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<b>15. Supplementary Notes</b> This paper is one of a series by the author on the topic of private sector financing of primary health services in Africa. The series includes Rwanda, Somalia, Upper Volta, Niger, Senegal, Liberia, Sierra Leone, Swaziland, and an Overview & Recommendations chapter.		<b>13. Type of Report &amp; Period Covered</b> Final, 1978 to 1983	
<b>16. Abstract (Limit: 200 words)</b> A survey of the literature on private sector support for primary health care was conducted for Niger. While it is recognized that Niger is a very poor country whose citizens suffer among the worst health conditions in the world, it is also recognized that a) external assistance for recurrent costs is growing less acceptable over time, and b) the vast majorities of poor populations in Africa do not rely on their national governments to provide services; they self-treat and rely on the services of traditional and self-styled practitioners. Any discussion of Niger must take notice that there are, at minimum, in Niger two societies within one border. The majority consists of the sedentary farmers (80%): the remainder are nomadic herders beyond the reach of the government. Findings, Conclusions, and Recommendations: Among the sedentary population, 1) Data have been collected in the Maradi Department regarding cost of primary care and utilization of such care. They have yet to be analyzed. 2) Investigate why more Village Health Teams have not yet been established. Are the constraints training, lack of effective demand for their services, and/or the poor transportation system? Among the nomadic population, 1) investigate the willingness of the nomads to pay for health services, considering especially the seasonal effects on the income stream of a private sector project. Eleven item bibliography.			
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**PRIVATE SECTOR RESEARCH RETRIEVAL AND ANALYSIS PROJECT**  
**Project No. 698-0135-3-6134605**

**NIGER**

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**PLEASE NOTE**

This paper is one of a series by the author on the topic of private sector financing of primary health services in Africa.

The titles in the series are the following:

"Private Sector Research Retrieval and Analysis Project: Somalia," October 18, 1983, NTIS Accession Number JDMCG/TR-83/1

"Private Sector Research Retrieval and Analysis Project: Liberia," November 29, 1983, NTIS Accession Number JDMCG/TR-83/2

"Private Sector Research Retrieval and Analysis Project: Upper Volta," December 20, 1983, NTIS Accession Number JDMCG/TR-83/3

"Private Sector Research Retrieval and Analysis Project: Niger," January 22, 1984, NTIS Accession Number JDMCG/TR-84/1

"Private Sector Research Retrieval and Analysis Project: Zimbabwe and Lesotho: Bibliographies," February 16, 1984, NTIS Accession Number JDMCG/TR-84/2

"Private Sector Research Retrieval and Analysis Project: Rwanda," February 22, 1984, NTIS Accession Number JDMCG/TR-84/3

"Private Sector Research Retrieval and Analysis Project: Swaziland," March 8, 1984, NTIS Accession Number JDMCG/TR-84/4

"Private Sector Research Retrieval and Analysis Project: Senegal," June 1, 1984, NTIS Accession Number JDMCG/TR-84/5

"Private Sector Research Retrieval and Analysis Project: Sierra Leone," June 2, 1984, NTIS Accession Number JDMCG/TR-84/6

"Private Sector Research Retrieval and Analysis Project: Overview and Recommendation - Household Expenditure Survey," June 2, 1984, NTIS Accession Number JDMCG/TR-84/7

## I. Introduction

The following paper is addressed to the issue of private payment for health services in Niger. While it is recognized that Niger is a very poor country whose citizens suffer among the worst health conditions in the world, it is also recognized that

a) external assistance for recurrent costs is growing less acceptable over time, and

b) the vast majorities of poor populations in Africa do not rely on their national governments to provide services; they self-treat and rely on the services of traditional and self-styled practitioners.

A quick look at the human resources in the health systems in Niger (1981) supports the preceding assertions. Data were unavailable regarding the Village Health Workers, the backbone of the rural system. For a country of 5.8 million persons, the following human resources were reported:

Physicians	102
Nurses	317
Nurse Auxiliaries	716

Any discussion of Niger must take notice that there are, at a minimum in Niger, two societies within one boundary. The majority (80%) consists of the sedentary farmers. They are the Nigeriens best known to the world. The others, the nomadic herders, are, to a great extent, beyond the reach of the government. While this makes them harder to describe, one feels intuitively that they could well benefit from private sector activities.

