- fournir les ressources supplémentaires pour aider le Ministère à étendre les services de santé à un nombre plus important de personnes et de villages.

La réalisation de ces objectifs dépendra des acquisitions antérieures sur les obstacles dominants qui constituent couramment des points chauds limitant à la fois la couverture et la qualité des services.

Le Ministère de la Santé a identifié plusieurs zones dans lesquelles de tels obstacles existent et a tracé les programmes-clés destinés à les surmonter:

1. Un programme permanent d'enseignement, de recyclage, et une régularité du contrôle et de la supervision du personnel de santé à tous les niveaux.

2. Le recyclage ou la réorientation du personnel de santé existant vers la santé publique, la médecine préventive, l'éducation sanitaire, la santé maternelle et infantile (y compris l'éducation nutritionnelle).

3. La capacité d'entretien des véhicules et de l'équipement médical pour permettre aux auxiliaires de la santé d'accomplir leur mission.

4. Des systèmes améliorés pour rassembler, analyser, interpréter et utiliser l'information (y compris la surveillance épidémiologique, les

statistiques de santé, et un système convenable d'information pour la gestion capable d'identifier les problèmes de gestion).

3. Expériences avec d'autres projets au Niger et ailleurs qui fourniraient

des informations utiles pour ce projet.

Les projets de santé dans d'autres pays, cités ci-dessous fournissent une information utile pour ce projet (certains en sont encore au stade du développement) :

Mali (Projet de Santé Rurale)

Togo (Personnel de Santé de Base)

Sénégal (Personnel de Santé de Base)

Ghana (Matrones de village et pratiquants traditionnels)

Cameroun (Ecole médicale CUSS)

Amérique latine (formation et utilisation de personnel de Santé base au Brésil, Guatemala, en Bolivie, Colombie, au Vénézuéla et au Nicaragua)

Caribes (formation et utilisation de personnel de Santé de base à la Jamaïque et à Haïti)

5. Issues possibles

5.1 Quels seront les effets du Projet sur les revenus et sur l'emploi?

L'extension des services de santé à d'autres villages exige que du personnel supplémentaire rémunéré soit engagé pour superviser et aider le personnel volontaire au niveau du village. Ceci fournira directement un emploi à un nombre limité de personnes

On s'attend à ce que l'amélioration et l'extension des services de santé conduisent à l'amélioration de la santé de la population rurale. Une meilleure santé augmentera la productivité potentielle (un des objectifs du programme général du Ministère).

Si les autres conditions permettent de rendre effectif cet accroissement potentiel en productivité, les revenus seraient aussi augmentés.

5.2 Est-ce que les méthodes à employer dans les services de santé sont appropriées aux situations physiques et sociales dans lesquelles les services sont dispensés?

Le Ministère de la Santé est maintenant, heureusement pourvu de services médicaux de base utilisant des équipes de santé de villages dans environ 1500 des 9000 villages du Niger. Les services sont développés partout avec la participation et la coopération des habitants du village, en utilisant les techniques d'"animation" développées et utilisées au cours des 15 dernières années par un autre organisme national qui travaille en complète coopération avec le Ministère de la Santé.

L'équipe de l'USAID et les experts-conseils, et le personnel de l'OMS sont d'accord pour estimer que le fait que le Ministère de la Santé insiste sur l'utilisation pour la santé rurale de personnel médical d'un niveau élémentaire et sur des services à peu de frais est une approche réaliste et possible des problèmes de santé du peuple nigérien. Ces politiques et le programme du Ministère en ce qui concerne le développement de services médicaux.

5.3 Est-ce que les services de santé développés sont à la mesure des moyens financiers de la population, et est-ce que le Gouvernement national sera capable de continuer à les supporter financièrement?

Les services de santé que le Ministère de la Santé développe actuellement sont destinés à fournir des services de base convenables au coût le plus bas par individu. Une partie des frais est payée par les villageois qui achètent des médicaments choisis, l'argent étant utilisé pour réapprovisionner le stock local de médicaments grâce à un fonds local tournant contrôlé par un comité de village. Les villageois poursuivent également leurs pratiques traditionnelles de paiement des matrones en nature pour les accouchements. Les services offerts par le Ministère de la Santé pourraient être utilisés par les villageois sans augmenter substantiellement le montant des dépenses actuelles des villageois pour les soins.

Le plein développement du programme de Ministère de la Santé pour les services de santé rurale ne sera pas achevé dans les cinq ans des activités du projet (voir la description du Projet pour les objectifs du Projet). Cependant, le Ministère s'attend à ce que des fonds soient disponibles en provenance du budget national et d'autres sources qui permettront le développement et le fonctionnement de tout le système. Les services fournis dans les zones rurales sont destinés à avoir des coûts par personne (à l'exclusion des paiements des villageois pour quelques médicaments) qui ne dépasseront pas les fonds disponibles par personne nationalement pour le fonctionnement du Ministère de la Santé.

5.4 Est-ce qu'un large soutien au secteur est la meilleure approche pour l'assistance de l'USAID en vue d'améliorer la santé et les programmes de santé au Niger?

Etant donné l'accord de base entre les politiques et les objectifs pour le secteur santé du Gouvernement du Niger et de l'USAID, et les progrès du Ministère de la Santé jusqu'à ce jour dans le développement et l'exécution des plans pour la réalisation de ces objectifs, le support au secteur santé semble être une approche souhaitable et réalisable pour améliorer la productivité et la qualité de vie du peuple du Niger. L'USAID à Niamey et les experts-conseils engagés dans le développement du projet ont été informés de la nécessité d'assurer que la capacité d'absorption du Ministère de la Santé permette d'utiliser au mieux un tel soutien.

Un projet en deux phases aurait pu être recommandé, avec une première phase destinée à améliorer la gestion du Ministère de la Santé, et des plans et la préparation du fonctionnement pour la seconde phase du soutien au secteur. Une telle recommandation n'a pas été faite pour deux raisons : premièrement le Plan Triennal du Ministère de la Santé montre qu'il est nécessaire d'avoir un tel soutien le plus tôt possible et indique un programme solide et raisonnable dans lequel un tel soutien pourrait être utilisé. Deuxièmement, AFRICARE a déjà reçu un contrat financé par l'AID à Washington pour fournir une grande partie de l'assistance qui aurait due autrement être fournie à un tel programme, et une assistance technique supplémentaire est directement à la disposition du Ministère de la Santé (en formation gestion, planification, systèmes d'information, et surveillance des maladies) dans le cadre du Projet Renforcement du Système de Prestation des Services de Santé (voir le plan d'exécution pour les buts du projet AFRICARE).

Une autre alternative pour un large soutien au secteur aurait été une assistance pour l'exécution accélérée d'un système pour la santé rurale dans une zone géographiquement limitée. Ici encore, le contrat AFRICARE supportera précisément un tel projet dans le département de Diffa. De plus le Ministère de la Santé Publique et le Gouvernement du Niger sont déjà engagés dans l'exécution à l'échelle nationale d'un système de prestation de services de santé rurale basé sur l'emploi d'équipes de santé de villages bien formés, bien supervisés et bien soutenus, et ont déjà commencé le processus de mise en oeuvre de cet engagement à l'échelle de toute la nation. Le support proposé

pour le secteur, combiné avec l'assistance technique d'AFRICANE, du Projet de Renforcement des Systèmes de Prestation des Services de Santé Publique, et d'autres donateurs, améliorera et accélèrera ce processus, en apportant de ce fait les avantages de services de santé adéquats de base à plus de personnes et plus rapidement.

Le large soutien au secteur santé est donc conseillé, non pas en excluant les deux approches possibles discutées, mais plutôt en conjonction avec elles.

6. Coordination avec les autres donateurs

Quelles sont les relations entre le projet et les projets d'autres donateurs contribuant au programme du Ministère de la Santé?

Le Ministère de la Santé met l'accent sur l'importance de la coordination de tous les nombreux projets du secteur Santé qui sont réalisés avec l'assistance d'au moins seize aides internationales différentes.

Le Ministère accepte correctement d'assumer cette responsabilité et assure que toutes les contributions des donateurs seront utilisées de façon à contribuer aux politiques et programmes du Ministère de la Santé sans déformer ou changer les priorités du Ministère de la Santé.

Les principaux donateurs contribuant au développement et au fonctionnement des services que soutiendra le financement proposé par l'USAID sont :

- le FED (construction et rénovation de bâtiments)
- le FAC (assistance technique)
- l'OMS (formation; techniques sanitaires)
- le PNUD

L'USAID/Niger aura besoin de poursuivre la coordination du développement et de la mise en oeuvre de ce Projet par des activités en liaison avec les autres activités du secteur Santé financés par l'USAID au Niger (Africare; OMS Projet Régional pour le Renforcement des Systèmes de Prestation des Services de Santé) et avec les autres aides officielles américaines au Ministère de la Santé (Peace Corps).

November 17, 1976

G. SUMMARY OF DISCUSSIONS BETWEEN THE MINISTRY OF PUBLIC HEALTH AND SOCIAL AFFAIRS OF NIGER, RDO/NIAMEY REPRESENTATIVES, AND THE PRP TEAM

Tuesday 12 October 1600

The Minister of Health, Chef de Bataillon Moussa Sala, the Secretary General of Health, Dr. John Wright, received the RDO/Niamey representatives (Mr. Albert Baron and Mr. Roy Harrell) and PRP team members (Dr. Eugene Boostrom, Mr. Gladstone Fairweather, and interpreter Mlle. Sylvie LeMontr er) in the offices of the Minister of Health.

The Minister of Health welcomed the team and commented on the following matters:

- (1) The Ministry of Health, since 1974, has been actively coordinating all international donor assistance in the health sector, contrary to statements regarding a "Manque de coordination" in documents which (USAID) RDO/Niamey had sent to the Ministry.
- (2) The Ministry's response to the documents related to the proposed Improving Rural Health project (translations into French of the PID and a summary report by Dr. Niels Poulsen based on his observations in Niger in September 1976) would be discussed with the group by Dr. John Wright and his high technical staff (the heads of the Divisions of the MOH). Dr. Wright would be the team's main contact in the MOH and would, with the team, review and modify suggested travel itineraries and work plans for the development of the PRP.
- (3) The Minister expressed his own interest, that of the MOH, and that of the Chief of State in seeing the proposed project move quickly through the PRP and PP development stages and begin to provide assistance to the MOH in the implementation of its Rural Health Program.

(Note added to English version of summary: The Minister of Health and the Secretary General mentioned in the initial meetings that persons outside of the GON would not be allowed to scrutinize the MOH budget. References to this were deleted from this summary in order to not increase once again their resistance to releasing financial and budget information, which had decreased somewhat in the intervening weeks.)

Tuesday 12 October 1630

The group left the Minister's office and reconvened in the office of Dr. Wright, where they were introduced to the high level professional staff of the MOH.

The following matters were discussed:

- (1) Dr. Wright explained to the group that the MOH takes full responsibility for coordination of international donor assistance in the health sector, and is disturbed by apparent lack of coordination by some donors (specifically the USA) among their own projects. As examples, he mentioned the seeming lack of coordination of activities related to the proposed Africare assistance to the MOH, the proposed Improving Rural Health Project, and the Peace Corps work. The Americans present explained that USAID is attempting to improve coordination and exchange of information among those US-supported activities, giving as examples the recent briefings of team members with Africare representatives in Washington and in Niamey and Dr. Boostrom's discussions with Drs. French and Poulsen in Abidjan.
- (2) Dr. Wright expressed his concern that multiple U.S. teams and visitors were occupying the time and efforts of him and his staff.
- (3) Dr. Wright expressed surprise that the PRP team did not include Dr. David French, whom he had expected on the basis of conversations in September. He explained that he had numerous technical problems with Dr. French's program but these could be discussed when Dr. French came to Niamey. He was also surprised that one of the expected team members (F. Gaynor) would not be coming and that a previously unannounced participant (J. Neal) was to participate but would not be arriving for several days.
- (4) Dr. Wright stated the MOH disagreed with the PID and the summary report submitted by Dr. Poulsen, and suggested that rather than try to use them as a basis for work the group should set them aside and begin anew. All agreed that some problems had arisen because of difficulties in translating the documentation into French.

- (5) The MOH asked that the initially planned departure for the team's field trip (14 Oct 76) be delayed in order to allow further discussions prior to the trip. A second meeting was scheduled for 15 Oct., at which time the PRP team would present and discuss with Dr. Wright and his staff an outline of the USAID PRP with questions and comments included in order to inform the MOH as to what kind of information would be needed by the PRP team and what level of detail would be required. The teams travel and work plans would also be discussed at that time.

Friday 15 Oct. 76, 1600

Dr. Wright and members of his high technical staff met with Mr. Harrell of USAID and PRP team members Boostrom and Fairweather (with interpreter) in Dr. Wright's office.

