

1. BEFORE FILLING OUT THIS FORM, READ THE ATTACHED INSTRUCTIONS.  
 2. USE LETTER QUALITY TYPE, NOT "DOT MATRIX" TYPE.

**IDENTIFICATION DATA**

<b>A. Reporting A.I.D. Unit:</b> Mission or AID/W Office <u>USAID/NIGER</u> (ES# _____)		<b>B. Was Evaluation Scheduled in Current FY Annual Evaluation Plan?</b> Yes <input checked="" type="checkbox"/> Skipped <input type="checkbox"/> Ad Hoc <input type="checkbox"/> Evaluation Plan Submission Date: FY <u>92</u> Q <u>3</u>		<b>C. Evaluation Timing</b> Interim <input checked="" type="checkbox"/> Final <input type="checkbox"/> Ex Post <input type="checkbox"/> Other <input type="checkbox"/>	
<b>D. Activity or Activities Evaluated</b> (List the following information for project(s) or program(s) evaluated; if not applicable, list title and date of the evaluation report.)					
Project No.	Project /Program Title	First PROAG or Equivalent (FY)	Most Recent PACD (Mo/Yr)	Planned LOP Cost (000)	Amount Obligated to Date (000)
683-0254	Niger Health Sector Support	86	8/95	\$20,300	\$18,467

**ACTIONS**

<b>E. Action Description Approved By Mission or AID/W Office Director</b> Action(s) Required	<b>Name of Officer Responsible for Action</b>	<b>Date Action to be Completed</b>
1. Contract remaining technical assistance required to assist MOPH in the implementation of planned cost recovery pilot tests under the AID/W Health Financing and sustainability project contract.	Carl Abdou Rahmaan	6/92
2. Extend PACD by an additional 24 months	Carl Abdou Rahmaan	8/92
3. Negotiate modifications in conditionality for the release of the 3 remaining cash transfers provided for under the project	Carl Abdou Rahmaan	8/92
4. Execute PAAD amendment to: a) add additional dollar funding to finance technical assistance to the GON over the planned 24 month project extension; b) negotiate an extension of the current technical assistance contract; and c) simplify procedures for disbursement of local counterpart funds.	Carl Abdou Rahmaan	8/92
	Cynthia Judge	12/92
	Harry Lightfoot	3/93

(Attach extra sheet if necessary)

**APPROVALS**

<b>F. Date Of Mission Or AID/W Office Review Of Evaluation:</b>			(Month)	(Day)	(Year)
			7	10	92
<b>G. Approvals of Evaluation Summary And Action Decisions</b>					
Name (Typed)	Project/Program Officer	Representative of Borrower/Grantee	Evaluation Officer		
Signature	C.A. Rahmaan	H. Gado	R. Mack...		
Date	5/20/93	9/28/93	7/28/93		

**ABSTRACT**

**H. Evaluation Abstract (Do not exceed the space provided)**

The Niger Health Sector Support Grant (NHSSG) represents A.I.D.'s earliest experience with the use of non-project assistance (NPA) in the health and population sector, combining project and non-project assistance to bring about important policy and institutional reforms. The five-year grant was signed with the Government of Niger (GON) in 1986, initially providing \$10.5 million in local currency upon completion of five tranches of conditions, and \$4.5 million in project assistance. Policy and institutional reforms were planned in six areas: 1. Cost recovery for hospital and non-hospital services; 2. Cost containment for hospital services and for drugs; 3. National health budget reallocation; 4. Personnel reallocation; 5. Health Planning and information systems development; 6. Family planning and population policy.

The scope of work for this Evaluation includes three components:

- i) analysis of progress, or lack thereof, in the achievement of policy objectives;
- ii) assessment of program management and related technical assistance and training support; and
- iii) identification of required modifications/changes in program objectives, strategy, and/or configuration.

The team, consisting of two external evaluators and an economist from REDSO-Abidjan, conducted interviews with more than 60 persons and reviewed documents, as the principal sources of information for the evaluation. Since grant program activities had taken place primarily in Niamey, field travel was not undertaken.

Design, institutional, and environmental constraints have prevented the NHSSG from achieving its objectives. The Grant's design structure of benchmarks locksteps policy arenas rather than encouraging progress in each arena and offers no direct rewards to those who are responsible for achieving the conditions precedent.

**Major Recommendations**

The evaluation team recommended that: 1) the grant be extended for an additional two years; 2) conditionality for the release of remaining cash transfers be restructured and disbursement procedures simplified; and 3) technical assistance arrangements be modified to provide more intensive support in the selected policy areas.

Lessons for NPA: As A.I.D.'s first health sector grant, the NHSSG had little experience to go on but its experience could help other such NPAs. The analytical basis for the Grant was well thought out and has served it well. However, insufficient attention was given to two issues: planning for the implementation of policy reforms; and the sheer volume of benchmarks required. To achieve policy reforms, government ownership is crucial, and it would seem essential to improve the incentive structure by linking satisfaction of mandated conditionality directly to the release of counterpart funds.

**C O S T S**

**I. Evaluation Costs**

1. Evaluation Team		Contract Number OR TDY Person Days	Contract Cost OR TDY Cost (U.S. \$)	Source of Funds
Name	Affiliation			
Anne-Marie Foltz, Team Leader	John Snow	IQC PDC-5929- 00-0109-00	\$48,815	Project 683-0254
Dayl Donaldson, Health Economist	John Snow	IQC PDC-5929 00-0109-00		
Bineta Ba, Health Economist	REDSO/WCA	12 days	TDY	Regional HPN
2. Mission/Office Professional Staff Person-Days (Estimate) <u>15 days</u>		3. Borrower/Grantee Professional Staff Person-Days (Estimate) <u>30 days</u>		

**A.I.D. EVALUATION SUMMARY - PART II**

**S U M M A R Y**

**J. Summary of Evaluation Findings, Conclusions and Recommendations (Try not to exceed the three (3) pages provided)**

**Address the following items:**

- |  |                             |
|--|-----------------------------|
| • Purpose of evaluation and methodology used     | • Principal recommendations |
| • Purpose of activity(ies) evaluated             | • Lessons learned           |
| • Findings and conclusions (relate to questions) |                             |

**Mission or Office:**

USAID/NIGER

**Date This Summary Prepared:**

May 19, 1993

**Title And Date Of Full Evaluation Report:**

Interim Evaluation, Niger Health Sector Support Project

**Summary:** The Niger Health Sector Support Grant (NHSSG) represents the Agency for International Development's earliest experience with the use of non-project assistance (NPA) in the health and population sector. It represents an attempt to combine project and non-project assistance to bring about important policy and institutional reforms.

The five-year grant was signed with the Government of Niger (GON) in 1986, with a funding of \$10.5 million in local currency funds available on the completion of five tranches of conditions, and \$4.5 million in project assistance. Policy and institutional reforms were planned in six areas: 1. Cost recovery for hospital and non-hospital services; 2. cost containment for hospital services and for drugs; 3. National health budget reallocation; 4. Personnel reallocation; 5. Health Planning and information systems development; 6. Family planning and population policy. Delays in implementation have extended the Grant until the end of 1992 while the total funding has increased to \$17 million, subsequently increased to \$20.3 million.

The scope of work for this Evaluation includes three components: i) analysis of progress, or lack thereof, in the achievement of policy objectives; ii) assistance and training support; and iii) identification of required modifications/changes in program objectives, strategy, and/or configuration. The Team, consisting of two external evaluators fielded by John Snow Incorporated, reviewed documents and interviewed officials in Washington in early January 1992. They began work in Niger on January 22, where they were joined by a health economist from REDSO-Abidjan. Interviews with more than 60 persons and reviews of documents served as the principal sources of information for the evaluation. Since grant program activities had taken place primarily in Niamey, field travel was not undertaken.

**Findings/Conclusions:** The GON, with the assistance of this Grant, has made considerable progress toward achieving its objectives. The most rapid progress and the most complete achievement of conditions has occurred for the family planning/population policy component. Other reforms which have shown progress are: studies have been completed on cost-recovery methods for non-hospitals with several options selected and soon to be tested in three regions; methods to improve hospital cost-recovery and cost-containment have been developed; and the national health information system (SNIS) has been installed and is generating data of use to policy makers and managers. In other areas, considerable analytical work has been carried out, although this has not yet translated into policy or institutional reform.

The Health Sector Grant, at nearly every stage of development, has moved more slowly than originally foreseen. Although the Grant agreement was signed by the GON and USAID in 1986, implementation did not begin until August 1987 when conditions were fulfilled for the first disbursement of counterpart funds (\$2.1 million). The achievement of the conditions precedent for the second tranche of counterpart funds occurred in mid-1990, but by then the Grant had been decertified because of problems in fiscal accountability. Only in September 1991 were the \$3 million for the second tranche deposited. They have not been disbursed by the GON.

The Grant's design structure of benchmarks locksteps policy arenas rather than encouraging progress in each arena and offers no direct rewards to those who are responsible for achieving the conditions precedent. The need to focus on more than 20 benchmarks in six areas has diffused activity and diffused available resources to the point that objectives are hard to achieve. The Grant's implementing institutions have contributed to the constraints: the GON's investment in personnel, institutional reform, and its willingness to focus on policy reform areas and to elevate these issues to the appropriate decision-makers, have been insufficient to move along activities and decisions; USAID has been too focused on achieving benchmarks, rather than program objectives; while the TA team, responding to both these institutions, has been overwhelmed by the need to produce evidence of progress toward benchmarks using a staff not highly experienced in policy development and working within a difficult institutional environment.

Also more work is needed to assure GON ownership of the reforms, to assure a GON investment in personnel, as well as to improve the transfer of skills by the technical assistance team and to avoid the substitution of their work for that of nationals. Future projects will have to look more closely at the national commitment to personnel and institutional capacity building and at the technical assistance team's skills in on-the-job training before deciding whether such goals are feasible under future programs.

Lessons for NPA: As A.I.D.'s first health sector grant, the NHSSG had little experience to go on, but its experience could help other such NPAs. The analytical basis for the Grant was well thought out and has served it well. Insufficient attention was given to two issues: planning for the implementation of policy reforms; and the sheer volume of benchmarks required. To achieve policy reforms, government ownership is crucial, something which has handicapped the NHSSG. The mechanism for disbursing counterpart funds, the Secretariat, has provided less than a satisfactory institution and suggests that NPAs consider other options for disbursement and accountability. It would seem essential to improve the incentive structure to link directly achievement of the policy reform with the reward of the counterpart funds. And finally, it might now be helpful for A.I.D. to begin synthesizing some of its NPA experience in the health sector across other countries to assist future planning. The evaluation team determined that under no reasonable timetable will the Grant be able to achieve all the benchmarks originally planned. In retrospect, they also noted that some of the objectives no longer seem realistic, necessitating that some priority activities be selected and that other less important or currently less feasible ones be left for subsequent projects.

**Major Recommendations:**

1. That the NHSSG be extended in time through the end of 1994 and that additional funds be sought to permit technical assistance to continue through the same date;
2. That the NHSSG be amended so that remaining tranches are restructured with the retention of four policy/institutional areas of reform, each with one set of conditions precedent to be accomplished at one time and with the local counterpart funds released linked and budgeted directly to implementation of activities in that area;
3. That USAID obtain supplementary financing for implementation and analyses of non-hospital cost-recovery pilot tests (planned to begin in 1994), through A.I.D.'s centrally-funded Health Financing and Sustainability project; and
4. That over the remaining LOP long-term and short-term technical assistance should be directed toward providing support in the above four policy arenas and should give priority to senior staff experienced in policy development. These assistants should serve as advisors to their national counterparts and be capable of providing them with on-the-job training.

**Recommendations for Future Follow-on Health Activities:**

The criteria for short-term and long-term sustainability, such as the development of sources for funding of health programs and such as government perception of ownership of its institutional and policy reforms, do not appear yet to have been well met in the case of the NHSSG.

Concern for financial sustainability guided the design of the NHSSG. To achieve in a short period of time the reforms in health sector finance necessary to fiscal sustainability is difficult in an unstable political and economic environment. Therefore, effort must be placed on prioritizing reform efforts based on the magnitude of their potential impact.

The ultimate sustainability objective of any development activity is to institutionalize: to have the nationals themselves capable of running that activity. In the case of the sector grant, the transfer of skills in policy reform and planning to the nationals has not occurred to the degree expected, despite long-term and short-term consultants in Niger. As a result, few of the skills in planning and policy analysis, in data collection and analysis, have actually materialized. Accordingly, the evaluation team made the following recommendation for follow on assistance in the sector:

1. Recommend a follow-on grant to continue and consolidate activities under the NHSSG. It should provide mainly project assistance. Given the current trend for donors in Niger to work in specific regions, USAID should consider balancing its present role of working within the central MOPH with support for service delivery in specific regions and with close coordination, if not consolidation, with the family planning activities now being undertaken by the Family Health and Demography project.
2. If NPA is used, recommend it be highly targeted with each tranche related to a significant reform in a single policy area.
3. Recommend continued support of central health information systems (SNIS) and development of regional information data processing capacity.

## ATTACHMENTS

**K. Attachments** (List attachments submitted with this Evaluation Summary; always attach copy of full evaluation report, even if one was submitted earlier; attach studies, surveys, etc., from "on-going" evaluation, if relevant to the evaluation report.)

Interim Evaluation, Niger Health Sector Support Project

## COMMENTS

**L. Comments By Mission, AID/W Office and Borrower/Grantee On Full Report**

The Mission consensus is that the team did an excellent job in assessing progress realized under the Grant; identifying key problems which have hindered implementation to date; and recommending program areas for Mission consideration during the planned redesign and amendment of the Grant. There is a sense, however, that the evaluation report was overly negative in tone, particularly as it relates to the operation of the Management Secretariat, with little discussion of the considerable progress made in improving procedures and strengthening its overall performance. The considerable time and effort invested in making the Secretariat functional is not evident in the report.

The report is noticeably silent on what clearly is one of the Grant's major accomplishments to date, i.e. the development and installation of one of the most technically advanced health and management information systems in Africa. While acknowledging the considerable work that remains to be done to fully transfer operational responsibility for the system to Nigerien counterparts, the Mission believes that the MOPH National Health Information System (SNIS) merits a more balanced presentation than that provided in the report. The MOPH has already taken or scheduled several actions to address recognized shortcomings of the system. A cadre of Nigerien technicians has been put into place, an extensive training program has been scheduled and a plan to computerize of all central and departmental directorates is underway. Accordingly, the reports presentation of SNIS might well have included discussion of the potential the system now provides for improving MOPH planning capabilities.

With respect to policy conditionality, the evaluation notes that "it would seem essential to improve the incentive structure by linking satisfaction of mandated conditionality directly to the release of counterpart funds." This is indeed the purpose of non-project assistance, and is generally what has happened under the grant. Because of the complex mix of conditions which were identified for specific disbursements, there were occasions when meeting some conditions did not result in immediate disbursements, owing to delays in meeting other conditions within the same tranche. In accordance with recommendation 3, the conditionality has been restructured to include related items.

Furthermore the report fails to mention the lack of continuity of executive direction in the Ministry of Public Health among operational constraints impacting on the implementation of the Grant. With the nomination of the most recent Minister in November 1991, the Grant has been managed under the direction of five different Ministers and three different Secretary Generals. Similar changes have been experienced under the technical assistance contract, with three major changes and a two-third turnover of advisors.

Finally, very little rationale is provided for the selection of the reform areas proposed for retention under an amended grant. Although we are in general agreement on the proposed areas, the justification for the selection of these areas is not self evident and would benefit from more discussion in the report.

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# INTERIM EVALUATION NIGER HEALTH SECTOR SUPPORT PROJECT

by

**Anne-Marie Foltz, Ph.D., Team Leader, Policy/Org. Specialist**  
**Dayl Donaldson, M.A., M.P.H., Health Economist**  
**Bineta Ba, Health Economist, REDSO-Abidjan**

May 1992



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**INTERIM EVALUATION  
NIGER HEALTH SECTOR SUPPORT  
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Dayl Donaldson, M.A., M.P.H., Health Economist  
Bineta Ba, Health Economist, REDSO-Abidjan**

**May 1992**

**Report prepared for USAID/Niger  
under HQC PDC-5929-1-00-0109-00.**

## **NIGER HEALTH SECTOR SUPPORT GRANT (INTERIM EVALUATION)**

### **EXECUTIVE SUMMARY**

The Niger Health Sector Support Grant (NHSSG) represents the Agency for International Development's earliest experience with the use of non-project assistance (NPA) in the health and population sector. It represents an attempt to combine project and non-project assistance to bring about important policy and institutional reforms.

The five-year grant was signed with the Government of Niger (GON) in 1986, with a funding of \$10.5 million in local currency funds available on the completion of five tranches of conditions, and \$4.5 million in project assistance. Delays in implementation have extended the Grant until the end of 1992 while the total funding has increased to \$17 million.

Policy and institutional reforms were planned in six areas: 1. Cost recovery for hospital and non-hospital services; 2. cost containment for hospital services and for drugs; 3. National health budget reallocation; 4. Personnel reallocation; 5. Health Planning and information systems development; 6. Family planning and population policy.

A mid-term evaluation in 1989 noted that implementation was occurring more slowly than planned. The purpose of this present evaluation (termed interim) was to assess progress and constraints, to assess management, and to identify required modifications. The evaluation was carried out in Niger from January 13-30, 1992 by three external evaluators.

#### **Findings/Conclusions:**

The GON, with the assistance of this Grant, has made considerable progress toward achieving its objectives. The most rapid progress and the most complete achievement of conditions has occurred for the family planning/population policy component. Other reforms which have shown progress are: Studies have been completed on cost-recovery methods for non-hospitals with several options selected and soon to be tested in three regions; Methods to improve hospital cost-recovery and cost-containment have been developed; and the national health information system (SNIS) has been installed and is generating data of use to policy makers and managers. In other areas, considerable analytical work has been carried out, although this has not yet translated into policy or institutional reform.

The Health Sector Grant<sup>2</sup>, at nearly every stage of development, has moved more slowly than originally foreseen. Although the Grant agreement was signed by the GON and USAID in 1986, implementation did not begin until August 1987 when conditions were fulfilled for the first disbursement of counterpart funds (\$2.1 million). The required Ministry structure, the DEP, was established in 1988, receiving legal

recognition in 1990. The achievement of the conditions precedent for the second tranche of counterpart funds occurred in mid-1990, but by then the Grant had been decertified because of problems in fiscal accountability. Only in September 1991 were the \$3 million for the second tranche deposited. They have not yet been disbursed by the GON.

Thus, although the original PAAD had foreseen the completion of a series of five benchmarks in policy and institutional reforms in five years, only two sets of benchmarks had been completed between 1986 and 1991. The Evaluation Team estimates that the GON will not be able to fulfill the conditions precedent for the third tranche before the end of 1992 when the Grant is scheduled to end.

**Constraints:** Design, institutional, and environmental factors have constrained this ambitious Grant from achieving its objectives in a timely manner.

The Grant's design structure of benchmarks locksteps policy arenas rather than encouraging progress in each arena and offers no direct rewards to those who are responsible for achieving the conditions precedent. The need to focus on more than 20 benchmarks in six areas has diffused activity and diffused available resources to the point that objectives are hard to achieve. Another design constraint has been the creation of the Secretariat to disburse counterpart funds (it was established originally for the Agriculture sector Grant). This institution has had difficulties in management. Although the Secretariat is now back functioning, this experience suggests for the future the consideration of alternate mechanisms for fund disbursement.

The Grant's implementing institutions have contributed to the constraints: the GON's investment in personnel, institutional reform, and its willingness to focus on policy reform areas and to elevate these issues to the appropriate decision-makers, have been insufficient to move along activities and decisions; USAID has insufficiently monitored the Grant's fiscal complexities and has been too focused on achieving benchmarks, rather than program objectives; while the TA team, responding to both these institutions, has been overwhelmed by the need to produce evidence of progress toward benchmarks using a staff not highly experienced in policy development and working within a difficult institutional environment.

Niger's economic situation had been declining for some time, but by 1990-91, it had led to a severe fiscal crisis for the government. Meanwhile, political shifts, particularly in 1991, first with strikes and civil unrest, then with the National Conference, and finally with the establishment of the Transition Government, made accomplishing even routine government business a formidable task. It certainly complicated the task of the NHSSG. Since the present political situation remains uncertain and the economic situation remains less than brilliant, it suggests that

modifications in Grant design must be made to respond to this new environment.

**Sustainability:** The criteria for short-term and long-term sustainability, such as the development of sources for funding of health programs and such as government perception of ownership of its institutional and policy reforms, do not appear yet to have been well met in the case of the NHSSG.

Concern for financial sustainability guided the design of the NHSSG. To achieve in a short period of time the reforms in health sector finance necessary to fiscal sustainability is difficult in an unstable political and economic environment. Therefore, effort must be placed on prioritizing reform efforts based on the magnitude of their potential impact.

The ultimate sustainability objective of any development activity is to institutionalize: to have the nationals themselves capable of running that activity. In the case of the sector grant, the transfer of skills in policy reform and planning to the nationals has not occurred to the degree expected, despite long-term and short-term training and despite the availability of three long-term consultants in Niger. As a result, few of the skills in planning and policy analysis, in data collection and analysis, have actually materialized.

More work is needed to assure GON ownership of the reforms, to assure a GON investment in personnel, as well as to improve the transfer of skills by the technical assistance team and to avoid the substitution of their work for that of nationals. Future projects will have to look more closely at the national commitment to personnel and institutional capacity building and at the technical assistance team's skills in on-the-job training before deciding whether such goals are feasible under future programs.