Some definitions are in order at this point. The private sector is that portion of the economy which does not receive government support exclusively. Purely private organizations (which receive no government support), publicly subsidized organizations, and community supported organizations are within the purview of this paper. The definitions are not arbitrary; we seek to know more about how individuals and groups attempt to build their self-reliance with regard to their health.

The purpose to this paper is to collect and synthesize what is known (primarily from among published sources available in the U.S.) about private financing of health services. The paper is organized in the following sections: in Section II are presented the Major Findings and Conclusions. As appropriate, recommendations are made which will fill in gaps, exploit valuable data resources, or better define a public policy issue. The last Section, III., is a discussion of the findings upon which this paper is based.

## **II. Major Findings, Conclusions, and Recommendations**

A. Within the sedentary, agricultural sector there is a strong tradition of community financed primary care.

1. Visit the Maradi Department and collect and analyze data which has already been collected. Specifically search for cost and demand related data for analysis.

2. Visit Village Health Teams in other parts of the country and review their revenue generating activities.

3. Visit Village Pharmacies and analyze the records

they keep.

In some cases the Village Pharmacies are the repositories for the Village Health Team records as well as their own records.

4. Conduct small sample surveys in unserved parts of the country and collect simple statistics regarding where people go to receive care, how they pay for such care, how much they pay, and, ideally, how large their incomes are.

5. Investigate why more Village Health Teams have not yet been established. Is the constraint the trained personnel? The lack of an effective demand? The weakness of the transportation system?

B. Within the nomadic, pastoralist sector there is only recent experience with modern health services. In light of the nomads distrust of government services, there may be an opportunity to help set up nomads in private practice, selling medicines, for example.

1. Monitor the activities of the Livestock Project's economist as the economist constructs the model of the pastoral health sector.

2. In cooperation with the economist, investigate the willingness of the nomads to pay for health services, considering especially the seasonal effects on the income stream of a private sector project.

3. Conduct small sample surveys among the nomads and collect simple statistics regarding where people go to receive care, how they pay for such care, how much they pay, and, ideally, how large their incomes are.

### III. Discussion

#### A. Financing Services for the Sedentary Population

Niger has an unusually long history of promoting rural self-financing primary health care services. In 1959 the GON initiated the Maradi Department Rural Health Project which today serves 700,000 people. In brief, it put minimally trained Village Health Teams into villages. The teams consisted of 1 - 2 secouristes (first aid and health promotion workers) and 1 - 2 matrones (birth attendants; often retrained sagesfemmes). District health budgets provided the original capital, from which the first supplies and medicines were purchased. The national government established prices for the medicines. Some common, inexpensive ones were free; e.g., mercurochrome, argyral, and methylene blue. The revenues from sales were to go to replenish the stocks of medicines. The health workers were either uncompensated or compensated in kind: food or donated labor to assist in farming (especially harvesting) activities. Anecdotal reference to this project has indicated it a) was successful in maintaining the supplies of medicines, and b) maintained adequate financial records. A visit to the Maradi Department to inspect some of the records may serve to improve our ability to reach conclusions and test hypotheses regarding longterm financial selfsufficiency in the sedentary Nigerien health sector.

The national Rural Health Program appears modeled after the Maradi Department project. Drugs were sold by the Community Health Workers at a uniform retail price. Revenues went to restocking the supplies and, where surpluses existed, to compen

sate the worker. The national government helped to finance the initial purchases of drugs. The bookkeeping functions went initially to the Village Councils, but later they were transferred to the Community Health Workers. Interestingly, many of the workers come from the families of the village leaders. (Stinson, p. 74) The positions were apparently viewed as privileges. It also served to indicate the support of local leaders for the concept of private selffinanced health services.

Government objectives have called for the expansion of the system and it has expanded, but not at the rate intended. As long ago as 1977 the MOH would only consider support of new Village Health Teams (VHTs) where there was a demonstrated level of village self-help support (auto-encadrement) which will assure the Team's continued functioning. (USAID, 1977, p. 23) Visits to unserved areas should be made to investigate the binding constraints on further and faster expansion.

