

Country Activity Plan

Strategy Statement for Niger 1996–1998

January 1996



Partnerships
for Health
Reform

PHR

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Abstract

The overall objective of PHR assistance is to increase access to higher quality health care services within available Nigerian resources. Efforts will focus on continuing management and cost recovery reform activities in the hospital and non-hospital sectors, and continuing institutional strengthening at the central level MOPH. USAID has programmed intensive decentralization activities at the district level through its pending bilateral health project. Consequently, the mission has requested that PHR focus on central-level activities that strengthen decentralization policy and health financing and management at the national level. Together, these efforts are designed to support and encourage the Government of Niger's goals of decentralization of health services.

After this assessment and activity plan had been prepared, a coup took place in Nepal in winter 1996; therefore these activities were never completed.

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Table of Contents

List of Tables	iii
Acronyms	v
1.0 Executive Summary	1
2.0 Introduction and Methodology	3
3.0 Background	5
3.1 Government of Niger's Health Reform Agenda	5
3.2 USAID's Support for Health Sector Reform in Niger	5
3.3 The Role of Other Donors in Cost Recovery and Cost Containment Reform Efforts	7
3.3.1 Health Reforms and Capacity-Building at the Central Level	7
3.3.2 Health, Nutrition and Population Programs	7
3.3.3 Strengthening Health Districts	7
3.4 Current Status of Reform Efforts in the Health Sector	8
4.0 Needs Assessment	9
4.1 Hospital Sector Reform	9
4.1.1 Policy and Program Issues and Constraints	9
4.1.2 Actions Needed to Complete the Reform Agenda	10
4.2 Financing in the Primary Health Care Sector	12
4.2.1 Policy and Program Issues and Constraints	12

4.2.2	Actions Needed to Complete the Reform Agenda	13
4.3	Central-level Policy Development and Institutional Strengthening	14
4.3.1	Policy and Program Issues and Constraints	15
4.3.2	Actions Needed to Complete the Reform Agenda	16
5.0	Proposed Assistance Under the PHR Project	19
5.1	Overall Strategy	19
5.2	Objective 1	20
5.3	Objective 2	22
5.4	Objective 3	24
6.0	Evaluation Plan	31
7.0	Management Plan	33
7.1	Proposed Staffing	33
7.1.1	In-Country Staff	33
7.1.2	US-Based Staff	34
7.2	Local Office	35

List of Tables

Table 1 Niger PHR Technical Assistance Summary of Objectives, Results,
Performance Measures, and Targets 21

Acronyms

CAP	Country Activity Plan
DDS	Direction Départementale de la Santé (department-level health authority)
DF/GP	Direction de la Formation et la Gestion du Personnel (Office of Personnel Training and Management)
DPHL	Directorate of Pharmacy and Laboratories
DPS	Direction de Promotion Sanitaire
DSNIS	National Information Health System Directorate
FAC	French Cooperating Agency
GON	Government of Niger
HFS	Health Financing Sustainability Project
HPN	Health, Population, and Nutrition
MFP	Ministère de la Fonction Public and du Travail (Ministry of Public Works)
MCH	Maternal and Child Health
MOPH	Ministry of Public Health
NFHD	Niger Family Health and Demography
NGO	Nongovernmental Organization
NHSS	Niger Health Sector Support Grant
NPA	Non-Project Assistance
PDS	Plan de Développement Sanitaire (Health Development Plan)
PHC	Primary Health Center
PHR	Partnerships for Health Reform Project
PNASSP	National Program for Strengthening Primary Health Care
QA	Quality Assurance
RHIP	Rural Health Improvement Project
SNIS	Système National d'Information Sanitaire (National Health Information System)
SNV	Dutch Development Agency
UNFPA	United Nations Family Planning Association
USAID	United States Agency for International Development

1.0 Executive Summary

The overall objective of the Partnerships for Health Reform (PHR) Project's assistance is to increase access to higher quality health care services within available Nigerian resources. Efforts will focus on continuing management and cost recovery reform activities in the hospital and non-hospital sectors, and continuing institutional strengthening at the central level MOPH. USAID has programmed intensive decentralization activities at the district level through its pending bilateral health project. Consequently, the mission has requested that PHR focus on central-level activities that strengthen decentralization policy and health financing and management at the national level. Together, these efforts are designed to support and encourage the Government of Niger's goals of decentralization of health services.