There is an explicit trade-off here between institution-building and instituting major policy reforms: to reinforce institutional capacity takes considerable time and effort. It is not possible simultaneously to obtain quick results in policy reform. Moreover, the development of sources for the financial sustainability (such as cost-recovery programs) involves long-term commitment from donors not only to support the study of mechanisms for policy reform, but also to support the difficult policy formation and implementation process which must ensue before one can expect to reap any financial rewards for the health sector.

**Lessons for NPA:** As A.I.D.'s first health sector grant, the NHSSG had little experience to go on, but its experience could help other such NPAs. The analytical basis for the Grant was well thought out and has served it well. Insufficient attention was given to two issues: planning for the implementation of policy reforms; and the sheer volume of benchmarks required. To achieve policy reforms, government ownership is crucial,

something which has handicapped the NHSSG. The mechanism for disbursing counterpart funds, the Secretariat, has proved a less than satisfactory institution and suggests that NPAs consider other options for disbursement and accountability. It would seem essential to improve the incentive structure to link directly achievement of the policy reform with the reward of the counterpart funds. And finally, it might now be helpful for A.I.D. to begin synthesizing some of its NPA experience in the health sector across other countries to assist future planning.

**Priorities for redesign:** We believe that under no reasonable timetable will the Grant be able to achieve all the benchmarks originally planned. In retrospect, some of the objectives no longer seem realistic. Some priority activities will have to be selected with other less important or currently less feasible left for subsequent projects.

We propose the following rationale for selecting reform areas. First, any reform selected must meet three criteria: it must address the original goals/objectives of the NHSSG; it must be within the original policy reform areas of NHSSG; it must not already have been accomplished. Second, we propose the following priorities for weighing selections:

- Reforms where significant work already underway (hospital cost recovery/management, SNIS);
- Reforms which can be achieved by end of a revised PACD;
- Reforms which will generate significant funds for health sector recurrent costs (cost-recovery, drug distribution);
- Institution building (SNIS, coordination of MOPH donor funding).

Using these criteria, priority should be given to: cost-recovery in non-hospitals; cost-containment in hospitals; drug distribution; and the national health information system.

#### **Major Recommendations:**

##### **A. Recommendations for the NHSSG**

1. That the NHSSG be extended in time through the end of 1994 and that additional funds be sought to permit technical assistance to continue through the same date.

2. a. That the NHSSG be amended so that the remaining tranches are restructured with the retention of four policy/institutional areas of reform, each with one set of conditions precedent to be accomplished at one time and with the local counterpart funds released linked and budgeted directly to implementation of activities in that area;

b. Funds continue to be managed by the Secretariat during the Grant period;

c. Four policy institutional reform areas as follows:

1. Hospital reform: Conditions precedent: GON enact legislation to establish Niger's three major hospitals as institutions with autonomous management;

2. Extend the Distribution of Drugs: Conditions precedent: Make operational the Directorate of Pharmacies; Develop two-year action plan to expand drug distribution system;

3. Development and Institutionalization of National Health Information System (SNIS): Conditions precedent: Increase Statistics Bureau staff by five persons;

4. Improve Coordination of Donor Financing in the Health Sector: Conditions precedent: Implementation of financial management system within MOPH.

3. Obtain supplementary financing for implementation and analyses of non-hospital cost-recovery pilot tests (planned to begin in 1992), through A.I.D.'s centrally-funded Health Financing and Sustainability project

4. Long-term and short-term technical assistance should be directed toward providing support in the above four policy arenas and should give priority to senior staff experienced in policy development. These assistants should serve as advisors to their national counterparts and be capable of providing them with on-the-job training.

#### **B. Recommendations for future follow-on health activities**

1. Recommend a follow-on grant to continue and consolidate activities under the NHSSG. It should provide mainly project assistance. Given the current trend for donors in Niger to work in specific regions, USAID should consider balancing its present role of working within the central MOPH with support for service delivery in specific regions and with close coordination, if not consolidation, with the family planning activities now being undertaken by the Family Health and Demography project.

2. If NPA is used, recommend it be highly targeted with each tranche related to a significant reform in a single policy area.

3. Continued support of central health information systems (SNIS) and development of regional information data processing capacity.

#### ACKNOWLEDGEMENTS

We wish to thank officials of the Niger Government, USAID, and several non-governmental organizations, as well as the technical assistance team of Tulane-Abt, for their help in carrying out this evaluation, including locating documents and patiently replying to our questions. We wish particularly to thank Carl S. Abdou Rahman and Oumarou Kané of the USAID/Niger Health office and Ibrahim Abou of the DEP,, Ministry of Public Health for setting up interviews and facilitating our work in Niger, as well as David Pyle and Mark Jordan of JSI-Boston for their consistent logistical support.

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## **TABLES**

### **MAIN TEXT**

1. Progress Towards Achievement of the Third Tranche of the NHSSG as of January 1992.
2. Approved and Actual Expenditures for NHSSG Sub-Projects
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## **I. INTRODUCTION: HISTORY OF GRANT**

The Niger Health Sector Support Grant (NHSSG) represents the Agency for International Development's earliest experience with the use of non-project assistance in the health and population sector. It represents an attempt to combine project and non-project assistance to bring about important policy and institutional reforms.

At the time the grant was designed, the Government of Niger (GON) was engaged in a program of structural adjustment with fiscal reform as a major focus. Studies carried out under the World Bank adjustment program identified issues of resource allocation and financial constraints in Niger's health sector. USAID/N, based on its experience with the Agricultural Sector Development Grant (ASDG I), adopted a sector grant approach with a dual purpose: "to facilitate policy and institutional reforms." and to "provide conditional budgetary resources for support of counterpart contributions or local currency requirements of selected health and population programs."<sup>1</sup>

On August 28, 1986, the GON and USAID/N signed a grant agreement for the NHSSG for \$15 million over five years. A portion of these funds (\$4.5 million) was allocated for direct project assistance while \$10.5 million of the grant, was to be released in 5 tranches upon completion of pre-specified activities intended to contribute to policy and institutional reform in six areas:

1. Cost recovery for hospital and non-hospital services;
2. Cost containment with respect to hospital services and drug purchasing and distribution;
3. Resource allocation within the national health budget;
4. Personnel allocation and management;
5. Health sector planning, information systems, and monitoring policy reforms;
6. Population policy and resources.

The first tranche of \$2.1 million of counterpart funds was disbursed in August 1987 when the GON fulfilled the conditions precedent for that tranche. The administrative mechanism for disbursing the Counterpart funds was the

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<sup>1</sup> Niger Health Sector Support Program, 683-0254, Program Assistance Approval Document, Vol I, Section II-7.

Secretariat which had already been established for the Agriculture Grant.

In February 1988, the MOPH formally created the Direction des Etudes et de Programmation (DEP), and designated it as the organizational unit within the MOPH responsible for carrying out the activities of the grant. Three long-term technical assistants from the Tulane University/Abt Associates International team took up their posts during the same month.

Conditions precedent (CPs) for the release of the second through fifth tranches were revised in August 1989, in response to a general concern that the pace of the original agreement was overly ambitious.

The mid-term evaluation of the NHSSG, conducted in August-September 1989, identified a number of factors affecting the program's slower than expected pace of implementation. In order to take account of these factors, the evaluators recommended amending the Grant to prioritize and limit the number of policy and institutional reforms to assure feasibility. They also recommended that the Secretariat be restructured, that the DEP's activities be institutionalized with an increase in national staff, and that technical assistants experienced in the policy arena be more closely involved in Grant development. In addition, they recommended a revision of impact indicators for the logframe and that the technical assistance team undertake analyses of the policy arenas for each of the policy/institutional reforms within the Grant objectives (See Annex 6-Table 1, for a list of mid-term evaluation recommendations and the actions taken).

Funding equivalent to \$2.2 million was subsequently added to the grant agreement to extend the technical assistance to March 1992. Later, the PACD was extended to December 1992, and the TA contract extended (no-cost) to the same date.

In November 1990, the GON and USAID/N reached agreement that the revised CPs for release of the second tranche counterpart funds had been met. However, subsequent to audits, the Grant had been decertified since January 1990; these funds of \$3 million could not be released for GON use until September 1991, when the accounting problems and procedures had been resolved and the Grant was again recertified.

## II. EVALUATION PURPOSE AND METHODS

The scope of work for this Evaluation (see Annex 1) includes three components: i) analysis of progress, or lack thereof, in the achievement of policy objectives; ii) assessment of program management and related technical assistance and training support; and iii) identification of required modifications/changes in program objectives, strategy, and/or configuration.

The Team consisting of two external evaluators, Anne-Marie Foltz, public policy/organizational specialist, and Dayl Donaldson, economist, short-term consultants fielded by John Snow Incorporated, reviewed documents and interviewed officials in Washington in early January 1992. They began work in Niger on January 13 and continued through January 30, 1992. On January 22, they were joined by a health economist from REDSO-Abidjan, Bineta Ba. All three team members had previously worked in Niger.

Interviews with more than 60 persons and reviews of documents served as the principal sources of information for the evaluation. (See Annexes 2 and 3 for the persons and documents consulted.) Access to officials and documents was facilitated particularly by Ibrahim Abou of the DEP, Ministry of Public Health and by Carl S. Abdou Rahmaan and Oumarou Kané of USAID. Since grant program activities had taken place primarily in Niamey, field travel was not undertaken.

On January 28, 1992, the Evaluation Team presented to USAID a 16-page briefing report in English and French which summarized its major findings, conclusions, and recommendations. On February 15, the Evaluation Team sent to USAID-Niger an expanded version of its report, incorporating comments received during discussions with Ministry of Public Health and USAID officials in Niamey on January 29-30. This final report incorporates comments received from the USAID Mission in April.<sup>2</sup>

The findings and recommendations in this evaluation are drawn as of the time of the team's visit to Niger, January 13-30, 1992. We have not been able, from this distance, to evaluate the opportunities and constraints presented by Niger's evolving political situation since that date.

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<sup>2</sup> Carl S. Abdou Rahmaan, HDO, USAID/Niger to David Pyle, JSI, April 17, 1992.

### **III. FINDINGS: ACHIEVEMENTS UNDER THE GRANT**

#### **A. Policy and Institutional Reform**

##### **1. Achievements for the First and Second Tranches**

During the first and second tranches, the GON formally established the DEP, set up a mechanism for handling counterpart funds (Secretariat and a Management committee), and made progress, particularly in the areas of hospital cost containment, non-hospital cost-recovery studies, and changes in family planning policy, as well as in the development of the information system.

The counterpart funds for the first tranche were allocated and disbursed to sub-projects during 1988-1989. Grant activity up through August 1989 was reported in the mid-term evaluation of 1989.

After mid-term evaluations and audits had pinpointed financial and management issues constraining the functioning of the Secretariat which was servicing both the ASDG I and the NHSSG, the grants were decertified in January 1990, with the auditors citing severe lack of controls over both project and operational expenditures. During the next year and a half, the USAID mission worked closely, and with considerable effort, with the GON to resolve these problems. As a result, the NHSSG was recertified in August 1991.

Meanwhile, by November 1990, the GON had satisfied the conditions precedent for the second tranche of the NHSSG. This was accomplished through the development of a series of studies on hospital and non-hospital cost recovery activities, on drug procurement, budgetary allocations, personnel training, and planning, as well as the development of the national information system (SNIS), and plans for diffusion of family planning and the development of a population policy.

##### **2. Progress Towards the Third Tranche**

Significant accomplishments (as of this writing) toward meeting third tranche conditions are summarized below (for specifics of benchmarks, see Table 1). During 1991, work was hampered by a period of economic crisis and political change. Labor union and student unrest intensified early in the year, and the National Conference, from August through October, drew nearly all attention. Little administrative work could be accomplished during this tumultuous period. The installation of the Transition Government in November 1991 permitted a return to more normal activities.

#### a. Hospital Cost Recovery and Cost Containment

Most of the analyses regarding hospital financial management, accounting practices, tariff structures, and patient registration and fee collection systems (over 23 studies/technical notes) were carried out in 1989 and 1990. Training in new accounting procedures, financed out of the NHSSG counterpart fund, was carried out at Niamey National Hospital (NNH) in 1990, but the new system has not been implemented. MOPH decision-makers have not adopted the studies' recommendations nor developed plans for implementing policy and/or administrative reforms. A Hospital Sector Workshop, scheduled for March 1992, is expected to facilitate the development of implementation plans regarding the GON's policy to convert three hospitals (Niamey, LaMorde, Zinder) into autonomous para-statal institutions. Adoption of recommendations and implementation plans during the workshop would help the GON meet several of the 3rd tranche benchmarks.

#### b. Non-hospital Cost Recovery Pilot Tests

A design for a pilot test of cost recovery efforts in rural health facilities was circulated to the GON and interested donors in December 1990. Donors indicated that prior to funding such pilot tests: an evaluation should be undertaken of the existing cost recovery experiences in Niger; and additional design work be undertaken. A "Comité National sur le Recouvrement des Coûts de Santé au Niger" was created by decree in March 1991 to carry out preparatory tasks for the pilot tests and to coordinate and follow-up implementation of the tests. A final draft of the study proposal was completed in October 1991 and reviewed in early January 1992. If funding for the tests can be secured in early 1992, the study can begin. The study's implementation and results from initial household surveys will meet the 3rd tranche benchmark. However, the final results from the study will be available no earlier than the end of 1993, delaying meeting of the 4th tranche benchmark until at least that time.

#### c. Drug Cost Containment and Management

The World Bank health project (CREDES, Mars 1991) carried out a study of the pharmaceutical system in Niger. This meets 3rd tranche benchmarks under this grant. Activities undertaken in the preparation of the cost recovery pilot tests could be accepted to meet other conditionality in these areas.

#### d. Financial Resource Allocation

Studies undertaken under UNDP/World Bank and FED funding analyzing the MOPH's investment and recurrent budget, and donor funding from 1987-1990 will serve to meet 3rd tranche conditionality under this area. Due to delays, the other CP is no longer of relevance.

#### e. Personnel Management

Given the political sensitivity of reallocation of personnel in the sector, activities in this policy area have received little attention. The MOPH has developed plans to allocate new graduates to rural areas at the beginning of their service. Neither Ministry officials, nor the Tulane-Abt technical assistance team considered reallocation of health personnel in the next two years a feasible option for the Ministry. We concur.

#### f. Health Planning and Evaluation

The third tranche CP requires preparation of a national health plan using a decentralized planning process. A pilot effort at decentralized planning was undertaken by the FAC in Zinder. The MOPH is planning to find donor assistance for developing health plans in other departments, but has no activities under way to undertake a national health plan.

The major activity under this component has been the development of the SNIS (Système National d'Information Sanitaire). (For a fuller analysis of the SNIS and its achievements, see Annex 5). Development of this information system had begun under the predecessor USAID grant, RHIP. Under the NHSSG, the technical assistance team has helped develop the reporting forms and carry out training in 1989. New reporting forms on morbidity and health center activities and utilization were introduced in 1990, with most non-hospital facilities participating by 1991. Tables and charts have been generated from these data and distributed to central Ministry and regional health officials. Formal feedback mechanisms are planned for implementation. Although data entry and table generation are carried out by nationals, most other organizational and analytical work on the information system continue to be carried out by technical assistants. In 1992, the team plans to assist the MOPH to train officials in the use of the SNIS as well as to establish a financial data tracking system and to update its infrastructure and logistics databases with training for data collectors and users from several Ministry Departments.

Activities for the evaluation section of this component for the third tranche have not yet been undertaken and are not planned.

#### g. Family Planning and Population Policy

All of the CPs under this policy area have been met for the 3rd through 5th tranches of the grant, with perhaps a CP related to acceptance of prices proposed by SOMARC for the sale of contraceptives in the social marketing project.

#### **B. Training Activities**

As of January 1992, four MOPH senior staff had been sent to the United States for long term training through schools of public health, including certificate training in English. Training of these degree candidates focussed on: management, health economics and financing, and health information systems, statistics, and epidemiology. The three candidates who completed their training have returned to positions in the Ministry as: Director of the Division for Health Delivery (DES), Deputy Director of the Division for Planning and Evaluation (DEP), and Director of the Bureau for Statistics in the DEP. Thus, their duties include, but are not limited to, implementation of policy and institutional reform arenas of the NHSSG. Ten other MOPH personnel have participated in seminars or short-term training courses conducted in other West African countries or the United States on subjects such as economic development, management, public health, and malaria eradication (For a list of participants, see Annex 6-Table 2). The Grant has also provided short term training through seminars and workshops in-country.

#### **C. Use and Impact of the Counterpart Funds**

##### **1. Administration of Counterpart Funds**

The management of counterpart funds by the Secretariat was the object of criticism by previous evaluators of both the NHSSG and ASDG and by A.I.D. auditors. The recertification of the NHSSG in mid-1991, was the result of considerable effort on the part of the USAID mission to assist the GON to clarify accounting procedures, to restructure the Secretariat, and to engage different personnel. The Secretariat now appears to have the capacity to perform its functions. Since no sub-project grants have as yet been allocated under the second tranche, it is too early to judge its actual functioning at the time of this evaluation.

## 2. Allocation and Impact of Counterpart Funds

During 1988-89, the first tranche of counterpart funds of \$2.1 million was allocated to 11 sub-projects and to pay for costs of the Secretariat. As of December 1991, 77 percent of the first tranche had been expended, with 138 million FCFA remaining in the Treasury (see Table 2). Expenditures related to the SNIS accounted for 23 percent of expenditures, with expenditures for Médecins sans Frontières and the operating costs of the Secretariat accounting for another 20 percent of total expenditure each. The operating costs of the DEP and special studies accounted for another 17 percent. Support to service delivery programs (ESV, LMD, MSF, PEV) accounted for about one third of total expenditure.

During 1989, counterpart funds comprised varying levels of overall operating expenditures for these service delivery programs (e.g. from about five percent for the EPI to over 25 percent for the diarrheal disease control program). Thus, the impact of the Grant's decertification was much greater, for example, on the diarrheal disease program which depended heavily on these funds, than on EPI which depended little on the Grant for its operating expenditures.

The second tranche of \$3 million was placed in a bank account for the GON in September 1991. Shortly thereafter, a meeting was called to inform sub-projects which had received funding during the first tranche that to obtain funds, they would have to submit new proposals for second tranche funding, even if they had not yet spent all their funds from the first tranche. It was unclear how much of those unspent first tranche funds would be recovered from the Treasury. According to sub-project directors and potential project submitters, the procedures for applying for second tranche sub-project grants are still not well known. Ministry criteria for sub-project approval have not been elaborated beyond those in the NHSSG PAAD and even application forms appear to be in short supply.

Before the end of January 1992, the Ministry had received at least nine sub-project proposals for the second tranche. It was planning to review all these sub-projects at the same time, and to forward the proposals it approved to the Secretariat and the Management Committee for review before the end of January 1992. When the Evaluation team left Niger at the end of January, not all the sub-project proposals had been submitted in final form, so it is unlikely that this timetable has been met. Meanwhile, the funds have been available and unused since September.

#### **IV. FINDINGS: CONSTRAINTS TO SUCCESSFUL IMPLEMENTATION**

The Health Sector Grant, at nearly every stage of development, has moved more slowly than the timetable originally foreseen. Although the Grant agreement was signed by the GON and USAID in 1986, implementation did not begin until August 1987 when conditions were fulfilled for the first disbursement of counterpart funds. The required Ministry structure, the DEP, was established in 1988, receiving legal recognition in 1990. The achievement of the conditions precedent for the second tranche of counterpart funds occurred in August 1990. This was more than three years after the date originally programmed (August 1987), and 31 months after the arrival of the technical assistance team. By then, the Grant had been decertified and it was only in September 1991 that the funds for the second tranche were deposited. By the end of January 1992, the second tranche funds had not yet been allocated and disbursed.

Although the PAAD had foreseen the completion of a series of five benchmarks in policy and institutional reform in five years, only two sets of benchmarks were completed between 1986 and 1991. The Evaluation team estimates that the GON will not be able to fulfill the conditions precedent for the third tranche before the end of 1992 when the Grant is scheduled to end.

The schedule in the PAAD had foreseen that funds would become available to the GON regularly, on an annual basis, which would have permitted their use for recurrent operating costs of program related activities. One of the consequences of the slow and irregular pattern of disbursement has been to create uncertainty regarding NHSSG funding for child survival activities, activities which require stable financing in order to be effective and sustainable.

In this section, we address the question of why the Grant is not achieving its objectives of institutional and policy reforms in the time frames set out for it. We identify the problems encountered in implementing this Grant agreement, taking account of three groups of constraints: 1) Grant design; 2) Implementing institutions; and 3) Exogenous environmental factors, that is, the political and economic situation in Niger.

##### **A. Design Factors**

The NHSSG was the first USAID health sector grant in Africa to incorporate non-project assistance into its design. It was innovative, ambitious, and had few models to follow. It was a unique combination of policy and

institutional reform, of project and non-project assistance. For the most part, its designers followed the model of the Niger Agriculture Sector Grant. The Grant designers developed a carefully thought out analytical basis for selected areas for policy and institutional reform with relevant conditions precedent. The lack of previous experience with such policy reform/NPA meant that the NHSSG designers could not have foreseen all eventualities. It is not surprising therefore that it is easier with the hindsight of five years to identify problems which escaped the scrutiny of the Grant's careful designers.

