Capitalisation of the handover of the MSF-CRENI to the Zinder National Hospital, Niger

EVALUATION REPORT

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MANAGED BY THE VIENNA EVALUATION UNIT

Acknowledgements

This evaluation was possible thanks to all the people that helped and supported the evaluator especially in the headquarters in Geneva and in the mission in Niger. In particular I want to thank the field staff in Zinder for welcoming me during my stay and to spare some time from their usually busy days to coordinate all the visits and interviews. Also I thank the Vienna Evaluation Unit, especially Mzia, for all her support during the whole process.

Table of contents

The Vienna Evaluation Unit

The Vienna Evaluation unit started its work in 2005, aiming to contribute to learning and accountability in MSF through good quality evaluations. The unit manages different types of evaluations, learning exercises and anthropological studies and organises training workshops for evaluators.

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Executive summary

The MSF-OCG handover process of the nutritional programme in Zinder was evaluated with the objective to assess best practices, challenges and lessons learnt of the handover/integration process of the Zinder CRENI to the hospital, with the main purpose to improve handover processes in such contexts as well as decision-making in future projects.

The evaluation has confirmed the pertinence of MSF in Zinder since 2005 and has contributed to the reduction of the infant mortality rate. All relevant actors (state, administration and other NGOs in the region) and the community have acknowledged the importance of MSF's presence in the contribution to the reduction of the infant mortality rate by implementing nutritional programmes with an excellent quality of services. The integration process, which started in 2010, has been a success mainly due to the political wills of all parties involved (mainly MSF and the Zinder National Hospital authorities) and the particularity of the National Zinder Hospital – it is not dependent on the region or district budget and it is a semi-private institution that generates some income. The time and effort devoted to this integration, although perceived by some as having lasted too long, has been adequate in the opinion of the evaluator, since external constraints (mainly security) and a progressive, well informed process of absorption of human resources into the CRENI has influenced the delay of the integration, which was initially planned to be completed in one year. In this sense the integration process can be considered a success.

However, there are several issues that need to be considered to guarantee the continuity of the activities in the CRENI with good quality standards of care. The integration process between MSF and the HNZ has mainly focused on maintaining a good quality of the *prise en charge* of nutritional cases. However, other management areas of the CRENI were not followed up well after the CRENI was managed by the HNZ.

During the peak season the hospital is not prepared to absorb all the extra human resources needed to manage the CRENI. In this sense MSF should continue to be involved in supporting the Zinder National Hospital in areas where some weaknesses have still been found: hygiene management, food and drug provision by partners, data collection and good follow-up of patients. This support should continue for at least one more year.

Finally, a reflection on the future of Chare Zamna should be done by the Niger mission because the current system of being an extension to the hospital within a District Health Centre does not seem to be viable.

Abbreviations

ALIMA	Alliance for International Medical Action
BEFEN	*Bien Etre de la Femme et de l'Enfant au Niger*
CRENI	*Centre de récupération nutritionnelle intensif (en interne (hospitalisation)*
CRENAS	*Centre de récupération nutritionnelle ambulatoire pour sévères*
CPS	*Chimio-prévention du paludisme saisonnier*
CRF	*Croix Rouge Française*
CS	*case de santé*
CSI	*Centre de Santé Intégré*
DRSP	*Directeur (ou Direction) Régionale de la Santé Publique*
DS	*district sanitaire*
ECHO	European Commission's Humanitarian Aid and Civil Protection department
HNZ	*Hôpital National de Zinder*
MSF	*Médecins Sans Frontières*
OCG	Operational Centre Geneva
OCB	Operational Centre Brussels
MSP	*Ministère de la Santé Publique*
OMS	*Organisation Mondiale de la Santé*
ONG	*Organisation non-gouvernementale*
PAM	*Programme Alimentaire Mondial*
PEC	*prise en charge*
SCF	Save the Children Fund
SUN	Scaling Up Nutrition
UNICEF	*Fonds des Nations Unies pour l'Enfance*
UP	*Unité pédiatrique*
3N	*les Nigériens nourissent les Nigériens*

1 Introduction

1.1 Background

The food security situation in Niger is one of the most difficult ones on the African continent. This is the result of many factors, being the most important ones a big demographic growth, a deficit in food production due to consecutive droughts and the late beginning of the rainy season that lead to a lack of food availability that is increased in some regions of the country including the Zinder region. Over the past ten years most acute food insecurities (International Food Insecurity levels 3 and above) have been observed in the western regions of the country and along the southern border with Nigeria, thus including the Zinder region[1]. Figure 1 describes the frequency of food security crisis in Niger.

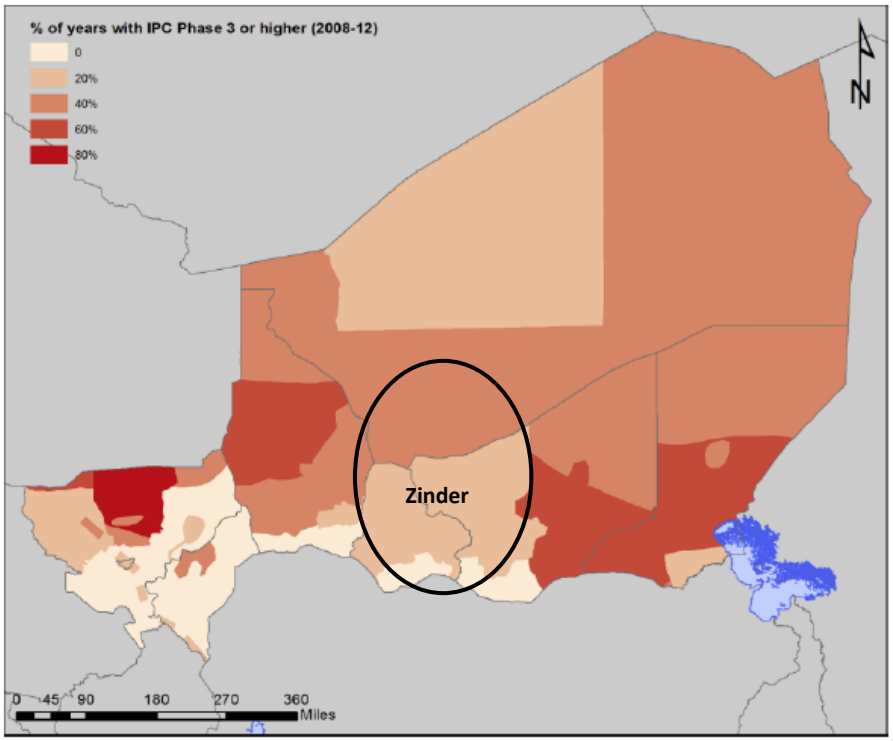

Fig 1. Frequency of crisis (Integrated Food Security Classification Phase 3), food security outcomes, 2007-2012. Niger Food Security Brief. May 2014