PHR activities will take place in a phased approach over a three-year period. In the first year, PHR will work with Nigerian counterparts to consolidate on-going management work at the country's three National Hospitals, extend selected systems developed for the national hospitals to the Niamey Reference Maternity Center, and strengthen prospects for cost recovery at the National Hospitals. Project activities will also address simultaneously financing, management, and quality of care issues (including both those perceived by patients, and those identified by hospital management and staff). PHR will use a quality assurance approach in the hospitals, shown to be effective in Niger in the primary health care sector in Tahoua, to advance internal hospital reforms and to improve the quality of services being provided.

In the non-hospital sector, we will consolidate on-going work to implement cost recovery nationwide and lay a base for decentralized management of cost recovery. At the central level, we will focus our efforts on capacity building by undertaking joint investigations with the MOPH and, in some cases, with Planning Ministry counterparts, of particular management and financial reform issues critical to successful implementation of envisioned reforms. The focus of our activities will be on PHC cost recovery policy, completing work on a central and decentralized personnel management system, and developing a base for linking hospital and non-hospital sector reforms in financing and decentralization.

In the second year of assistance, PHR will reinforce Year One activities, and add a field demonstration integrating hospital and non-hospital cost recovery and service delivery. Efforts to strengthen resource allocation and management practices will be to the cost recovery objectives from Year One at National Hospitals. In the third year of PHR assistance, we will work with our counterparts to continue the field demonstration, reinforce other Year Two activities, incorporate findings from studies and technical assistance into national policy, and disseminate findings.

PHR's technical assistance approach will emphasize:

- ▲ *Tools for implementation and analysis*, such as strategic programming, cost and demand analysis, budgeting and accounting systems, fee system design, and quality assurance processes.
- ▲ *Capacity building and training for counterparts, teams, institutions*, which can include in-service counterpart training, short-term courses, study tours within Africa as well as to the US, team-building and group setting of objectives, problem analysis, performance monitoring, horizontal cooperation and information sharing across MOPH units and across ministries and NGOs.

- ▲ *Local field demonstration of what works*, and the use of the findings from the demonstration, as well as from other studies to advance policy development through the joint conduct of studies and field demonstration with local counterparts, consensus-building workshops and policy briefs.

After this assessment and activity plan had been prepared, a coup took place in Nepal in winter 1996; therefore these activities were never completed.

2.0 Introduction and Methodology

USAID has been a strong supporter of health sector reform in Niger since the mid-1980s. One of USAID/Niamey's three strategic objectives (SO1) for its 1995–2002 strategic plan is “*the increased use of family planning and maternal/child health (FP/MCH) services and improve child nutrition for lower fertility and infant/child mortality rates.*” The Mission provided PHR with \$400,000 in FY '95 Field Support funds to provide short and long-term technical assistance to continue and consolidate progress made in improving management and cost recovery in the hospital and non-hospital sectors of Niger. The PHR Project sent a three-person team to Niger from December 4–16, 1995 in order to develop a detailed Scope of Work for PHR activities which would contribute to the achievement of SO1 over the next three years. The team was composed of Charlotte Leighton, Ph.D., the PHR Technical Director; Francois Diop, Ph.D., Technical Officer for PHR and previous long-term resident advisor in Niger for the Health Financing and Sustainability (HFS) Project (the predecessor to PHR); and Dale Downes, M.P.A., hospital management consultant to PHR and previous long-term advisor on hospital reform in Niger through the Niger Health Sector Support Grant.

A draft Scope of Work was developed by the team following a series of needs assessment meetings with Niger Ministry of Public Health (MOPH) officials and administrative personnel of the Niger national hospitals and the newly-built Niamey Reference Maternity Center. This SOW was presented to Dr. Dan Blumhagen, HPN Officer for USAID/Niamey at the end of the team's visit. Dr. Blumhagen expressed his approval of the plan that was presented and instructed PHR to prepare a more detailed proposal. This CAP responds to that request and covers activities under the broad area of health reform for a total of three years and at a cost of approximately \$2,000,000.