The first and largest constraint has been the design of benchmarks (conditions precedent) which are spread over six policy areas, thereby coupling together unrelated policy and institutional arenas. Such a structure assumes that benchmarks across each of the policy areas can be completed at the same time. The fact that policy and institutional development proceeds at different rhythms in different arenas, was not recognized at the time of the Grant's design. There is little incentive and no reward for the GON to complete benchmarks in one area since it has first to complete conditions in other policy areas for that tranche.

This coupling of the policy arenas led the primary actors, the technical assistance team, USAID, and the GON, to focus on completing benchmarks, rather than completing policy and institutional reforms, planning horizontally across areas, rather than longitudinally within a policy arena. As a result, work has focussed around benchmarks, not around tasks related to one policy arena, which may comprise several benchmarks.

The second design constraint to policy and institutional reform is that in several of the six arenas, fulfilling all the benchmarks will not necessarily result in the implementation of a policy reform. For example, fulfilling all the conditions for the cost-recovery non-hospital component will result in the completion of pilot studies, but not in the implementation of cost-recovery in rural health centers, nor necessarily in rural health centers receiving the regulatory authority to retain part of their costs-recovered to improve health services delivery. For the hospital cost containment component, all the benchmarks call for studies, not for implementation. Nor were resources for implementation necessarily foreseen by the Grant's designers. Thus, for some of the policy areas, simply studies preparatory to reform were envisioned. These are necessary for reform, but may not be sufficient.

The third constraint has been that the amount of the grant (now \$17 million) is relatively small considering that

its resources must be allocated among six policy and institutional areas (comprising more than 20 sub-areas).<sup>3</sup> By comparison, the ASDG I provided more than three times the funding for fewer reform areas, while USAID has provided more than \$10 million just for family planning and population reforms.<sup>4</sup> Some of the reforms had high political costs. Thus, for a policy reform such as cost recovery, to which the labor unions had declared their opposition, considerable leveraging was needed to find ways to reconcile policy opponents. The NHSSG was designed to get the GON to make major policy and institutional reforms in many areas, but held out skinny carrots as incentives.<sup>5</sup> However, there has been one unexpected benefit: the NHSSG's activities to build institutional capacity within the Ministry, particularly within the DEP, has contributed to the Ministry's success in garnering funding from other donors.

The fourth design constraint was the placement of the counterpart funds under the Secretariat and its mechanisms for disbursing funds. The structure selected was one created for the ASDG. It has proved to serve neither grant well. Now, with revised procedures and new staff at the Secretariat, it may have the capacity for functioning appropriately. However, the assumed cost savings that were expected to accrue to the health grant from piggy-backing the two grants, may never be realized because of the Secretariat's inefficiencies before Grant decertification and because the NHSSG continues to pay 40 percent of the Secretariat's costs while generating less than 25 percent of the funds processed.

The counterpart fund procedures for approving sub-projects are complex. Potential promoters, even during the present round for the second tranche, told us they still have not been informed of what procedures they are to

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<sup>3</sup> In actual terms, the \$10 million of the NHSSG counterpart funds was significant in relationship to the size of the MOPH budget. For details, see discussion page 20 and Annex 4.

<sup>4</sup> The availability of this funding for family planning and population from USAID, as well as funds from other donors, may explain in part, why nearly all the Grant's benchmarks for family planning and population policy have already been reached as of this writing.

<sup>5</sup> As one observer quipped: "The carrots were small potatoes."

follow, nor what criteria are being used by the DEP to judge which projects will be submitted to the Secretariat and the Management Committee which awards the grants. Judging by the projects awarded during the first tranche and those so far submitted for the second tranche, the links between fulfilling benchmarks and receiving rewards (counterpart sub-project funds), are not evident. Those who receive sub-projects are not necessarily those who have achieved the benchmarks for that tranche. Thus, the sub-projects do not serve primarily as rewards to those who fulfill the conditions precedent or support directly the activities in policy reform areas.<sup>6</sup>

The PAAD's guidelines for use of the counterpart funds provided flexibility. However, most proposals were submitted for funding as if in competition for investment funds when, more often, the requests were for recurrent operating funds. Had each tranche of counterpart funds been released on an annual basis, these would have constituted about 20 percent of the annual non-salary recurrent costs of the sector. Release of the counterpart funds on other than an annual basis thus introduced a significant fluctuation in the recurrent resources available to the sector and to particular programs such as Diarrheal Disease Control and Village Health Teams which depended heavily on them for operating funds.

In summary, the counterpart fund mechanism does not serve as a direct link between condition fulfillment and reward because of its complex structure and its continued cumbersome procedures and its relatively small disbursements.

A fifth problem in design was that the original expectations of achievement were clearly unrealistic, even before major political and economic problems became evident in 1990-1991. In August 1989, the USAID mission and the GON extended the time frames for most of the benchmarks in the third project amendment. Although they extended the implementation deadlines, they did not change the Grant's overall objectives nor the specific wording of most of the benchmarks. After reviewing the mid-term evaluation (September 1989) which concluded that the Grant program was too ambitious for the human and fiscal resources available, and which suggested some prioritization of reforms, USAID

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<sup>6</sup> During the first tranche, the largest amount of sub-project money was made available to the DEP for support of the DEP (five staff persons, cars, fuel, etc.), the health information system (also within the DEP), and for studies (also managed by the DEP).

and the GON decided to defer decisions on modifications until after the completion of the second tranche. Since then, no design modifications have been undertaken.

A potential final constraint in design was that, originally, the achievement of some of the NHSSG's objectives depended upon studies being carried out by the World Bank project which was to be launched at the same time. The linking of conditionality and financing in these two donors' projects was innovative and a good demonstration of inter-donor cooperation. However, the World Bank's project fell even farther beyond in its scheduling than did the NHSSG. This cooperative venture therefore also demonstrated the risks for the USAID program if the other donor's linked project were delayed. To overcome this problem, the NHSSG agreed to carry out the three studies which had originally been planned by the World Bank to prevent further delays in its own work program. Although the potential constraint did not materialize, its threat suggests the need to build in some coordinating mechanism among donors to minimize such a risk in the future. Achievement of policy reforms might be simplified if either: i) a donor has a lead role in setting the reform agenda with the GON with other donors play a supporting role with respect to this agenda, or ii) mechanisms such as the "Comité Pilotage" are developed to coordinate donors' policy dialogue with the GON within a policy area.

#### **B. Institutional Factors**

Three major institutional groups have been jointly responsible for implementing the Grant: the GON, USAID/N, and the technical assistance team of Tulane-Abt. Although it was difficult prospectively to predict the appropriate roles of each partner, it is somewhat easier for the Evaluation team to look retrospectively and identify some of the gaps in institutional capacity which constrained grant implementation in a timely manner.

The GON formally agreed to the Grant and to its objectives, but its activities in implementing the Grant have not always shown a serious dedication to the Grant's overall objectives. At no time during the past years, have sufficient resources in personnel been made available by the GON to carry out most of the activities foreseen under the Grant. For example, despite recommendations of the 1989 mid-term evaluation and two subsequent analyses from the Tulane-Abt technical assistance team documenting the need to increase staff in the DEP and particularly within the Bureau of Statistics, the DEP's functioning staff has barely increased (see Annex 5). As a result, most program related activities including the drafting of work plans and the

monitoring of progress toward benchmarks are carried out by technical assistants with only minimal transfer of skills to national counterparts. The long-term training in the United States provided under the grant to four nationals should, in theory, improve this situation, but so far, the three who have returned have not taken, so far, initiatives on grant-related activities.

One of the factors for the GON's limited involvement in Grant implementation may be the lack of continuity in executive direction in the Ministry of Public Health. Since 1986, the Ministry has experienced five Ministers and three Secretary-Generals. In a Grant program which is directed toward implementing major policy and institutional reforms, such frequent changes in leadership are not conducive to smooth management of reform programs.

As a result, decision-making processes within the MOPH have been slow, while the process of building natural constituencies for policy arenas outside the Ministry has shown little progress. Perhaps the most significant example of this has been the non-creation of the inter-Ministerial committee which was to have monitored policy development under the grant. This committee was part of the original Grant design. Its creation was recommended by the mid-term evaluation in 1989, but to date, no action has been taken.

USAID had believed originally that non-project assistance would require less direct management on its part than would project grants. However, the implementation of the NHSSG, this complex hybrid of non-project and project assistance, has proved this notion sadly wrong.<sup>7</sup> Even with USAID's hiring (through the Trust fund), of a full time national to monitor the counterpart fund, the administrative burden on USAID has been such that it was unable to monitor closely the Grant's fiscal procedures. Nor has it been able to provide strong support for carrying out reforms. Confounding these difficulties in implementation, is that during eight months of 1990, the USAID mission was without a health officer who could vigorously pursue Grant objectives.

Although USAID staff have been well aware of many problems, they have been slow to apply solutions, whether those recommended by external evaluators or those agreed to

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<sup>7</sup> Erna Kerst, Lessons Learned in the Design of Sector Grants in Niger, 1984-1990, March 1991, p. 40.

in internal decisions.<sup>8</sup> Management problems with accounting for ASDG funds at the Secretariat spilled over into the health sector grant through the delays in recertification. Finally, USAID staff, like everyone else associated with the grant, got caught up in following benchmarks which are numerous and numbingly detailed, making it difficult to keep sight of the larger Grant objectives.

The technical assistance team has provided valuable assistance to the MOPH to assure that benchmarks are met. However, they, too, have been caught up in the "chasse aux conditions préalables," and since, under their contract, they are responsible for seeing that the benchmarks are reached, they most often find themselves doing the work, just to assure that it gets done. Thus, their labor substitutes for that of the nationals and the transfer of skills does not take place as it should.

The technical assistance contractors, Tulane-Abt, have used considerable short-term technical assistance to supplement their long-term field advisors (see Table 3). Their studies, of excellent quality, have had trouble being heard, read, or used at policy levels, in part because they are complex and presented in a style more academic than oriented to policy makers, in part because they have had to pass through a review process starting within the DEP where their work is most often held up for lengthy revisions.

A final constraint for the technical assistance team has been the decision agreed to by all the implementing institutions to field a relatively junior team. This constrains their ability to act with authority in the policy arena, or even to develop the policy analyses needed to identify how to proceed with reforms.

### **C. Environmental Factors**

The period of the Health Sector Grant, 1986 to 1992, has been for Niger a period of difficulties for its economy and of uncertainties for its political and administrative structures. Inevitably, these have influenced the ability of the GON to respond to and implement the ambitious program of reforms adopted in 1986.

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<sup>8</sup>For example, USAID decided to defer the midterm evaluation's recommendation to reevaluate priorities until after the completion of the second tranche. However, since this was accomplished in mid-1990, no action has been taken. Or, USAID's decision in December 1989 to revise the Grant's logframe seems not to have been implemented.

Niger's economic prospects started to decline in 1981 with the decrease in the world price for uranium, followed by years of drought which affected both agricultural and livestock production. During the early 1980s, the GON adopted a number of measures to restrain overall public sector spending under both IMF Standby and World Bank Structural Adjustment programs.

During the latter half of the 1980s, GDP growth in Niger averaged less than 1 percent per annum. The most recent IMF/World Bank financed adjustment program is being revised because of non-performance during the recent period of political change in Niger.

Since 1987, the GON has responded to a decline in tax revenues by reducing non-personnel recurrent expenditure, and has fallen into arrears on paying its bills.<sup>9</sup> External aid has increasingly become an important source of financing for all government operations. Nevertheless, in contrast to national general budget trends, local budgetary revenues have generally increased.<sup>10</sup>

As a result, by 1991, the Government was operating under financing coming mostly from donors while managing just to maintain payments of salaries to its civil servants (running two months behind, as of this writing).

This same period saw many shifts in the political structure. Under the military regime of General Kountché (1974-1987), a Conseil Militaire Supreme (CMS), composed of senior military officers and departmental and selected arrondissement administrators, directed the development of the state and the economy. The death of Kountché in 1987 and his succession by General Saibou marked the beginning of a transition from military to civilian rule. In May 1989, the CMS was replaced by the Conseil Supérieur d'Orientation Nationale. A political party (MNSD) was created, with its structure paralleling that of the state. In September 1989, a new constitution was adopted with elections for a President and National Assembly held in December 1990 for a single slate of candidates nominated by the MNSD.

This transition to one-party civilian rule was not popularly received. There followed a period of unrest with demonstrations and strikes culminating in the decision to convene a National Conference which took place from July to

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<sup>9</sup> GON is in arrears in payment of utility bills (NIGELEC, OPT, SNE) and to ONPPC.

<sup>10</sup> Darbera, R. and Hall, R. (December 1991).

November 1991. The Conference defined the political, social and economic steps to be taken by a Transition Government formed in November 1991 which is to govern until January 1993. Meanwhile, multi-party democratic elections are planned for late 1992.

These political changes, while encouraging, have shifted the locus of policy making several times during the course of a Grant whose objectives are to institute policy reforms. They have also had an unsettling effect on the conduct of routine business within the ministries. For example, during the months of the National Conference, even those who actually showed up for work were held spellbound by the radio broadcasts of Conference proceedings with the result that little work actually could be accomplished. These events create an environment of uncertainty for those concerned with policy and institutional reform. Meanwhile, the civil service, suffers from many of the same problems as in neighboring African countries, lack of motivation among workers, promotion not tied to performance, low salary scales and uncertain payments. Thus, any understanding of progress toward institutional and policy reforms has to take into account the constraints which have been imposed by the difficult economic and political times which Niger has traversed in recent years.

## **V. ANALYSES AND CONCLUSIONS**

### **A. General Considerations**

The GON, with the assistance of this Grant, has made considerable progress toward achieving its objectives. The most rapid progress and the most complete achievement of conditions precedent has occurred for the family planning/population policy component. Reforms which have shown progress are: Cost-recovery options in non-hospitals which are soon to be tested in three regions; Studies to improve hospital cost-recovery and cost-containment; and the national health information system (SNIS) which has been installed and is generating data of use to policy makers and managers.

These considerable achievements must be balanced against the snail's pace at which Grant implementation has moved. Much of the work undertaken has resulted in excellent analytical documents, but has not necessarily translated easily into policy or institutional reform.

The factors constraining achievement of Grant objectives were discussed in Section IV, above. They can be attributed to the Grant's design which was too complex and ambitious for the time; to the implementing institutions; and to the difficult political and economic environment.

The Grant's implementing institutions have contributed to the constraints: the GON's investment in personnel, institutional reform, and its willingness to focus on policy reform areas and to elevate these issues to the appropriate decision-makers, have been insufficient to move along activities and decisions; USAID has insufficiently monitored the Grant's fiscal complexities and has been too focused on achieving benchmarks, rather than program objectives; while the TA team, responding to both these institutions, has been overwhelmed by the need to produce evidence of progress toward benchmarks using a staff not highly experienced in policy development and working within a difficult institutional environment.

Although the political environment remains uncertain and the economic situation is less than brilliant, these are not insuperable barriers to carrying out the Grant's objectives. They suggest rather that needs are greater and that some modifications must be made to respond to this new environment in which the Transition Government may represent a window of opportunity. They also suggest that in this new political environment, those who would advocate policy and institutional reform need first to analyze and understand the actors and issues.

We believe that under no reasonable timetable will the Grant be able to achieve all the benchmarks originally planned. Some priority activities will have to be selected with other less important or currently less feasible ones left for subsequent projects. This will require amending the Grant agreement.

Although in the short-term, a health sector grant can do little to improve the political and economic environment, the Grant can be amended to improve its design and to take better account of the characteristics and capacities of its implementing institutions. Design issues are discussed immediately below. Strengthening institutional capacity is discussed below in Section V-B.

The Grant's design structure of benchmarks locksteps policy arenas rather than encouraging progress in each arena and offers no direct rewards to those who are responsible for achieving the conditions precedent. It needs to be redesigned. The need to focus on a large number of benchmarks in six areas has diffused activity and diffused available resources to the point that objectives are hard to achieve. This suggests that in redesigning the Grant program, the GON and USAID concentrate on a more concentrated set of policy and institutional reforms.

The Grant was extremely ambitious. In retrospect, some of the objectives no longer seem realistic; others have already been reached. In the time that is left, the Grant implementors should concentrate on those activities which fulfill objectives and yet are feasible given the existing political environment, time and resource constraints.

Given that priorities must be set, we propose the following rationale for selecting reform areas. First, any reform selected must meet three criteria: it must address the original goals/objectives of the NHSSG; it must be within the original policy reform areas of NHSSG; it must not already have been accomplished. Second, we propose the following criteria for weighing selections:

- Give priority to reforms where significant work is already underway (e.g. hospital cost recovery/management; SNIS; child survival)

- Give priority to reforms which can be achieved by the end of a revised PACD. For example, if the revised PACD is December 1993, this would eliminate from consideration certain reforms such as non-hospital cost-recovery whose pilot tests would not be completed by that date and manpower reallocation which does not

appear to be a feasible accomplishment within that time period.

-Give priority to reforms which, in the long run, can generate funds for health sector recurrent costs, for example, cost-recovery and drug distribution reforms.

-Give priority to reforms which support institution building, for example, support to the SNIS and to the MOPH's activities to coordinate donor funding.

If one follows these criteria, the priority policy reforms are cost-recovery in non-hospitals; cost-recovery and cost-containment in hospitals, drug distribution, and the national information system. Although reform of the budgetary process may be a worthwhile goal, it appears to be beyond the scope of the NHSSG. The reallocation of health personnel is already being reviewed by the Ministry to see how it can post newly graduated health workers to rural areas. Beyond these efforts, it is probably unrealistic to expect the GON at this time to institute policies in personnel distribution, a politically sensitive issue, which even most first-world countries have not yet successfully resolved.

Other donors are already providing support for decentralized planning. As the GON moves, as it appears to be doing, more fully into a program of decentralization, USAID may want to analyze the constraints and opportunities in this area and to consider whether some decentralized activities should not be the focus for USAID activity in a follow-on program or project.

Meanwhile, USAID's most useful contribution to planning is the development of the DEP, and particularly the development of the SNIS, which not only provides data useful for planning, but also provides training for health officials in how to use the data.

#### **B. Issues of Sustainability: Institutionalization**

During economically precarious times, such as those Niger is presently experiencing, it may be unrealistic to expect a government to be able to increase financial outlays to sustain USAID supported activities during the life of the program. However, it is essential to continue to meet other criteria for short-term and long-term sustainability, such as the development of sources for financial sustainability of health programs and such as government perception of ownership of its institutional and policy reforms. In the case of the NHSSG, these criteria do not appear yet to have been well met.

Financial sustainability of health services in Niger clearly was a principal concern which guided the design of the NHESSG. The experience of the NHESSG suggests that achieving in a short period of time all of the reforms in health sector finance which would appear necessary to achieving this fiscal sustainability is difficult, at least in an unstable political and limited economic environment. Additional effort must be placed on prioritizing reform efforts based on the magnitude of their potential impact from a service provision and financing perspective, and on their political and institutional feasibility.

The criteria for use of the counterpart fund, while providing the maximum flexibility for use of the funds, did not provide sufficient certainty about the availability of the grant's recurrent budget support for child survival programs to encourage the development of medium-term program plans. Had each tranche of counterpart funds been released annually, these funds would have constituted about 20 percent of the annual non-salary recurrent costs of the sector. Release of the counterpart funds other than annually introduced a significant fluctuation in the recurrent resources available to the sector. Such fluctuations in recurrent funding do not best promote public health objectives, nor do they facilitate continuity of inputs, such as supervision, important for the functioning of health programs at all levels of the health system.

In terms of government perception of ownership of reforms, it is hard to find a locus of concern for them within the Ministry of Public Health. No one at the Ministry, particularly at the DEP, is closely monitoring the policy/institutional reforms of the grant to move them along. The lack of staff assigned to the DEP and particularly the statistical bureau are signs of the lack of commitment to these activities.

The ultimate objective of any development activity is to institutionalize: to have the nationals themselves capable of running that activity. In the case of the sector grant, the transfer of skills in policy reform and planning to the nationals has not occurred as expected, despite long-term and short-term training and despite the availability of three long-term consultants in Niger.

Responsibility for this lack of institutionalization lies with both the Nigerians and with the Americans. From the Nigerian side, are three factors. First, are those factors endemic to the civil service (not only in Niger, but in many African countries) which discourage individuals from acquiring and/or applying skills. Professionals are frequently transferred from one position to another with a

stay of two years in any one post being considered unusually long. The locus for responsibility for decision-making and for hierarchical responsibility within the administrative hierarchy is unclear, making it difficult for junior staffers to know what is expected of them and what their work tasks are, while senior officials have difficulty coordinating work and enforcing discipline. This looseness of administrative structures affects, for example, the organization of tasks in the DEP, and particularly in the statistics unit.

The second factor has been the Ministry's inability to assign sufficient staff on a permanent basis to the SNIS to allow the transfer of skills and experience to take place. Thus, to develop the nuclear staff necessary to run an information system, would have required a decision to staff that unit permanently with qualified persons who could have benefitted from additional training.

Finally, a third factor which has discouraged technology and skill transfer has been the Nigerien view of the role of technical assistants as employees who are to carry out explicit tasks within Ministry bureaus, rather than to serve as advisors to assist and train Nigeriens to carry out these tasks. The co-mingling of the DEP work plan with the work plan of the technical assistance team has served to confuse further the relationship. Even the task of monitoring the NHSSG, which according to the Grant agreement, should be the responsibility of the Ministry, has in fact, been allowed to default to the technical assistance team.