In terms of the epidemiological profile, the leading causes of child mortality are: malaria (27.3 percent), cough and cold (18.6 percent), pneumonia (10.7 percent) and diarrhoea (10.1 percent). Malaria rates most commonly increase during the peak of the rainy season (June to September), when food access and resources are lowest and rates of acute malnutrition tend to be highest. Despite the progress made to reduce infant mortality rates (under-five mortality has decreased by nearly 40 percent in the last ten years), malnutrition remains an important public health issue in the country [2]

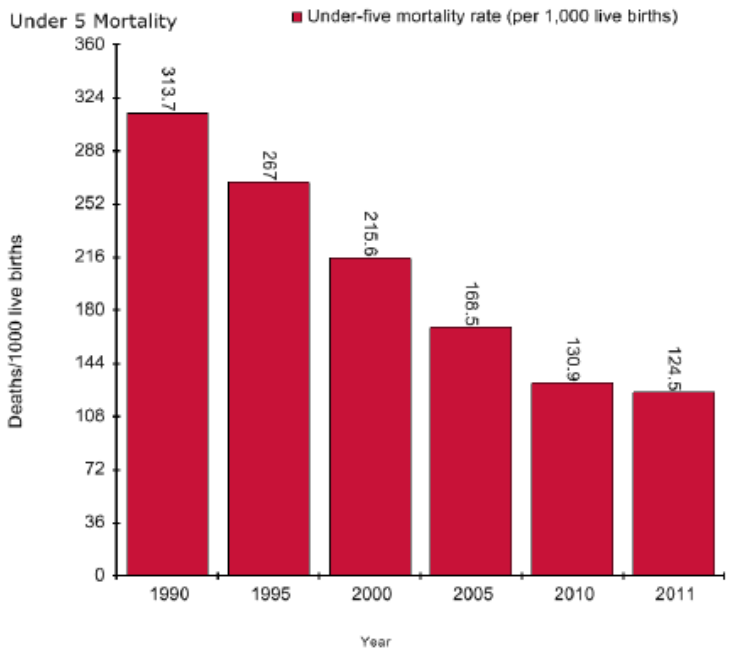

Fig 2. Under-five mortality rate in Niger. Niger Food Security Brief. May 2014

The Operational Centre Geneva (OCG) is running medical operations since 2005 in Niger and the Zinder region following the big nutritional crisis that affected the country with the main objective of the mission to reduce the under-five mortality rate with a particular focus on the *prise en charge* (PEC) of sever acute malnutrition cases and their associated pathologies. Almost ten years after, the mission has undergone important operational and strategic changes, from the management of 1 CRENI and 7 CRENAS in the Mirriah DS, the handover of the activities in Mirriah in 2009 to the NGO BEFEN/ALIMA, the management of CRENI and CRENAS in Magaria, the involvement of nutritional activities in the Zinder DS with the construction of a CRENI inside the Zinder CSI (CRENI "Sharé Zamna") in 2010, to the transfer of the CRENI to the HNZ in 2013.

1.2 Methodology

The methodology of the evaluation comprised a revision of key documents and reports linked to the mission and specifically to the Zinder project and integration process, interviews with key actors in the country and in the Zinder region trying to make a healthy balance between MSF staff and other actors such as NGOs representatives, partners in the Zinder project, administrative and health authorities.

1.3 Limitations

There were three main limitations of the evaluation that were all due to the dates of the visit (mid-July):

1. The visit was carried out when peak malnutrition season (from July until December) started. This resulted in a full presence of and support from the MSF team in the HNZ CRENI and Charez Amna. For this reason it was not possible to evaluate how the CRENI functioned without the support of MSF (integration process) which is the main objective of this evaluation. However, turning this limitation into an opportunity, it allowed seeing the interaction between MSF and MSP staff working together and identifying some challenges linked to this interaction.
2. Many key staff in the headquarters in Geneva were on holidays, so it was not possible to have interviews with important staff of the cell that follows the Niger mission as well as the director of operations.
3. The time of the visit coincided with the ending of the Ramadan festivity. This resulted in many holidays happening in Niger and also in the difficulty to reach traditional leaders for interviews.

2 Findings

2.1 Programme adjustments

The following chapter aims to briefly describe the context and operational changes that led to the ultimate decision to start a handover/integration of MSF activities into the HNZ and to evaluate its pertinence.

2.1.1 Context changes

The context has undergone critical changes in terms of politics, security and health, especially since 2011. Even though the purpose of this evaluation is not to make an in-depth evaluation of these changes, it is worth to briefly mention some of the key changes in the country that influenced the operational decisions in the MSF mission in Niger.

In terms of political changes, the most relevant ones are the election of the current president in Niger resulting in the recognition of malnutrition as a public health issue in the country and leading to important changes including a set of initiatives in the country such as the Scaling up Nutrition (SUN) or the "3N" (*les Nigeriens nourrissent les Nigeriens*), a greater decentralisation giving more autonomy to regions and districts and a massive recruitment of health staff across the country. These initiatives are mainly the materialisation of a working group on integration that started in 2008[3] with the main objectives to identify the current deficits in the nutrition activities within the national health structures and to establish actions and recommendations for an integration of nutritional activities into these health structures. This was also one of the reasons why there was a political will between the health authorities in the HNZ and MSF to start a handover/integration process in the MSF project.