PHR's assistance over the next three years will assist USAID in achieving several of the expected results under SO1. The project's assistance is most directly targeted towards the achievement of Result 1.3: *Greater financial and institutional support for health services, including policy reform.* This has been the focus of PHR's predecessor project, HFS, in Niger over the past few years and will continue to be the focus of activities under PHR. Cost recovery in the primary health care (non-hospital) sector now needs to move from the pilot stage to national implementation. PHR activities in the area of PHC financing will involve providing assistance to the central level MOPH to develop, monitor and support health reform and the extension of cost recovery nation-wide. This assistance will include helping to identify constraints and search for solutions to policy issues related to health finance and decentralization, helping to finalize legal and administrative rules and decrees, assisting in the development of a fee structure for PHC health services, and assisting in the development of guidelines for district personnel to assist in the implementation of cost recovery. Hospital level activities are designed to accelerate the achievement of hospital autonomy in the country's three National Hospitals and the Niamey Reference Maternity Center through cost recovery and management reform.

PHR activities will also support the achievement of other Results under SO1. For Result 1.1, *Improved FP/MCH services in the public sector (selected districts)*, PHR will help USAID to improve the delivery of quality health services through training in administration, management, finance and quality assurance. As part of hospital management reform under PHR, the project will introduce the use of quality assurance management practices at National Hospitals and the Niamey Reference Maternity. To support Result 1.2, *An expanded and improved private sector, including NGOs, providing FP and MCH promotion and services*, a study of the role of the private sector is planned for the first year of PHR assistance. A policy workshop will be held early in the second year of PHR assistance to translate the results of this study into implementation of health reforms.

Central-level institutional strengthening under PHR will include a review of current policies and development of new policies and guidelines which will expand PHC service coverage by encouraging the participation of private providers. PHR assistance will also support the achievement of *Result 1.5, A public better informed of key policies and legislation affecting citizens' rights and responsibilities (public health)*, by conducting an awareness campaign to build consensus on cost recovery and to lay the groundwork for the establishment of health committees at all PHC facilities, by setting tariffs for health services using data from Niger to determine fees which are affordable by the population, and by monitoring the impact of reform on the population and their ability to pay for services. These activities will help to strengthen the capabilities of local health facilities and authorities to manage their own resources and services, thereby contributing to USAID's goals related to democracy and governance.

3.0 Background

3.1 Government of Niger's Health Reform Agenda

The Government of Niger (GON) has had a strong commitment to the process of decentralization since the mid-1980s. This commitment came about as a result of a poor economy and declining foreign assistance resource base. Upon initiation of the democratization process, the GON initiated a structural adjustment program that cut across all sectors of the government. The structural adjustment program has included among its reform efforts the liberalization of the economic system, the promotion of the private sector, and the development of human resources.

Within the health sector, the GON's policy reform efforts aimed at decentralizing the delivery and financing of health care services have been undertaken within the hospital sector and also within the primary care, or non-hospital sector. These efforts have been greatly assisted by all donors working in the health sector. Donors are realizing that the amount of financial assistance they can provide the GON is becoming increasingly limited and that they must assist the GON in its efforts to increase the sustainability of the health sector. Currently, foreign assistance finances approximately 95% of capital investments and 20% of operating expenses within the Ministry of Public Health (MOPH) budget.

In October 1993 the MOPH finalized its National Health Plan 1994 - 2000. Major components of this plan include the decentralization of the delivery and financing of health care services within the hospital and non-hospital sectors.

3.2 USAID's Support for Health Sector Reform in Niger

USAID has been one of the MOPH's strongest supporters in its efforts to create a more sustainable health care sector. USAID/Niger began its assistance to the MOPH in 1976 with a grant provided to Africare for a health project in the department of Diffa.

In 1978 USAID/Niger initiated its first bilateral project, the Rural Health Improvement Project (RHIP) which continued until 1986. This project focused on training village health workers as a means of improving the health of the rural population by increasing their access to medical care.

In 1986 USAID/Niger initiated the Niger Health Sector Support (NHSS) grant which was the first non-project assistance (NPA) grant effort for USAID in health in Sub Saharan Africa. The NHSS was designed to strengthen the institutional capacity of the GON to identify and implement policy reform efforts in the health sector. The NHSS has been extended through March 31, 1996.

In 1988 USAID/Niger initiated its third bilateral health project -- the Niger Family Health and Demography (NFHD) project. The NFHD project was designed as the first phase of a long-term commitment to assist the MOPH with implementation of family health and population programs. The NFHD project ended on December 31, 1995.

In addition, several centrally-funded projects have been active in health sector reform and related areas. The Quality Assurance project has been working closely with MOPH personnel in the Tahoua Department to introduce QA techniques into the planning and management of primary health care services since 1992. A national QA workshop presenting the results of Tahoua was held in December 1995, and a national Quality Assurance workshop will be held in early 1996 based on the success of Tahoua. The QA project also carried out a measles initiative using QA methods. The BASICS Project is developing and testing approaches for the integrated case management of childhood illnesses in the same two districts -- Say and Boboye -- where the cost recovery pilot tests took place under the HFS Project.