On the American side, efforts to promote institutionalization have been diverted. The technical assistance team, under pressure to complete the benchmarks, has tended to undertake studies and activities themselves, rather than assisting the Nigeriens to complete them. They have tended not to get involved in assisting in organizational development, in part because they were unwelcome, and in part because they are relatively inexperienced and therefore have had to rely on their backstoppers to provide guidance.

As a result, few of the skills in planning and policy analysis, in data collection and analysis, which were expected to be institutionalized under the Grant Agreement, have actually materialized. Future projects will have to look more closely at the national commitment to personnel and institutional capacity building and at the technical assistance team's skills in on-the-job training before deciding whether such goals are feasible under a future program.

In conclusion, considerably more work needs to be done to institutionalize the reforms under the NHSSG, to assure GON ownership of the reforms, to assure a GON investment in personnel, as well as to improve the transfer of skills by the technical assistance team and to avoid the substitution of their work for that of nationals. There is an explicit trade-off here: to reinforce institutional capacity takes much time and effort. It is not possible simultaneously to obtain quick results in policy reform. Moreover, the development of sources for the financial sustainability (such as cost-recovery programs) involves long-term commitment not only to studying mechanisms for such policy reforms, but also to providing support for the difficult policy formation and implementation which must ensue before one can expect to reap any financial rewards for the health sector.

### **C. Lessons from Non-Project Assistance and Policy Reform**

When the NHSSG was designed, there was little experience with non-project assistance in the health sector. The designers drew on Niger's ASDG I and used the same mechanism, the Secretariat, for management of the local currency funds. Since then, at least six African countries, including Niger, have instituted Economic Policy Reform Programs.<sup>11</sup> In the health and population sector, grants have been implemented for four African countries: Nigeria, Ghana, Botswana, and Kenya. Six countries (Benin, Malawi, Namibia, Ghana, Guinea, and Mali), have sector grants for education.

These programs are diverse across four characteristics. First, they differ by purpose: some are targeted as nearly pure budgetary support; some are directed toward policy reforms; others are directed toward institutional reforms or institution-building.

Second, these grants differ considerably whether they are directed toward general economic policy (EPRP) or toward particular sectors, in which case the policy environments for the sectors may be sufficiently different to make comparisons unhelpful.

Third, the reforms differ by whether they are directed toward central government activities, or toward decentralized regional governments, or toward the private

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<sup>11</sup> See, for example, Joseph M. Lieberman, A.I.D. Economic Policy Reform Programs in Africa: A Synthesis of Findings from Six Evaluations, Center for Development Information and Evaluation, U.S. A.I.D., December 1991.

sector. Recent analyses suggest that the latter two arenas may prove more productive of reforms.<sup>12</sup> Finally, the reform programs have employed different mechanisms for programming and disbursing the local currency funds.

This fluster of activity in developing NPAs since 1985 has not yet resulted in much systematic synthesis of findings across sectors, policies, and countries, even within one region, such as Africa.<sup>13</sup>

Certain criteria appear important to the success of these NPAs. First, one needs a good analytic base as to the significance of the reforms proposed. In the case of the design of the Niger grant, this was certainly the case. The analyses carried out in the PAAD were well grounded. However, the design team assumed that studies of the policy reform would lead to adoption and implementation of reform. It did not sufficiently analyze how study results would be translated into policy and did not plan for how this process of adoption and implementation would take place.

We were told that, for the Nigeria health sector grant, the one lesson learned was that the first tranche is easier to achieve than later tranches. This is partly due to design (the first tranche is usually designed to be easier because policy-makers are already concerned about the reform), partially due to momentum, (policy-makers lose interest). This pattern has not exactly been the case with Niger. Achieving the first tranche benchmarks took a long time, a year, but then, achieving the later benchmarks took even longer.

Another lesson that is emerging across these grants is that the government commitment/ownership is essential to achieving reforms and that when NPAs are done "right," they lead to ownership. In the case of the NHSSG, except in the area of family planning, the only policy reforms which have actually been carried out to date, have been modest. The cost-recovery reforms for non-hospital facilities, even if only for pilot tests, have had a tenuous existence. During the past five years, they have been debated, approved, set

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<sup>12</sup> See, for example, U.S. A.I. D. Africa Bureau Task Force, Beyond Policy Reform: A Concept Paper, Distributed December 21, 1991.

<sup>13</sup> Two notable exceptions are Jerome Wolgin, Fresh Start in Africa: A.I.D. and Structural Adjustment in Africa. March 1990; and Lieberman, op. cit. However, neither of these studies brings to bear findings on social sector reform programs.

aside, delayed, debated, included, excluded, and eventually included in the policy debate and finally adopted at the National Conference in November 1991. In retrospect, this history shows a limited commitment to cost-recovery at the highest levels of government.

One of the original designers of the NHSSG noted the need for flexibility in designing NPA grants if they were to survive and achieve their objectives.<sup>14</sup> Nevertheless, when problems in design were identified, USAID did not appear to have sufficient flexibility to move quickly to redesign.

Another design problem was that the Secretariat as a mechanism for disbursing the counterpart funds did not serve the NHSSG well. Although additional staff had been added by the Ministry of Plan to manage the counterpart funds, the Secretariat did not function well in accounting for disbursements made. The NHSSG had established a complex grant-giving and accounting institution more understandable to Americans familiar with grant procedures than to Nigeriens. In the future, ASDG II will not use the Secretariat mechanism. Future health sector grants might also do well to consider other options for allocation, disbursement, and accountability of counterpart funds.

In conclusion, this experience with the NHSSG would make us cautious about using non-project assistance for institutional or policy reform in the health sector in Niger in the future. It may be possible to achieve similar effects by using project grants which require the Government to achieve certain conditions precedent before project activity can begin. This may be a more effective approach, particularly for institutional reform and particularly when the funds will be supporting recurrent costs.

If non-project assistance is to be used to stimulate policy reform, each tranche should be targeted to accomplish a single specific reform, with the funds released directly tied to supporting implementation of that reform. Design should be sufficiently simple so that both nationals and USAID officials can understand expectations and implementation.

In the light of Niger's commitment to administrative decentralization, the design of any future grant must take into consideration whether to continue support for institutionalization exclusively within the central ministry

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<sup>14</sup> Erna Kerst, Lessons Learned in the Design of Sector Grants in Niger, USAID/N, March 1991.

as under the NHSSG, or whether to allocate some support, as well, or instead to regions, particularly if one could be assured of strong regional commitment in selected areas.

Future NPA in the health sector should separate tranches which provide funds for implementation of a policy reform, from tranches providing funds for recurrent budget support of public health programs. Conditions precedent to release of the latter type of funds would be better applied at the start-up of the grant. If any additional conditions precedent are set for release of funds on an annual basis these should be related to development of skills in program planning and management.<sup>15</sup>

Finally, with the experience gained from the NHSSG and with the growing experience from NPAs in health and population in other African countries, A.I.D. Washington might consider beginning to synthesize its NPA experience across other countries to draw lessons learned and to assist future planning.

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<sup>15</sup> One example of a possible CPs for release of on-going recurrent budget support would be to require the MOPH to provide an annual report covering progress in the Child Survival programs receiving counterpart funding during the past year, plans for the coming year, and documentation of the levels and allocations of all donor funding for the program.

## **VI. RECOMMENDATIONS**

We present our recommendations in two groups: those relating to the present health sector grant to permit it to accomplish its major objectives; and those relating to lessons learned from this innovative combined non-project/project assistance grant to permit planning for a follow-on activity when the NHSSG ends. Each recommendation is preceded by a short paragraph summarizing the conclusions which lead to that recommendation.

### **A. Recommendations for the Niger Health Sector Support Grant**

The following recommendations are proposed to modify the Grant's mechanisms to assure that it can achieve its original objectives.

#### **1. NHSSG EXTENSION**

##### **Conclusions:**

Despite a difficult economic environment and despite recent political uncertainties, the GON continues to make progress on reforms foreseen in the Grant although at a pace much slower than expected. Although there has been some transfer of skills, the MOPH will continue to need technical assistance to carry out most of the activities foreseen under the Grant.

##### **Recommendation A-1:**

We recommend that the NHSSG be extended in time through December 1994 to permit activities to be completed and that additional funds be sought to permit technical assistance support to continue through December 1994.

#### **2. BENCHMARK AMENDMENT**

##### **Conclusions:**

a. Certain policy/institutional benchmarks and their policy reforms within the Grant structure are no longer appropriate either because they have already been achieved, or because they are no longer relevant, or because the Ministry has already chosen another related course of action, or because achievement of the benchmarks chosen is not an effective means to that particular reform.

b. The Grant's design locksteps the policy arenas rather than encouraging progress in each arena while it offers no direct rewards to those who achieve the conditions. The sheer number of policy/institutional areas which need to be

addressed for any single tranche overwhelm the institutional capacity to respond.

c. Methods and criteria for obtaining sub-project funding from counterpart funds remain unclear and poorly communicated. The procedure of approval is slow.

d. The National Health Information System (SNIS), which is an institution considered of high priority by all senior MOPH officials, remains understaffed after five years of technical assistance. It still lacks the national staff necessary to carry out all but the most minor activities.

e. Priorities need to be set for selecting targeted activities to be supported under the Grant (For more detail, see Section V-A). The criteria for selection of reforms are as follows: addresses original goals of NHSSG; included as part of original NHSSG program; has not been accomplished. Priorities should also be given to reforms where significant work is already under way; which can be achieved by revised PACD; which can generate funds; and which support institution-building in MOPH.

#### **Recommendation A-2:**

a. We recommend that the Grant Agreement be amended so that the tranches are restructured with the retention of only four policy/institutional areas of reform, each with one set of conditions precedent to be accomplished prior to release of a tranche of counterpart funds. We recommend that the counterpart funds made available for each area of reform be linked directly to the implementation of activities within that area.

b. We recommend that funds continue to be managed through the Secretariat during the Grant period. To accelerate review procedures and because the Ministry of Plan is well represented in the review process through its presidency of the Management Committee, we recommend that the Ministry of Plan no longer be required to review separately sub-projects.

c. We recommend that the following four policy/institutional reform areas, with their conditions precedent, and single disbursements replace the existing last three tranches of the Grant agreement:

1. Hospital Reform:

**Conditions Precedent:**

a. The GON enact legislation permitting the establishment of Niger's hospitals as public institutions with autonomous management. Such autonomy must include the ability of hospital boards to establish fee levels, retain fees collected, and establish the respective fiscal responsibilities of the national government and the hospitals.

b. The MOPH will establish a plan for implementation and detailed budget for use of the counterpart funds to be released upon achievement of conditions.

**Use of Counterpart Funds:**

Funds can be used for any aspect of the implementation plan with priority for: i) development of human resources capacity to manage hospitals; and ii) equipment for management information systems, particularly financial management systems.

2. Extend the Distribution of Drugs

**Conditions Precedent:**

a. Make operational through the appointment of appropriate staff, the Direction of Pharmacies and Laboratories. Minimum staff would include a pharmacist and a management/finance expert.

b. Develop at least a two-year action plan to expand the drug distribution system in Niger through this unit and the ONPPC. Input from other donors active in the area of drug policy, i.e. FED, RESSFOP, World Bank, should be sought to develop and co-finance this plan.

**Use of Counterpart Funds**

Funds can be used for any investment expense related to the expansion of the drug distribution network (e.g. purchase of vehicles for drug transport, opening of Popular Pharmacies in any of the 13 arrondissements lacking them, construction of the regional warehouse in Zinder); or for activities that would lead to the increase in the use of generic, essential medicines according to standard treatment protocols.

3. Continued Development and Institutionalization of the National Health Information System (SNIS)

**Conditions Precedent:**

a. The MOPH will assign five full-time additional permanent staff to the Bureau of Statistics in the DEP. These persons will have the following profiles:

- 1 Computer Programmer
- 2 Techniciens superieurs in statistics
- 1 epidemiologist
- 1 data entry clerk

b. The MOPH will establish a plan for implementation and detailed budget for use of the counterpart funds to be released upon achievement of the conditions precedent.

**Use of Counterpart funds:**

Funds may be used for developing the information system, including training of personnel at the central and peripheral levels, maintenance of equipment, printing of forms and reports, supplies.

4. Improve Coordination of Donor Financing in the Health Sector

**Conditions Precedent:**

a. The MOPH will incorporate into its management information systems in the DEP and DAAF a component that permits it to track in detail implementation and expenditures for donor-financed programs/projects.

b. The MOPH will establish a plan for implementation and detailed two-year budget (assuming release for January 1993), for use of the counterpart funds under this tranche to be released upon achievement of the conditions precedent.

**Use of Counterpart funds:**

Funds may be used for budget support of programs such as: i) essential health programs aimed at improving child survival; ii) support for DEP planning activities. Funds should be available for release in annual amounts for FY1993 and FY1994.

### **3. ADDITIONAL FINANCING FOR COST-RECOVERY TESTS**

#### **Conclusions:**

The non-hospital, cost-recovery pilot tests which are about to be launched will require long and short-term technical assistance at least through 1993. Adequate funding for these requirements is not currently available in the technical assistance contract for the NHSSG. A.I.D.'s centrally-funded Health Financing and Sustainability (HFS) project has funds available for such applied research activities. Further, the management of HFS by Abt Associates can insure the continuity of technical and management oversight of these studies.

#### **Recommendation A-3:**

We recommend that financing for the long and short-term technical assistance required for the tests be sought from the applied research component of the HFS project. Financing for local currency costs associated with the tests should be programmed out of the second tranche funds of the NHSSG, complemented by funding from other donors. Oversight of the pilot tests by the "Comité National sur le Recouvrement des Coûts de Santé" should continue.

### **4. TECHNICAL ASSISTANCE**

#### **Conclusions:**

The technical assistance team of Tulane-Abt has provided support to the MOPH by carrying out most of the benchmark requirements under this Grant. Its task to provide leadership for policy reform has been complicated by being housed within the DEP (and seen by the DEP director as DEP employees) rather than as advisors/trainers whose scope of work necessarily takes them into relations with many different directions of the Ministry and the Secretary General's office. In the light of the recommendations above to focus on particular policy/institutional areas, the job descriptions for the technical assistance team should be modified to meet revised sector grant needs. Their placement within the MOPH needs also to be reconsidered.

#### **Recommendation A-4:**

a. We recommend that long-term and short-term technical assistance be provided under the grant for the three policy/institutional reform areas specified above, 1) hospital management and financing; 2) Drug policy; 3) Information systems, particularly financial management systems. At least one long-term team member should be

experienced in policy development and that USAID and the contractors give priority to the recruitment of senior long-term team members.

b. We recommend that technical assistants be sufficiently skilled to be able to provide on-the job training to their counterparts and that they be viewed by those both within and without the Ministry as advisors and trainers, and not as substitutes for the labor of their national counterparts.

c. We recommend that work plans for technical assistants be developed in collaboration with the various directions of the Ministry with which they work and that these work plans be approved by the office of the Secretary general (or deputy Secretary general). These work plans should differ from those of the DEP, reflecting the different responsibilities of the technical assistance team and the DEP staff.

## **5. USAID MANAGEMENT**

### **Conclusions:**

The complexity of managing the sector grant requires frequent, if not constant USAID involvement in planning and implementation. During the Grant's early history, monthly management meetings between the technical assistance team and USAID officials served as an effective means of identifying problems, needs, and solutions, although follow-up was always a little less certain.

Most of the activities under the Grant involve other donors. Coordination among donors has been good, but it could be improved if there were formal regular coordinating meetings among donors involved in the health sector.

### **Recommendation A-5:**

a. The recently reinstated formal management meetings between USAID officials and the technical assistance team should be continued, with responsibility for follow-up of problems clearly delineated and with resolution followed up by USAID mission management.

b. We recommend that USAID encourage the development of a formal mechanism for donor coordination in the health sector through the establishment of monthly meetings bringing together relevant donors.

**B. Recommendations for Future USAID Health Grants for Follow-on Activities**

**Conclusions:**

To sustain the efforts in policy and institutional reform begun under the NHSSG, continued inputs will be needed after the Grant ends at the end of its extension period in 1994. The original non-project assistance format of the grant, while providing some advantageous results, has also been difficult to manage, to implement, and to use as a tool for reform.

While some budgetary support to the Ministry of Public Health should be considered in this period of economic difficulty, given Niger's political and economic environment and the configuration of its health sector, only non-project assistance that is highly targeted should be considered as an incentive to policy reforms, while considerably more weight should be given to project assistance for accomplishing institutional reforms.

Areas that will continue to need support are non-hospital and hospital cost-recovery systems and institutionalization of the national health information system. Other areas of concern that need to be addressed in the future are decentralization, particularly of planning and supervisory activities and the need to deliver integrated maternal and child health and family planning services. These latter areas have received relatively little attention under the NHSSG, focussed as it is on developing institutional capacity at the central level.

**Recommendation B:**

1. We recommend a follow-on health grant be structured to provide mainly project assistance. Given the emerging trend for donors to work within specific regions of Niger, careful consideration will have to be given to balancing USAID's role with respect to support for functions retained by the central MOPH and support for improvement of service delivery in a specific geographic region, with particular concern for the delivery of primary care, MCH and family planning services. The follow-on grant should also seek close coordination, if not consolidation, with the family planning activities now under the Family Health and Demography Project.

2. We recommend that if non-project assistance is used in a follow-on grant that it be targeted either to complement aspects of project assistance efforts, and/or to implement change in policy areas which have received considerable

attention in the past. This NPA should be highly targeted with each tranche related to a significant reform in a single policy area <sup>16/</sup>. Given the complexity of policy adoption and implementation requirements, non-project assistance should attempt to achieve change in only a few limited areas. Support for studies, workshops, and seminars in areas of emerging policy concern should continue, and consideration given to including a tranche to be programmed after the second or third year of the grant to respond to these emerging needs.

3. We recommend continued support of central information systems and development of regional information data processing capacity.

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<sup>16/</sup> For example, if the pilot tests for non-hospital cost recovery are successful, conditions precedent for the GON to adopt a policy of, and develop an implementation plan for, non-hospital cost recovery throughout the country would be linked to release of a tranche of counterpart funds for the start-up costs of non-hospital cost-recovery nationwide.

**TABLE 1; PROGRESS TOWARDS ACHIEVEMENT OF THE THIRD TRANCHE OF THE NHSSG AS OF JANUARY 1992**

**CONDITIONS PRECEDENT TO THE THIRD TRANCHE**

**PROGRESS AS OF JANUARY 1992**

**I. COST RECOVERY**

**a. Hospitals**

- i. Report prepared analyzing patient registration and fee collection systems at other hospitals.**

Frederiksen/Garekan (August 1990) Analysis of Patient Registration & Fee Collection Systems at Hospitals other than NNH, Niger

Recommendations accepted for improving patient registration and fee collection systems & facilities;

Recommendations not reviewed.

Plan for implementation of changes prepared & implementation started.

No plan prepared.

- ii. Accounting system at Niamey Hospital revised according to recommended system; all appropriate staff trained.**

Hospital staff trained in 1990. New system not implemented.

Plan prepared, if appropriate, for adoption of the revised accounting system for all hospitals.

No plan prepared.

- iii. Report prepared for sample of CHDs & hospitals on services received by types of patients & actual costs of delivering services w/ analysis of relationship between costs of delivering the services and payments;**

Cost accounting study for NNH not followed up for other hospitals.

Analysis of possible revised fee/payment schedules.

Analysis not performed.

Recommendations made for revised fee/payment schedule.

Recommendations not made.

**b. Non-hospital Services**

- i. Pilot studies of all selected cost-recovery options started and on-going. Preliminary reports prepared.**

Proposal for pilot study reviewed by CR Committee in January 1992. Efforts to secure funding underway. Projected study completion date Nov. 1993

**II. COST CONTAINMENT**

**a. Drug Purchasing**

- i. Mechanism to monitor the application of the essential drug list implemented.**

MSP: Direction de Pharmacie et Laboratoire created January 1992 not yet staffed.

- ii. Study initiated to analyze drug procurement & distribution practices to make recommendations on ways to reduce drug costs (through purchase of generic drugs, bulk purchase).**

CREDES (Mars 1991) "Etude sur l'Extension du Systeme de Distribution des Medicaments", World Bank.

**b. Hospitals**

- i. Study of hospital management in national hospitals completed with recommendations for cost containment measures.**

Study not undertaken.

Action plan for reform & monitoring

No plan prepared.

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### III. FINANCIAL RESOURCE ALLOCATION

- i. Analysis made showing allocations of the operational & investment budget 1986-88 by major classification (including personnel, medicines, transport, central administration, peripheral services, others) in order to estimate the percentages allocated to each service level. Tables prepared showing budget allocations for hospitals and other services. Analysis made of the differences in these allocations when using operational and investment budgets. Wong/McInnes (May 1991) "Niger Public Expenditure Review: The Health Sector", UNDP/World Bank. Colomer (Decembre 1991) "Appui Budgetaire a l'Adjustement Structural Secteurs Sante et Education", FED.
- ii. Analysis made of the allocations to personnel & hospital services in the 1989 budget (operational & investment separately) and the differences from estimates made for the 2nd tranche displayed. Same studies as III.i above.
- iii. Target percentages proposed by the two parties for the personnel & hospital allocations for 1990, favoring non-hospital services (primary & secondary) & controlling allocations for personnel. Targets not developed.