The position of the traditional provider should be investigated in both settings: those with and those without Village Health Teams. MOH policy should encourage exploitation of the complementarity between the traditional practitioners and the Village Health Teams. At a minimum, the traditional practitioners should be viewed as providers of services for which people are willing to pay. Since 1966, the Village Chief Council (VCC) has advised the MOH that there is an earnest desire to participate in the health delivery system but that the MOH must at least be cognizant of the moral values of traditional medicine and its widespread acceptability. (Ibid., p. 23)

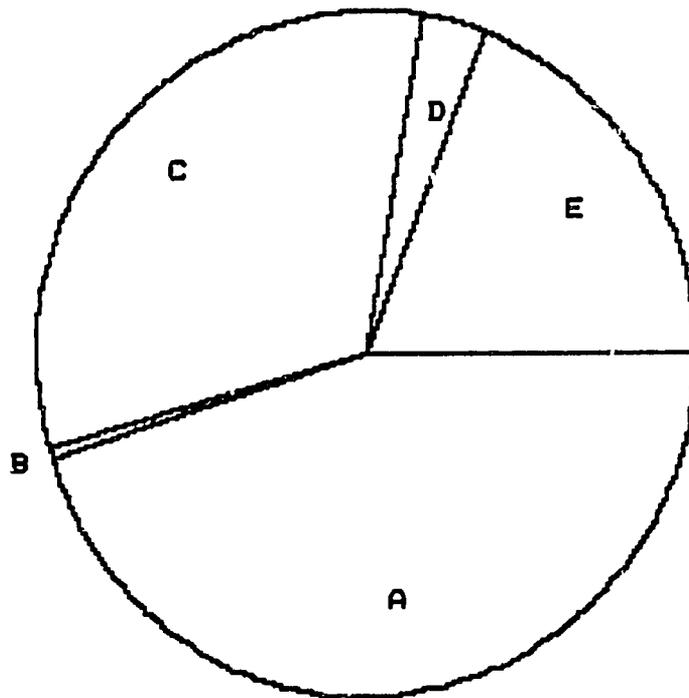
The charts on pages 6A - 6D were constructed from data in

"Les Charges Recurrentes du Secteur de la Sante Publique," by Tankari, et al. They included costs paid by the GON, external assistance, and users. Note the very small portion of the dispensaries' expenditures which went to transport in 1982, yet the very high share of costs going to medicines. Is the cost of transport somehow included in the price of medicines? It would seem likely. Is the cost of transport, then, that of patient transport? If it is, consider direct policy initiatives reducing the cost of transportation, given its large fraction of expenses, especially in health posts. Finally, if transport does refer to patient transport, consider the effects of who pays the cost of transportation on its use. If the patient must pay for his transportation individually, it is likely to interfere with his use of services.

#### B. Financing Services for the Nomads

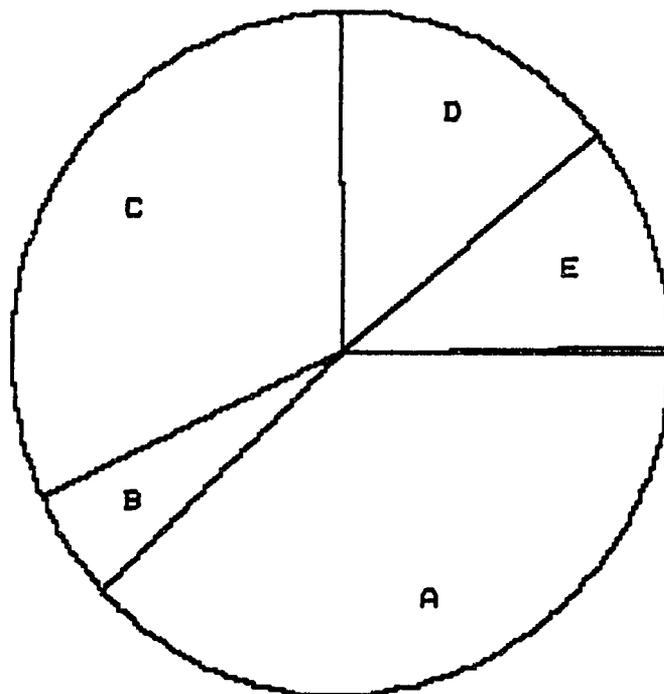
The nomads of Niger have relied, almost exclusively, upon the private provision of health services. They have traditionally viewed the national government in an adversarial role, and show a strong bias against public sector services (except immunizations). Until recently, the only contact the nomads reportedly had with the national government occurred when taxes had to be paid. The government made little effort to reach the nomads with services, and later, when it did, the government health workers were viewed as tax collectors. (Ibid., p. 33) Furthermore, they felt singled out to bear an especially stiff tax burden, so noncompliance was high. Government policy recognized the nomads' increased accessibility each year at the end of