Another change in terms of access to healthcare is the gratuity of services in children less than five that was put in place in 2006 that includes the consultation, laboratory exams, imaging diagnosis, drugs, hospitalization and surgery[4].In terms of security, a number of incidents in the country mainly caused by the expansion of radical Islamists groups in the region led to a temporary reduction of the teams in the Zinder project in 2012 which brought about a restriction of international teams in Niger. This resulted in a lost to follow up of the integration process in Zinder and a delay of the initial handover timeframe and a working group on integration.

2.1.2 Operational changes

The first project in Zinder consisted of the opening of 1 CRENI and 7 CRENAS in the Mirriah Department, with the main objective to reduce the morbidity and mortality associated with malnutrition in children less than five years of age, and also the response to medical emergencies and mass vaccination campaigns. In 2008 MSF-CH was involved in the rehabilitation of some CSI. In 2010, it handed over the activities in Mirriah district to the NGO BEFEN/ALIMA and the integration strategy with the HNZ began. The choice to support

the construction of the CRENI within the HNZ is due to the particular set-up of the health structures in the Zinder district: absence of a district hospital in Zinder district (while in the other six districts there is a district hospital) and a National Hospital (only two in the country) that directly depends on the Ministry of Health.

Since 2012, the mission strategy also mentions prevention activities[5]. However, in Zinder the prevention activities were not implemented. During the interviews there was a consensus that prevention activities are essential for the success of the integration. Both health and administrative authorities emphasised the need to develop more community/prevention activities in order to reduce the number of cases arriving at the CRENI.

The current experience in CPS and plumpy dose distribution in the Magaria project could be used in Zinder to evaluate the effects on both the number of severe malaria cases and the number of admissions in the CRENI in Magaria and to implement these activities in Zinder.

Despite the main objective of the mission since its beginning was to reduce the mortality and morbidity of children under five years of age, the focus as from 2010 was to integrate/handover activities to other partners. In the case of Mirriah the project was handed over to BEFEN/ALIMA[6], and in Magaria and Zinder the partners were the MSP. Under this perspective the main operational change was to shift from leading the nutritional response to support the MSP in the management of malnutrition in a progressive way. MSF described its approach since 2009 as a "progressive shift from an emergency strategy to an integration and reinforcement of capacities of the institutional actors". The context change has been a major driver for this shift but has also been carefully addressed by MSF-OCG in a progressive way to endure a good output of the handover, especially in terms of maintaining good quality of care in the management of malnutrition.

The presence of MSF in the Zinder region has been highly valuable and pertinent. There was a consensus among all the interviewees that MSF has played a key role in the region to reduce the morbidity and mortality of children and its presence has made an impact on the health of many people in Niger. Both the interventions and the operational changes seem to be justified and follow clear paths and reflection.

The political will of the state to include nutrition as a public health issue and to develop concrete plans and initiatives to deal with this issue were crucial for the MSF mission in Niger to change its strategy towards a handover/integration process in Zinder.

2.2 Handover/integration process

2.2.1 Development of the integration

Summary of the handover/integration process in the HNZ:

1. 2010 Construction of the CRENI in the HNZ plus an intensive care unit (*soins intensifs*) to manage complicated paediatric cases. The CRENI is set up first in Chare Zamna (inside the Zinder CSI).
2. 2011 Construction of the CRENI ends and the first admissions in the CRENI in the HNZ starts (May 2011). During this time MSF still supports the HNZ with staff (paid by MSF under HNZ contracts), medical material and continuous training. During the peak season, Chare Zamna works as an extension of the CRENI.
3. 2012 Consolidation of the integration: this meant the decision to handover/integrate the MSF activities to/in the HNZ. The consolidation was included as the main point in the MoU[7].
4. 2013 Finalisation of the integration.
5. 2014 Management of the CRENI by the HNZ during the first 5 months of the year and support by MSF (full presence) during the peak season (starting in July). The support includes the opening of Chare Zamna during the peak season as an extension of the CRENI (managing phase T and phase II patients)[8].

The HNZ is a National Hospital (only two in the country). It is a third-level, regional reference hospital that is not dependent on the regional or district health authorities but it is directly dependent on the MSP. Therefore, the HNZ has a more independent decisive power and availability of resources that are not dependent on the region or district budget. Because of the existence of this regional hospital, the Zinder district does not have a district hospital like the rest of the five districts in the region. The political will of the director (that arrived 2012 with a firm commitment to integrate the CRENI in the HNZ) was decisive for the success of the integration/handover process. The hospital also implements the gratuity of services in children less than five. However, the director of the hospital referred that the State has a delay of two years in reimbursing the hospital for these services. Even though the effect of the population in terms of increasing the access to healthcare due to this policy was not evaluated, the director of the NHZ referred that it has had a good effect on improving the health of the population, but it is creating a big debt inside the hospital, and this could put in danger the continuity of this policy. Even though there is no immediate consequences on the malnutrition cases in the NHZ (because there are other partners that fulfil the needs of the patients at the CRENI), it should be a point to analyse with the health authorities for a long term success of the programmes without the support of partners.

Besides the support of the CRENI, MSF also supported the intensive care unit (*soins intensifs*) that managed neonates and severely ill paediatric cases. Since the beginning, agreements with the HNZ were signed describing the scope of the collaboration and integration/handover process. Despite the plans to integrate the CRENI in the hospital, the first MoU was signed in 2012 after an evaluation of the HNZ was done to see the feasibility of a successful handover/integration to the public health system. The initial goal was to

handover the activities in 2012, but finally the integration was completed in December 2013. 2012 was marked by a number of security incidents that led to the reduction of expat staff in Zinder as described earlier in the document that held back and delayed the integration process.