### IV. RESOURCES MANAGEMENT

#### a. Personnel

- i. Action plan elaborated & implemented started taking into consideration personnel programming (quotas) by level of basic training based on budget projections 1988-1991. Target: 20% of schedule completed. Budget projections not developed. No plan developed.
- ii. Application of personnel programming (quotas) for health services according to recurrent budget projections for 1989-1991. Budget projections not developed. Quotas not applied.
- iii. Overall training program revised and annual in-service training programming established based on needs assessment & taking into consideration primary health service programs & job descriptions. DFPS developed 5 year training program.
- iv. Operations research started on different supervisory systems for VHT; Continued efforts on the part of NGOs. Studies implemented on supervision for other health facilities. Studies not undertaken.

#### b. Drug Availability

- i. Analysis started on availability of essential drugs in health facilities, particularly regarding chloroquine & oral rehydration packets. No analysis started.
- ii. Study underway for extending nation-wide drug distribution system. CREDES (Mars 1991) "Etude de l'Extension du Systeme de Distribution des Medicaments".

## a. Planning Process

- i. National plan document using decentralized planning process prepared & implementation started; MSP seeking donor funding for preparation of regional health plans.

Annual plan document updated including: integration of study & research results from prior year, strategies related to available resources, objectives justified with data available on mortality, morbidity, & service utilization. Last health plan dated 1987, See V.a.i above re: regional planning.

- ii. Capacity of management information systems expanded to include data on health services utilization; National information system installed in 1990.

Establishment of mechanisms for information feedback to health facilities and improved use of information. Tables prepared but no formal feedback mechanism.

## b. Evaluation

- i. System established for monitoring of policy reforms and their integration into health planning & programming. No system designed nor established.

Proposal for centralized review system for studies & operational research prepared. No proposal prepared.

- ii. Centralized review system for studies & operational research implemented. No system designed nor implemented.

- iii. Procedure implemented for on-going updating of calendar for studies & operational research; No procedure designed nor implemented.

Progress report prepared.

No report prepared.

## VI. FAMILY PLANNING &amp; POPULATION POLICY

## a. Family Planning Law

- i. Promulgation of legislation or decree legalizing the use and distribution of contraceptives and provision for family planning services. Legislation passed.

## b. Population Policy

- i. Publication of the comprehensive demographic policy of Niger. Policy published.

## c. Contraceptives

- i. Study of import duties & feasibility & advisability of charging for contraceptives underway. Import duties & private sector pricing: Baird/Teklamarium (June 1991) Trip Report, Niger Assessment" SOMARC.

**TABLE 2: APPROVED AND ACTUAL EXPENDITURES FOR NHSSG SUB-PROJECTS (FCFA)**

SUB-PROJECT	FUNDING APPROVED		ACTUAL EXPENDTR		AMOUNT REMAINING	
	AMOUNT	%	AMOUNT	%		
Secretariat	92,581,598	15.2%	92,581,598	19.6%	0	
Appui a la DEP	50,668,333	8.3%	43,726,696	9.3%	6,941,637	
SNIS	146,291,578	23.9%	107,728,823	22.8%	38,562,755	
Journee D'Etudes	24,259,310	4.0%	24,259,310	5.1%	0	
Supervision Generale	30,444,000	5.0%	5,285,913	1.1%	25,158,087	
Projets MSP	160,128,092	26.2%	96,242,707	20.4%	63,885,385	
LMD	32,078,492	5.2%	20,048,527	4.2%	12,029,965	
ESV	50,717,600	8.3%	33,875,507	7.2%	16,842,093	
Seminar/Atelier	35,332,000	5.8%	6,799,485	1.4%	28,532,515	
Etudes Politiques	42,000,000	6.9%	35,219,188	7.5%	6,780,812	
PEV	14,010,000	2.3%	10,423,435	2.2%	3,586,565	
Medicins SF	92,700,000	15.2%	92,700,000	19.6%	0	
<b>TOTAL</b>	<b>611,082,911</b>	<b>100.0%</b>	<b>472,648,482</b>	<b>100.0%</b>	<b>138,434,429</b>	<b>22.7%</b>

**Table 3: SHORT-TERM TECHNICAL ASSISTANCE AND BACKSTOP VISITS  
NHSSG, 1988-1991**

NAME OF CONSULTANT	DATES OF ASSIGNMENT	POLICY AREA & SUBJECT
<b>1988:</b>		
-----		
Taryn Vian	Jun 15-Jul 11, 1988	Prep: Hospital Studies
Sif Ericsson	July 1988	
Vince Brown	July 1988	Decentralized Planning
Felix Lee	July 10-29, 1988	Computer programming Database conversion
Marty Makinen	July 24-30, 1988	Backstop visit
Nancy Mock	July 24-31, 1988	Backstop visit
Eric Swedburg (intern)	Jul 10-Sep 4, 1988	Database conversion
Karen Budd (intern)	Jul 22-Sep 8, 1988	Study: MOH/SA 1988 Budget
Marty Makinen	Oct 29-Nov 3, 1988	Backstop visit
Taryn Vian	Oct 29-Nov 12, 1988	Prep: Hospital Acct
Holly Wong	Nov 27-Dec 21, 1988	
<b>1989:</b>		
-----		
Nancy Baughman	Jan 3-Mar 31, 1989	
Marty Makinen	Jan 4-7, 1989	Backstop visit
Nancy Mock	Feb 6-16, 1989	Backstop visit
Holly Wong	Mar 27-Apr 24, 1989	
Nancy Mock	Aug 6-11, 1989	Backstop visit
Michael Edwards	Aug 13-Feb 11, 1990	SNIS Programming Computer Training
Marty Makinen	Aug 20-Sep 2, 1989	Backstop visit
Greg Becker	Oct 21-Nov 12, 1989	
Steve Franey	Oct 22-27, 1989	
Keith McInnes	Oct 28-Nov 18, 1989	Wkshop: Non-Hosp CR
Ricardo Bitran	Nov 5-12, 1989	Wkshop: Non-Hosp CR
<b>1990:</b>		
-----		
Harry Godfrey	Jan 10-Feb 24, 1990	EPI CEIS
Felix Lee	March 6-11, 1990	EPI Computer Programming
Greg Becker	Mar 20-Apr 5, 1990	Study: Hospital Cost Containment
Therese Fortier	Feb 1-Mar 26, 1990	Study: Training Plan
Nancy Mock	March 1990	Backstop visit
Keith McInnes	May 20-Jul 16, 1990	Facilitate HEcon Transition
Jonathan Smith	June 1-19, 1990	Study: VHT Financing
Noreen Qualls	May 28-Jun 15, 1990	Study: VHT Costs
James Setzer	May 21-Jun 20, 1990	Study: Manpower Plan
Patricia Daly	May 23-Jun 13, 1990	Study: Manpower Plan
Kirsten Fredericksen	Jul 22-Aug 16, 1990	Study: CHDs Registratn
Ricardo Bitran	August 1990	Backstop visit
Greg Becker	Oct 8-25, 1990	Prep: Non-Hosp CR Study
James Setzer	Nov 22-28, 1990	Study: NNH Triage
Francois Diop	Dec 1-21, 1990	Backstop visit
Michael Edwards	Dec 26-Jan 18, 1991	Prep: Non-Hosp CR Study SNIS Programming

1991:

\*\*\*\*\*

Greg Becker  
Keith McInnes  
Marcia Weaver  
Nancy Mock  
Ricardo Bitran

April 1991 (USA)  
May-Sept 1991  
August 1991 (USA)  
December 1991  
December 1991

Summary: NNH Triage Study  
Prep: Hospital Wkshop  
Summary: Hospital Tariffs  
Backstop visit  
Backstop visit

**ANNEX 1**

**INTERIM EVALUATION:NIGER HEALTH SECTOR SUPPORT GRANT**

**STATEMENT OF WORK**

Attachment 1 - Statement of Work  
Interim Evaluation of the Niger Health Sector Support Grant

**I. Purpose:** The purpose of this procurement is to recruit a two-person team to conduct an interim evaluation of the Niger Health Sector Support (NHSS) Grant.

**II. Background:** The Niger Health Sector Support (NHSS) Program signed on August 28, 1986 is a seven-year sector grant to assist the Government of Niger (GON) to achieve desirable and significant health and population policy reforms and to provide domestic capital to finance essential health service activities promoting child survival. The NHSS Grant is essentially a resource transfer, with a foreign exchange component to finance technical assistance, studies and training. To date, a total of \$17.2 million has been provided through the program's two components. The Project Assistance (PA) component (683-0254) provides \$4.7 million to finance long- and short-term technical assistance, training, evaluation and audit services. The Non Project Assistance (NPA) component (683-0276) provides \$10.5 million in resource transfers, divided into five increments which are to be disbursed to the GON following satisfaction of policy reform conditionality. The revised Program Assistance Completion Date (PACD) is December 31, 1992.

The conditions precedent to release of each increment of the resource transfer are related to the following policy reform areas and purposes:

1. Cost recovery in the hospitals: to analyse present cost-recovery efforts, propose changes to improve cost-recovery, implement changes and monitor improvements (i.e. increases) in cost recovery;
2. Cost recovery in non-hospital services: to test selected approaches to cost-recovery for curative services, assess each, prepare and implement a national cost-recovery policy;
3. Cost containment in drug purchasing and distribution and hospital management: to determine approaches for reducing cost of drug acquisition and distribution, monitor the implementation of these approaches, and make adjustments as needed to further reduce costs; and to identify methods for reducing resource needs at the hospitals by improving management and monitoring the implementation of management improvements;

4. Resource allocation in the national health budget: to analyze present resource allocations in the health budget, particularly in relation to allocations for hospitals and for personnel, to propose targets for more appropriate levels of these resources (and thereby free up more budgetary resources for drugs and primary health care services), and monitor budgets and expenditures to assess whether these targets are met;

5. Management of health personnel resources: to improve allocation of personnel resources as related to staffing of rural health facilities, strengthen training through better planning and coordination, and strengthen utilization of personnel by insuring more effective supervision and overall structuring of primary health care services;

6. Health sector planning: to install more useful health and management information systems, to establish health planning procedures incorporating decentralized planning policy, and preparing and revising on a regular basis a national health plan; and

7. Population policy and services: to extend and legalize family planning service delivery and facilitate the importation and distribution of contraceptives; to conduct the analyses needed for the preparation and promulgation of national population policy.

Implementation of the Grant has proceeded slower than originally anticipated. The conditions precedent to the first disbursement for the technical assistance and related portions of the grant were met in the spring of 1987; the conditions precedent for the first increment of dollar transfer were met at the end of August, 1987, six months after the date given in the grant agreement.

Subsequently, the GON made notable progress in several policy areas. Proposals were developed to pilot test cost recovery systems for non hospital services. Procedures were designed to improve tariff structures, accounting and patient registration systems at Niamey hospital and improve cost recovery. A list of essential medications to be sold at reduced prices was developed and adopted. Alternate schemes were considered to lower costs of drugs purchased by the para-statal pharmaceutical monopoly. A management information system was developed and installed. Also, a law authorizing the use of contraceptives was enacted and a draft national population policy was prepared and submitted for formal GON approval.

A mid-term evaluation of the program was carried out in September 1989 and conditions precedent to the second dollar transfer were met in November 1990.

### III. Specific Tasks:

The evaluation of the NHSS Grant will require the services of a Health Economist/Planner and a Public Policy Research and/or Organizational Specialist. The evaluation will be carried out over a three-week period, beginning in early December 1991, and include 3 principal components: 1) analysis of progress, or lack thereof in the achievement of policy objectives; 2) assessment of program management and related technical assistance and training support; and 3) identification of required modifications/changes in program objectives, strategy and/or configuration.

1. **Non-Project Assistance:** The team will conduct a thorough analysis and assessment of policy and institutional reforms enacted under the NHSS Grant, including a discussion of their contribution toward achievement of the project purpose and the extent to which they have or have not been fully implemented. To that end, the team will review each of seven policy reform areas of the NHSS Grant and detail barriers and constraints which have hindered further progress in implementing policy and institutional reform measures as required by the conditions precedent for subsequent dollar transfers to the local counterpart fund.

The team will also assess GON success in the implementation of health policy reform in general, i.e., the nature and effectiveness of the policy-making process and resulting policies. This assessment will include discussion of MOH internal organization and institutional capacity, existing mechanisms for intra- and inter-ministerial coordination and decision-making and overall knowledge of and commitment to the objectives of the Grant. It will also examine the quality of studies performed to date for use in analyzing policy reform areas, delineating policy reform issues, and assessing policy reform impact.

2. **Project Assistance:** The evaluation team will review the extent to which technical assistance (TA) and training inputs provided under the Grant, and USAID and GON program monitoring and management, have contributed to the achievement of NHSS program objectives. This review will examine the appropriateness of the current long- and short-term TA configuration; the performance of the Tulane/Abt TA contract, including the relevance, timeliness, quality and use of advisory services provided under the contract and the success of the resident team in transferring skills to the GON; and the complementarity of these and other TA resources contracted directly by USAID or through buy-ins to existing centrally funded contracts. It will also assess the selection and placement of long-term training participants and the effectiveness of the MOH as the counterpart and implementing agency, particularly the lack of performance and utilization of oversight mechanisms such as the planned high-level Policy Reform and Review Committee.

**3. Recommendations for New Policy or Institutional Reforms:** Within the framework of the NHSS program purpose, the team should develop recommendations, as appropriate, for new reform initiatives that would assist the GON in accelerating progress toward the satisfaction of existing conditions precedent and achievement of program objectives. These recommendations should be presented in such a way as to assist the Mission in engaging in an expanded policy dialogue with the GON. In this regard, the evaluation team should draw a clear distinction between recommendations for changes that would represent a modification, continuation or strengthening of reform measures that are a part of the existing NHSS program, changes which might evolve out of conditionality already in place, and changes that would represent completely new reforms.

The team will also address issues related to the capacity of the GON to implement identified policy reform measures and the extent that economic policy reforms have been instrumental in helping to increase the sustainability and effectiveness of the health care delivery system.

**IV. Briefing and Reports:** The team will be briefed and oriented upon arrival at USAID/Niger. Two working days prior to departure, the team will provide the mission with a narrative draft, in English and French, of the executive summary of the evaluation report, detailing their principal findings, conclusions and recommendations. During final debriefings with Mission and host government officials, the team will further elaborate on points contained in the draft executive summary. Within two weeks following their departure from Niger, the team will forward the complete draft of the evaluation report for Mission review and comment. The mission will have 5 working days to review the report and prepare written comments. The team will incorporate these comments into the final report, which must be received by the Mission within 10 days following their receipt by the contractor.

The final report will include an executive summary, a detailed description of the team's findings and specific conclusions arrived at during the evaluation, lists of all individuals interviewed and documents consulted, and a summary of recommendations.

**V. Relationships and Responsibilities:** The team will work under the guidance of the Mission Health Development Officer or his designee. One member of the team must be designated as team leader. Ms. Benita Ba, the REDSO/WCA Health Economist will participate as the AID representative on the evaluation team. The Mission NHSS Program Coordinator and Controller staff will also provide assistance to facilitate the team's work.

The team will work in collaboration with the Director of the MOH Direction of Studies and Planning (DEP) and other designated Nigerian counterparts, as appropriate. The team may also be asked to report occasionally to the Secretary General of the MOH.

**VI. Performance Period:** The performance period will be a total of approximately 30 days, with an estimated 3 weeks devoted to in-country fieldwork to begin on or about December 2, and end on or about December 21, 1991. This phase will be preceded by approximately 2 days preparation work in Washington, analyzing documents, interviewing AID and contractor staff and meeting with other relevant people and organizations. A six-day work week will be authorized for the in-country fieldwork phase of the evaluation.

**VII. Qualifications:**

**A. Health Economist/Planner** - This individual should have at least a masters level degree (preference given to doctorate) in economics, with an emphasis in health economics. The candidate should have at least five years working in applied health economic studies and/or policy development and implementation, with at least three years working in developing countries, preference given to Francophone West African countries. A minimum French language capability of FSI S-3, R-3 will be required as well as strong writing skills in English. The candidate should also have experience in the application of applied research in health policy development, measurement of the impact of health policy reform and strong program evaluation skills.

**B. Public Policy Research/Organizational Specialist** - This individual should have a master level or advanced degree in public administration, business, international affairs or other areas pertinent to the issues being evaluated, and must have strong experience in evaluating policy and regulatory reforms, and in assessing reforms in terms of program objectives. The candidate should also have experience in policy and/or organizational analysis, assessment of management and information systems and a minimum French language capability of FSI S-3, R-3 with strong writing skills in English.

ANNEX 2

PERSONS CONTACTED

**NIGER**

**Ministry of Public Health**

Saidou Souleymane, Minister  
Dr. Moha, Abdou, Secretary-General  
Maiga Adboulaye, Deputy Secretary-General  
Mme. Gado Hadiza, Director, DEP  
Ibrahim Magagi, Deputy Director, DEP  
Ibrahim Habou, Sociologist, DEP  
Dr. Mounkaila Abdou, Chief, Statistics Bureau, DEP  
Mme. Madougou Ramatou, Computer Technician, DEP  
Abdoulaye Abou, Librarian/documentalist, DEP  
Mme. Marie Abdoulaye, Director, DAAF  
Mme. Salifou Marie, Deputy Director, DAAF  
Habibou Kala, personnel chief, DAAF  
Dr. Maoude Hamissou, Director, DES  
Kadri Koda, Deputy Director, DES  
Maman Sofo Bawa, DES  
Saley Souleymane, DES  
Alzouma Guida, Coordinator, Diarrheal Disease Program  
Dr. Colette Geslin, Proj. Pritech  
Dr. Moussa Jatou Idi, Director, EPI Program  
Nouhou Hassan, accountant, EPI program  
Dr. Soga Garba, Director of DHMM  
Dr. Amadou Sekou Sako, Director, Niamey Hospital  
Dr. Halarou, former DDS of Zinder  
Ian Sliney, Technical assistant, Tulane-Abt  
John Izard, " " " "  
Carla Willis, " " " "  
Sylva Etain, Technical Advisor, Nutrition

**Ministry of Social Affairs and Development**

Dr. Maidouka Halima Diallo, Director, Family Planning  
Div.

**Ministry of Finances and Plan**

Issaka Hamani Bawa, Director DFI, President of the  
Comité de Gestion  
Aridouane Ibrahim, Executive Secretary, Management  
Committee

## **USAID**

George Eaton, Director  
Valerie Dickson-Horton, Deputy Director  
Richard Macken, Program Development Officer  
Beatrice Beyer, Program Officer  
Michael McCarty, Economist,  
Pamela Callen, Controller  
Margaret Brown, Agriculture Development Officer  
Helen Soos, General Development Officer  
Carl S. Abdou Rahmaan, Health Development Officer  
Susan Wright, Population Officer  
Nancy Lowenthal, Child Survival Coordinator  
Oumarou Kané, Counterpart Fund Coordinator

## **OTHER ORGANIZATIONS AND INDIVIDUALS**

FAC Advisor to Zinder DDS, Dr. Pierre Guillaumot  
Family Health and Demography Project/URC, William  
Emmet, Director  
Medecins sans Frontieres, Dr. Monique Lefort, Laurent  
Lacoste  
ONPPC: Dr. Galadima Ousmane, Exec. Director  
Mahamane Sekou, Director, Commercial Branch  
RESSFOP, Dr. Leon Tahier  
UNICEF, Dr. Maximin Ouoba, Bob Davis  
World Bank, Pierre Nignon

## **UNITED STATES**

### **A.I.D.- Washington**

Nancy McKay, Niger desk  
Jerry Wolgen, ARTS, Africa Bureau  
Jay Smith, Economist, ARTS, Africa Bureau  
Dennis Carrol, Office of Health, Research and Dev.  
Robert Emery, Office of Health, Research and Dev.  
Gary Merritt, Nigeria desk  
Dawn Liberi, former Niger HDO  
Abbe Fessenden, CDIE  
Juan Buttari, CDIE

### **Other Individuals/Organizations**

Ricardo Bitran, Abt Associates  
James Setzer, Abt Associates  
Edward Brown, World Bank  
Willem van Egan, World Bank

### ANNEX 3

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**ANNEX 4**  
**REVIEW OF HEALTH SECTOR FINANCE IN NIGER**  
**AND REFORMS UNDER THE NHSSG**

**I. INTRODUCTION**

The purpose of this annex is to provide detailed information regarding the evolution of health sector resource allocation and financing policy from 1985 through 1992, to delineate how the NHSSG contributed to this evolution, and to evaluate constraints to achievement of the overall reform objectives of the NHSSG. Section II of the annex reviews information about trends in health sector finance during the early 1980s and their influence on design of the NHSSG and other donor programs in Niger. The section also reviews activities under the NHSSG and evolution of policy through to 1992. The policy areas reviewed are: i) health sector budgetary allocation, ii) hospital cost-recovery and cost containment, iii) non-hospital cost recovery, and iv) drug cost containment and extension of the delivery system. Section III of this annex attempts to draw from this review lessons learned for design and implementation with respect to health sector financing reforms.

**II. EVOLUTION OF HEALTH SECTOR FINANCING POLICY AND ADMINISTRATIVE REFORM UNDER THE NHSSG**

**A. Resource Allocation: Budget**

**1. Problem Analysis: mid-1980s**

During the early 1980s, GON investment expenditure for the health sector equalled no more than 2 percent of overall investment expenditure. The recurrent budget for the Ministry of Health and Social Affairs (MOH/SA) remained relatively constant in real terms, and was equal to about 6 to 7 percent of the overall GON recurrent budget. Real expenditure per capita declined over the period, and was equal to 730 FCFA in 1984. By 1985/6 the balance of government recurrent financing for the sector was shifting towards payment of personnel in contrast to other inputs. In addition, a disproportionate share of financial resources were allocated to finance hospital services (50%) serving primarily urban areas where only 15 percent of the population resides.