RECURRENT EXPENDITURES IN HEALTH POSTS, 1982  
SOURCE: TANKARI, ET AL



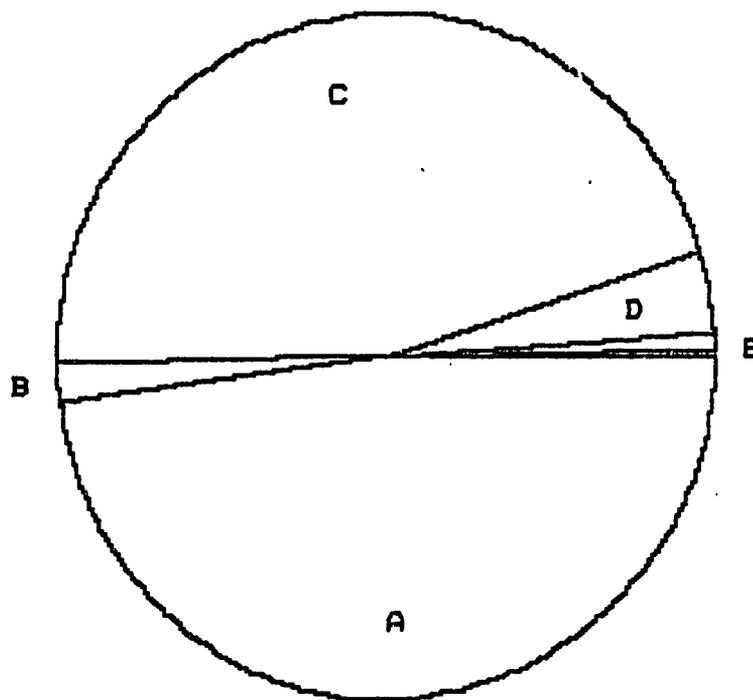
A: SALARIES=45%  
B: ADMINISTRATION=1%  
C: MEDICINES=32%  
D: FOOD AID=3%  
E: TRANSPORT=19%

RECURRENT EXPENDITURES IN MEDICAL CENTERS, 1982  
SOURCE: TANKARI, ET AL



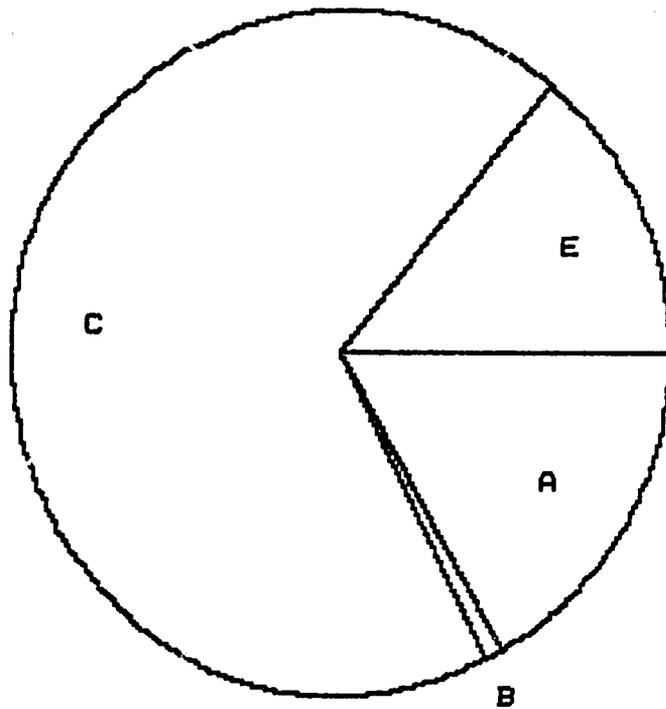
A: SALARIES=38%  
B: ADMINISTRATION=5%  
C: MEDICINES=32%  
D: FOOD AID=14%  
E: TRANSPORT=11%

RECURRENT EXPENDITURES IN RURAL DISPENSARIES, 1982  
SOURCE: TANKARI, ET AL



A: SALARIES=48%  
B: ADMINISTRATION=2%  
C: MEDICINES=45%  
D: FOOD AID=4%  
E: TRANSPORT=1%

RECURRENT EXPENDITURES FOR MOBILE HEALTH TEAMS, 1982  
SOURCE: TANKARI, ET AL



A: SALARIES=17%  
B: ADMINISTRATION=1%  
C: MEDICINES=68%  
E: TRANSPORT=14%

the dry season and attempted contact then, with both health workers and tax collectors. Tax compliance and health service utilization were thus higher at the end of the dry season but only when it was unavoidable.