The main objectives of the integration in 2012 and 2013 were:

- The integration of human resources in the HNZ
- The provision of medical materials and drugs for the CRENI and the *soins intensifs*,
- The creation of the *comite de pilotage* that will meet every month to follow up all the activities and work plan of the handover/integration process as well as to discuss the difficulties that arose and how to address them.
- The signing of a MoU between the HNZ and UNICEF
- The signing of an MoU between the HNZ and PAM
- A communication campaign to inform the community about the partnership

In 2014, the MoU focused on the MSF support after the handover. This mainly comprised the support of the HNZ during the peak season with human resources in the HNZ (mainly to treat phase I patients), the re-opening of Chare Zamna to manage phase T and phase II patients, support of the *sons intesifs*, support in medical supplies and drugs if needed (including provision of material to the laboratory and blood bank) as well as the transfer of patients from the HNZ to Chare Zamna. The support is based on a system that was implemented throughout the integration/handover process and is called a binome. This means for each HNZ staff, there will be an MSF staff and they will work together. This binome includes the CRENI supervisor, the CRENI major, medical doctors and nurses. By some interviewees this was seen as a set-back of the integration since some positions currently held by HNZ staff have enough capacity to manage their responsibilities without the support of their MSF binome. These positions include the pharmacy manager, the main nurse in the CRENI and the Medical Responsible of the CRENI

It is important to mention that the integration process, as described in the MoUs signed between MSF and the HNZ, mainly focused on maintaining a good quality of *prise en charge* of nutritional cases and the provision of medical material and drugs. However, other areas of the management of the CRENI were not mentioned in the MoU and can have an effect on the overall quality of the service:

- Overall management and supervision of the CRENI and the soins intensifs: During the whole integration process, MSF took naturally the lead in the management of the CRENI. The binome work had also the objective to reinforce the management of the CRENI in some specific position, mainly with the nurse supervisor (CRENI major) and the medical responsible of the CRENI. The current binome setting of these two key managerial positions seem to the evaluator not focused on reinforcing managerial capacities but still focused on the patient management.
- Hygiene control in the CRENI. This aspect of the CRENI was according to the MSF staff was substandard when the HNZ managed the CRENI. Even though there was training done during the handover process on the hygiene management of the CRENI, it was not

possible for the HNZ staff to follow up or take the hygiene management a main point in the CRENI overall management

- Soins intensifs. Special attention should be paid to the soins intensifs since this area represents a key element in the reduction of infant mortality rate. As commented previously the integration was focused on the nutritional aspect (CRENI) of the pediatric management in the hospital. However, MSF has also committed to reinforce and support the management of newborns, regardless of their nutritional status. With a lack of well trained staff in neonatology in the country, this was considered both by HNZ and MSF staff a true challenge when the CRENI was handed over to the NHZ. Despite the main focus of this capitalization was on the CRENI, the management of the soins intensifs remains a true challenge for the NHZ.

In terms of the integration process of the human resources, the transfer of MSF staff into the HNZ was progressive and well informed. At the beginning of the integration in 2011, MSF and the HNZ agreed to have all staff under the contract of the HNZ even though MSF contributed economically by paying the salaries of staff. In 2013, the HNZ took over the responsibility of the salary of all staff in the CRENI. This has been one of the biggest challenges of the integration/handover process since the salaries of the HNZ are lower than the MSF salaries. However, the process was progressive and well informed and resulted in a successful absorption of the staff by the HNZ. However, in May 2014, four out of five medical doctors in the CRENI resigned and went to work in other MSF sections, which resulted in a temporarily high mortality rate in the CRENI.

The currently available staff of the HNZ for managing the CRENI succeeded to stabilize the situation and provide a good quality of care at the CRENI (see the chapter 2.2.3 for the medical outcomes). However, both health authorities as well as MSF staff that were interviewed acknowledged the fact that there are limited human resources for managing the peak season.

The NHZ is not yet prepared to absorb all the extra human resources needed to manage the CRENI during the peak season.

2.2.2 Partners

1. BEFEN/ALIMA. MSF handed over the CRENI and CRENAS in Mirriah to BEFEN/ALIMA in 2010. Despite the handover of activities, BEFEN/ALIMA continues to have a close link with MSF in Zinder as approximately 30% of cases at the CRENI are referred from Mirriah, and also because MSF has supported ALIMA in terms of supplies when they had ruptures. According to the first meeting of the *comite de pilotage*[9] BEFEN helped the HNZ with some materials during February 2014. The interviewees of BEFEN/ALIMA expressed that they could take over the nutritional activities in Zinder in the event that MSF completely closes its project. “We would have an ethical obligation to take over the nutritional activities in Zinder”. BEFEN/ALIMA, as MSF in Zinder, is funded by ECHO.
2. UNICEF. MSF has a local agreement with UNICEF to support with therapeutic food and drugs for patients at the CRENI. According to the UNICEF representative, this agreement worked pretty well as MSF had a good follow-up of the needs of patients and could

forecast the orders in a timely manner to prevent stock-outs. During the time when the CRENI was managed by the HNZ, there were difficulties in the orders. This had to do with limitations of supplies by UNICEF but it was also due to a lack of supervision and forecast of the NHZ to prevent stocks-outs. During the time of the visit, MSF resumed the leadership of the orders and was responsible for the requests.

3. PAM. MSF has a local agreement with PAM to support in terms of food for the relatives of the patients during their stay at the CRENI. This agreement has worked very well according to the PAM representative. However, during the time when the CRENI was managed by the HNZ, no orders were placed by the HNZ to PAM. This issue was highlighted during the meeting of the *comite de pilotage* in June. The main challenges expressed by the PAM representative were similar to the ones with UNICEF: a lack of supervision and forecast capacity of the HNZ. There is a will from PAM to sign a local agreement with the HNZ in order for relatives of patients to benefit from food during their stay at the HNZ and also to support the HNZ in developing capacities for manage orders in a timely manner and forecasting the quantities.
4. Save the Children. Even though SCF is not a direct partner of MSF, it is important to mention that they have an important presence in the Zinder region, supporting CRENI and CRENAS. In 2015, SCF will be reviewing their 5-year plan (2016-2020). The representative of SCF commented that they are open to any discussion of taking over some nutrition activities in Zinder district.

2.2.3 Data analysis

Data was analysed to evaluate key indicators in the CRENI. As commented previously, the HNZ managed the CRENI from January to June 2014 without the support of MSF in terms of human resources. Therefore, data analysis was done comparing these 6 months from 2012 to 2014[10]. The most important aspect of the period where the NHZ managed the CRENI alone was the fact that by the end of April four out of five medical doctors had resigned, and therefore the medical supervision was limited.

In terms of the main performance indicators, it is important to mention that the target indicators of the MSF protocol and the MSP protocol vary[11,12]. Table 1 summarised the main differences between both protocols.