- (1) The PRP team gave Dr. Wright and his staff copies in French of the PRP outline and a cover note briefly explaining the team's objectives and expectations. The group discussed these and agreed to discuss them again at a third meeting, to be held on Tuesday, 19 October 76, at which time the Ministry would also be given additional materials (in the form of drafts of sections of the PRP) for consideration at the meeting and for discussion after the team returned from its field trip.
- (2) Dr. Wright gave the team copies of a financial document, showing suggested scheduling and use of the proposed AID assistance to the MOH over a five year period, the amounts of that assistance which might be used in each of several budget areas (in comparison to planned MOH investments under the 1976-78 Three Year Plan) during the first three years, with less detail during the last two years (due to the GON three year planning cycle). This document had been developed since the previous meeting. He also gave the team copies of a previously developed document showing MOH health personnel deficits in 1975 and proposed training programs (and costs) for 1976-1978 intended to decrease those deficits. The group discussed these documents.

- (3) The group discussed the team's proposed travel itinerary (including the addition of a visit to Tahoua at Dr. Wright's suggestion). It was decided that due to distance and the GON requirement that only five-car caravans attempt the trip to Bilma the team would be unable to visit ^{that site} as Dr. Wright had suggested.
- (4) Dr. Wright assured the team that telegrams announcing the team's composition, purpose, and itinerary were being sent to all necessary GON officials in the areas to be visited and that no Ordre de Mission would therefore be sent with the team. These arrangements were being handled by the Ministry of the Interior.

Tuesday, 19 Oct. 76 1630

Dr. Wright and members of his staff met with Mr. Harrell, Dr. Boostrom, Mr. Fairweather, Mr. Neal and Mrs. Neal in Dr. Wright's office.

- (1) Dr. Wright expressed surprise that a person who had not been mentioned in discussions at the previous meetings (Mrs. Neal) was present at the meeting and that it was proposed that she accompany the team on the field trip. He stated that this would cause problems, especially since the American Embassy's letter regarding the trip (including the names of the travellers) had already been sent to other ministries and the Ministry of the Interior had already sent telegrams based on that letter, at the recommendation of the Ministry of Health. He said that he would attempt to inform the other ministries involved of the proposed change, but could not predict what might result.
- (2) The team gave Dr. Wright and his staff copies of draft sections of the PRP written since the previous meeting. The group then discussed both those sections and the earlier PRP outline. Specific points of discussion included the following:

- (a) The Ministry had earlier discussed at length the possibility (Mentioned in section draft "issues") of using persons selected from among the best village health team members as paid supervisors of others, but had rejected the idea.
- (b) Mr. Harrell stated that he and Dr. Poulsen had found that most of the nurses they met on their field trip mentioned shortages of gasoline and money, and asked how materials and money flow from the center to the periphery. Dr. Wright responded that at present in Niger, as elsewhere, no one has sufficient money or gasoline. He said that gasoline credits are sent to the departments. Financial credits are sent to Prefets and the DDS every six months to finance their health services, and trimestral credits are sent to support hospitals.
- (c) Dr. Wright mentioned four technicians whom ^{he} expected Africare to be sending to assist the Ministry: a statistician, a health and nutrition educator, a vehicle repair and maintenance technician, and a technician to work with electrical and mechanical apparatus.
- (d) Dr. Wright said that the Ministry doesn't accept the WHO suggestion of a "donor club" to coordinate health sector aid, and noted again that since 1974 the Ministry has been coordinating such aid. Mr. Harrell repeated Mr. Baron's earlier suggestion that the Ministry of Health might want to use some of the funds from the project currently being planned in its efforts to improve such coordination.

November 18, 1976

H. SUMMARY REPORT OF USAID PRP TEAM'S FIELD TRIP TO OBSERVE HEALTH SERVICES IN THE DEPARTMENTS OF TAHOUA, AGADEZ AND DIFFA.

The party traveling on the field trip consisted of:

Dr. Eugene Boostrom (Team Leader)
Mr. James Neal (Fiscal Analysis/Health Systems Management)
Mr. Gladstone Fairweather (Health Manpower and Training)
Mr. Roy Harrell (RDO/Niamey Representative)
Mlle. Sylvie LeMontreer (Interpreter)
Mrs. Rubi Neal (accompanying Mr. Neal)
Two USAID Chauffeurs

The Group's travel itinerary, previously agreed upon with the Ministry of Health, was followed exactly, and GON regulations regarding contacts with local officials were observed throughout the trip. All local Prefets and Sous-Prefets were helpful in providing or arranging for lodgings and meals for the group, in addition to arranging contacts with local MOH officials and providing information about their areas of jurisdiction.

Before the first (Tahoua) interview with departmental health authorities, the team agreed upon a basic outline of topics for discussions, which was used in all of the meetings. Topics included:

- (a) Main health problems, main health services problems, and any problems unique to the area
- (b) Hospitals and/or other health facilities and services.
- (c) Services provided at health facilities.
- (d) Sanitation and water supplies.
- (e) Village Health Team training and use (including supervision)
- (f) Maintenance of vehicles and equipment
- (g) Supply systems (including drugs) and availability of supplies.
- (h) Coordination of Hygiene and Mobile Medicine teams with other health services.

ITINERARY

Wed 20 Oct. Fly from Niamey to Tahoua. Met by USAID vehicles and drivers in Tahoua. Visit Tahoua Hospital and interview DDS and his staff

Thu 21 Oct. Tahoua - Agadez. Hospital. Team meeting in evening.

Fri 22 Oct. One vehicle (JN, RN, GF) Agadez - Arlit
One vehicle (EB, RH, SL) Agadez - Iferouane

Sat 23 Oct. Meet Dr. Dreisbach (Medical Missionary operating dispensary in Iferouane)

Sun 24 Oct. Interview Dr. Dresibach and meet his staff. Visit MOH Dispensary and interview State Nurse.

Mon 25 Oct. Iferouane - Arlit (Second vehicle)
1600 H visit CM. 2100 H Team meeting.

Tues 26 Oct Arlit - Agadez

Wed 27 Oct. Agadez - Zinder

Thu 28 Oct Zinder - Gouré. Visit CM/Dispensary at Gouré.

Fri 29 Oct Gouré - Diffa. Visit Hospital Center and interview DDS and staff. Visit CM (formerly a hospital at Maine-Soroa.

Sat 30 Oct Diffa - N'Guigmi - Diffa. Visit N'Guigmi Sous-Prefet and CM with DDS. Interview CM State Nurse.

Sun 31 Oct. Final meeting in morning with Prefet, Sous-Prefet, DDS and other local officials. Team meeting in afternoon.

Mon 1 Nov. Diffa - Zinder

Tue 2 Nov Zinder - Maradi

Wed 3 Nov. Maradi - Niamey (Stop at private hospital in Galmi. Interview with staff.)

NOTES FROM DISCUSSIONS WITH MOH PERSONNEL DURING FIELD TRIP

(The following notes are intended to highlight selected topics which have special importance for the expansion and operation of the Ministry's Rural Health Services System.)

TAHOUA

General

The Department of Tahoua has about one million inhabitants and a surface area of 145,000 km². Health service facilities consist of:

- 1 Departmental Hospital Center (Tahoua; 183 beds)
- 1 Private Hospital (at Galmi)
- 7 Maternities (in 7 arrondissement capitals)
- 25 Health posts or dispensaries
- 1 Tuberculosis Center (in the Departmental Hospital)
- 1 PMI Service (in Tahoua)

There is a Hygiene and Mobile Medicine Team for the Department. MCH activities take place in arrondissement health facilities, but there are no detached arrondissement MCH facilities. West Germany has provided assistance to Tahoua Department's health service since 1963.

Health Problems

(See attached table. The DDS stated that the figures on the table were about the same as for 1974 and 1975, except that malaria is increasing throughout the department).

Health Services Problems

- (1) Insufficient numbers of personnel
- (2) Lack of medicines (although the department receives additional medicines from UNICEF, etc.)
- (3) Administration of funds at the departmental level - The DDS feels that more responsibility for administration of funds and for administration in general could be placed at the departmental level. The Assistant Director for Health Services was trained in administration in France.
- (4) Equipment, vehicles and maintenance are less of a problem in Tahoua Dept., than elsewhere, because West Germany supplies and maintains equipment and vehicles. However, that project is scheduled to end in 1977 and no qualified Nigerien technicians are available to take over repair and maintenance.

Sanitation and Water Supply

Potable water is supplied in Tahoua and Koni through a system administrated by the Director of Water and Forests and directed by Nigelec in Niamey. There is also potable water in each arrondissement capital. A village water supply program exists but has not yet reached all villages. In an attempt to educate the people about the problems of impure water, Dr. Nargoungou has recently begun a health education program in which the rural nurses meet periodically with the people to discuss:

- (a) basic hygiene (Food sanitation, personal sanitation)
- (b) water purification
- (c) animals - how to kill and preserve meat

The population response has been good in the Tahoua area, and during 1977, the program is expected to extend to other areas in the Department.

Training

Secouristes training began here in 1972 at the initiative of interested CM chiefs. The movement has been quite successful on the village level and is expanding during the next 2 years. The DDS proposes to try to train 2 secouristes per village in 12 day courses. All will be retrained for at least five days every two years.

Matrone training began in 1974 and has been successful in spite of less widespread acceptance than is found for the securist program. Matrone training is more elaborate and intensive than securist training. The department has developed its own training courses and reporting forms (including a monthly drug inventory) for both secouristes and matrones. Village "Comite de Gestion are trained at the same time as the secouristes and matrones.

The following table indicates past and projected future availability of trained secouristes and matrones in the department:

	1974	1976	1978
Matrones	30	264	544
Secouristes	(Dispensed by drought)	170	250

Sixteen "Matrones de Cartier" (who do no deliveries, but refer patients to the Maternity Center) are also working in the town of Tahoua

Coordination of Hygiene and Mobile Medicine Team

The Hygiene and Mobile Medicine Team's main function is immunization (and epidemic control) but they also provide basic care while in villages. They make a complete coverage of the department on a two to three year cycle. The chief of the local CM is informed of all planned and completed activities.

AGADEZ

General

Agadez, the largest department in Niger, has extremely difficult terrain, enormous transportation problems, and a high population of nomads.

Health service facilities include:

- 1 Departmental Hospital Center (Agadez; with approximately 100 beds; well equipped by MOH).
- 2 private hospitals
- 3 Health Centers (staffed by State Nurses)
- 8 MOH dispensaries (staffed by certified nurses)
- 3 private dispensaries

Three more MOH dispensaries are to be added. The private facilities operated by mining consortia and missionaries, cooperate with the MOH facilities.

Health Problems

- (1) High incidence of tuberculosis
- (2) Malnutrition
- (3) Trauma (knife wounds)
- (4) Birth-related problems

Health Services Problems

- (1) Patients come to hospital only when very ill, and then leave before completing treatment.
- (2) Many cases (often 25 per month for some dispensaries) must be evacuated from dispensaries to hospital, over bad roads and transportation (vehicles and maintenance) is inadequate. Land

Rovers must be replaced every two years; there is no mechanic. Only one of the six available LandRovers is in good enough condition to travel to Bilma. It is often necessary to use aircraft to evacuate patients, either within the Department or to Niamey; the costs involved (15,000 CFA/hour) are prohibitive.

- (3) It is difficult to provide health services to the large nomadic population.

Training

Secouristes and matrones are given eight days of common training together, after which the matrones alone receive four additional days of training. Training is limited by the shortage of financial resources for training. (Working with Animation Rural, the department spent 1.6 million CFA to train eight matrones and fourteen secouristes in Bilma.)

The following table shows the numbers of secouristes and matrones by arrondissement and the numbers of villages which they serve:

	Agadez	Arlit	Bilma
Secouristes	15	20	3
Matrones	6	8	14
Villages Served	17	17	12

Sanitation and Water

Over 100 wells which were functioning in 1975 are currently not in use. An additional 53 have become contaminated or nonproductive. While water is plentiful in the bush, people must come long distances. However when the Ministry of Public Works has consulted the MOH as to where to dig wells, the people have generally come and the wells are well utilized.

Additional wells (110 in 1976) are being dug throughout the Department.

Coordination of Hygiene and Mobile Medicine Team

Coordination is better now than it was in the past. The DDS directs such coordination and the two services (general and mobile) work well together. The size of the department, poor roads, and the large nomadic population limit the coverage of the population by the mobile team.

DIFFA

General

The capital of the department is the town of Diffa, which is located between two larger towns, N'Guigmi and Maine-Soroa. Africare provided assistance to health programs in Maine-Soroa until 1974, and recently signed an agreement with AID/Washington to provide further assistance, this time concentrating on the entire department and involving collaboration with the MOH at the national level. Specific plans for that assistance remain to be developed by Africare and the MOH.

Health Personnel

Health personnel include 4 physicians (DDS and 3 French), 11 State Nurses, and 1 Sage Femme (although there are three maternities in the department).

Health Problems

- (1) Malaria
- (2) Amebiasis
- (3) Schistosomiasis
- (4) Venereal Disease
- (5) Conjunctivitis

There is reportedly little tuberculosis and little malnutrition in the department.

Health Services Problems

- (1) The DDS and Prefet discussed the attached list of needs for their departments health services with the team at their final meeting.