**2. Conditions Precedent in the NHSSG**

Addressing these overall trends and sectoral constraints trends formed the basis of the design of benchmarks for the Niger Health Sector Support Grant (NHSSG). However, the design and implementation of the NHSSG seems to have considered analyses of the MOH/SA budget as primarily an exercise in monitoring the progress of reforms to shift GON resources from personnel inputs and hospital services. The NHSSG included conditionality about the GON and USAID setting target percentages for allocation of GON recurrent budgetary resources by category from the third through fifth tranche. The growing importance that donor resources were

playing in the financing of the recurrent costs of the sector was recognized at the time of revision of the grant's benchmarks and analysis of the MOH/SA's budget was thereafter considered to include the investment as well as the recurrent budget.

### **3. Progress in Budget Analysis and Allocation under the NHSSG**

During the first year of project implementation (1988) a student intern carried out an analysis of GON resources in the sector. It was also proposed that analysis of the allocation of donor resources in the sector be carried out by a second intern, but the MOH/SA held up approval for this individual, and this work was first postponed, and eventually not carried out <sup>1/</sup>.

Not until 1991 were analyses carried out of the allocation of the overall MOH/SA's investment and recurrent budgets. These studies were financed by the UNDP/World Bank (Wong and McInnes, and McInnes and Wong, both May 1991) and by the FED (Colomier, Decembre 1991). These studies make it possible to review the evolution of resource allocation and financing in the health sector during the latter half of the 1980s, and to assess the impact of the NHSSG on these trends. Comparison of financial data for the health sector for 1989 <sup>2/</sup> with data for 1980 and 1985 suggests that trends observed in the early 1980s have continued through the latter part of the decade. The claim of the MOH/SA on the budget of the State appears from the figures cited to have remained constant from 1985 to 1989 at nearly 7 percent. However during the same period, GON recurrent financing for the sector <sup>3/</sup> declined from 52 to 43

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<sup>1/</sup> There is evidence that the DEP/MSP did not find analysis of the investment budget a "high priority". The November 1989 Management Meeting Minutes indicate that contract expenditures were being reviewed to determine if sufficient funds remained for short-term technical assistance for analysis of the investment budget. Evidently analysis of the investment budget was either not considered feasible or important enough to have had funds earmarked in the workplan for it.

<sup>2/</sup> FY 1989 was selected for this comparison over 1990 for several reasons: i) the Ministry of Social Affairs was separated from the Ministry of Health in 1990, ii) the GON's fiscal year was shifted from October to September to January to December in 1990 and straight line adjustments to the figures for the 15 month period to equal a 12 month period may be misleading.

<sup>3/</sup> However other figures for 1989 (Wong and McInnes, May 1991) show MOH/SA's budget to have remained as 6.9 percent of the total budget and Colomier's (Decembre 1991) figures for 1990 suggest that the health sector budget rose to 8.1 percent of total GON expenditure.

percent of total sectoral recurrent expenditure. Over the same period, donor funding increased from 10 to 19 percent of total health expenditure, while household expenditure for hospital fees and drugs remained with a constant share of about 37 percent (see Annex Table 4.1) <sup>4/</sup>.

Allocations for personnel compensation increased from 45 percent in 1980 of government financing for the MOH/SA to 58 percent in 1990. Allocations for medicine and vaccines declined from 31 to 19 percent, and for transport from 10 to 4 percent, while allocations for other recurrent expenditure increased from 14 to 19 percent to GON recurrent financing for the sector. Donor financing for recurrent expenses of the sector shifts the balance of personnel to materials balance from 58 to 42 percent to 43 to 57 percent (see Annex Table 4.2). While in 1985, an estimated 50 percent of the government's recurrent health budget was allocated to hospitals, in 1990 this had risen to 58 percent. Government support for non-hospital services declined from 40 to 30 percent during the same period. Donor financing again shifts the balance of recurrent financing for hospital as compared to non-hospital services from almost 2:1 (for GON budget only) back to a ratio of 1:1 (see Annex Table 4.3).

#### **4. Status of Budget Allocation Reform by 1992**

The above suggests that reform efforts have, to date, had little impact on halting or reversing the trends in the allocation of resources observed in the early 1980s, nor in generating financing from cost-recovery activities for the health sector. To a considerable extent the decline in Niger's economy and in government revenue has limited the GON's options with respect to the reallocation of financial resources. In addition, the growth of donor resources for non-personnel inputs, and non-hospital programs, have provided little incentive to GON decision-makers to shift their resources in these areas.

The likely continued importance of donor resources for the financing of investment and recurrent costs of the sector highlights the need for improved donor program and financial coordination. There is now considerable interest in instituting program budgeting in the MOH and MSA/PW to facilitate allocation of donor funds, and also to develop mechanisms to improve the disbursement of available funds so as to alleviate the social costs of the continuing structural adjustment program. In addition, starting with the "Journées d'Etudes" in Dosso in 1988 there has

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<sup>4/</sup> Other sources of financing for the health sector not accounted for in Annex Table 4.1 include: i) household payments for private physician/clinic services, ii) expenditures of local governments (arrondissement/commune level) for health (Darbera and Hall, December 1991).

been discussion of decentralization of health sector finance. The 1989 budget was to allocate to departments investment and operating budgets except for personnel and operation of programs at the national ministry level. As efforts to achieve decentralization move forward, access to disaggregated information on donor expenditure by geographic departments will be important to facilitate the planning of resources.

## **B. Hospital Cost Recovery and Cost Containment**

### **1. Situation Analysis: mid-1980s**

Studies conducted by the MOH/SA and MOP in the mid-1980s with World Bank financing, found that about 50 percent of the GON's recurrent expenditures in health were allocated to Niger's 8 hospitals which provide primarily curative services to the 15 percent of the population that resides in urban areas. Allocation of GON investment expenditure was found to be similarly skewed in favor of hospital services, and mechanisms were not in place to review the recurrent cost financing implications of donor contributions for hospital construction or equipment.

While a system of charging for hospital services had been created by decree (No. 62-127/455) in 1962, fee levels had not been changed, nor was the collection of charges rigorously enforced. It was estimated that if the 1962 tariff system were rigorously applied revenues would cover 40 percent of Niamey National's and 13 percent of Zinder hospital's operating expenses. A modified hospital tariff structure was proposed in 1984 that was estimated would have generated revenue equivalent to 65 percent of Niamey National and 55 percent of Zinder hospitals' operating expenses. While this new charge schedule was rejected by the Council of Ministers, in June 1985 it was decreed: "... that there will be a rigorous application of existing legislation concerning fees for medical visits, exams, hospitalization and medical evacuations" <sup>5/</sup>.

### **2. Donor Efforts at Time of NHSSG Design**

As part of overall efforts to restrain and influence overall public sector expenditure, the World Bank's structural adjustment programs in the early 1980s included conditionality regarding allocation of resources in the health sector. Growth of hospital revenue over the period 1982 to 1988 in both nominal terms (by 190 percent) and as a percent of hospital recurrent expenditure (from 4 to 7 percent) suggests that efforts taken to improve hospital fee collection during this earlier period had a positive effect (see Annex Table 4.4).

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<sup>5/</sup> Kelly, P. et.al. (1985), p. 106 and 134-5.

The Bank's Niger Health Project, appraised in February 1986, included conditionality regarding the conduct of studies and subsequent development of action plans for hospital services, specifically:

- o Study of hospital fees and proposal of action plan by August 31, 1986.
- o Study of the cost-effectiveness of shifting services from NNH to the University Hospital, with proposal of action plan by September 30, 1986.
- o Study of hospital management, including financial management, with proposal of action plan by March 31, 1988.

Funds for implementation of activities identified in the action plan were to be financed by the Bank project.

In addition, medical doctors from countries such as France have traditionally been placed in Niger's hospitals to providing medical and other technical support.

### 3. Conditions Precedent of the NHSSG

Given the issues identified regarding hospital services, and the planned inputs from the Bank project, the original design of the NHSSG included conditionality to reinforce the implementation of the Bank's activities in the hospital sector. In addition, conditions precedent were included in the NHSSG to: i) design a system to improve the patient registration and fee collection systems at NNH; ii) revise the accounting and reporting systems at NNH to permit on-going monitoring of hospital expenditure, revenue, and cost recovery; and iii) report on improvements made in hospital management.

By the end of 1988, it was recognized that the Bank project was experiencing significant delays in carrying out the hospital studies, and it was agreed to shift these to be carried out by the TA team under the NHSSG. Revision of the benchmarks, finalized in the Third Amendment to the NHSSG (dated July 1989), added conditions to conduct studies of: i) patient registration and fee systems at hospitals other than NNH, ii) the costs of providing services and relationship of costs to fees charged, and iii) hospital management. Conditions precedent were also added regarding the GON review and adoption of the studies recommendations and preparation of plans for implementation. However, funds for implementation of these plans (certainly at hospitals other than NNH) were not added to NHSSG counterpart funds, and it is unclear whether funds in the Bank project could still be utilized for these purposes.

None of the benchmarks selected addressed the disincentive to collection of fees posed by the policy that all revenue generated by the hospitals reverts to the Ministry of Finance with 50 percent to be returned for additional compensation of hospital personnel. Improvements in fee collection otherwise does not directly benefit the operation of the hospital, nor is available for improvement in the quality of services.

#### **4. Progress in Hospital Reform during the NHSSG**

Over the period from the TA team's arrival in March 1988, until January 1992, at least 23 memos, papers, or studies regarding hospitals in Niger have been prepared under the NHSSG. The bulk of these studies was completed by September 1990, with a study of patient triage and a paper synthesizing the findings and recommendations of all the hospital studied carried out in 1991.

The conduct of the studies involved the services of the economists on TA team, 6 expatriate consultants, 4 Nigerien consultants, and economists on the DEP staff. Delays and other difficulties were experienced in obtaining DEP concurrence for scopes of work for the studies, approval of the consultants proposed to carry out the work, and in obtaining comments on draft reports and approval for final reports. Reports cannot be referred to the Conseil de Ministres without first DEP and then MSP approval. In at least one case, the failure of the DEP to review a study of hospital costs prevented it from being formally presented to the Ministry by the consultant who had carried it out.

To the knowledge of the evaluation team, only the studies regarding improvement of accounting systems at NNH and other hospitals have reached the implementation stage. The Nigerien consultant who had developed the new accounting system (identified by the MOPH through contacts at the MOP) was engaged to train personnel at NNH in its application. Counterpart funds were used to pay the consultant. The agreed upon fee level, thought to be a weekly rate, turned out to be a daily rate in excess of USAID's maximum limit for expatriate consultants. Training activities at NNH were not completed and, due to the decertification of the NHSSG, additional counterpart funds were not available to complete the training and extend it to other hospitals.

Proposals to revise hospital tariffs were reviewed at the Journees d'Etudes at Dosso in 1988, and development of legislation permitting hospitals to be managed as semi-autonomous institutions by the end of 1990 was proposed at the Journees d'Etudes at Maradi in 1990. An Ad Hoc Committee for Niamey National Hospital was formed by early 1990, and the economist on the TA team was invited to participate in meetings of this committee. While this Committee has continued to meet under the presidency of the Secretaire General Adjoint (SGA), members of the TA team have not continued to participate in these meetings. Review of a proposal for capital

improvements to the NNH by a consultant for the FAC has likely drawn attention of the Committee away from management and cost recovery activities for which there has not been any funding.

## **5. Status of Hospital Reform in 1992**

The share of MOPH recurrent expenditure allocated to hospital services has increased from 50 percent in 1985 to 58 percent by 1990, with about 17 percent of total donor recurrent financing also being spent in hospitals. Information regarding hospital revenues after 1988 had not been collected or analyzed by the DEP, and thus it is not possible for the evaluation team to ascertain whether improvements in hospital fee collections continued after 1988.

The establishment of hospitals as "institutions with a public character but autonomously managed" was among the policies recommended by the National Conference in 1991, and actions to put in place this policy were included in the action plan for the Transitional Government. The MOPH has developed a draft text regarding this policy step <sup>6/</sup>. The 1992 workplan for the TA team includes the conduct of a workshop in March 1992 to review the hospital studies, review proposed new legislation, and develop plans to implement approved policy and administrative reforms. The workplan indicates that efforts will be made after the conduct of the workshop to identify funding to carry out the implementation plan. However, donors such as USAID and the World Bank should consider giving the MOPH some preliminary indications of the level of funding likely to be available for activities to improve hospital cost recovery and containment so as to facilitate the development of realistic plans by the workshop participants.

### **B. Non-Hospital Cost Recovery**

#### **1. Situation Analysis: mid-1980s**

Non-hospital health institutions in Niger in 1985 consisted of 53 maternities, 28 MCH centers, 39 medical centers, 230 rural dispensaries, 25 medical posts. In addition, over 12,000 (secouristes and matrones) had been trained by the Rural Health Improvement Project (RHIP) to provide basic health services covering about 45 percent of Niger's villages <sup>7/</sup>. About 31 percent of Niger's population is estimated to live within 5 km of a health institution in Niger. However, even if capital for expansion of health infrastructure were available, the geographic expansion of services would be limited by the GON funds available

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<sup>6/</sup> The TA and evaluation teams requested access to a copy of this draft text but have been unable to review it prior to internal MOPH processes.

<sup>7/</sup> USAID/Niger (July 1986), p. III-1.

for the recurrent costs of health services. In 1985, about 40 percent of the MOH/SA recurrent budget was allocated to the financing of non-hospital services. The paucity of essential drugs at rural facilities suggests that the level of recurrent financing for essential inputs was inadequate even at that time. Up to the mid-1980s, donor financing for non-hospital services primarily supported the VHT program.

By the mid-1980s, studies of the potential for cost recovery for non-hospital services had already been conducted or were planned. These studies documented evidence that the population was willing to pay for health services, but that poverty would limit the amount that they could pay. By 1985, the Ministry of Plan (MOP) had developed a possible fee schedule for non-hospital services but which was not implemented<sup>8/</sup>. However, VHWS were allowed to charge for the drugs they dispensed in order to replenish their stock of drugs. Evaluations of the VHT system found that the medical stocks of the VHWS tended to decapitalize where there was not on-going supervision to aid in stock management, pricing, and in providing a local source of drugs from which to restock.

In the private sector, the GON had established policies to allow for the opening of private depots for the sale of drugs. While growth in the number of these outlets, from 40 in 1985 to 110 in 1990, provides the rural population with increased access to drugs, profits from drugs sales from the depots cannot be utilized to finance other aspects of the delivery of rural health services. This possibility exists for pharmacies opened and operated by cooperatives.

## **2. Donor Efforts at Time of NHSSG Design**

The Bank's health project included conditionality regarding the performance of a study to develop appropriate cost recovery measures for basic health services. An action plan for implementation of the study's findings was to have been presented by December 31, 1988, and funds for implementation of the plan were included in the project. In addition, the Bank project was directly to fund basic health and family planning program activities (e.g. malaria control, CDD, EPI, MCH, and family planning), as well as develop health education and nutrition programs. The incremental recurrent costs associated with these project activities were estimated as 355 million in 1985 FCFA, or a 10 percent real increase in the recurrent budget of the MOH/SA. These incremental costs were to be financed in part from revenues collected at rural facilities (100 million FCFA), and sales of chloroquine (26 million FCFA), as well as from increased hospital revenue (200 million), and savings from medical evacuations (200

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<sup>8/</sup> USAID/Niger (1986) p. III-6.

million) <sup>9/</sup>.

At this time, the Belgian project in the Mirriah arrondissement was already developing standard treatment guidelines for common illnesses in Niger, and was experimenting with combining training of dispensary nurses in these standard treatment protocols with the sales of drugs at the dispensary.

### **3. Conditions Precedent of the NHSSG**

The original conditions precedent in the NHSSG regarding cost recovery for non-hospital services centered on conducting pilot tests (2nd tranche), and development of a national non-hospital cost recovery policy and nationwide implementation (3rd to 5th tranches). Revision of the benchmarks in 1989 slowed down the pace of action to require development of a detailed plan/protocol for the pilot tests with implementation started (2nd tranche), continuation of tests with preliminary reports (3rd tranche), results used to design a national policy on non-hospital cost recovery and to develop an action plan for national implementation (4th tranche), and implementation of the plan (5th tranche).

### **4. Progress in Non-Hospital Cost Recovery Policy under the NHSSG**

It is clear from review of the minutes of the Monthly Management Meetings between the TA team and USAID that efforts were initiated at the beginning of the project to engage the DEP and MOPH in the development and adoption of a plan for pilot tests of different mechanisms for cost recovery for non-hospital services. Initial reasons given for delays were that the DEP had to wait for the Prime Minister's office to respond to the recommendations regarding cost recovery made at the Journées d'Etudes at Dosso in August 1988. An initial draft of a proposal for the pilot tests was prepared by May 1989, but the DEP did not seem ready to commit to conducting the tests. By August 1989 it was determined that one cause of the delays was that different donors were pushing different approaches to reach different agendas <sup>10/</sup>. As a consequence it was decided to conduct a workshop at Kollo on non-hospital cost recovery in November 1989. At this meeting, the MOPH indicated it would like to have a pilot test site in each department with one of three payment systems (fonds de solidarite, depots de medicaments, cartes de sante). Use of the Mirriah

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<sup>9/</sup> World Bank (February 26, 1986) p. 19, 23.

<sup>10/</sup> The Bank for example had made a proposal to sell health cards, FCFA 1000 in urban areas, and FCFA 500 in rural areas. The FED wanted to evaluate the Belgian experience in Dosso as a possible model for replication, UNICEF was attempting to promote the sale of drugs as part of the Bamako Initiative.

experience as an adequate pilot test of the method of payment per episode of illness was rejected by the MOPH.

Efforts to revise the protocol for the pilot tests continued. However, the Journées d'Etudes at Maradi in August 1990 recommended immediate nationwide implementation of non-hospital cost recovery based on a model of arrondissement-level managed systems of cost recovery based on fees for drugs and procedures, with consultations and preventive services provided free-of charge. It was proposed that the revenues generated be used to improve the quality of services including the provision of essential medicines (complemented by purchase of medicines at Popular Pharmacies or depots), and support for VHTs. Popular resistance to this proposal turned the MOPH back to consideration of proceeding with pilot tests, and a second proposal for the pilot tests was presented to the donors in December 1990. In response to this proposal, the donors set out conditions precedent to their agreement to finance the pilot tests <sup>11/</sup>. In March 1991, the Secrétaire Générale (SG) of the MOPH created by decree a "Comité Nationale sur le Recouvrement des Coûts de Santé" (Comité Pilotage) to take the actions necessary to meet the conditions precedent for the studies, and to ensure the coordination and follow-up of pilot test activities. Working groups to address each of the conditions precedent were developed from among members of the committee. Work was carried out over most of the remainder of 1991.

##### **5. Status of Non-Hospital Financing and Cost Recovery Reform Efforts by 1992**

By 1991, the number of non-hospital facilities in Niger numbered: 72 maternities, 42 MCH centers, 260+ rural and village dispensaries. GON recurrent financing for non-hospital services declined to about 30 percent of total MOH/SA expenditure in 1990 from 40 percent in 1985 <sup>12/</sup>. Donor financing became a significant source of recurrent financing, comprising about 61 percent of total

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<sup>11/</sup> The conditions precedent were to: i) evaluate the experiences of the Belgian project at Tiberi (direct payment) and of the EC at Mirriah (indirect payment), ii) development of materials and plans for training of medical staff in standard treatment and drug management, iii) development of a plan for the least cost purchase and separate management of essential drugs within ONPPC, and iv) nomination of a group to follow the progress of the MOPH in revision of the pilot test proposal. It was anticipated that 6 to 9 months would be required to carry out all of these conditions precedent.

<sup>12/</sup> While the MOPH and Department of SA were separated in 1990, studies of trends in health financing combined budget and donor resources for both for purposes of comparison with figures before 1990.

non-hospital recurrent expenditure in 1989.

Cost recovery for non-hospital services was a topic discussed by the Health Sub-committee of the Social and Cultural Commission at the National Conference in 1991. While adoption of a cost recovery policy was resisted by some participants, the Conference did recommend adoption of a cost recovery policy and to go ahead with implementation of the pilot tests.

A third proposal for the pilot tests was developed by October 1991, but was not reviewed by the "Comite Pilotage" until January 1992, after the conclusion of the National Conference and preparation of the Action Plan for the Transitional Government. The proposal was accepted by the committee and the World Bank pledged US\$500,000 in drugs for the pilot test areas. The remainder of financing for the studies will have to come from the NHSSG, or other USAID sources. An overall budget was not included in the proposal, so it was not possible during the evaluation to determine what share of NHSSG funds (technical assistance or counterpart) will be required for the tests. However, since the current TA contract for the NHSSG ends in December 1992 it is clear that additional funds for the technical assistance required for the tests will be required.