Table 1: Summary of the main differences of performance indicator values

	MSP protocol		**MSF protocol**
	target indicators	*Alarming indicators*	
Cure rate	>75%	<50%	>80%
Default rate	<15%	>30%	<10%
Mortality rate	<3%	>10%	<5%

The way data is collected by the MSP and MSF for the CRENI are similar. The main differences are:

- Data collection by the MSP is done monthly (calendar), while MSF collects data weekly (epidemiological weeks)
- The MSP's source document is the registration book, while MSF uses the clinical records

The *taux de gueris* was above the acceptable ranges in both MSP and MSF protocols, the lowest *taux* being 86.5% in June 2012 and the highest 97.3% in March 2014. In terms of the *taux d'abandon* the rates were acceptable in both MSP and MSF protocols, the lowest being 0.7% in May 2014 and the highest 7.1% in February 2012. The *taux de mortalite* was 4.3% on average in 2012, 3.9% in 2013 and 4.0% in 2014. This average is acceptable for MSF protocols but it is above the acceptable range (without being an alarming value) for the MSP protocol. The highest *taux de mortalite* was 8.6% in May 2014, coinciding with the resignation of four medical doctors in the CRENI. Even though it is difficult to establish a direct relationship between these two factors, all of the interviewees agreed that the increased mortality rate was because of a lack of medical supervision, especially in the night shifts, at the CRENI. The lack of medical doctors in May highlights the instability of human resources the hospital faces and the consequences it has on quality of care.

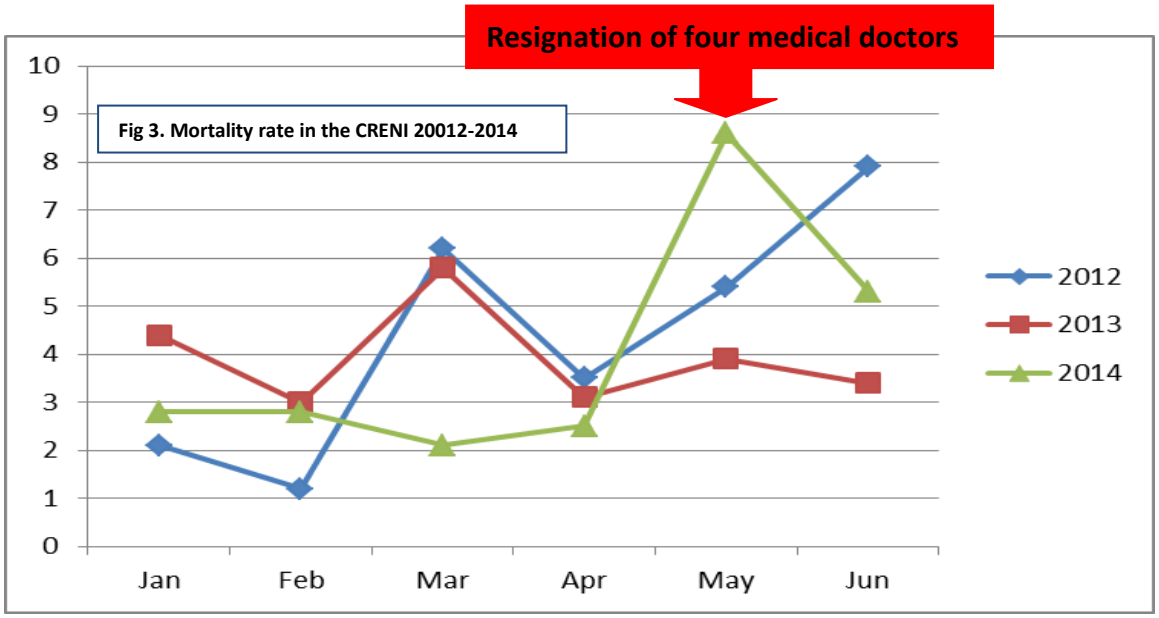

Fig 3: Mortality rate related to the CRENI between 2012 and 2014

In terms of staff and supervision at the CRENI, it is important to mention that the MSP has a two-shift rotation of staff (12-hour shift), while MSF has a three shift rotation (8-hour shift). This issue has been reported during the interviews with MSP authorities and MSF staff as one aspect that can influence the quality of care as there is a consensus that a three shift rotation is better. However, limitations in resources from the MSP are hindering a change of the current shift rotation as this would imply more staff working at the CRENI.

Another aspect that was not directly evaluated during the evaluation is the hygiene conditions because at the time of the visit MSF was involved in the CRENI supporting the hygiene measures (which were according to MSF protocols and standards). However, some

health authorities and MSF staff that were interviewed commented that hygiene measures were not optimal during the time when the NHZ managed the CRENI.

The integration process has been a success in terms of maintaining a good quality of services regarding the *prise en charge* of patients as the mortality rates have been similar to the ones of the previous years (with the exception of May 2014).

2.2.4 Other integration/handover experiences

MSF in Niger has experienced two handover/integration processes with other health authorities that were not successful: one in Magaria (MSF-OCG) and another one in Dakoro (MSF-OCB).

- Magaria: The handover to the district authorities was done in 2012 since the CRENI was inside the CSI in Magaria and because the district was the highest health authority in Magaria [13]. The handover included the district to take over the overall management of the CRENI and to absorb the human resources needed to run a CRENI. The period between the starting of the integration/handover and the time it was implemented was 4 months, which was considered to be too short according to the people interviewed in Magaria. The main result of this experience was that the district could neither take over the overall management of the CRENI nor was it able to take over the high number of human resources to run the CRENI. This resulted in a high incidence of mortality rate in the CRENI during 2012 and made MSF-OCG return to manage a 100% of the CRENI in Magaria in 2013 until this date. According to the interviews, the main difficulty was that the district does not have the resources or the capacity to run a CRENI. This experience helped the integration/handover process in Zinder and many lessons learned came out that supported the successful integration/handover in Zinder.
- Dakoro: A similar situation was experienced by MSF-OCB in Dakoro with the district[14]. A MoU was signed and a number of staff that were working in the CRENI run by MSF-OCB was absorbed by the district. One important aspect to mention is that the staff now being paid by the district asked to be included as MSP staff and not as district staff. The MSP contract is a much more stable one than the district contract and has more benefits. The MSP refused to have these staff under MSP contracts and the main result was that soon after the integration/handover process was finalised, all new staff resigned, which resulted in an increase of the mortality rates in the CRENI. MSF-OCB did not returned to Dakoro but instead found another partner (BEFEN/ALIMA) to take over the activities.