- (2) The 110 bed hospital at Maine-Soroa is functioning as a CM, while the 44 bed CHD at Diffa lacks needed equipment and buildings.
- (3) Additional medical and paramedical personnel are needed (e.g.: a surgeon who could work in one or more of the three presently unused surgical blocks; laboratory and X-Ray technicians; sage femmes.
- (4) It is difficult to provide services to the nomads.
- (5) Transportation is inadequate, with few vehicles available and no maintenance provided within the department. (Although a well equipped garage is located at the Maine-Soroa health facility, there is no mechanic).
- (6) Training funds are needed to continue the training of Village Health Teams.
- (7) Additional dispensaries are needed.
- (8) Equipment repair and maintenance is inadequate.

Training

110 of 500 villages have been covered by the program which trains secouristes, hygienists, and matrones. Secouristes and hygienists receive 15 days of training together. Matrones are given 15 days of training at the Maternity. The DDS would like to train 50 matrones, 50 secouristes and 50 hygienists each year for each of the three arrondissements (a total of 450 persons trained per year), but needs added training funds in order to do this.

Coordination of Hygiene and Mobile Medicine

The Hygiene and Mobile Medicine team works in coordination with the general health services and maintains communication with the DDS.

SECTION IV
CONSULTANT'S REPORT

Health Financial Management/Logistics

Input to Revision of Health
Sector Analysis, Development
Assistance Program/Project
Review Paper Preparation

Niger, West Africa
October 14, 1976 - November 24, 1976

James P. Neal

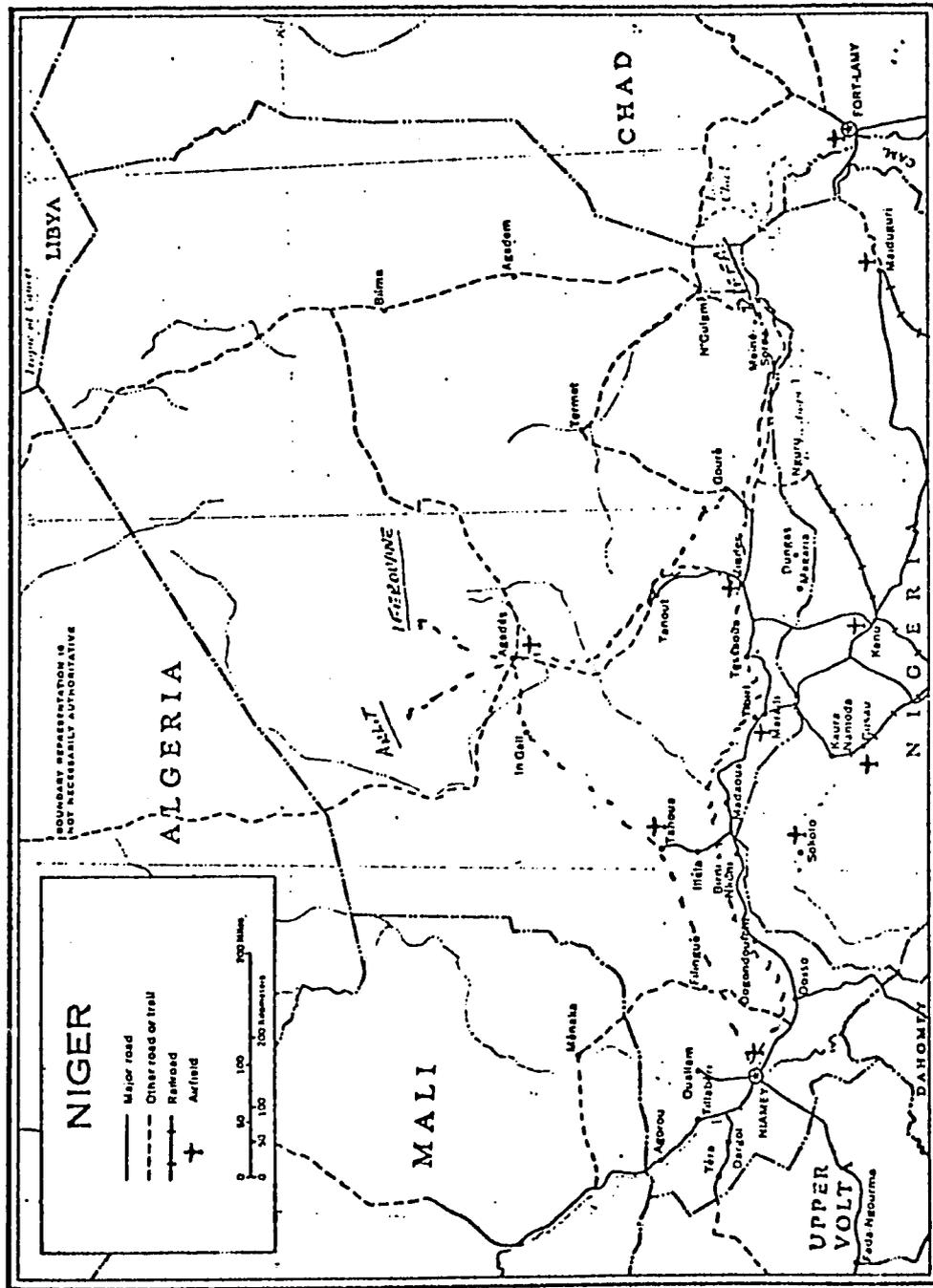
Consultant

December 9, 1976

A. KEY PERSONS CONTACTED

Date	Place	Name
10.16.1976	Niamey	Mr. Roy Harrel, USAID Program Officer.
10.17.1976	Niamey	Mr. Albert Baron, USAID Regional Development Officer.
10.18.1976	Niamey	Dr. John Wright, Secretary General of Health, MOH.
10.18.1976	Niamey	WHO Representative.
10.20.1976	Tahoua	Dr. Nargoungou Abdoulaye, DDS. Mr. Lacualy Ladjo, Director CHD.
10.22.1976	Agadez	Dr. Yansambou Boubacar, DDS. Mr. Beidou Abdoulaye, DDS Adjoint.
10.25.1976	Arlit	Mr. Nouki Gmbo, DDS(State Nurse)
10.27.1976	Aderbissinat	Miss. Catherine Sunshine, Peace Corps Volunteer
10.28.1976	Goure	Mr. Ousseini Kaimama, DDS(State Nurse) Mr. Ali Doungou, Sous-Prefect. Mr. Ali Salatou, Adjoint Sous-Prefect.
10.28.1976	Maine-Soroa	Mr. Djibo Jaharou, Chef CM. Mr. Rhony Issonfon, Sous-Prefect.
10.29.1976	Diffa	Dr. Abdou Hamani, DDS. Mr. Jeoun Edouard Mahamane, Director CHD. Mr. Mindaoudou Makko, Chef CM. Cne Ibrahim, Prefect. Sous-Prefect.
10.30.1976	Nguigmi	Director of Hospital.
11.04.1976	Niamey	Mr. Jay P. Johnson, Assistant RDO, USAID.
11.09.1976	Niamey	Mr. Issa Camara, Chief, Training, Health education and Nutrition education.
11.11.1976	Niamey	Mr. Abdulah Kane, WHO Sanitary Engineer.
11.19.1976	Niamey	Dr. Maigai, Assistant Secretary General of Health, MOH.
11.19.1976	Niamey	Mr. Maiga Abdoulaye, Director, National School of Public Health. Mr. Ousscyni Garba, Assistant Director, National School of Public Health.
10.20.1976 to 11.03.1976		Mr. Yacouba Nouhou and Mr. Souley Salifon, Drivers, American Embassy, accompanied us on the trip.

B. MAP OF NIGER



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C. SCOPE OF WORK

On November 5, 1976, the consultants met to review the original scope of work in the light of our experiences to date. My role was that of Budget-Fiscal Analyst or Health Economist. According to the work plan for Niger Rural Health Sector Support:

"Budget-Fiscal Analyst or Health Economist.
This person shall be responsible for analyzing the health budget going into support of primary and preventive health services for rural population; assess the GON, AID, and other donor agencies' inputs in the health field and make cost-benefit studies of the health sector."

It was agreed that to the extent possible the following outline would be followed in order to provide the information to be used in the PRP, in DAP revision and later in the P.P.

- 1) GON spending in the health sector(MOH)
 - (MOH budgets over the last 5-10 years in absolute amounts, as a percentage of GON total budgets, and in terms of purchasing power of CFA)
 - Projected overall budget figures for MOH for next 3-5 years.
- 2) Analysis of current/recent MOH use of available funds
 - Presentation of MOH-GON breakdown of MOH budget in categories which they use(personnel, equipment, etc.; PMI, Grandes Endemics, etc.)
 - Analysis of available data to indicate estimated current/recent spending on rural health.
- 3) Presentation and analysis of budgetary aspects of Three Year Plan.
 - Does projected spending indicate that GON-MOH priorities are those indicated in the plan narrative?
 - Does projected spending seem adequate to accomplish plan's objectives
- 4) Presentation of available information on current and planned health sector contributions of other donors.
- 5) Budget tables required for PRP(as described in Handbook 3)
- 6) Existing systems for fiscal control within the MOH and within the overall GON financial system.
 - What changes in these systems would allow the GON to provide AID with adequate information to assure AID funds were being used as agreed by MOH and AID?
- 7) "Cost-Benefit Analysis"
 - Probably not feasible.
 - Certainly not feasible during project development.
 - Cost-Effectiveness studies could be carried out during project implementation, with suggestions provided now by budget-fiscal analysts

1. Strengthening of Health Delivery Systems

It was expected at the onset that Dr. David French, director of the SHDS project, headquartered in Abidjan would be available to meet with us, the Africare representatives, and the MOH officials. As matters developed, however, Dr. Paulsen returned to Niamey having been briefed by Dr. French.

There were several reasons for this:

- The Africare Project provides for 4 direct hire specialists:
 - 1 public health doctor
 - 1 health statistician
 - 1 automobile mechanic
 - 1 medical equipment maintenance technician

There is no provision for other technical expertise.

Question: What is breadth of activity, where does this program get technical assistance and support if needed?

The SHDS Program is specifically organized to:

- Develop health planning and management capabilities.
- Strengthen disease surveillance and control data systems.
- Increase skills and improve utilization of health personnel at local level.

Question: How much assistance is SHDS willing or able to provide? in short run? in long run?

The Niger Rural Health Sector Support proposal is considered to be broad base sector support of the entire low cost delivery system.

Question: To what extent could this support program assist in bringing about coordination between these various AID supported programs?

These discussions have been ongoing and are yet in need of further clarification.

Some of the existing needs which SHDS could address immediately (should it be requested by the MOH to do so) are the following:

- Provide consultants as appropriately required to complement the rural health team to be supplied by Africare in development of a statistical reporting system and/or other appropriate assistance.
- Assist the responsible individual to be assigned by the MOH to develop a Management Information System by the provision of appropriately qualified short term consultants.
- Assist the responsible individual assigned by the MOH to expand the numbers of trained specialists by the provision of appropriately qualified manpower and training specialists as short term consultants

One of the way in which the Niger Rural Health Sector Support project could provide some locus of coordination is to provide for a program officer within this project who would be able to fulfill this function

2. Cost/Benefit Analysis

Consideration has been given to formulation of a cost/benefit mechanism with which to measure cost effectiveness of the service component of the MOH health care system. It has been determined that there is not enough firm data available at this time to do this effectively. An attempt should be made during the process of program formulation to selectively do such analysis. It should be possible if the raw data is made available by the MOH. Such data was not made available to this team.

It is possible, however, from our appraisal of how the system operates to make the following subjective comments regarding alternatives

- It is obviously more productive to utilize motivated and effective volunteers than equivalent members of paid staff to provide basic health services and information to scattered villages of different sizes and tribal representation.
- It is more effective to bring individual health providers together for frequent intensive periods of training and retraining at centrally located sites according to staff availability. This is now done.
- It is much easier to supervise and control individual health care providers by assuring an adequate means of transportation to a mobile supervisor. This is in process of expansion.
- Considering the variety of terrain it is more effective to provide a variety of means of transportation to assure appropriateness of the travel mode. This is now attempted although a system of effective repair, maintenance and standardization of equipment and parts has not been developed..
- When skills are in short supply it is ordinarily more effective to group the collection of skills at designated central locations for teaching and service, mobile and non-mobile, according to need. This is in process of implementation.
- When materials and supplies are both costly and in short supply, it is necessary as a minimum to have a system of control and accountability for those critical items. This is partially done though capability is limited.

3. Community Participation

The low cost health care delivery system presently employed in Niger uses a "voluntary" principle as basic to its organization. This is not unlike numerous health care institutions in the U.S. which employ this concept. In the U.S. it is quite common to find hospitals and other organizations (Red Cross, etc.) operated by volunteer Boards of Directors which include the health care professionals of the cadre (executives, medical staff, etc.). It is also quite common to find a broad base of specialized volunteers. The U.S. health care system has evolved from this type of community involvement. The GON recognizes the value of these inputs to its system of health care delivery.

4. Impact on Costs

As with the system employed in the U.S. the use of volunteers in large numbers complicates cost determination (as in Catholic orders).

It is impossible to establish relative costs unless relevant cost factors are applied against relevant units of service. For example, if services are provided by volunteers one may establish the value of the services and compute what they would cost if paid for. Since so much of the health care system in Niger is provided by volunteers it complicates efforts to establish the "true" percentage of values expended in the various segments of the health delivery system.