The nomads are, as a result, strong candidates for private sector activity. Moreover, beyond their distrust and avoidance of government involvement is their higher personal wealth, as compared to the sedentary farmers of the south. Their wealth is embodied in their flocks and a well developed trading system has grown up around the use of animals as the currency of exchange. Thus, they distrust the government and, unlike many other rural African population groups, are presumed to be able to afford to pay for services. (USAID, undated, p. 55) Finally, because their wealth is also a source of high quality protein and other nutrients, their health conditions are less severe than those of the farmers. It may be worth investigating this situation wherein private sector providers, Nigerian or foreign, may find, on the demand side, an interested population able to pay for health services. On the supply side, however, the cost of producing and delivering services to a nomadic population may be overwhelming. The market conditions for private sector services to the nomads deserves attention. As recently as 1977 financial data regarding the cost of producing health services anywhere in the country were absent, making empirical economic analysis impossible. (Ibid., p. 46) A search for data should be made to permit analysis of the market potential for private provision of services. In the absence of such data, simple baseline data should be

collected in the field for preliminary analysis. The Niger Integrated Livestock Production Project called for work by an economist to construct a model of the market and estimate the effect of government policies on prices. The economist is to also determine the subjects of short-term studies that need to be undertaken, bottlenecks where investment in market infrastructure might prove useful, and policy issues that will be investigated. (USAID, 1983, p. 43) The Livestock Project should be the first place to look for this important market analysis.

### C. A Constraint to Private Sector Investment: the GON Investment Code

"The GON investment code has some inherent and systemic problems. All investment projects are subject to GON review and the process often involves long delays. To qualify for GON approval, investment activities must: a) give priority to the use of local materials, b) train Nigerien managers and supervisors, c) open their capital to local investors, and d) obtain government approval of prices prior to sales. Weaknesses of the investment code are: a) benefits granted do not respond to a well-defined industrial development strategy and subsector priorities, b) there are no standard guidelines and methodology to determine which benefits an investment project requires or deserves, and c) there is no gradual transition to competition - when benefits expire, the enterprise must suddenly pay all taxes and face open competition." (USAID, 1983, p.12)

As a condition of receiving continued IMF loans, the GON has had to adopt austere fiscal reforms; primarily subjecting all

government expenditures and donor projects requiring counterpart funding to scrutiny. As a part of those reforms, the GON has directed renewed attention to the private sector, with the hope that the private sector will be strong enough to carry the Nigerien economy after the revenues from uranium slow down. Toward that end the government has stated the following intentions:

- 1) to strengthen existing enterprises, by removing internal and external bottlenecks to their operations, by facilitating their rehabilitation and by giving priority to extension and modernization projects of existing firms;

- 2) to increase the contribution of Nigerien nationals in the development of industries and to assist small and artisan enterprises through the provision of training and credit;

- 3) to give priority to industries which process agricultural/livestock and mining products and to create an industrial base ensuring the country's economic independence in years to come;

- 4) to pursue the promotion of import substitution and export oriented industries to improve balance of trade and develop commerce with neighboring countries. (USAID, 1983, pp.13-14)

The private industrial sector may be a strong candidate for health activities, especially in the formulation and packaging of medicines. The Office National des Produits Pharmaceutiques et Chimiques (ONPPC), the National Bureau for Pharmaceutical and Chemical Products is already involved in such activities. It appears to be a dynamic, expanding organization under strong

leadership (Barokas, et al, 1981, unpagged, Section 2.81) Extreme caution need be taken when attempting to modify the operations of an extant, successful organization in a fragile environment such as that of Niger. At this time, the possibilities of expanding the operations of ONPPC should be investigated, but non-aggressively.

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