These experiences show the difficulties of handing over projects to district authorities due to the problems of negotiating more resources needed to run a CRENI and ensuring a continuity of the work as the availability of resources is not always guaranteed.

3 Conclusion and discussion

3.1 Lessons learned from the integration/handover process

- The integration process between MSF and the HNZ has mainly focused on maintaining a good quality of the *prise en charge* of nutritional cases. However, other areas of the management of the CRENI were not well followed up after the CRENI was managed by the HNZ.
- HNZ is a very particular health structure in Niger: it is a national hospital that is not dependent on the region or district budget or administrative processes in the region and district in Zinder; it is a semi-private hospital that generates some income; there is a strong political willingness of the authorities to take the lead in the management of nutrition in the region. Previous handover/integration experiences with the district health authorities and structures have not been successful as there seem to be not enough resources or political will.
- The collaboration between the HNZ and MSF was very good. The handover strategy was well designed and closely followed up by both partners. The following aspects were key to the success of the integration:
  - Signing of MoU with clear description of roles and responsibilities of each partner.
  - Creation of the *comite de pilotage* to follow up the advances of the process, discuss the challenges and jointly resolve them.
  - A progressive, well informed process of absorption of human resources, which allowed MSF staff with many years of experience in the management of malnutrition to be taken over by the HNZ in a progressive way and to accept the conditions of the HNZ.
  - The binome setup helped to reinforce the capacities of the HNZ staff and share the responsibilities of the work at the CRENI.
- Despite the success of the HNZ in managing the CRENI, the NHZ is not yet prepared to absorb all the extra human resources needed to manage the CRENI during the peak season. This implies a big amount of human resources that are not included in the HNZ budget.
- The extension of the HNZ CRENI (Charez Amna) located outside of the hospital and within Zinder's district health centre (CSI) cannot be managed by the HNZ since it is working inside a health district structure and it will be difficult to continue with this setup.
- One big challenge for the health authorities in Zinder is the management of the soins intensifs after an eventual withdrawal of MSF from the region. Despite there are some initiatives that are being discussed (such as the transfer of the current soins intensifs place next to the pediatric emergency ward, the start of a medical faculty in the HNZ and the transfer of the maternal/pediatric ward to its new location outside the HNZ), there is no clear strategy of the NHZ on how they will manage the soins intensifs without the support of MSF

- It is extrememlly important that the HNZ makes an analysis of the overall needs in the HNZ to manage the CRENI during the peak season. This initiative should be lead by the HNZ with the support from MSF in order to make an official request and lobby the national health authorities for the coming peak season so that the HNZ can manage the CRENI with an acceptable quality during the whole year.

3.2 Operational /strategic findings

- The presence of MSF in Zinder was highly appreciated and relevant. There is an open recognition from health and administrative authorities of the work and contribution MSF had to the health of the people in Zinder. The strategic choices the mission has gone through seem to have been appropriate in terms of the adapting context. In regards of security, the impression of the evaluator is that the current security rules are very strict compared to the current context situation in Zinder.
- The mortality rate of the CRENI from January to April 2014 (during the absence of MSF in the hospital) was maintained within normal ranges. In May, due to the lack of medical doctors in the CRENI, the mortality rose to 8.6%. This issue highlights the importance of the intra-hospital management of severely malnourished patients. The clinical management of acute severe malnutrition in Niger is still a cornerstone in reducing morbidity and mortality in children under five years of age.
- MSF has not carried out preventative activities in Zinder (mainly seasonal chemoprophylaxis prevention and distribution of plumpy dose). These sorts of preventive activities are very important to lower the burden of the CRENI in Zinder and can help the HNZ to manage the peak season of malnutrition. There is a lot of focus on resilience and community programmes on malnutrition and health authorities have asked for more involvement (of MSF) in community activities.

4 Recommendations

- MSF should now focus on supporting the HNZ in areas where there are still weaknesses to be followed up by the HNZ staff. These are: hygiene management, food and drug provision by partners, data collection and good follow-up of patients.
  - MSF should be a key player in developing MoUs between UNICEF, PAM and the HNZ. These agreements to ensure the continuity of provision of food, medical materials and drugs by these partners should be included in the *comite de pilotage* as a key aspect for follow-up.
  - MSF should now focus on training and supporting the HNZ staff in hygiene, overall supervision, data collection and reporting since the *prise en charge* of patients has been well managed by the HNZ staff.
- The HNZ is a very particular health structure in Niger. Therefore, it is difficult to replicate this experience in another project in Niger. The key elements of a successful handover/integration are
  - the political will of health authorities,
  - joint analysis of the capacity of the health structure to absorb the activities and human resources needed to continue the programme and
  - an open and clear handover/integration process with clear MoUs, creation of follow-up committees and a follow-up after the handover is completed.
- In order to have a complete and responsible handover of all activities during the whole year to the HNZ in the CRENI, MSF needs to remain in Zinder for at least one more year to ensure that the HNZ can manage the CRENI during the peak season. MSF's involvement should focus on the following aspects:
  - Continue to participate in the *comite de pilotage* but more and more as an observer and not leading.
  - Lobby the health authorities to find the resources needed to manage the peak season. The current MSF intervention in Zinder can help the health authorities to evaluate what the needs during the peak season were so the HNZ can request extra resources from the MSP.
  - Progressively reduce support and presence in Zinder in the next year. MSF should focus on the main gaps identified during the current peak season (i.e human resources, training in specific areas).
  - Help find another partner that can continue to support the CRENI during the peak season. BEFEN/ALIMA and Save the Children seem to be the obvious partners that could do that.
- There needs to be a reflection of the MSF teams on how to better relocate Chare Zamna in the context of the integration. These reflexions can include the creation of a district CRENI at the district health centre (where Chare Zamna is currently located) managed by the district or more space needs to be found in the HNZ to accommodate more beds for the peak season.