Measurement of actual amounts of money expended in terms of the costs of operating the two National Hospitals as a percentage of total expenditures does not adequately reflect the "value" of the broad base. The existing fixed structures and those in process of development, as well as necessary staff, provide supportive capability to the broad base. Again, adequate detailed data is not presently available to make adequate assessment of this at this time.

D. REPORT ON MEETINGS WITH SECRETARY GENERAL, MINISTRY OF HEALTH AND SOCIAL AFFAIRS.

1. Initial Meeting

There were several meetings with the Secretary General and his staff prior to the 15 day, 4,500 kilometer, tour of the country and randomly selected health care facilities, and locations. The consultants were given information regarding the projected Operational Plan of the Ministry of Health and Social Affairs as requested during these sessions. It was evident that much effort had been expended at various levels of the government and the ministry in order to develop an adequate Operational Plan for the health sector to support and carry out the three-year development plan of the government. In the course of the early meetings the consultants were given a proposed budget distribution for allocation of \$12.5 million USAID sector support funds over a five-year period. ("Couts Programation Triennale au 15 Octobre 1976") It was against this tentative projection of need that questions were formulated, and inquiries made during the tour of the country. On the spot observations were made regarding the adequacy of existing facilities, equipment, vehicles and other required resources. A copy of that document is attached to this report.

2. Final Meetings

Upon return of the consultant group from the tour of the country, a meeting was again scheduled with the Secretary General and his staff on Friday, November 19, 1976. He requested that questions for discussion be presented in writing in advance. The period between the return of the team from the tour on November 3 and the scheduled meeting of November 19 was utilized in seeking out information related to field observations and in review of documents previously acquired. As a result of this review a list of questions were developed which were designed to elicit concurrence with our conclusions and/or to provoke relevant discussion about the feasibility of a sector support grant. The questions were prepared and submitted to the Ministry on November 17. The meeting was held on Friday, November 19 as scheduled.

The questions posed and a summation of the answers received are as follows:

1. Planning

We have seen copies of the Three Year Development Plan. We have reviewed the 1976 Budget.

Question: Does overall plan now exist for the MOH other than as expressed in these documents? For 1976? 1977? etc.? If so, may we see it or have a copy for our use?

Answer: There are no other plans. (There have been two meetings of the Health Sector Study Group, 1975 and 1976, another scheduled for 1977)

2. Budget

Question: Are budget distributions available in which we may see breakdown of budget allocation by departments? Arrondissements? Of personnel? Pharmaceutical and medical supplies? past three years? Next three years?

Are distributions of expenditures available for 1975 and 1976 according to above allocations? May we have this information?

Answer: This information is not presently available in usable form. The reason it is not available is that the MOH system has not previously required it, and the staff available to compile this information is limited.

As regards the budget for FY 1978, the Ministry would not know until June or July 1977 what the appropriations would be for FY 1978. It is hoped that the budget will be increased from FY 1977 levels but he does not know what the Ministry of Finance will do. For example, upon review this July the MOH was given an additional 15% for FY 1977 over the previous year. The usual rate of increase from year to year averages 8%. Of course there is always the continuing problem of inflation.

3. Organization

We have reviewed existing organization charts of the MOH.

Question: Are there organization charts in greater detail?

By function or activity of personnel?

Have there been other organizational changes recently?

Are additional organizational changes contemplated during the next year? two years? three years?

Answer: No, although this is in process. The new organization as revised in Tahoua is in process of implementation. It is contemplated that this will be available soon, but one must realize that the organization has undergone considerable change in the past two years.

Comment: One must notice on the new organization chart that the chain of command is from the central government through the prefectures of the seven departments. The DDS reports to the prefecture. The prefecture controls all activities in the Department. The infrastructure organization is that of a military unit. The overall direction is centralized control through the military structure with such mechanisms as the Health Study Group to provide input in the form of recommendations to the central ministry. All actions of the ministry must have approval of the Supreme Council.

4. Management Information System

We have reviewed the proposals of Africare regarding the provision of assistance in developing a statistical reporting system.

Question: Has the Ministry of Health given consideration to development of a management information system also? If so, what is planned? If not, what is needed to develop a plan?

Answer: The Ministry is not relying on Africare for development of a statistical reporting system. The Ministry intends to do this themselves and at present there is a person assigned to this task. It is expected that Africare will provide some assistance to this project. This has not yet been worked out however.

Comment: Basic to control of an enterprise is the capability to cause predictable action. In managing the investment of capital and causing achievement of operational objectives it is necessary to have a sound mechanism for budgeting and accounting. In order for the system of budget and accounting to function properly an adequate information system is required.

The type of information system to be employed must relate to the needs of the using institution in such a way that all required information is transmitted where it is needed when it is needed in a useful form and context.

The system of reporting and accountability thus developed may be simple or complex depending on the needs of the user. The system need not be complicated as long as it is effective. Through use of such a system it is possible to cause change and improvement in management performance and to monitor results.

Of course, it is expected that Africare will assist with development of a statistical reporting system at the national level as well as in the development of a prototype system in Diffa Department.

Question: Will existing accounting system be capable of providing adequate reports as required by USAID to provide reasonable assurance of use of funds according to agreement? Capable of providing cost information for use of MOH? Are there computers available in Niger? Are they available for use of the MOH? If so, is use of computer contemplated in near future? If not what is required to develop this capability during the next year? next two years? next three years?

Answer: The system at present is not constructed to achieve this. However, since the system must be updated it is not precluded. There is computer capability available from the Ministry of Finance. There has been no consideration given to its use by the MOH.

5. Logistics

We have seen the road conditions, some of the existing garages, generators and refrigerators and note some existing external assistance and proposed assistance by providing mechanics.

Question: Has consideration been given to development of appropriate maintenance training program for drivers? management personnel? (in addition to mechanics) Has consideration been given to development of refrigerator repair technicians? others? Has consideration been given to development of programs or systems to carry out these objectives by Africare, SHDS, others?

Answer: At present technicians are generally trained abroad for the most part at Lome in Nigeria and Yaounde. There is no training provided for the type of mechanics needed in Niger to provide regular maintenance and repair of vehicles and equipment of various sorts. There is a great need for this as existing resources are very few and fragmented. Technical equipment must be sent out of the country at times for minor calibration, adjustment or repairs. The mechanics that are available are often temperamental and difficult to locate or not available where they are needed. It is not unusual for a vehicle to be inoperable for lack of a spare part. An example was given of a new car of French manufacture which could not be used for lack of a replacement tire.

In the course of this discussion, it became clear that the problem of maintenance was even more complicated than just shortage of trained manpower and spare parts in the usual sense. The complicating factor was that Niger has been dependent on donations from outside of Niger for both vehicles and equipment. Since this is the situation the vehicles and all sorts of equipment are not standardized. The vehicles, air conditioners, refrigerators, etc are from dozens of different manufacturers in a number of foreign countries. To maintain an appropriate inventory of spare parts is prohibitive in terms of cost. Again as with construction of buildings, donors will often provide the equipment, but Niger must provide the money to operate and maintain the equipment provided. This has proven difficult in the past. Of course, the sector support grant would provide a new way of dealing with these problems. There is yet much work to be done in working this out. Prior to this, every foreign embassy in Niamey had been approached and requested to provide assistance in resolving the problem. None have been able to do so. Africare has made a proposal to assist with this problem in Diffa and in developing a prototype. The German team in Tahoua has provided a mechanic there.

Logistics: Given size of country and terrible roads, logistics pose one of the most difficult problems. Roads - each facility uses the most effective means of transport. Land Rovers are most often used. In those instances where workers do not have vehicles available to make required tours they are often made by utilizing camels, horses, or other local means. There are often cultural complications in that rural persons who are ill may not agree to ride in a motorized vehicle in all cases. National Policy regarding this is it is a criminal offence for an individual to refuse transport of a sick person if requested to do so if regular vehicles are not available. Then use of other vehicles is made - the prefecture, police, military, other.

Equipment: Effort to be directed toward

- Small equipment for all sanitary structures.
- Heavy equipment in hospitals and medical centers (but only to improve or complete their possibilities).
- Creation of efficient maintenance services - the personnel will have to become conscious of the need to maintain all equipment for which they are responsible in good condition.

Pharmaceuticals: National Office of Pharmaceuticals and chemicals (ONPPC) which is the only supplier for Nigerien Health facilities and which supplies pharmacies in the most important towns 46% of the total budget other than personnel costs is designated for medicines. This entire sum is turned over to ONPPC where it is then allocated according to the importance of each facility. The MOH decides the allocations and notifies each post of how much it will receive. Orders for medicine are made every six months, and may not exceed the amount allocated. MOH in conjunction with departmental directors has made a list of appropriate and available medicine.

6. Management

We have noticed that a number of the Departmental Assistant DDS have been trained abroad in management. We understand there are others.

Question: What is their role envisioned to be in the health sector? Are additional numbers to be trained in the next 3 years? If so, how many?

Answer: This question has been previously handled in great detail in the material previously given to Dr. Boostrom and Mr. Harrel along with other relevant information.

Specifically, the information is to be found in the proceedings of the Tahoua Planning Conference of last July.

Comment: We were provided with another copy of the Tahoua conference material.

7. Coordination

It has been estimated that as much as 50% of the incidence of disease is due to water borne disease. There are extensive well drilling programs, and other programs existing or in process of development.

Question: How does the MOH coordinate its efforts with these programs?

Answer: In the past, there was very little input from the Ministry of Health. Presently the Ministry serves on a joint committee at the level of the responsible Ministry and does have input in the planning. This could be improved as increased staff time becomes available to work on these problems.

8. USAID Sector Support

Question: Would it be possible for the Secretary General to review the "Couts Programation Trensale" which had been given to the consultants and revise it to fit USAID/PRP format? We also explained the need for detailed justification of the amounts requested by category of need.

Answer: That could be done. The revision would be delivered to the American Embassy on Monday, November 22nd.

Comment: The revised document was delivered to USAID at the American Embassy on Monday morning, November 22nd as promised, and a meeting was scheduled for Monday afternoon at 4:30. As it turned out, it was a long and fruitful meeting.

At 3:30 p.m. on November 22, 1976 a fourth meeting was held at the Ministry of Health and Social Affairs. Those in attendance were Dr. Wright, Secretary General; Dr. Maigi, Assistant Secretary General; Mr. Jay Johnson, Assistant Regional Development Officer, USAID; Mr. Roy Harrel, Program Officer, USAID; Dr. Paulsen, Regional Health Officer, USAID, Abidjan; Dr. Eugene Boostrom and James P. Neal APHA consultants.

As had been previously requested Dr. Wright presented and discussed a revised proposal for utilization of anticipated health sector support funding. "Document #2 - Proposition Utilization Funds USAID, au 20 November 1976." Each section of the document was discussed in detail and in general discussion. All questions put to Dr. Wright by those present were answered quite candidly and in a forthright manner.

In summary, the categorical rationale for the requested distribution of funds over the five-year period was present as follows:

From the onset, and throughout all meetings with the Ministry and responsible officials in the field it was the consensus that some needs were more urgent than others in terms of early and sustained fulfilment. These concerns were:

- Adequacy of facilities and support utilities.
- Adequacy of equipment and supportive maintenance and supplies.
- Adequacy of means of transport and supportive maintenance and supplies.
- Adequacy of numbers and skills of personnel.

Although not always given the same order of priority, the above concerns were observed to be realistic in terms of the conditions observed and the programs proposed. The questions most often raised by the consultants related to the reality of the need, the feasibility of the proposed resolution and the absorptive capability of the health care unit.

The position of the Ministry regarding the phasing of the supplemental funding has been consistent throughout the meeting and ensuing discussions. In brief, it is that the development plans have been formulated and approved as reasonable and objective. A proposal has been tentatively made for a health sector support grant. Having this support would enable the Ministry to achieve its objectives more rapidly in an orderly manner. For maximum impact and optimum flexibility it is necessary to have the support funds phased in with larger initial amounts appropriately allocated. This position was consistently questioned by the Program Officer, USAID, Mr. Harrel.

On the basis of observation in the field and discussion with numerous others it would appear that the position of the Ministry has merit. A categorical summation of the Ministry's presentation is as follows:

Category I - Renovation, Repair and Construction of Facilities

The policy of the Ministry is to repair, renovate and/or construct and equip new facilities in that order of priority. Where possible, repair or renovation of existing structures is preferred and planned. It is only in the extreme case that new structures are contemplated. In the past, it has been rather difficult to adhere to the intent of the policy in all cases due to the variety and inclinations of the various donors. In some instances, the donors will only provide the building, in other instances the building and its support systems. It is unusual for a donor to provide funds for renovation or repairs. Ironically, numerous buildings thus constructed are now in need of repair or reconstruction. Problems of maintenance are increased because of the variety of construction methods and equipment. Of necessity these practices will continue until a better method is worked out, at least through the existing Three Year Plan.

As proposed, the initial support for repair, renovation and construction of buildings would be \$1,624,000 the first year, \$1,421,000 the second year dropping to \$406,000 the third year. The phasing would permit 62% of the requested allocation of \$4,915,000 to be available to support the FY 1978 and FY 1979 objectives, and the remainder to be expanded at a lesser rate during the remaining three years of the program.