Additional issues regarding non-hospital cost recovery policy and the pilot tests include:

o Legal texts regarding non-hospital cost recovery for non-hospital services will not be developed until after the pilot tests. However, local authorities involved in the test efforts can develop the legal texts necessary to conduct the tests in their administrative areas <sup>13/</sup>. This procedure raises the possibility that cost recovery efforts can be initiated in areas other than the pilot tests if local authorities are interested. For example, UNICEF is planning to initiate cost recovery through charges at the health facility in 4 districts. Efforts to share information between the pilot tests and these other efforts should be given priority within meetings of the "Comite Pilotage" to facilitate learning across efforts. Also, in view of the continued movement towards decentralization, consideration should be given to whether a uniform national policy regarding cost recovery for non-hospital services is necessary, or whether local governments can set their own policy within some general guidelines by the national government.

o A decision regarding the source of drugs for the pilot tests is still pending. The lower the cost of the drugs procured, the lower the tariffs can be set to achieve full cost recovery for the

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<sup>13/</sup> DEP/MSP (8 Janvier 1992) "Proces-Verbal de la Reunion sur le Recouvrement des Coûts des Soins de Sante".

drugs. One set of estimates suggest that purchase of drugs from Mediciens sans Frontieres would be only as half as expensive as purchase from ONPPC. However, prior to adopting a decision to purchase drugs through a non-ONPPC sources, the Comite Pilotage should ensure that the MSF estimates include freight, insurance, customs, storage and transport charges - as do the ONPPC prices. Further, given that the pilot tests are to lead to national implementation of cost recovery efforts, the trade-off between any cost savings against longer term considerations of institutional sustainability should be given careful thought. Efforts to assist the ONPPC to shift their purchase of essential drugs from the lowest cost suppliers would seem to be the best long, run course of action, and could also facilitate the lowering of prices of drug sales from Popular Pharmacies and other private outlets, as retail prices are set a fixed margin above ONPPC prices.

o Tariffs for the pilot tests still remain to be set. Recommended prices for the indirect method of 300 FCFA per household per year with 50 FCFA per adult episode of illness and 25 FCFA per child are estimated would cover only 7 percent of drug costs if purchased from ONPPC. Recommended prices under the direct payment system of 200 FCFA per adult episode and 100 FCFA per child episode of illness would alternatively generate 14 percent of the costs of drugs from ONPPC. If tariffs were set to cover the cost of ONPPC drugs (estimated MSF prices are about half as much but may not include all relevant costs), then the required tariffs under the indirect method (80% tax, 20% fee scenario) are estimated at 7,478 FCFA per household with per episode charges between 25 and 600 FCFA depending upon whether treatment is for an adult or child, and requires antibiotics or not. Under the direct payment option, estimated fees per episode to cover ONPPC drug costs range from 125 to 3015 FCFA per episode, again depending upon the age of the patient and illness. Further consideration must be given to tradeoffs between the objectives of full cost recovery and appropriate medical treatment. Further, it would be expected that the higher the tariff, the more potential exists for patients to negotiate an intermediate price with the provider to obtain free care, or alternatively to seek to purchase drugs from alternative sources.

Other issues regarding setting tariffs for the tests warranting further consideration by the "Comite Pilotage" include: i) relationship of the level of fees for services at hospitals vs. Medical Center level vs. the dispensary level, ii) setting of policies regarding care for indigents, and iii) revenues net of additional administrative costs.

o An issue, which will be perhaps be more critical at the phase of national implementation, will be choices regarding the phasing of introducing cost recovery. One option is to proceed geographically through all levels of the system, another option would be to start with facilities at the CM level, and when systems

are established at these levels move to the dispensary level.

C. Drug Policy, Cost Containment and Extension of Delivery System

1. **Situation Analysis: mid-1980s**

An essential input to the treatment of common, life threatening illness (e.g. malaria, ARI), or for the provision of family planning services, are drugs and contraceptives. Thus to achieve expansion in access to health services, and in improving the quality of services, emphasis must be placed on the policies which guide the selection and use of drugs, and the system(s) which deliver these products.

In 1985, 1,150 million FCFA, or 24 percent of the MOH/SA's recurrent budget, was allocated for the purchase of drugs and vaccines. This expenditure would have been equal to 310 FCFA per capita (US\$ 0.69) if distributed equally in the population. It was estimated that 55 percent of drugs purchased by the MOH/SA were distributed to hospitals, 44 percent to rural facilities, and 1 percent to the central administration. During the same year, an estimated 3,700 million FCFA of drugs were sold through pharmacies and depots, with approximately half of these sales through outlets in Niamey. The ratio of value of publically distributed drugs to household purchases decreased from 1:2.3 in 1980, to 1:3.2 in 1985. Donors' drug contributions to Niger in the early 1980s are not well documented, but included drugs for stocking of VHT kits. Generally donations were made in kind, and thus did not facilitate the ONPPC's efforts to order appropriate kinds and quantities of drugs.

The production, importation, and distribution of drugs in Niger is carried out by a government para-statal the National Office of Pharmaceutical and Chemical Products (ONPPC). While the ONPPC, with the MOH/SA, had developed lists of the products which different institutions in the health system were authorized to sell, the total number of products handled by the ONPPC totalled about 4000. The popular pharmacies, or regional commercial outlets of the ONPPC, were located in 18 of Niger's 35 arrondissements. These pharmacies sell drugs to MOH/SA facilities, private drug depots, VHWS, and to the public. There were 40 private drug depots in Niger in 1985. Prices were controlled with a 28 percent markup on essential drugs, and a 32 to 35 percent markup on all other items. Price reductions of 20 percent are made to depots and VHWS so that these agents can make a profit without an additional markup in sales to the public in the more peripheral areas. While easy to monitor, this system of margins builds in an incentive to sell more expensive name brand drugs, in lieu of cheaper generics.

Policies developed at the "Debat de Maradi" in 1983 and the "Journées d'Etudes in Agadez" in 1984 called for the efforts to

increase ONPPC's productive capacity for essential medicines, to open popular pharmacies in all of Niger's arrondissements, and to systematize procedures for the opening of private depots. Progress in achieving these objectives, of course, was limited by the investment capital available to the ONPPC from the GON (non-existent in 1984 and 1985), or through its own profits, and the investment capital available to private entrepreneurs.

## **2. Donor Efforts at Time of NHSSG Design**

The World Bank's Health project, in an effort to support Niger's efforts regarding an essential drugs policy, was to finance activities aimed at improving the drug procurement process, as well as to finance a feasibility study on alternative ways to extend the drug distribution system. An action plan based on this study was to be presented to the Bank by March 31, 1989, and funds for implementation of aspects of this plan were included in the Bank project. In addition, the Project was to provide an initial stock of chloroquine for the National Malaria program, for which funds were to be collected to establish a special revolving fund for financing of these medicines <sup>14/</sup>.

## **3. Conditions Precedent of the NHSSG**

The original project design identified drug policies and practices as an important area for reform. Conditions precedent of the NHSSG were designed to achieve progress with regard to: i) cost recovery for essential medicines (e.g. chloroquine, ORS, contraceptives), ii) cost containment through improvements of purchasing of bulk, generic drugs by the ONPPC, and iii) improvement and expansion of the drug distribution system through public and private sectors. Reports were to be prepared showing the cost savings from improvement procurement practices. Revisions of the conditions precedent in this area were minor.

## **4. Progress in Drug Policy Reform and System Extension during the NHSSG**

One of the subject sessions at the Journées d'Etudes of Dosso in 1988 concerned the drug procurement and pricing policy. A policy regarding essential drugs was recommended, but a system did not exist to monitor its implementation. While the slow conduct of the World Bank project resulted in several of the policy studies being shifted to the NHSSG, the Bank continued to plan to conduct the study on extension of the drug system, and to that extent continue to retain a lead agency role in this area. The project did undertake however a study of drug purchases in 1988 for the MOH/SA. The study found that while purchases of essential medicines comprised about 91 percent of the products purchased,

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<sup>14/</sup> World Bank (February 26, 1986), p. 11, 13-14, 23.

that these purchases comprise only 41 percent of total drug expenditure. While the same data were collected for 1989, analysis of these data was not considered worthwhile given there had been no response to the analysis of the 1988 data. Also, the Bank had concluded preliminary arrangements to carry out their study of extension of the drug distribution system <sup>15/</sup>.

By August 1989 the GON had made a request for emergency aid to purchase anti-malarials. Uncommitted funds were not available in the counterpart fund for this request, and USAID's willingness to consider alternative funding would be based on GON willingness to move forward with cost recovery policy. In September 1989, a proposal was forwarded to the SG to develop a national pharmaceutical committee. The proposal was returned without comment. A decree creating a Division of Pharmaceuticals and Chemicals within the MCH/SA was written to meet second tranche conditionality under the NHSSG, but to date, no positions have been staffed in this division. Short-term consultancies on Niger's drug policy and systems were planned for 1990 but were not carried out. In April 1991, USAID's Family Health and Demography project attempted to launch a 3 part study of drug logistics systems to determine whether there would be more efficient ways to deliver essential medicines and contraceptives to MOH/SA facilities. The scope of work for this study was not approved.

Preparations for the pilot tests included a working group to analyze how ONPPC would handle the procurement, storage, and distribution of drugs for the pilot tests. Preparations for the pilot tests also involved development of facility level systems for drug stock management and financial accounting. To a considerable extent consideration of issues related to implementation of the essential drugs policy and questions of cost recovery (especially for non-hospital facilities) are now engaged in through developments in the pilot studies, and through discussions of the "Comite Pilotage".

In 1990, the ONPPC presented a proposal to the "Programme Sectoriel d'Importation" seeking 911 million FCFA for investment capital to improve their information system, purchase of transport, construction of a regional warehouse at Zinder, construction of three new Popular Pharmacies, and rehabilitation of production equipment. In addition, the ONPPC has a program with the Government of Holland and with the FED whereby these donors provide drugs, the sale of which provides funds which are placed into a special counterpart fund for uses jointly determined by a committee

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<sup>15/</sup> This study did use the 1988 NHSSG analysis. This illustrates the fact that while a study may not immediately be used by a government for policy change, that it may influence the thinking of several donors engaged in policy dialogue with the government, and thus have value to conduct.

including representatives of the MOPH, ONPPC, MOP and donor organization.

#### **5. Status of Drug Policy Reform and System Expansion in 1992**

By May 1991, the first part of the Bank financed study of the drug distribution system (CREDES) was available in draft form. This study identified a number of problems in the drug system. Two of the key problems noted were that the development of drug policy and the application of existing regulations in this area was weak, and that only 24 percent of ONPPC's purchases were of generic products. Among the study's recommendation was a call for a "Direction de la Pharmacie et du Medicament" be established within the MOPH to coordinate activity in drug policy areas. This recommendation was echoed at the National Conference that recommended that the MOPH make the "Direction des Pharmacies et Laboratoires" in the MOPH functional.

Another finding of the study was that growth of drugs sales through pharmacies more than doubled during the decade, so that sales in pharmacies were more than 4 times higher than the value of drugs budgeted for distribution through MOH/SA facilities. This growth has occurred in spite of the fact that possibilities for expansion of drug distribution and cost recovery for drugs through the private sector have received little attention from donors, and the CREDES study lacks development of strategic options for expanding the distribution of drugs in Niger and their related investment costs.

By early 1992 the MOPH was seeking assistance from donors for emergency aid to purchase essential drugs for MOPH facilities. The initial request did not indicate how the MOPH had estimated the value of drugs required for the emergency program, and at the time of this evaluation, donors were in the process of seeking clarification on this issue.

### **III. FACTORS WARRENTING ADDITIONAL CONSIDERATION IN DESIGN AND/OR IMPLEMENTATION OF HEALTH SECTOR FINANCE REFORMS**

Recommendations for policy reform regarding financial resource allocation and generation, and regarding extension of the pharmaceutical supply system, have been made in public forum in Niger since the "L'Appel de Maradi" in 1983; and continuing through the "Journées d'Etudes" at Agadez in 1984, in Dosso in 1988, in Maradi in 1989; and as recently as the recent "Conference National" in 1991. Given the consistency of the type of reforms recommended over this period, it is worth considering the question of why policy and administrative reforms were not achieved in the health sector financing in Niger.

A. Prioritize Areas for Reform

One reason that the NHSSG may have had difficulty achieving policy reform would be that during at least 1990 and 1991 senior policy makers would have been focussed on changes in the overall political system thus making it difficult to raise a multitude of health policy issues to their attention. While the NHSSG was perhaps AID's first attempt to systematically address the problems of resource allocation and financial sustainability of services in the health sector, in view of the continued deterioration of the economic situation, application of criteria for selecting among financing reforms would seem appropriate for the prioritization of reforms. Criteria such as the magnitude of cost savings or revenue generation and the feasibility of implementation, could have been used to have guided the emphasis of efforts in the health finance area. With regard to Niger it would appear that more emphasis in the future should be given to regular efforts at analysis of the allocation of government and donor budgetary resources with a view to increase the efficiency and equity in the distribution of financial resources for health that are already available. Further, given the level of government, donor, and household expenditure for drugs, increased emphasis should be given to efforts to lower the unit cost of drugs through all outlets in Niger. Finally, given the long run sustainability of drug sales through the private sector, additional thought should be given to providing investment capital for expansion of the system of public, cooperative, and private pharmacies in Niger.

B. Increased Emphasis on Political/Institutional Analyses in Development of Strategies

While studies were conducted under the NHSSG to develop recommendations for change, or illustrate the consequences of particular actions, similar effort was not placed on identifying what interests would both support and resist the proposed recommendations, and on development of strategies to move the recommendations onto implementation. For example, physicians and hospital staff in Niger would directly benefit from improved hospital collections as half of the revenue collected is returned as additional salary benefits. The self-interests of these groups were not fully exploited to put into place improved systems for enforcement of hospital fee collection. On the other hand, labor group resistance to cost recovery for health services blocked adoption of implementation of the Maradi recommendations, and the fact that these groups again raised strong objections to cost recovery at the National Conference highlights the continued political sensitivity of this policy issue, especially during an election year.

C. Organize Studies to Increase Their Effectiveness in Policy Dialogue

The experience of the NHSSG with respect to hospital cost-recovery and cost containment suggests that the disaggregation of hospital issues into a number of small studies may have slowed reform by increasing the number of approvals required for scopes of work, consultants, and draft reports. Further, the large number of studies increased the number of documents which policy-makers had to review to consider recommendations and develop implementation plans. Organization of analyses into fewer studies of larger scope, conducted by teams of expatriates and Nigeriens, with a greater emphasis on synthesis of findings and recommendations, might have provided hospital reform issues with greater visibility and allowed for earlier progress towards implementation. Further, the experience of the NHSSG in the development of the pilot studies of non-hospital cost recovery suggests that increased visibility and effectiveness may be achieved through the development of a committee consisting of the various GON parties for coordination of donor policy dialogue and funding.

D. Short vs. Long Term Technical Assistance

Design of NPA should give careful consideration to the strengths and limitations of short-term technical assistance to achieve policy and administrative reforms. Unless the short-term technical assistance is provided on a repeating and regular basis the consultants are unlikely to be able to develop the necessary understanding of the technical issues and political processes to know what to recommend, nor to have developed the necessary personal relationships through which to influence policy makers. Further, it is unclear whether repeating short-term technical assistance can bring about administrative changes such as those hoped for under the hospital cost recovery and cost-containment components of the project, especially when the number of Nigerian staff with advanced training and senior experience in hospital administration is limited.

Regarding long term technical assistance, comments and recommendations elsewhere in this report regarding the substitution of the work of long term technical assistance for that of host country nationals, resulting in a lack of transfer of skills and long-term institutionalization, pertain to health care financing as well as other areas under the grant. Additional investment in long-term training of host country nationals would facilitate the transfer of skills through later on-the-job training.

E. Increase Incentive Value and Sustainability of Use Counterpart Fund

As discussed in more detail elsewhere in this report, the structure of the benchmarks and counterpart fund mechanism did not

clearly identify the financial reward for making a particular policy change, nor allow the funds released to be used immediately for implementation of the policy change.

The guidance for use of the counterpart funds, while providing flexibility for their use in the implementation of reforms and financing of Child Survival activities, did not serve as a good mechanism for programming recurrent budget support for health sector programs. Conditions precedent for each tranche were not met on a regular year by year basis leading to lack of certainty about when tranches would be available. Decertification of the Grant further delayed the availability of NHSSG funds when conditions precedent had been met. Proposals are submitted for consideration as though in a competition for investment funds, when in fact the inputs requested and activities to be funded are most often recurrent in nature. Had the tranches of the NHSSG been released on an annual basis as planned, they would have been equivalent to about 10 percent of the overall recurrent budget, and 20 percent of the non-personnel recurrent budget resources of the MOH/SA. Released on an ad hoc basis they introduced a significant level of fluctuation in the recurrent resources available to the MOH/SA. Thus the counterpart fund mechanism did not support the development of multi-year programs for Child Survival activities based on expected on-going levels of government and foreign assistance.

Breakdown of the counterpart funds into those to be released for implementation of policy reforms, and into those which are to be programmed as ongoing recurrent budgetary support for Child Survival activities is recommended. The latter funds should be released in pre-determined amounts on an on-going annual basis, perhaps in response to presentation of an annual program plan for the MOH/SA which minimally identifies activities and related financing from all sources for key programs such as EPI, CDD, MCH, VHTs, etc.

F. Strengthen Mechanisms for Donor Coordination in Policy Dialogue and Sectoral Financing

While not directly involved in the NHSSG, problems in the implementation of studies and activities under the policy component of the World Bank's Health project affected the progress of policy and administrative reforms under the NHSSG. While several studies were shifted to be carried out under the NHSSG, responsibility and funds from the Bank project for implementation of reforms were not. In the future, achievement of policy reform and an associated course of action might be facilitated if either: i) a donor has a lead role in setting the reform agenda with the GON with other donors play a supporting role with respect to this agenda, or ii) mechanisms such as the "Comite Pilotage" are developed to coordinate donors' policy dialogue with the GON within a policy area. In addition, the widespread recognition that there should be

more donor coordination in the sector should be turned into action through development of a regular calendar of meetings.

Given the increasingly important role of donor resources in financing the investment and recurrent costs of the sector, recent efforts to track donor financing should be continued, but with information further disaggregated by program, input, and geographic region of the country.

Annex Table 4.1: NIGER - RECURRENT HEALTH EXPENDITURE, 1980-1990

(Millions Current FCFA)

	1980 1/		1985 1/		1989 2/	
	Amount	%	Amount	%	Amount	%
GDP	536,200		705,000			
GON Budget	45,800		70,400		100,291	
% of GDP	8.5%		10.0%			
MOH/SA Budget	3,040	52.4%	4,833	49.6%	6,893	45.9%
% of GDP	0.6%		0.7%			
% of GON RC Budget	6.6%		6.9%		6.9%	
Donor Financing	559	9.6%	1,100	11.3%	2,528	16.8%
Household Expenditure	2,200	37.9%	3,816	39.1%	5,582	37.2%
Hospital Fees 3/	65		116		280	
Drug Purchases 4/	2,135		3,700		5,302	
TOTAL HLTH EXPENDITURE						
Nominal Terms	5,799	100.0%	9,749	100.0%	15,003	100.0%
Real Terms						

## Notes:

- 1/ Unless other wise noted, figures for 1980 and 1985 are from: Kelly, et.al. (1985)
- 2/ Unless otherwise noted, figures for 1989 are from: Wong & McInnes (May 1991) Figures for 1989 used in lieu of figures for 1990 as the budget for that year comprised 15 months.
- 3/ Hospital fees for 1985 from Djbrilla, K. (Juin 1990), tableau 29. Hospital fees for 1980 and 1989 estimated from trend data from the same report.
- 4/ Household expenditure for drugs for 1980 from: Metz, X. (Fevrier 1984), p. 23. Sales to other clients (private pharmacies and depots increased by 50% to account for mark-ups). Household expenditure for drugs for 1989 from: CREDES (Mars 1991), p. 16. Household expenditure for drugs for 1985 estimated as mid-point from other estimates.

Annex Table 4.2: NIGER - ALLOCATION OF FINANCING BY INPUT CATEGORY

	1980 1/		1985 1/		1989 2/		1990 2/	
<b>GON BUDGET</b>								
Personnel	1,368	45%	2,487	51%	3,593	52%	3,725	58%
Medicines/Vaccines	942	31%	1,150	24%	1,400	20%	1,224	19%
Transport	304	10%	360	7%	315	5%	247	4%
Other	426	14%	836	17%	1,585	23%	1,258	19%
<b>TOTAL GON</b>	<b>3,040</b>	<b>100%</b>	<b>4,833</b>	<b>100%</b>	<b>6,893</b>	<b>100%</b>	<b>6,453</b>	<b>100%</b>
<b>DONOR FUNDING</b>								
Personnel	n.a.		n.a.		500	20%	n.a.	
Medicines/Vaccines	n.a.		n.a.				n.a.	
Transport	n.a.		n.a.		2,028	80%	n.a.	
Other	n.a.		n.a.				n.a.	
	n.a.		n.a.		2,528	37%	n.a.	
<b>TOTAL</b>								
Personnel	n.a.		n.a.		4,092	43%	n.a.	
Medicines/Vaccines	n.a.		n.a.				n.a.	
Transport	n.a.		n.a.		5,328	57%	n.a.	
Other	n.a.		n.a.				n.a.	
	n.a.		n.a.		9,421	100%	n.a.	

Sources:

1/ Kelly, P. et.al. (1985).

2/ Wong, H. and McInnes, K. (May 1991).

Details on breakdown of 1989 budget by input category from Colomier, J.P. (Decembre 1991).