5 Annexes

5.1 Terms of reference

Terms of reference for the capitalisation of the handover of the MSF CRENI to the Zinder National Hospital, Niger, 2014

Subject / mission:	**MSF-OCG Niger**
Commissioned by:	**Mission/Cell 3**
Starting date:	**June 2014**
Duration of evaluation:	**4 weeks, 1 evaluator**
ToR elaborated by:	**HoM / RP**

1. CONTEXT

In Zinder ITFC, the process of integration has been launched in 2011 with a progressive scaling up in the capacities of the Ministry of Health (MOH) to deal with malnutrition and paediatric cases in the National Hospital of Zinder (HNZ)

MSF worked in collaboration with the MOH on a daily basis in the hospital, but the final medical responsibility remained under MSF.

Early 2012, MSF has started to support to paediatric emergencies for children under five (triage, intensive care unit and emergency hall). The 120 beds of the ITFC have been divides as follows: 60 beds for intensive care and 60 beds for the 3 nutritional phases. Some beds have also been added for observation and triage in an extension build for this specific purpose.

The processes ended the 31st of December 2013, with the handover/integration of the activities in the HNZ and no MSF presence/staff in the HNZ.

The table below shows some indicators of the CRENI for 2014.

INDICATEURS*	JAN	FEVR	MARS
Admissions	262	202	135
Taux de mortalité	2,8%	2,8 %	2,1%
Taux de sortis guéris/transfert	94,7%	95,8%	97,2%
Tx d'abandon	2,5%	1,4%	0,7%
GPM (Gr./Kg./Jr.)	16.93	21.08	18.07
DMS	7.7	8.9	9.1
Enfants sortants reçus le vaccin rougeole	17.2%	41.1%	35.3%

*Source : MOH database

2. OBJECTIVES AND SCOPE

The primary objective of this capitalization is to inform the MSF OCG and partners about best practices, challenges and lessons learnt from the Handover/integration process of the Zinder CRENI to the Hospital, with the main purpose to improve handover process in such context and decision making in future projects.

Secondary objectives are:

- To support the cell/mission in defining possible exit strategies in Niger.
- To develop a briefing paper in order to share with key partners (MOH, donors, NGOs) highlighting the best practices, challenges and lessons learnt from the Handover in Zinder

3. KEY EVALUATION QUESTIONS

- What was the medical impact on the quality / mortality of the MSF departure from the Zinder hospital CRENI, since January 2014.
- Was MSF handover strategy and timing appropriate for that context?
- What lessons can be learned for future implementation of a handover strategy in Niger.
- To what extend the Zinder strategy could be replicable with other medical structures in Niger.
- To what extend the hospital can face the next peak?

4. EXPECTED RESULTS

Written report providing:

- A comprehensive capitalisation of handover process
- A thorough documentation of best practices and challenges of the handover
- Detailed lessons learnt/evaluation of the handover process in order to use it in similar settings in Niger

5. PRACTICAL IMPLEMENTATION

- 1 week of preparation – familiarizing with the information provided by the previous evaluation team
- Field-visit of 2 weeks to conduct more interviews - both MSF & MoH at district, Region but also Niamey
- 1 more week to write up the report and integrate feedback

6. METHODOLOGY

- Use the information (interviews, documents) collected by the evaluators team for the "Niger evaluation of the emergency response in Zinder and Magaria projects"
- Medical analysis of the data including nutrition at the district level, plus looking at BENEF referral's cases and outcome

5.2 List of interviewees

Name	Function
Siége MSF OCG	
Severine Ramon	Adjointe Responsable de Programme, Cellule 3
Souheil Reaiche	Responsable de Programme, Cellule 3
Mission Niger	
Karl Joseph Nawezi	Chef de Mission
Veronique Van Frachen	Coordinaterice Medicale
Kaho Djiala (Francis)	Adjoint MedCo
Mulki Ahmed Abdullahi	Resposable supply
David	Epidemiologiste
Zinder	
Georges Tomamu	Responsable Terrain
Christian Mopipi	Logisticien/Admin Projet
Hipolyte Mboma	Responsable Medical Terrain
Haboubacar Souleymane	Superviseur d'Equippe paramédicale 2 HNZ
Ali Saley	Statisticien
Boureima Hama	Responsable Medical Creni HNZ
Jules	Medecine Medical Charez Amna
Fatuma Adamou	Enfermiere Superviseur Creni
Magaria	
Modeste Tamkaloe Azamezu	Responsable du TerrainT
Abdel Kader Hamani	Responsable Medical CRENI
Sections MSF	
Rachid Bada	Adjoant MedCo, MSF OCB
Jean Paul Kimeni	Epidemiologiste, MSF OCB
Niger (non-MSF)	
Agences, Institutions, ONG, société civile	
Sabin Ogussan	Responsable du Terrain UNICEF, Zinder
Yao Jean	Chef Sous-Bureau, PAM
Didier Tamakaloe	RT, Zinder, Safe the Children Fund (SCF)
Abdoul Aziz	Responsable Terrain Zinder, ALIMA/BEFEN
Moutari Ousmane	President du Conseil des Sages, Zinder
Autorités Santé	
Dr Garba Djibo	Directeur Regionale de la Sante Publique, Zinder
Dr Habibou Moussa Oumani Issa Yahaya	Directeur General, Hopital National de Zinder (HNZ) Director Adjoint
Elisha Nassara Nourou Mariama	Point Focal Nutrition, Direction Regional de la Sante Publique
Dr Oussein Soumana	Medecin Responsable Pediatrie, HNZ
Marafa Fatima Riba	Medecin Chef du District, Zinder
Madougou Hawadu	Infirmière Major du CRENI
Autorités administratives, traditionelles et religieuses	
Bachir Sabo	Maire de Zinder
Oumarou Issa	President du conseil des Sages