In theory, all capital improvements and new construction which has been approved by the GON from the various requests of the Ministry of Health are included in the Three Year Plan. Also included in the plan is the expected source of funding for individual projects (FAC; FED; FNI; etc.). All items included in the plan are not yet funded. All of the putitive funding may not materialize and some of the structures recently constructed are rapidly disintegrating and major items of equipment are in need of replacement or augmentation.

It is estimated by the Ministry that the amount projected for this category of expenditure would be expended in proportionately equal amounts for renovation and repair or construction of new facilities. Should it be necessary to do so, the Ministry is prepared to furnish a list of specific needs by project.

Since all of these projects are well into the planning phase, or as in the case of much needed reconstruction or repair, (due to faulty original construction) are critically past due; there does not appear to be a problem regarding the rate of absorption of funding. Also, it would seem that the possibility of success of the over-all program would depend in large measure upon improvement in the facilities which are available.

Category II - Technical Medical Equipment

Discussion of this category of need proved to be as frustrating at the level of the Ministry as it had been in the field during the course of the country tour. As observed in the field there was little equipment of any kind available outside of the schools of public health, medicine or nursing and/or the hospital centers. Where supportive equipment was physically present it was often in need of repair.

The amount of money to be provided is relatively small compared to the observed need for such basic equipment. Although there is not a comprehensive list of individual equipment needs showing the aggregate need, equipment on hand and the net need, there is a list of the minimum requirements for each type of facility for which the Ministry is responsible. A copy of this list is included in the report of the Tahoua Health Study Group conference of July 1976 which is attached to this report.

The requested allocation for Technical Medical Equipment is \$406,000 the first year, \$326,000 the second year, \$206,000 the third year and the remainder spread over the last two years. It is noted that 50% of the proposed \$1,455,280 is requested during the initial two years. The amounts requested would appear to be absorbable as proposed.

There is an existing pressing need for the equipment which is included in this category for use of personnel now employed, and to facilitate the efforts of those employed in the contemplated expansion of the basic health system. Due to the phasing as proposed, some of the equipment purchased with these funds could be available in early 1978. As in the case of facilities, availability of this equipment in adequate quantities is a key factor in assuring success of the program which is planned.

Category III - Free Medications for the Village Health Teams

This item must be phased into the area in which the drugs will be utilized. As the number of village health teams are increased in an area the stocks

of the Pharmacy Populaire serving the area must be replenished at the new levels of need. As the numbers of dispensaries and matrons increase the utilization of medications and supplies must appropriately increase. These are all basic medications.

It is conservatively anticipated that during the five year period some 25% of the villages will have coverage, this will be up from the present 10%. It is also hoped that more of the Nomadic population will be reached through means yet to be developed.

The expenditures for medications is proposed to be \$203,227 the first year, the same amount the second year, and \$126,000 the third year. 64% of the total requested is to increase the stock levels during the first two years to accommodate the acceleration of drug utilization. The remaining 36% spread over the last three years is to accommodate the anticipated turnover of stocks.

Category IV - Vehicles

The goal of the Ministry is to provide at least one vehicle for each supervising physician in addition to the general service vehicles which are needed. The categorical funds to be provided by USAID would permit the Ministry to provide these vehicles. This amount does not include the cost of maintenance.

The proposed phasing would permit supplemental expenditures of \$569,100 the first year, \$284,550 the second year, \$569,100 the third year and the remaining \$418,634 to be expended over the remaining two years. The increase in the third year is to provide replacement for vehicles on a rational basis. This schedule would contemplate replacement of vehicles on what is estimated to be the present average, with minimal maintenance. Given the weather, ruggedness of the terrain, the condition of the roads and the accelerated wear and tear to be experienced, these are conservative estimates.

It is expected that these vehicles will be purchased from an approved supplier of a type and model suitable to the use for which the vehicles are to be utilized. Ease of maintenance and economy of operation are primary considerations. Experience with American made vehicles in Niger has not been good. A list of vehicle requirements is included in the Tahoua report which is attached.

Category V - Training, Supervision and Retraining

It is contemplated that 3,000 villages will have Village Health Teams upon completion of the current Three Year Plan. This, of course, is dependent upon the success of the Ministry in recruiting and training the necessary personnel to support this program.

At present there are 1,258 villages with Secourists and 1,800 with Matrons. After three years it is necessary to provide a program of continuing education. The supplementary funding would provide this capability. There are 500 nurses who must also receive this type of training. This is in fact a retraining to recycle personnel in terms of the new health policies of the country and to increase the skill level of existing personnel.

The key to successful operation of a voluntary low cost health care delivery system is the quality of supervision and consistent training and retraining. The motivation is maintained at a high level through this sustained contact. Therefore, the expansion of the basic system is directly related to the training, supervision and retraining capability of the system. Mobility of key personnel is important to the success of this program.

The programmed expenditure of 77.7% of the total request for this type training during the first two years would appear realistic since most of those to be provided this type of training are already on board.

Category VI - Materials Maintenance

For some period of time the Ministry has solicited assistance from any source for help with the problem of maintenance of equipment and vehicles. There is a mechanic provided by the German team in Tahoua. Maintenance of the varied stock of motor vehicles throughout the country is a nightmare. The few mechanics otherwise available are very independent and difficult to find when services are required. These mechanics were named and individually discussed.

Africare is proposing to establish a garage complete with mechanic to train others in the Diffa Department. This has been considered a pilot project which could be replicated as resources are available to do so.

The Ministry has plans to establish garages in Maradi, Agadez and Zinder as soon as possible. The allocations projected would permit this to be done.

There is yet a need for assistance in development of this project.

Category VII - Sanitation and Hygiene

The amount projected for this category of activity is considered too modest. It is basically for the construction of latrines and similar facilities. The money is for purchase of cement and similar materials. The labor is to be provided free.

Having met with the one sanitary engineer in the country, and having observed the public accommodations and facilities, the wells and how they are used, the markets, the flies and mosquitoes, it is difficult to imagine what the priorities should be.

Category VIII - Administration and Miscellaneous

Included in this category are additional personnel costs and other administrative costs such as the cost of printing paper, supplies and materials. None of these type costs were included in the other categories

MILLIONS / CFA

COUTS PROGRAMMATION TRIENNALE AU 15 OCTOBRE 1976

I

	A récluse	Sûrs	III A Trouver	Soit par AN en supplémen			1ère Année	2è Année	3è Année	Propos
I) Bâtiments à Reconstruire ou à remettre en état	970,700	62 % Total 1 564,500	1,209	403	200	200	200	200		
Bâtiments à Construire.....	1 202,800									
II) Equipements techniques médicaux	445	1/5 = 89	356	118	50	50	50	50		
III) Médicaments gratuits pour ESV	195	1/5 = 39	156	52	40	40	40	40	2	
IV) Véhicules.....	678,100	1/5 = 225	453,100	151	120	120	120	120	10	
V) Frais de Formation - Supervision Recyclages.....	221,500	1/5 44,300	177,200	59	50	50	50	50	2	
VI) Entretien des Matériels.....	225	1/5 45	180	60	50	50	50	50	4	
VII) Hygiène et Assainissement.....	100	1/5 12	88	30	30	30	30	30		
VIII) Vaccins (forfaitaire 150M/an)	450	1/5 90	360	120	80	80	80	80		
IX Divers 10 % 10% Administration, etc..	500	1/5 100	400	133	80	80	80	80		
TOTAL.....	<u>5 582</u>	2 208,800 = 39,5 %	3 379,300 = 60,5 %	1 127 = 20 % du Total = 33 % de ce qui reste	700	700	700	700		

REPUBLIQUE DU NIGER

CONSEIL MILITAIRE SUPREME

MINISTERE DE LA SANTE PUBLIQUE
ET DES AFFAIRES SOCIALES

AU 14 OCTOBRE 1976

(Estimations - Propositions)
en millions CFA

1°/ Montant <u>Total</u> du Programme triennal (T.P.T.)	=	5.588		
2°/ Financements obtenus (F.O)	=	2.208	=	39,5% du Total
3°/ <u>A Trouver</u> (A.T.)	=	3.379	=	60,5% "
ce qui représente par An	=	1.127	(20% du Total
)	33,33% de A.Trouver

4°/ <u>Aide USAID Proposée par Niger</u>	=	<u>1.960</u>)	35% du Total P.T
Pour la période triennale)	58% de A.T du P.T

Cela représenterait environ :

Pour la 1ère année 700 Millions	=	12,5% du <u>Total</u>	=	62,1%	de	A Trouver
2ème année 700 Millions	=	12,5%	=	62,1%	de	"
3ème année 560 Millions	=	10% du Total	=	49,6%	de	AT

Il resterait pour la 4ème année 560 Millions)			=	960	=	32% de l'Aide proposée par
5ème année 400 Millions (<u>USAID</u>

Environ 3 Milliards
(12 Millions de Dollars)

REPUBLIQUE DU NIGER
 MINISTÈRE DE LA SANTÉ PUBLIQUE
 ET DES AFFAIRES SOCIALES

DOCUMENT N° 2

(Proposition utilisation fonds USAID)

22 NOV. 1976

AU 20 NOVEMBRE 1976

RUBRIQUES INVESTISSEMENTS	FONDS à trouver A	Moyenne annuelle	PROF. SITECHS FONDS U.S.A.I.D				TOTAL a+b	% a+b A
			Oct. 1977 _a	Oct. 1978 _b	Oct. 1979 _c	TOTAL a+b+c		
I) Bâtiments à reconstruire ou à remettre en état Constructions nouvelles	1.209	403	400	350	100	850	750	62
II) Equipements techniques médicaux	356	119	100	80	50	230	180	50,5
III) Médicaments gratuits pour E.S.V.	156	52	50	50	30	130	100	64,1
IV) Véhicules	453	151	140	70	140	350	210	46,3
V) Formations - Supervision - Recyclages	180	60	60	80	30	170	140	77,7
VI) Entretiens des matériels	180	60	60	60	20	140	120	66,6
VII) Hygiène et Assainissement	90	30	30	30	30	90	60	66,6
VIII) Administration - Divers 10%	400	133	100	100	54	254	200	50
TOTAUX EN MILLION CFA	3.024	1.008	940	820	454	2.214	1.760	58,2
TOTAUX EN MILLION DE DOLLARS	12, 2926	4,0975	3,820	3,330	1,850	9	7,150	

N.B. 1°) Dollar estimé à 246 F CFA
 2°) Reste à trouver par le Niger pour la période Triennale finissant en Septembre 1979
 $12,2926 - 7,150 = 5,1426$ Millens dollars (1.265 millions CFA)

E. Background Information

1. History

A Republic in West Africa's Sahara region, Niger was incorporated into French West Africa in 1896. Rebellions were constant, but when order was restored in 1922, the French made the area a colony. In 1958 the voters approved the French Constitution and voted to make the territory an autonomous republic within the French Community. The Republic adopted a Constitution in 1959 and in 1960 withdrew from the Community, proclaiming its independence.

On January 1, 1973 Niger joined the seven-nation Economic Community for West Africa, whose purpose is to promote regional economic development.

An Army coup on April 15, 1974 ousted President Hamani Diori, who had held office since 1960, claiming Diori had mishandled relief for the terrible drought that has devastated Niger and five neighbouring sub-Saharan nations for several years. An estimated 2 million people were starving in Niger, but 200,000 tons of imported food, half U.S.-supplied, substantially ended famine conditions by the year's end. The new President, Lieut. Col. Seyni Kountche, chief of staff of army, installed a 12-man military government, suspended the Constitution, dissolved the National Assembly and banned political groups.

2. General Social and Economic Considerations

In 1975 the estimated population of Niger was 4.5 million with a projected growth rate of 2.7%. The average per capita income was estimated to be slightly above \$100 per annum. The country is one of the poorest in the world and has in recent years suffered heavily from drought and insect infestation which prevents habitation of arable land and devastates existing crops. Famine was prevented by sizeable food imports.

Among other constraints to economic development and effective governance are poor soils. Four fifths of the soil is desert or semi-desert and the rest has low levels of soil fertility, which is probably declining, while rainfall is irregular or insufficient. In addition, the country is large (489,000 square miles), land locked, with heavy dependence on external factors. The illiteracy rate is 90% and available technical ability and skills are scarce.

Most of the country is sparsely populated by nomadic herdsmen and/or sedentary farmers (density of 9.2 per square mile). There are several ethnic groups: Hausas, 53.7%; Djermas and Songhais, 23.6%; Fulanis, 10.6%; Beriberi-Mangas, 9.1%. The people are Moslem, Animist and Christian. Some of the people speak French. Most speak Sudanic dialects.

Against this mosaic, a new government took over in 1974 which

places emphasis on regional and social equality, justice and "life enhancing" economic growth.

a. Short term economic projections

It is estimated that the total capital requirements necessary to keep the country's external financial position in equilibrium will accelerate. These requirements will be met through the growing interests of the traditional foreign donors to the Saelian countries, and increasing involvement of Arab oil-producing countries in Niger. Great inflows are expected to grow more slowly than net capital requirements which means that the share of loan financing is likely to rise. This will probably lead to higher, but manageable, debt ratios.

Local prices for petroleum products, capital goods and production inputs, fully reflect international price increases. Most ongoing construction projects are faced with very large cost over-runs. The cost of infrastructure projects has roughly doubled between 1973 and 1975.