Annex Table 4.3: NIGER - HEALTH SECTOR EXPENDITURE BY TYPE OF SERVICE

(Millions FCFA)

	1985 1/		1989 2/		1990 2/	
	Amount	%	Amount	%	Amount	%
<b>GON BUDGET</b>						
Hospital	2,417	50%	3,895	57%	3,743	58%
Non-Hospital	1,933	40%	2,206	32%	1,936	30%
Schools	0		138	2%	129	2%
Central Admin.	483	10%	620	9%	645	10%
<b>SUB-TOTAL</b>	<b>4,833</b>	<b>100%</b>	<b>6,893</b>	<b>100%</b>	<b>6,453</b>	<b>100%</b>
<b>DONOR FUNDING</b>						
Hospital	n.a.		31	1%	n.a.	
Non-Hospital	n.a.		1,888	75%	n.a.	
Schools	n.a.		24	1%	n.a.	
Central Admin.	n.a.		619	24%	n.a.	
<b>SUB-TOTAL</b>			<b>2,528</b>	<b>100%</b>	<b>n.a.</b>	
<b>GON + DONOR</b>						
Hospital	n.a.		3,926	42%	n.a.	
Non-Hospital	n.a.		4,094	43%	n.a.	
Schools	n.a.		162	2%	n.a.	
Central Admin.	n.a.		1,240	13%	n.a.	
<b>TOTAL</b>	<b>n.a.</b>		<b>9,421</b>	<b>100%</b>	<b>n.a.</b>	

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Sources:

1/ USAID/Niger (July 1986) NHSSG PAAD.

2/ Wong, H. and McInnes, K. (May 1991). Inconsistancies in figures reported in this document corrected through application of reported percentages to sub-totals for GON budget and donor financing.

Annex Table 4.4: NIGER - HOSPITAL RECURRENT BUDGET AND REVENUES, 1982-1988

	(Million FCFA)			
	1982	1984	1986	1988
MOH/SA BUDGET	3,805.1	4,451.0	5,071.1	5,895.4
<b>HOSPITAL BUDGET</b>				
Assumption 1	1,902.6	2,225.5	2,535.6	2,947.7
% MOH/SA Bdgt	50.0%	50.0%	50.0%	50.0%
Assumption 2	1,719.9	2,154.3	2,616.7	3,230.7
% MOH/SA Bdgt	45.2%	48.4%	51.6%	54.8%
<b>HOSPITAL REVENUE</b>				
Niamey National	71.2	68.1	99.1	151.0
LaMorde	0	0.0	0.0	10.1
Zinder National	0	8.5	10.5	10.4
Other CHDs	5.4	16.5	32.4	50.9
<b>TOTAL REVENUE</b>	<b>76.6</b>	<b>93.1</b>	<b>142.0</b>	<b>222.4</b>
% Hosp Bdgt 1/	4.0%	4.2%	5.6%	7.5%
% Hosp Bdgt 2/	4.5%	4.3%	5.4%	6.9%

Notes:

Assumption 1: Hospitals' share of MOH/SA recurrent budget a constant 50%.  
 Assumption 2: Percent of MOH/SA budget to hospitals estimated at 50% in 1985 and at 58% in 1990. Assumed that rate of change before and after 1985 was 1.6% per year.

Source: Djibrilla, Karamako (Juin 1990) Analyse des Budgets de Fonctionnement et d'Investissement du Secteur Sanitaire au Niger, Tableaux 8 & 29.

B

## ANNEX 5

### THE NATIONAL HEALTH INFORMATION SYSTEM

#### SYSTEME NATIONAL D'INFORMATION SANITAIRE (SNIS)

##### A. Background

The Development of a health management information system for the Ministry of Public Health (MOPH) of Niger has been a focus of USAID activities since 1984. Under the Rural Health Improvement Project (RHIP), USAID provided technical assistance and computer equipment to help develop data available to the Ministry and the means to analyze it. This included the development of databases on the infrastructure, vehicles, and improvements in the infectious disease reporting system.

Under the Niger Health Sector Support Grant (NHSSG), the development of "routinized data collection, analysis, and feedback...by the MOH"<sup>1</sup> became the focus for institutional reform within the Ministry. This reform was intended not only to provide data for Ministry planning and to develop a health planning process within the Ministry, but also could assist in monitoring the effect of policy and institutional reforms undertaken under the grant.

During the past four years, the technical assistance team has worked with the Ministry to standardize the methods of reporting by developing the standardized reporting forms to be used by health facilities, by standardizing the modes of data recording, synthesis, and transmissions, and by installing computers at the central Ministry to permit rapid analysis. Short-term technical assistance has been provided to evaluate and improve the EPI reporting system and to program computers.

The reports are synthesized by the Districts (Circonscription Medicale) and sent to the Departments where they are again synthesized and sent on to the central Ministry. At the Ministry, vaccination reports are analyzed by the EPI program; most of the other reports are directed to the DEP for analysis.

**B. Analysis of System's Functioning:** The Health information system is referred to as the SNIS, (National health information system).

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<sup>1</sup> Agency for International Development, Niger Health Sector Support Program, Program Assistance Approval Document, July 1986, Vol. I, II-10.

## **1. Data Collected:**

As of 1990, new reporting forms were introduced for health centers throughout Niger, mandating quarterly reporting on morbidity, pre- and post-natal consultations, vaccinations, nutritional surveillance of children, infant consultations, and family planning activities. Hospitals are not yet included in this reporting system. The Ministry is planning to develop the necessary tools to include hospitals during 1992, although one expatriate expert thought it would take at least two years to implement that sub-system.

From the vantage of the DEP offices in the Ministry, it is not easy to see how complete reporting is. An evaluation of the system at the end of 1990 suggested that there were considerable gaps in reporting.<sup>2</sup> These studies triggered a memo from the Ministry reiterating the Ministry's standards for reporting and responsibilities for transmission of reports.<sup>3</sup> More recent data shows more complete reporting, even if some problems persist. We were told that these problems were caused not so much by the failure of health facilities or regional health authorities to complete reports, but by failures in transmission of the reports. For example, the DEP's records were missing several reports from Zinder Department for the first three quarters of 1991, while we were told, the Department itself had a full record of all reports.

In addition, the Ministry has several other sources of data. Under the RHIP, a data base of health facilities and logistics management (vehicles) had been established in the Direction of health facilities (DES). This has not been kept up to date. On the other hand, the Direction of Administrative Affairs and Finance (DAAF), which also received support under the RHIP and under the NHSSG for its database on personnel, has kept it functioning and up-to-date.

## **2. Organization, Management, and Resources of the System:**

At the central Ministry, management of the SNIS is officially within the DEP's Bureau of Statistics and Epidemiology (which is subsumed under its Division of Studies and Statistics), but other directorates and programs also manage and process data, particularly, the EPI program, the Diarrheal Disease Program, as well as the DES and DAAF noted above. The Grant program has

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<sup>2</sup> See John R. Izard, "Evaluation de la Mise en Oeuvre du Systeme National d'Information Sanitaires," April 1991.

<sup>3</sup> Ibrahim Magagi, "Note d'Information," DEP (February/March 1991).

provided support to these other programs and directorates to develop their information systems.

Since the beginning of the Grant, and since the creation of the DEP in 1988, and its official designation in 1990, the Bureau of Statistics has always been short staffed. This shortage has prevailed even while the DEP as a whole increased its permanent professional staff from 10 to 15. In 1989, the Bureau of Statistics had two permanent professional staff and one technical assistant from Tulane. In November 1989, Dr. Nancy Mock prepared a report on the organization and staffing needs of the DEP which recommended reorganization of the Bureau of Statistics and proposed an increase of staff to six professionals.

In 1992, at the time of this evaluation, despite considerable increases in demands upon the Statistics Bureau to process and analyze data as well as to provide support to other programs and directorates, the Bureau had increased only to three permanent staff: a chief, a librarian, and an epidemiologist.<sup>4</sup> In addition, a computer technician had been hired through counterpart funds, and one person was working as a volunteer.

We found some uncertainty about how the work of the Bureau of Statistics was organized and who was responsible. There had been no staff meetings since the new chief had taken over many months ago. We observed in 1992, as evaluators had in 1989, that most of the logistical and analytical work undertaken by the Bureau, continued to be carried out by the Tulane technical assistant who did not appear to be providing support for the organization of Bureau work.

Since 1985, USAID has provided the Ministry with computer equipment to permit easy data storage and analysis. Twelve computers had already been provided in 1985 during the RHIP. In 1989, an additional seven computers were provided, most of them assigned to the DEP. As of August 1991, only two of these were in excellent condition, while eight were no longer functional, and the rest required repairs at least once every six months.<sup>5</sup> These high computer mortality and morbidity rates suggest some of the problems of maintaining computerized systems under Sahelian

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<sup>4</sup> The former chief of the Statistics Bureau had, since the appointment of a new chief, found employment on Demographic and Health Surveys outside the Ministry. No one could tell us if or when he would return.

<sup>5</sup> Direction des Etudes et de la Programmation, Ministère de la Santé Publique, "Dossier de Requete a la subvention au Developpement Sanitaire pour le Sous-Projet, S.N.I.S", December 4, 1991, Annexe 1.

conditions without intensively protected environments and careful maintenance programs.

The information system has benefitted from the Sector Grant through the activities of the technical assistants and also directly from the Counterpart funds. The information system was funded as a sub-project under the first tranche counterpart funds with FCFA 146 million, of which 73 percent was spent before funds were blocked by the Treasury and the Grant was decertified. These funds provided for evaluation of the system, as well as the development, printing, and distribution of the reporting forms. The information system has requested funding for FCFA 107 million for 1992 from the second tranche counterpart funds. The purchase of additional computer equipment is planned through the use of the USAID project funds.

As far as we could tell, the Ministry of Health has not financed any of the information system's operating costs since the Grant began. In fact, there appears to be no operating budget for the DEP at all, and at least for 1991, we were told, there were no actual operating expenditures for the Ministry as a whole from Treasury funds.

### **3. Analysis, Dissemination, and Uses of Data:**

The Bureau of Statistics has produced tables, graphs, and maps of 1990 data from the health facility reporting system, and from the DAAF personnel database. There are data on the major diseases (malaria, diarrheal disease, respiratory infections) as well as major infectious diseases. These tables/charts/maps are available upon request from the Bureau. They have also been sent to the Department Directors (DDS). As of yet, there has been no attempt to assemble a formal document such as a statistical yearbook. In April 1991, when the Ministry put together its analyses of health policy and programs to submit to the National Conference deliberations, it did not appear to use any of the data from the national information system.

When we asked Ministry officials whether they used data from the SNIS, they replied that it was difficult to get at and that they were usually told it was not in a form ready to be used. However, the logbook kept in the computer room since late last year, shows that there have been 10 to 15 requests per month for tables or data. Meanwhile, the DAAF's personnel database has been used as the source of information for planning the assignment of newly graduated health personnel and also to assess the distribution of married female health workers to evaluate the extent of the problem of assigning them to posts where their husbands are located. The DEP is planning in 1992 to publish a bulletin which would provide a more rapid means to disseminate information from the system.

### C. Conclusions

The SNIS has made considerable strides since the beginning of the Grant, particularly with the institution of the routine reporting system from health facilities. It has laid the foundation for an effective and efficient computer-based information system. However, there has also been some backsliding on some of the databases such as the logistics and infrastructure information, which had been established before the NHSSG began.

What is unsettling to the evaluation team is the lack of Ministry involvement in what has been accomplished. There has been little investment in personnel by the Ministry. Needs for staffing have been ignored. Although it may be too much to expect of a government going through severe economic crisis to supply operating funds for an information system which it has recognized as vital to its interests, it is not too much to ask for qualified personnel from a government dedicated to maintaining its civil service employment.

After more than six years of support to its information systems (including the RHIP grant), the Ministry continues to have little sense of ownership of the information system and few cadres who are capable of taking it in hand.

The Evaluation Team heard much about the lack of absorptive capacity of the MOPH for technical assistance. We observed that perhaps the pattern was more one of substitution, substitution of national effort by expatriate effort. This finding suggests that a condition precedent for future development efforts should be the tangible investment of the MOPH in the personnel necessary in order to run an effective SNIS.

**ANNEX 6**

**TABLES**

- 1. 1989 NHSSG Evaluation Recommendations, and Actions Taken**
- 2. Short-term and Long-term Training under the NHSSG**

ANNEX 6 - Table 1  
1989 Midterm Evaluation Recommendations  
and Actions Taken

RECOMMENDATIONS

ACTIONS

a Redefinition of priorities

institution-building e.g. staffing of DEP, staffing of statistical services, restructuring of the secretariat

three economists allocated to DEP  
no new staff for statistical services  
secretariat has been restructured

Give lower priority to the national health plan, redistribution of health personnel, decentralized planning

the MOH is planning to reallocate health personnel in general and women in particular  
the process of decentralized planning has been started and Zinder already has his plan financed by FAC  
other regional plans will be financed by other donors  
but methods for decentralized planning are poorly developed to permit nationwide utilization  
there are no standards nor guidelines for planning  
the TA team has submitted a proposal in their 1991 work plan, but there is no response from the MOH

Use the SNIS data to produce yearly statistical book and further, to develop the national health plan

no action has been taken

b-Immediate actions

-restructuring of the secretariat

the secretariat has been decertified, reorganized and recertified

-study of the reorganization of the DEP

an official decree was prepared by the MSF outlining the structure and responsibilities of the DEP  
despite a December 1990 proposal submitted by the TA team for a study of DEP personnel management, there is no progress

-nomination of one staff member of the BSP to follow the grant and designation of a Nigerian counterpart to every

no action has been taken

Annex 6 - Table 1 (p.2)

long-term upon arrival in Niasey	
-training of the health personnel in the new SNIS	personnel were trained but are not yet given the human and material means to implement the new system
-do the annual review and assessment of the program	no action has been taken by the senior officials of both USAID and the GN
c- Modification of the CPs	
-additional CPs for the second and third installments related to the restructuring of the secretariat, the counterpart funds, the reorganization of the OEP and the statistical services	this proposition is considered by USAID as to be in contradiction of the recommendation of reducing the CPs and focussing on priorities
d- Responsibilities of the GN, USAID and long-term TA	
-more involvement of the Ministry of Plan in the SGP activities and supervision	no much involvement of the Ministry of Plan
-activation of a committee of senior GN and USAID officials	no action has been taken
-nomination of a senior OEP member to monitor policy development	no action has been taken
-USAID should improve its financial monitoring of the counterpart funds and continue to work with other donors	USAID is planning to provide the technical assistance to the secretariat for the installation of their accounting systems and the Tulane TA team will design and implement similar systems for the MSP  there is not yet a formal donor coordination structure dealing with health matters

-the TA should do more technology transfer benefiting Nigeriens	no effort has been made
-the Tulane team should move away from comprehensive studies to isolated studies considering the fact that each policy has its unique environment	no progress has been made
-continue with the TA team at least for two years	the team has been kept for at least two years
-use of recurrent short-term TA	is being done with Abt and JSI consultancies
e- Have indicators of Program Impact	indicators have not yet been developed

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Out of nineteen(19) recommendations, three(3) can be considered as done. three(3) are partially done and thirteen(12) are not done at all. So most of the mid-term recommendations have not been followed.

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**ANNEX 6 : TABLE 2**  
**NHSSB<sub>1</sub> - Short and Long-term Training**  
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Project No.: 683-0254.00 HEALTH SECTOR SUPPORT GR. AUTH: 00/20/86 PACD: 12/31/92

<u>Trainee Name</u>	<u>Train Object.</u>	<u>Sex</u>	<u>Age</u>	<u>Start Date</u>	<u>Complete Date</u>	<u>Pyt Str</u>	<u>Funding Proj/Amend No.</u>	<u>Document Amount</u>	<u>Avg Cost/Partic.</u>	<u>Major Field of Study</u>	<u>Training Facility</u>
<b>Status &gt;ACTIVE&lt;</b>											
NOMA, NOUNKAILA	MS	M	35	01/06/91	12/10/92	N	683-0254.00-1-71054 2	988,139	988,139	MISC PUBLIC HEALTH	TULANE U
<b>Status &gt;ACTIVE&lt; Totals: Participants: 1</b>								<b>Funding:</b>	<b>988,139</b>		
<b>Status &gt;COMPLETED&lt;</b>											
ABDOU, NOUNKAILA	CERT	M	34	03/05/89	05/31/89	N	683-0254.00-1-70895 5	989,640	989,640	ENGL LANG TRNG (ELT)/AMER	GEORGE WASHINGTON U
ABDOU, NOUNKAILA	MPH	M	34	05/31/89	06/11/91	N	683-0254.00-1-70895 5	989,640	989,640	MISC PUBLIC HEALTH	TULANE U
CHAIROU, IBRAHIM	SEN	M	35	06/24/88	02/11/88	N	683-0254.00-1-68835	924,204	912,102	ECONOMIC DEVELOPMENT	U MICHIGAN
DIALLO, ANINATOU EL MADJI AM	CERT	F	31	07/05/91	00/02/91	N	683-0254.00-1-60002 1	914,696	97,348	MISC PUBLIC HEALTH	CTR AFR ETUD SUP GES
GADO, HADIZATOU	DJT	F	34	05/29/90	06/19/90	N	683-0254.00-1-60001	913,500	913,500	MISC PUBLIC HEALTH	BOSTON U
GADO, HADIZATOU	CONF	F	34	06/20/90	06/21/90	N	683-0254.00-1-60001	913,500	913,500	CONTROL OF SPECIAL DISEASE	CENT DISEASE CONTROL
GADO, HADIZATOU	DJT	F	34	06/22/90	09/01/90	N	683-0254.00-1-60001	913,500	913,500	MISC PUBLIC HEALTH	BOSTON U
HADI, GADO	SEN	M	39	06/26/91	07/10/91	N	683-0254.00-1-60007 1	90,889	92,963	MALARIA ERADICATION	U DUAG-INST U TECH
HANIBOU, NIYE	SEN	M	33	02/06/88	02/26/88	N	683-0254.00-1-60709	914,980	97,490	MANAGEMENT TRAINING	USAID/SENEGAL
HAROUNA, HANIBOU	SEN	M	30	06/24/88	08/11/88	N	683-0254.00-1-68835	924,204	912,102	ECONOMIC DEVELOPMENT	U MICHIGAN
HAROUNA, HANIBOU	SEN	M	30	02/08/88	02/26/88	N	683-0254.00-1-60709	914,980	97,490	MANAGEMENT TRAINING	USAID/SENEGAL
ISSAKA, IBI	CERT	M	34	06/03/91	06/21/91	N	683-0254.00-1-60006	92,495	92,495	MISC PUBLIC ADMIN	CTR AFR NGHT/PERF CD
HAGAGI, IBRAHIM	CERT	M	32	03/05/89	05/31/89	N	683-0254.00-1-70894	955,676	955,676	ENGL LANG TRNG (ELT)/AMER	GEORGE WASHINGTON U
HAGAGI, IBRAHIM	MS	M	32	06/01/89	00/22/90	N	683-0254.00-1-70894	955,676	955,676	GENERAL PUBLIC HEALTH	BOSTON U
HANOUDOU, MARIAMA	SEN	F	24	06/26/91	07/10/91	N	683-0254.00-1-60007 1	90,889	92,963	MALARIA ERADICATION	U DUAG-INST U TECH
HAOUDE, HANISSOU	CERT	M	33	03/05/89	05/31/89	N	683-0254.00-1-70896 1	961,676	961,676	ENGL LANG TRNG (ELT)/AMER	GEORGE WASHINGTON U
HAOUDE, HANISSOU	MPH	M	33	06/01/89	12/23/90	N	683-0254.00-1-70896 1	961,676	961,676	MISC PUBLIC HEALTH	TULANE U
NOMA, NOUNKAILA	CERT	M	34	00/06/90	12/31/90	N	683-0254.00-1-71054 2	988,139	988,139	ENGL LANG TRNG (ELT)/AMER	GEORGE WASHINGTON U
SIBBO NOUNOUNI, BAOUBA	CERT	M	32	07/05/91	00/02/91	N	683-0254.00-1-60002 1	914,696	97,348	MISC PUBLIC HEALTH	CTR AFR ETUD SUP GES

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ANNEX 6 - TABLE 2

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Project No.: 683-0254.00 HEALTH SECTOR SUPPORT GR. AUTH: 08/28/86 PACD: 12/31/92 (...cont'd)

<u>Trainee Name</u>	<u>Train. Object.</u>	<u>Sex</u>	<u>Age</u>	<u>Depart Date</u>	<u>Complete Date</u>	<u>Pvt S/r</u>	<u>Funding Doc/Amend No.</u>	<u>Document Amount</u>	<u>Avg Cost/Partic.</u>	<u>Major Field of Study</u>	<u>Training Facility</u>
Status >COMPLETED< (.....cont'd)											
ZAGBI, SAMI	SEN	M	39	06/26/91	07/10/91	M	683-0254.00-1-60007 1	\$8,889	\$2,963	MALARIA ERADICATION	U QUAB-INST U TECH
Status >COMPLETED< Totals: Participants: 20								Funding:	\$607,887		

Project No.: 683-0254.00

[ TRAINING ACTIVITY SUMMARY ]

Participants: 21	Men: 16	Planned: 0	Transfers: 0	Funding: \$696,026
	Women: 5	Active: 1	Cancelled: 0	
		Completed: 20	Terminated: 0	
		Pvt Sector: 0	Non-Returned: 0	

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R E P O R T S U M M A R Y

Trainees:	<u>21</u>	Planned:	0	Transfers:	0	Funding:	\$696,026
Mens:	16	Active:	1	Cancelled:	0		
Women:	5	Completed:	20	Terminated:	0		
		Pvt Sector:	0	Non-Returned:	0		

[ Note: Trainees who have transferred are accounted for separately and are not included in summary figures for Trainees. ]

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