5.3 Framework of evaluation process

ISSUE	FINDING	EVIDENCE	CONCLUSION	RECOMMENDATION
Good quality of care	The mortality rate of the CRENI from January to April 2014 (during the absence of MSF presence in the hospital) were mantained within normal ranges	Data from the CRENI. Interviews with staff	The CRENI has managed well the prise en charge of nutritional cases in the absence of MSF support	The HNZ can manage well the prise en charge of patients by itself, even if the absence of MSF support in the CRENI.
Increased mortality rate in the CENI in May 2015	Mortaily rate in the CRENI in May 2014 was 8,6% after 4 out of 5 doctors resigned	Data from the CRENI. Interviews with staff	Medical staff is essential to mantaine good quality indcators at the CRENI	HNZ should ensure a permanent presence of medical staff in the CRENI in order to mantain good quality indicatores, especially mortality rate
Focus of the integration is on the prise en charge	The integration process between MSF and the HNZ has focused mainly on mantaining a good quality of the prise en charge of nutritional cases. However, other areas of the management of the CRENI were not well followed after the CRENI was managed by the HNZ	Interviews of staff; MoUs signed.	The integration process has been a success in mantaining a good quality of services regarding the prise en charge of patients but other areas needs to be reinforced.	MSF should now focus in supporting the HNZ in areas where there are still weaknesses to folow by the HNZ staff. These are: hygiene managemen, food and drug provision by partners, data collection, good follow up of patients
Lack of capacity of the HNZ	Despite the success of the HNZ in managing the CRENI, the NHZ is not yet prepared to absorb all the extra human resources needed to manage the CRENI during the peak season.	Interviews of staff at the HNZ, interviews with MSF staff in Zinder, Intervioews with administrative staff in Zinder	The hospital needs still the support from a partner in order to manage the CRENI during the peak season	In order to have a complete and responsible handover of all activities during the whole year to the HNZ in the CRENI, MSF needs to remain in Zinder for at least one more year to ensure that the HNZ can manage the CRENI during the peak season. This support can be directly (MSF support), to lobby the health authorities to find the resources needed to reuor to help find another partner that can continue supporting the CRENI during the peak season
Change in Charez Amna setup	The extension of the HNZ CRENI (Charez Amna) located outside the hospital and within Zinders district health centre (CSI) cannot be managed by the HNZ since it is working insde a health district structure	Interviews with the health district and regional authorities	There needs to be a change on how the extension of the CRENI (Charez Amna) will copntinue to work as the current setup will not be accepted by health authorities	There need to be a reflecction of the MSF teams on how to better relocate Charez Amna in the context of the integration. These reflexions can include the creation of s district CRENI at the District health centre (where Charez Amna is currently located) managed by the district or to find more space in the HNZ to build more beds for the peak season
Prevention activities	MSF has not carried out preventative activities in Zinder (mainly Seasonal Chemoprophylaxis prevention CPS and distribution of plumpy dose)	MSF reports, interviews, MSF data in Magaria regarding the impact of CPS	The current experience in CPS and plumpy dose distribution in the Magaria project could be used to start preventative activites in Zinder	MSF should engage in preventative activites for malaria and malnutition as it has been doing in the Magaria project to lower the number of admissions to the CRENI, and therefore lower the burden of admissions and patients in the HNZ during the peak season.
Zinder Handover	HNZ is a very particular health structure in Nlger: it is a national hospital that does not depend on the region or district budget or administrative processes in the region and district in Zinder; it is a semi private hospital and that generates some income; there is a strong political willingess of their authorities to take the lead in the management of nutrition in the region.	MSF reports, interviews with health and administrative authorities	A combination of factors, being one of the most important one the political will of authorities to take over a MSF project is essential of its success.	Due to these particularities, it is difficult to replicate this handover experience in other projects in Niger.
Zinder Handover	The colaboration between the HNZ and MSF was very good. The handover strategy was well designed and closely followed up by both partners. However, due to external factors (security incidents and the retreat of MSF project in Zinder) the handover process was not properly followed up in 2012, delaying the initial handover plan	MSF Handover reports, Interviews with MSF Staff	The handover process initially set to conclude in one year (2010) was finally achieved at the end of 2013. Even though it may seen as long it was appropiate. The many tools used to follow up and implemented (MoUs, montlhy meetings, progressive integration of MSF staff to the HNZ) were crucial for this success story	Setting appropiate MoUs that clearly describe the responsibilities and activities of each of the partners, as well a continuoes accompaniment of the process are essential for a succesful handover process. Teams must also be aware that external factors can cause delays in the handover. The most important factor to conclude a handover process should not be a timeframe but to accomplish all the objctives set by both partners

5.4 General recommendations for handover

General Recommnedations	
MoU	Done
Agreements on Budget and Proposal	
Communication on Negotiation Results	Good at coordination level (mission and project) not so good at field staff level
Acceptance of incoming actor	Done
Involvement of Nat key staff in the handover process	Done
Propper Management and documentation	Partial, some documents where only available at field level and not at coordination level
Monitoring in case of emergency	Done (MSF
Steps for the handover	
Decision on project handover within MSF	
Agreement on the strategy	Done
Time table	No
Identification of the partner	
Project presentation document	No (The MoU replaces this document)
Minimal package of activities in case partner cannot take over	Done (Intervention during peak, Opening of Charez Amna
Preparation of both partners	
Facilitate a capacity assessment	Yes, however I had access only to an unfinished draft (Evaluation Rapide HNZ)
Strategic handover plan	Partial, it is in the year strategic/Annual Plan
Legal, financial and admin risks	Done
Budget on all the costs	Done
Transition period and involve staff members	Done
Project Preparation	
HHRR	Yes
Brief staff properly	Not very well especially for the interventions after the handover process (peak)
Define key national staff	Yes
Perform final staff evaluations	Not evaluated
Organize courses	Done
Medical activities	Done
Update and circulate medical guidelines	Yes
Finalize stats and reports	Yes
Links to expert advisors	Yes
Pharmacy	Done
Drug procurement	Done
Update inventory	
Admin and HHRR	
Indemnities for NS	Not evaluated
Hand out work certificates	Not evaluated
Handout admin rules and procedures	Not evaluated
Staff files updated	Not evaluated
Prepare checklist for new, resigned, dismissed and transferred staff	Not evaluated
Close final payrolls	Not evaluated
Financial and legal preparation	
Compliance with national legislation	Yes (for the CRENI
Logistics	
Inventory	Yes (of donations)
Final rehabilitations of project structures	Done

Document and organisational preparation	
Doc with the last plan of action	The MoU
Communicate agreements with other NGOs	N/A
Capitalization	
Finalise admin docs, stats and reports	This was my work! ☺
Capitalie on experience	This was my work! ☺

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