The Three Year Interim Plan(1976-1978) is essentially a summary of ongoing and some new projects to be used pending formulation of a comprehensive long term development plan. The present policies of the government places emphasis on direct economic controls and public sector involvement in management of the economy. Along with this, is increasing centralization of decision making power.

The 1975-1976 budget shows a 72% increase in tax revenues and a 66% increase in recurrent expenditure appropriations over the 1974-1975 budget. Revenue increases are projected from profits in industrial, commercial and mining enterprises and from import and export duties. On the expenditure side, most important expenditures relate to education and health. 15% of the budget for education is for a Television education scheme previously introduced.

Availability of foreign capital assistance does not at present appear to be a key development constraint. The lack of well prepared projects, local skills and management capacity are probably more important factors.

b. Long term economic considerations

Any long term economic consideration must focus on the potential of Niger rather than present performance. Although this approach is speculative and not very exact it is the only approach consistent with the development plans of the country.

As a primary goal, emphasis has been placed on long term self-sufficiency in food production. It is necessary to establish per capita production quotas and emergency reserves. Annual stock level requirements of grain must also be determined and achieved to prevent unreasonable price fluctuations. There is an urgent need for additional research in improved agricultural techniques.

While Niger should be able to feed itself now(1976), given normal weather, a serious deficit is likely during next five or six years unless something drastic is done to improve production levels of millet and sorghum.

It is in Niger's long term interest to achieve and maintain self-sufficiency in food, but not at the expense of export crops.

Use of irrigation projects to achieve agricultural sufficiency is a marginal solution for the foreseeable future due to the extremely high cost of development of such projects. The government, however, places high priority on development of irrigation systems as a means of reducing dependency on the weather. There is need for better extension services and strong management in the new irrigation projects that are developed. Much research is needed as regards utilization of irrigation as a solution to this problem.

Live stock is one of Niger's principal material resources. Private cattle ownership and communal grazing land tends to lead to over-grazing and destruction of the very resource that sustains the population. Important key to resolution of this problem is the long term development of a balance between grazing land, cattle population and watering points.

Forestry is an industry no less important to the country than agriculture and live stock. A long term strategy for utilization and development of forest resources must be based on a recognition of the vital importance of trees and forests in protecting the country against desert encroachment, and soil erosion and to provide building material and firewood. Firewood is the country's most important source of energy. Firewood costs as much as the food it cooks.

Because of the appetite of goats for the young trees, and the long dry season the establishment of forests is difficult and very expensive. To date, GON budget allocations for forestry development have been limited.

Niger's mineral development is considered to have significant potential. At present, the increased mining of uranium is making additional revenues available through taxation that can be used for the development of other sectors. Although it provides relatively little domestic employment, uranium mining does stimulate employment activity in the local areas by providing limited peripheral employment in the Department of Agadez. There is a plan for development of a coal fired steam generating plant near the city of Agadez. In addition to providing electrical current to the city it should also provide limited employment in the area.

A search for oil is continuing although a previously announced discovery at Lake Chad was of no economic significance. Search for minerals other than uranium and oil is presently focused on phosphates which seem to be available in quantity.

Notice of the attendees was drawn to the very particular importance which has been given for the past two years to development of the social sector by the government of Niger. Especial notice was drawn to the primary consideration given social justice in program development. It was pointed out that the health budget has become the fourth in terms of priority of the state, and would receive highest priority within the development plan commencing in October 1976. It was suggested, however, that these efforts of the government would amount to naught unless some change took place in the thinking of those responsible at all levels within the health sector.

As a factual matter the long term success of the health sector program was considered to be:

- For Niger: of assuming its own health expenses.
 - For each Nigerien: of assuming responsibility for his health.
- These objectives are considered achievable only in the distant future, but in any case are the only valid ones on the individual or national level. These objectives of consequence are dependent for success upon the voluntary, generous and permanent contribution of each individual.

As an outcome of the deliberations many points were made throwing light or giving a new light to the following fundamental problems:

- Administrative structure of the Ministry of Public Health and Social Affairs - proposal of a new organizational structure.
- Personnel: its motivation, training and working condition.
- Education and scholastic medicine.
- Vaccination.
- Chemical prophylaxis of anti-malarial program.
- Working resources of personnel; pedagogical, technical and logistical.

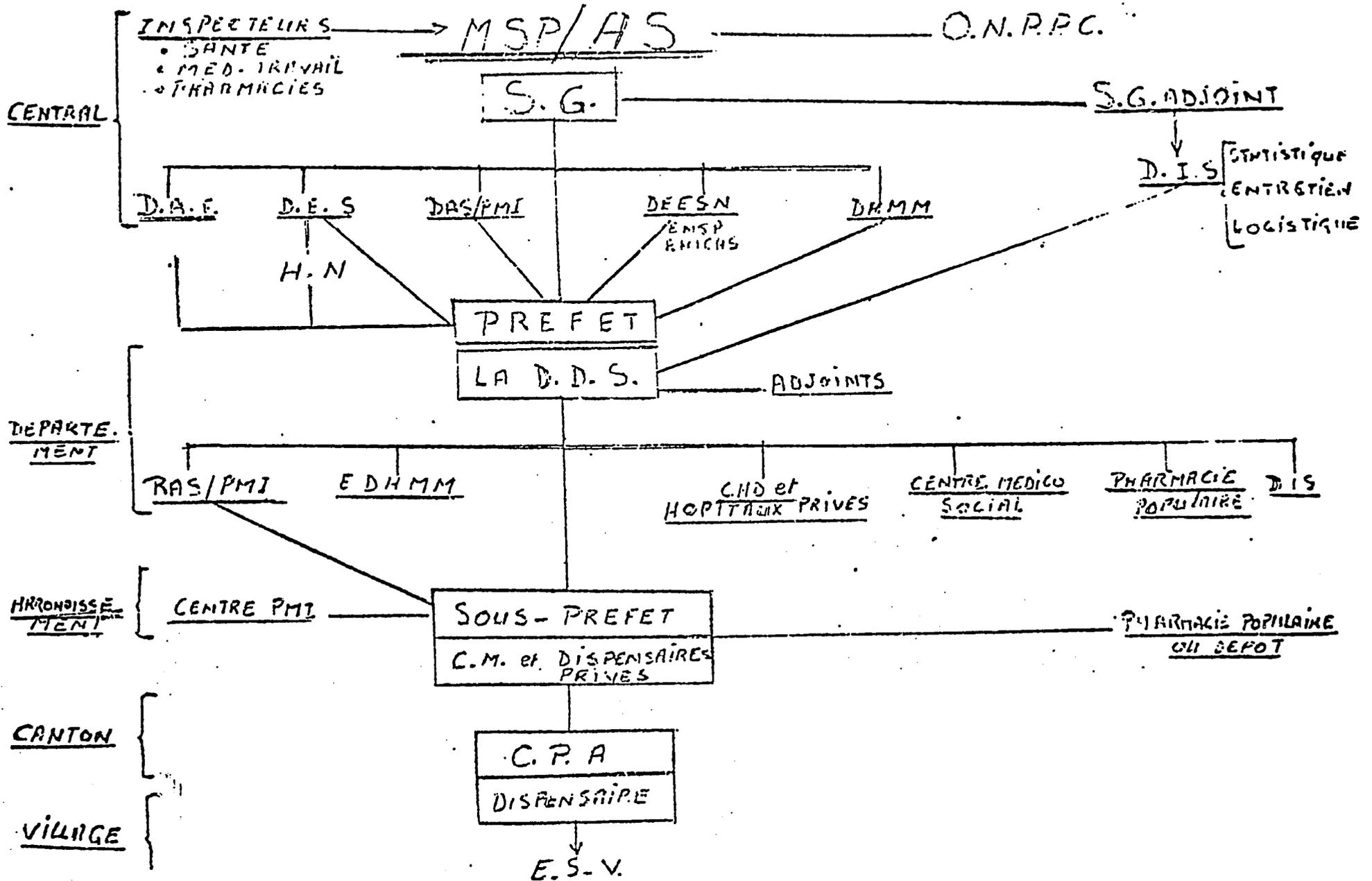
Consideration was given to the serious problems of maintenance of equipment and buildings. The difficult problem concerning medications received special attention.

The meeting of the second Health Study Committee consolidated the bases of the government of Niger health policy and the carrying out of the Triennial Plan. In addition, the conditions upon which modern medicine could incorporate traditional medicine and pharmacopia have been defined. The meeting produced a veritable mine of information to be cataloged by the ministry and provide direction for future activities. Some of the suggestions were immediately incorporated by the ministry with others under consideration.

A third meeting of the Health Study Group has been scheduled for 1977 probably in Diffa or Agadez Department. That body will have at its disposal the documents and activities growing out of the meeting of this year.

The new organization of the Ministry of Health and Social Welfare which has been developed at this conference is as shown on the accompanying organization chart.

PROPOSITION D'ORGANIGRAMME



IV-25

F. Financial Considerations

1. External Assistance

During the five year period 1970 to 1974 there was a total of 66 billion CFA francs (US \$269,382,600) in external assistance of which 48 billion CFA francs (US \$195,916,800) or 73% was from grants and 18 billion CFA francs (US \$33,468,800) or 27% was in the form of loans. In terms of sectoral allocation the approximate percentage distribution was as follows:

Roads and bridges	32%
Agriculture farming and hydraulic	20%
Education and health	20%
Industry and mines	9%
Administrative and economic structures and unclassified miscellaneous	20%

In 1975 the total external assistance to Niger had risen to approximately 42 billion CFA francs or US \$183.5 million per annum. As reported, however, of this total US \$60,367,774 was for emergency aid, technical and pre-investment activity and US \$123,287,840 was for capital investment. Of the US \$60,367,774 expended, US \$25,714,995 had been for emergency aid operations and US \$34,652,779 or 19% of total aid received was for technical assistance and pre-investment activity.

The greater part of the emergency aid was in the form of supplies with which to cope with the food deficits resulting from the drought of 1974. In addition to food this emergency aid consisted of trucks, fuel, spare parts, seed and insecticides. As indicated by all reports, the agriculture sector remains the number one priority in terms of assistance needs.

The most important donors through 1975 concentrated their efforts in three or four sectors with the result that in many other sectors the aid from outside was very limited. It is acknowledged that the government logically attaches great importance to the needs of agriculture, education, health, transport and communications. On record, the industrial sector has received only a small proportion of the technical assistance in 1975.

The assistance in the health sector for 1975 was largely represented in the cost of medical personnel. The identifiable assistance programs directly related to health as they existed in 1975 was as follows in US dollars:

* United Nations Program for development. Annual Report on the External Assistance to Niger, 1975. Niamey, June 1976.

Project/Activity	Assistance source	Amount committed	Duration	Description of Assistance and location
1. <u>PNUD Projects</u> National School of Public Health	PNUD	\$ 585,010 (\$ 138,422)	Jan.1972 Oct.1976	Personnel: \$ 420,570 Training: \$ 115,336 Material: \$ 40,956 Miscellaneous:\$ 8,148
2. <u>Organizations of the United Nations systems other than the PNUD</u>				
Hospital Assistance	PAM	\$1,816,800 (\$ 140,000)	Oct.1975 Oct.1980	Cost of food and transport. Place: Niamey
Strengthening of the health services	OMS	\$ 446,157 (\$ 185,770)	1974-1976	Cost of 2 experts and of sanitary equipment.
Assistance to OMS the Faculty of Medical Science of the Univer- sity of Niamey		\$ 96,000	Jan-Dec 1975	Cost of 2 experts. Place: Niamey
Programs of instruction	OMS	\$ 69,300	Jan-Dec 1975	Scholarships for higher studies in Europe.
3. <u>Bi-lateral Programs</u>				
Assistance to the Central Hospital	Federal Republic of Germany	\$ 500,000	1975	Personnel: 5 doctors 1 mechanic Material: 3 land rovers Place: Tahoua
Assistance in Health	Belgium	\$ 297,777	Jan-Dec 1975	Personnel: \$240,000 Operating cost:\$57,777 Place: Dossé
Furnishing of Medical Assistance	AGDI	\$ 700,000 (\$ 75,000)	Sept.1973 April 1975	Cost of medical provisio (supplies)
Project of technical assistance in health	FAC	\$ 555,555	Jan-Dec 1975	Not available

PNUD - United Nations Program for Development
 PAM - World Food Program (ONU/FAO)
 OMS - World Health Organization
 AGDI - Canadian Agency for International Development
 FAC - Fund for assistance and cooperation (France)

Project/Activity	Assistance source	Amount committed	Duration begin-end	Description of Assistance and location
3. Bi-lateral programs (cont)				
Assistance to MOH	Lybia	\$ 140,000	Jan-Dec 1975	35 vehicles furnished
Assistance to the SABHA neighbourhood	Lybia	Not available	Jan-Dec 1975	Cost of 35 loads of medical material
Strengthening of the Health Services	USAID	\$12,400,000 (\$110,000)	1973 1980	Cost of measles vaccine
Onchocerciasis	USAID	\$ 6,000,000 (\$100,000)	1974 1979	To assist in the international efforts to free the zone of Bay of Onchocerciasis
Assistance in Health	URSS	Not available	June 1975 May 1977	Personnel: 3 doctors Place: Niamey
4. Non-Governmental Agencies				
Purchase of medicines for the hospitals and dispensaries of Niamey	CARITAS	\$ 44,444	1975	Cost of purchases
Assistance to MOH	Peace Corps	\$ 219,840	Jan-Dec 1975	Personnel: General: 24 Medical office: 1
Technical assistance to Tchirozeren dispensary	OXFAM	\$ 35,555	Jan 1974 Dec 1975	Cost of technical assistance Place: Tchirozere
Assistance to Galmi Hospital	SIM	\$ 48,888	Jan-Dec 1975	Personnel: Doctors: 3 Nurses: 12 Material: Operating room and radio room Place: Maradi
Assistance to the Leprosy Hospital at Maradi	SIM	\$ 41,173	Jan-Dec 1975	Personnel: 4 Equipment for the operating room and radio Place: Maradi

USAID - United States Agency for International Development
 URSS -
 CARitas - Catholic Charities
 OXFAM - Oxford Food Aid Mission
 SIM - Southern Interior Mission

Project/Activity	Assistance source	Amount committed	Duration begin-end	Description of Assistance and location
<u>4. Non-Governmental Agencies (cont)</u>				
Assistance to the Quescgamae Hospital	SIM	\$ 11,111	Jan-Dec 1975	Personnel: Nurses: 2 Equipment for the operating room Place: Quescgamae
Assistance to the Maradi Hospital	SIM	\$ 17,777	Jan-Dec 1975	Personnel: Doctors: 1 Cost of food Place: Maradi

It is noted that a number of the above programs are continuing through the present time. These programs are not included in the annual operating budget of the MOH but are considered supplemental to the acknowledged health needs and programs of the MOH.

Current Assistance Plan

The major development objectives of the government of Niger are contained in the Three Year Plan for 1976-1978. Included in these objectives is an acknowledgement of the relationship existing between education, health and overall development. According to the plan almost all donor assistance is channeled into development activity and therefore capitalized.

In addition, in order to effectively implement and accelerate the development process the efforts and resources of numerous external sources of assistance have been solicited and utilized in the formulation of the existing Three Year Plan. For the most part these funds are also channeled into capital investment, transport and equipment.

Of 136 billion CFA francs capital which will be invested during the projected Three Year Plan 88 billion CFA francs will be invested in the para-public, semi-public and private sectors. During this period it is expected that external aid to the public sector will amount to approximately 70 billion CFA francs (which has essentially been obtained) with expected distribution and source of distribution as shown in Table #1.

As related to buildings, the present policy of the GON is to first renovate buildings already in existence and then to undertake extension and/or new construction when it is absolutely necessary. This was not the policy previously, and in some instances facilities were provided which are either not needed where located or too expensive to operate as designed. In order to provide a modicum of control, foreign aid funds are channeled into the National Investment Funds(FNI) organization through several organizations. This year, for the first time there is no contribution by France to the FNI fund.

SIM - Southern Interior Mission

Table #1

(245CFA=US \$1)

FY 1976-1978 Plan

Distribution of External Aid to Niger, Public Sector

(In billions of CFA)
(In actual US \$)

	Amount	%
Infrastructure, Public Works and Hydraulic	33.3 (\$135,917,280)	47.6
Rural Production	28.0 (\$114,284,800)	40.0
Human Resources	7.3 (\$ 29,795,680)	10.4
Industry, Mines and Trade	1.4 (\$ 5,714,240)	2.0
Total	70.0 (\$285,712,000)	100.0

Table #2

FY 1976-1978 Plan

Distribution of External Aid to Niger by Source

(In billions of CFA)
(In actual US \$)

Source	Rural Production	Infrastructure Public Works Hydraulics	Human Resources	Industry Mines Commerce	Total
ACDI	1.600,0	2.063,5	-	-	3.663,5
Saudi Arabia	1.200,0	1.920,0	-	-	3.120,0
BAD	761,0	1.550,0	1.102,0	-	3.413,0
BIRD	5.170,0	6.234,0	-	-	11.404,0
FAC	3.861,0	4.154,1	2.233,7	444,7	10.693,5
FED	3.265,0	9.420,0	2.229,0	-	14.914,0
FNI	1.831,8	8.026,5	6.209,8	2.332,9	18.401,0
PNUD/ONU/	1.862,5	650,6	222,1	454,5	3.189,7
RFA	3.220,0	4.080,8	525,0	207,0	8.032,8
USAID	2.605,8	180,0	-	-	2.785,8
Autres	4.026,6	2.667,0	882,3	281,7	7.857,6
Total	29.403,7 (\$120,014,142)	40.946,5 (\$167,127,235)	13.403,9 (\$54,709,357)	3.720,8 (\$15,186,816)	87.474,9 (\$357,037)

Table #3

FY 1976-1978

Distribution of FNI Contribution

	(In billions of CFA) (In actual US \$)			
	<u>Acquired</u>	<u>Negotiable</u>	<u>Total</u>	<u>%</u>
Rural Production	788,5	1.043,3	1.831,8 (\$7,477,473)	10,0
Infrastructures, Public Works and Hydraulics	1.509,5	6.517,0	8.026,5 (\$32,760,964)	43,6
Human Resources	903,6	5.306,2	6.209,8 (\$25,345,922)	33,7
Industry, Mines and Trade	306,5	2.026,4	2.332,9 (\$9,521,964)	12,7
Total	3.508,1 (\$14,318,664)	14.892,9 (\$60,786,860)	18.401,0 (\$75,105,522)	100,0

It is noteworthy that the contribution of Niger in its development through FNI contribution is 18.401 billion CFA francs. Considering the limited resources of the country this is a substantial contribution to development.

The para-public, semi-public and private sectors anticipated investments amount to about 48 billion CFA francs and are as follows:

	<u>Amount</u>	<u>%</u>
Infrastructure, Public Works and Hydraulics	28.42 billion (\$115,999,072)	59.2
Industry, Mines and Trade	19.58 billion (\$ 79,917,728)	40.8
Total	48.00 billion (\$195,916,800)	100%

This 48 billion investment is to be financed by utilization of resource from the bank system, and an adequate policy of self financing.

Health Sector Total Investment-Development 3 Year Plan 1976-1978

In millions of CFA

	FAC/CMS ONG	FED	FAC	Roual Follerman	Belgium	Sub-total	FNI	TOTAL
Department								
Niamey		83,000	100,000	150,000		433,000	355,000	788,000
Dosso		116,000			77,500	193,500	51,000	244,500
Zinder		80,000				80,000	50,000	130,000
Diffa		97,000				97,000	35,000	132,000
Agadez		35,000	70,000			105,000	5,000	155,000
Tehoua		20,000				20,000	270,000	290,000
Mareadi		142,000	70,000			212,000	425,000	637,000
Equipment	255,000					255,000		255,000
Vehicles	357,000					357,000		357,000
Sub-total	612,000 (20.5%)	573,000 (19.7%)	340,000 (11.4%)	150,000 (4.9%)	77,500 (2.6%)	1,752,500 (58.6%)	1,236,000 (41.4%)	2,988,500 (100%)
Recovering charges								
Building							675,000	675,000
Vehicles							250,000	250,000
Sub-total							925,000	925,000
TOTAL	612,000 (15.6%)	573,000 (14.6%)	340,000 (8.7%)	150,000 (3.8%)	77,500 (2.0%)	1,752,500 (44.8%)	2,161,000 (55.2%)	3,913,500 (100%)

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b. Assistance Programs in Process

In August 1976 the World Health Organization identified and reported the following projects in the health sector, or directly related, at various stages of progression.

United Nations Programs:

- UNDD - Development of the Ishazer valley. This project completed in 1975 contained 4 dispensaries under construction for which staff has not yet been provided by the MOH.
- Applied Research on Epidemiology and Trypanosomiasis control. A US \$2,290,500 program, agreements were signed in 1975.
- UNICEF - Integrated rural development program which began in 1974 but which made no progress until now.
- Regular UNICEF program of assistance to the MOH., BCG, leprosy drugs, technical equipment, vaccines.
- 91,250,000 CFA francs provided in September 1975 as emergency program.
- UNO - Credit attributed to health of US \$450,000. Equipment has been exported since June 1976 and contains insecticide (20 metric tons), equipment for 10 clinical laboratories and 8 vehicles with spare parts.
- PAM - Food Assistance to Vulnerable Groups.
- Niger 2072 program which began in 1975 of US \$1,816,000. Target population is children suffering from malnutrition in Protection Maternal and Infant (PMI), sick people in hospitals, tuberculosis patients under treatment and students in the nurses' training programs.
- Niger 2028 program which started in 1975 of US \$2,306,000 which provides food for children from primary boarding schools and from wandering schools. Overall there are 33,660 children in this project. Another project touches 4,000 children from secondary boarding schools
- An additional project provides food assistance within programs of reforestation, wells, roads and other collective efforts.

Multilateral Programs

- FED - European Funds for Development.
The third FED 1972-1975 provided funds for the expansion of the National Public Health School Building in the amount of 270 million CFA francs and for the expansion of hospitals and dispensaries in the amount of 2,140 CFA francs.

Multilateral Programs(cont)

- FED - The fourth FED which will last 4 years will provide for construction of a departmental hospital in Niamey at a cost of 200 million CFA francs, and construction of 20 maternity hospitals and/or dispensaries with equipment for 641 million CFA francs.
- FAD - African Funds for Development.
Construction and equipping of Health Sciences School at a cost of 1.400 million CFA francs.
- Entente- Construction of one PMI building in Niamey.
States

Bilateral Programs

- France - Will provide about 1 billion CFA francs in 1976-1977 in the form of:
- Staff assistance: 35 doctors (including 7 volunteers from the military service); 3 drugists (including 1 volunteer); 1 administrative staff member working at the MOH.
 - Technical Equipment: To provide for the needs of the Endemic Disease Service, dispensaries and medical centers.
 - Construction: Provision of a Mental Health Center.
- West Germany - Has provided a long term loan in the amount of 120 million CFA francs for improvement of the sanitation in provision of water for the city of Niamey, Maradi, and Zinder. This work is in process.
- Belgium- Has provided 75 million CFA francs during the period 1974 to 1976 for a medical team including Departmental director staff in Dosso. The current agreement in the amount of 400 million CFA francs makes provision for a public health team which will be used especially at the Health Sciences School.
- Nether lands - Currently provides one doctor and some nurses at Niamey department of health office.
- Canada - Has agreed to provide medical participation in the Zinder department for a three year period.
- USSR - Currently provides a medical team in Maradi and hospital equipment in Niamey.
- Peoples- Provides a medical team in Niamey.
Republic
of China
- Lybia - Provides logistics and equipment for the health services.

Bilateral Programs(cont)

- USAID - Has programs related to health, nutrition or food production which involve US \$40-50 million with activities extending into 1983. The National Cereals Program is now operational.
- Operation Niamey is an integrated rural health program with a health component included in the project which involves 500 villages in the Niamey department scheduled to start this winter.
 - Niger range and live stock is not yet operational.
 - Niger rural health support is scheduled to start next year and the agriculture economic research and training program is also scheduled to start next year.
 - Basic Health Services Consolidation Project Africare which was conceived as a US \$336.5 million project and recently funded by USAID for US \$2,818,107 subject to approval by the MOH and other conditions. The proposal is yet under discussion between Africare representatives and the MOH.
 - Regional program support currently includes the Agrhymet project and the Niger River Development Project(headquartered in Niamey); the Entente African Enterprise Program; Entente Live stock; Entente Food Production and the Regional Onchocerciasis Area Program.

It is expected that USAID will provide increasing amounts of assistance to Sahelian projects on a multi-donor basis over the next several years. It is accepted that assistance will be required for more than a 10 year period of time.

Non-Governmental Agencies

The major non-governmental agencies operating in Niger are Caritas, Misereor, Sudan Interior Mission, Church World Service and the Peace Corps.

The Sudan Interior Mission supports a 200 bed hospital at Galmi and a Leprosarium. The Mission's budget is approximately 30 million CFA francs. The Church World Service provides pumps for village wells and the Peace Corps provides 24 volunteers.

c. Program Coordination

The numerous and varied organizations which provide assistance to the MOH have not been "organized" by the MOH and solicited on a project basis. There is a person designated to coordinate the available assistance which is offered by non-governmental agencies to make linkages "easier" at the national level.

The MOH solicits and/or discusses needs with potential donors. The Minister of Plan and Minister of Foreign Affairs are involved where governments are concerned. Within the MOH donors are referred to departments on discussions of the health sector which is in need of the services which are offered. It is in this way building construction program or projects are handled as well as needs for equipment and vehicles. Personnel, including medical staff are ordinarily integrated into existing national organization structures and hierarchies on a basis of need. All expatriate personnel observed were providing service on an integrated basis.

The unit for internal coordination and control of the various programs of the MOH related to development are obviously under staffed. Increasingly buildings are completed and remain empty due to lack of staff. Personnel must be provided for and trained. Systems for control of supplies and maintenance of equipment must be developed. These activities should relate to the availability of facilities and the need for services at those locations. External assistance could be used to better advantage with a comprehensive plan for provision of needed services.

In a period of expansion and growth it is necessary to maintain balance and control of the developing system. There is a need to determine in advance the operating cost which will become ongoing operating costs of the system in process of development. These projects must then be "caused to happen" according to a pre-conceived plan. The observed health care system appears to be in process of re-organization with plans yet to be objectively quantified.

There is presently a need to assess the cost of the expanded health care system based on existing and projected capital and non-capital operating costs of an expanded health care system. These projections should at least be made through 1982 based on the additional investment projected in the existing Three Year Plan for 1976-1978 and the expanded services and coverage which is to be provided at the community level. To the extent that it is possible to do so this should be attempted during program design phase of program development.

A comprehensive plan would also assure that construction of facilities is compatible with existing priorities and to the extent possible that service programs are responsive to observed needs.

Table #4

(245CFA=US \$1)

Distribution of the 3.9 billion CFA francs(US \$15,918,240) investment in the Health Sector by source(Three Year Plan 1976-1978) (in millions of CFA francs and in actual US \$)

	<u>Amount</u>	<u>%</u>
FNI	2,161,000 (\$8,740,338)	55.3
FED	573,000 (\$2,338,757)	14.6
FAC	340,000 (\$1,387,744)	8.7
Roual Fallermar	150,000 (\$ 612,240)	3.8
Belgium	77,500 (\$ 316,324)	2.0
FAC/OMS/ONG	612,000 (\$2,497,939)	15.6
Total	3,913,500 (\$15,973,341)	100.0

Assistance funds which have been received by the GON and budgeted as expenditures in the 1976 operating budget, none of which is specific to health, are as follows: (In millions of CFA francs and in actual US

<u>Source</u>	<u>Amount</u>
IDA - ASECNA - Agence pour la securite de la navigation arriene(Agency for security of aerial navigation)	8.250 (\$ 33,673)
FAC-OPT - Fond de Aide et cooperation(France) (Fund for aid and cooperation)	7.705 (\$ 31,449)
CCCE - SONERAN - Conseil de cooperation et Compatibilite Economique(Council of cooperation and economic compatibility)	2.705 (\$ 11,041)
BAD Niger OPT - Bank Africaine de development (African Development Bank)	50.730 (\$207,061)
USAID	9.250 (\$ 37,755)
Total	78.635 (\$320,959)

F. Budgetary Control

At present the government of Niger uses a system of budgeting and accounting derived from the French. The system is centralized with all receipts received by the treasury where accounts are kept and where transfers and exchanges are recorded, and indebtedness controlled. There is now an explicit policy that all obligations of government must be budgeted prior to expenditure, and all expenditures accounted for.

There is no evidence of "program budgeting" and/or "responsibility accounting" in the accepted meaning of these terms. There is available computer capability to the treasury and conceivably establishment of such a system could be a possibility worthy of future exploration.

The 1975 budget was an interim budget in the sense that it was a carry over from the previous regime. It was used to minimize disruption and to provide continuity while formulating a program of development and reorganization of government process.

1. Revenue - FY 1976 Budget

During the 1975 Budget Year a substantial financial relief was obtained from the proceeds of uranium exports. The increasing source of new income has facilitated the GON implementation of its development plan. It is estimated that income from uranium will approximate 4.5 billion CFA francs during FY 1976.

In presenting a balanced budget for FY 1976 the GON revised the tax structure so that coupled with increases in the GNP a relative increase of 78% was achieved over FY 1975. A summary of these revenue estimates (billions of CFA francs) is as follows:

<u>Nature of Tax</u>	<u>1974</u>	<u>1975</u>	<u>1976</u>	<u>Difference</u> <u>1976/1975</u>	<u>Relat</u> <u>value</u>
Direct Taxes	3.885.000	4.195.000	7.397.000	+3.202.000	+ 76
Indirect Taxes	2.145.000	2.605.000	4.490.000	+1.885.000	+ 72
Customs Duty	4.960.000	5.638.000	10.050.000	+4.412.000	+ 78
Registration fees	435.000	501.000	1.152.500	+ 651.500	+130
Total	11.425.000	12.939.000	23.089.500	10.150.000	78
	(\$46,632,280)	(\$52,811,822)	(\$94,242,103)	(\$41,428,240)	

2. Expenses - FY 1976 Budget

The FY 1976 budget detail is presented to the extent that detail distribution permits. One of the difficulties in making judgments or conclusions based on the data is that certain major items of expense are not distributed. Personnel costs and transportation costs other than maintenance are the main items of undistributed cost and account for one half of the total budget expense.

We inquired of the MOH regarding the availability of distribution of budget allocations and/or expenditures. We were told that the budget was not constructed in that way and that this was just not available. It is contemplated that a management information and statistical capability will soon be developed. We were told that the individual responsible for this was already on board and working on this development.

In touring the country and visiting departmental hospitals, clinics and maternity centers in the various sections it was evident that existing needs for renovation and repair of buildings and for acquisition and maintenance of equipment are as acute as the need for trained personnel. Inadequate facilities, equipment, numbers of trained personnel, variety of medications and supplies were observed to be the rule rather than the exception.

The distribution of budgeted and allocated expenses are as shown on pages

• Accountability and Reporting

The financial management system of Niger is basically a cash system of receipts and disbursements rather than an accrual basis of account. The records are maintained in that way. There has been no attempt to establish systems of accounting and reporting which would provide acceptable planning information. It is possible that in keeping with the concept of a low cost simple system of health delivery, that this is the system to be preferred. It should be modified to provide suitable statistics, and management information.

Although records are kept at all levels of use, and reports made to the next higher level, the form and content is for the purpose of simple tabulation and summation for provision of information to the next highest level in the system.

At the lowest level reporting is accomplished by simply "ticking off" the occasion of service in the proper place on a form which is graphically designed so that the reporter need not be able to read or write in a specific language or at all. In a country such as Niger, one may need to communicate through ten or more dialects in the course of a day if he has occasion to deal with large numbers of people. Literacy in these circumstances becomes a relative matter.

Responsibility for reporting is placed with the secretary-treasurer of the Village Health Team. The other members of the health team, the president, secourist and matron provide this information to him respective of need and service. He is obligated to record and to report to the next highest level.

THE CON BUDGET

The budget expenditures and change in category of expenditures the past three years are as follows:
 (In Millions 000 of CFA)
 (In Actual \$US)*

<u>Title</u>	<u>1974</u>	<u>1975</u>	<u>1976</u>	<u>+ or - 74-75</u>	<u>+ or - 75-76</u>	<u>% 74-75</u>	<u>% 75-76</u>
1 Public Debt	379.600 (\$ 1,549,375)*	663.085 (\$ 2,706,448)*	1.640.480 (\$ 6,695,783)*	+ 283.485 (\$1,157,072)*	+ 977.395 (\$ 3,989,334)*	+ 74.68%	+ 147.40%
2 Public Works	554.470 (\$ 2,263,124)*	244.325 (\$ 997,235)*	235.600 (\$ 961,625)*	- 310.145 (\$1,265,887)*	- 8.725 (\$ 35,612)*	- 55.94%	- 3.57%
3 Services	10.088.910 (\$41,178,894)*	10.861.830 (\$44,333,644)*	14.568.085 (\$59,461,096)*	+ 772.920 (\$3,144,750)*	+ 3.706.255 (\$15,127,450)*	+ 7.66%	+ 34.1%
4 Public Intervention	3.244.630 (\$13,243,281)*	3.546.635 (\$14,475,945)*	7.866.435 (\$32,107,640)*	+ 302.005 (\$1,252,663)*	+ 4.319.800 (\$17,631,694)*	+ 9.31%	+ 121.80%
Total	14.267.610 (\$58,234,617)*	15.315.875 (\$62,513,029)*	24.310.600 (\$99,226,145)*	+1.048.265 (\$4,278,598)*	+ 8.994.725 (\$36,712,869)*	+ 7.35%	+ 58.73%

245 CFA = \$1 US)

COII budget allocations for 1974-1976 were as follows:

Percentage Budget Distribution By Year And Percentage Allocation By Activity

	1974	1975	1976
Assemblée nationale	1.93%	-	-
Conseil Economique et Social	0.14%	-	-
Cour Suprême	0.08%	-	-
Presidence	3.46%	2.99%	2.05%
Secretariat d'Etat La Presidence	0.09%	-	-
Promotion humaine	0.91%	-	-
Information	0.62%	0.80%	0.86%
Affaires etrangeres	3.33%	4.28%	3.41%
Development	0.66%	1.46%	3.75%
Defence nationale	8.16%	7.85%	6.34%
Justice	0.80%	10.86%	0.62%
Interieur	10.22%	10.08%	7.38%
Function Publique et Travail	0.57%	0.53%	0.33%
Finances	28.67%	29.18%	43.88%
Affaires economiques du C.I.	0.43%	0.57%	0.33%
Economie rurale	7.30%	7.29%	4.09%
P.T.T.	0.05%	0.03%	0.07%
Travaux publics	7.01%	7.13%	-
Mines	1.42%	1.37%	0.48%
Education nationale - Jeunesse	16.31%	17.90%	13.30%
Sante	7.84%	7.45%	6.90%
Conseil national - Development	-	0.16%	-
C.N.D.	-	-	0.12%
Jeunesse -Sport	-	-	0.61%
T.P.	-	-	4.79%
Total	100%	100%	100%

A summary of the current FY 1976 operating budget of the MOH is as follows: (in millions of CFA)

III	<u>Services</u>	<u>CFA</u>	<u>\$US</u>
	Personnel	717.550	2,928,752
	Materials	792.570	3,234,955
	Transportation	155.350	634,076
	Total	<u>1.665.470</u>	<u>6,797,782</u>

Included in the public works section of the budget for the benefit of the health sector are the following amounts:

II	<u>Public Works</u>	<u>CFA</u>	<u>\$US</u>
	Material	600	2,449
	Housing	200	816
	Total	<u>800</u>	<u>3,265</u>

The total operating budget is as follows:

III	Services	1,665,470	6,797,782
II	Public Works	800	3,265
	Total	<u>1.666.270</u>	<u>6,801,047</u>

PPP/DAP

Operating Budget - MOH - FY 1978

Distribution of Operating Expenses Other Than Remuneration Of Personnel (In Millions Of CFA)

245 CFA=\$1 US

*(In Actual \$ U.S.)

Service/Activity	Materials							Transport				
	Operation of services	Technical materials	Electricity and water	Food and clothing	Telephone	Building maintenance	Pharmacy	Total	Maintenance of vehicles	Living & travel	Carburant	Total
Cabinet - DOS	3,300	-	2,100	-	3,300	-	-	8,700	8,350	-	-	8,350
Direction MOH	655	-	-	-	-	-	-	655	-	-	-	-
Sub-Total	3,955 (\$16,143)*	-	2,100 (\$8,571)*	-	3,300 (\$13,469)*	-	-	9,355 (\$38,184)*	8,350 (\$34,082)*	-	-	8,350 (\$34,082)*
National Hospitals												
Niemey	15,000	3,500	27,000	45,000	3,000	-	-	93,500	1,500	-	-	1,500
Zinder	4,200	2,500	8,000	18,000	1,000	-	-	33,700	1,000	-	-	1,000
Sub-Total	19,200 (\$78,367)*	6,000 (\$24,489)*	35,000 (\$142,857)*	63,000 (\$257,143)*	4,000 (\$16,326)*	-	-	127,200 (\$519,184)*	2,500 (\$10,204)	-	-	2,500 (\$10,204)*
Departmental Services												
Anti-TB Center	5,500	4,000	10,000	13,000	2,000	3,000	-	37,500 (\$153,061)*	4,500	-	-	4,500 (\$18,367)*
Mobile Hygiene	1,280	220	6,000	6,000	250	-	-	13,750	-	-	-	-
National School of Nursing	4,500	1,000	2,000	-	1,000	-	-	8,500 (\$34,694)*	12,000	-	-	12,000 (\$49,979)*
Community Medical Centers	4,500	-	5,600	7,980	550	-	-	18,630 (\$76,041)*	-	-	-	-
Non-distributed Expenses	82,735	3,000	5,400	20,000	2,500	10,000	-	123,635 (\$504,633)*	21,000	-	-	21,000 (\$85,714)*
Sub-Total	-	-	-	-	-	-	454,000 (\$1,853,061)*	454,000	-	57,000	50,000	107,000 (\$435,735)*
Sub-Total	98,515 (\$402,102)*	8,220 (\$33,551)*	29,000 (\$118,367)*	48,980 (\$191,755)*	6,300 (\$25,714)*	13,000 (\$53,061)*	454,000 (\$1,853,061)*	655,015 (\$2,677,612)*	37,500 (\$153,061)*	57,000 (\$232,663)*	50,000 (\$204,082)*	144,500 (\$589,795)*
Total	121,670 (\$496,612)*	14,220 (\$58,041)*	66,100 (\$269,796)*	109,960 (\$448,858)*	13,600 (\$55,510)*	13,000 (\$53,061)*	454,000 (\$1,853,061)*	792,570 (\$3,234,979)*	48,350 (\$197,347)*	57,000 (\$232,663)*	50,000 (\$204,082)*	155,350 (\$634,082)*

J.P.Neal/11.17.1978