Of the three bilateral projects described above, the NHSS grant has had the most profound impact on decentralizing the delivery and financing of health care services. The NHSS was divided into three phases: evaluation and policy formation; consensus building and policy adoption; and policy implementation. The NHSS focused its efforts on three major areas of reform: financial and human resource allocation; cost containment and cost recovery; and family planning and population policy development. Using a combination of technical assistance and non-project assistance, the NHSS has achieved considerable success in all three areas.

In the area of cost recovery and cost containment, the NHSS has undertaken policy reform and implementation within the hospital and non-hospital (PHC) sectors. Within the hospital sector, the reform efforts concentrated on establishing the three national hospitals as parastatal organizations, and have involved designing the management and financial systems necessary for the hospitals to operate semi-autonomously from the central level of government.

Within the non-hospital sector, reform efforts have involved assisting the MOPH with pilot testing and evaluating two proposed methods of financing primary health care, and with the development of a policy framework which would permit the development and implementation of cost recovery activities in all districts across the country.

The total sum of bilateral assistance provided through the three projects described above has been approximately \$75 million, plus another \$22 million in non-project assistance. Historically, non-project assistance funds have been provided only after the MOPH achieved agreed-upon policy reform goals, and then were deposited in a local bank for eventual disbursement to "sub-projects" which were designed to implement global national health reform goals. The sub-projects were developed by various entities, which for the most part, were not part of the central level of government. Therefore, the development of the sub-projects nurtured and provided budgetary support to the process of decentralization. The USAID mission request for PHR assistance is designed primarily to advance and complement the work carried out under the NPA grant mechanism.

3.3 The Role of Other Donors in Cost Recovery and Cost Containment Reform Efforts

Other donors have played somewhat smaller roles in cost recovery/cost containment reform efforts in Niger. All cost recovery/cost containment efforts undertaken under the NHSS grant were coordinated with other donor activities. A synopsis of other donor efforts is provided below:

3.3.1 Health Reforms and Capacity-Building at the Central Level

In addition to support from USAID under the NHSS grant and HFS, sectoral reforms in the Niger health sector have received variable support mostly from the World Bank and the EEC. At the central level, most of World Bank\IDA and EEC support has focused on restructuring the drug procurement and supply system and the parastatal organization responsible for the purchase of drugs and medical equipments. Most of the support in drug policy development and institutional strengthening is being currently provided by the EEC. In addition to support to sectoral reforms, the World Bank\IDA health project has continued to provide support to capacity building efforts through institutional building at the central ministry, support of in-country training of medical and paramedical personnel, and funding of short and long-term training in public health related fields. A few bilateral donors have continued to provide support in specific areas: the French Cooperation Agency (FAC) in the hospital sector and in the commercial distribution of drugs, and the Belgian Medical Cooperation in medical training and the funding of short-term training in public health.

3.3.2 Health, Nutrition, and Population Programs

In addition to USAID support, major direct support to health related programs have been provided through multilateral donor organizations. A malaria control program has been supported by the World Bank\IDA health project starting in the late 80s. Many donors are contributing to the control of diarrheal diseases program and the extended immunization program. Additional support to maternal and child health and family planning programs are being provided mainly by the World Bank and UNFPA. Finally, the World Bank and UNICEF are providing complementary support to health education and nutrition programs.

3.3.3 Strengthening Health Districts

Since the publication of the national health development plan in 1994 which emphasizes the decentralization of the health system, donor activities are being reoriented towards supporting the development of health districts. Through the Dutch development agency (SNV), EEC support for the development of districts will be focused in the Tillaberi region. UNICEF is currently covering the region of Maradi with the implementation of the Bamako Initiative. Preparation of the second health project of the World Bank is underway and six districts in the Diffa, Maradi and Zinder regions have already been identified. Other bilateral donors providing support to health district development are the Belgian Medical Cooperation in rural districts in the Dosso region and one urban district in Niamey; the French Cooperation Agency in the department of Zinder; and the Canadian International Development Agency in the Dosso region.

3.4 Current Status of Reform Efforts in the Health Sector

Within the hospital sector, the MOPH continues to make progress in its development of the national hospitals as semi-autonomous parastatals. This progress includes:

- ▲ Passage of laws to establish hospitals as parastatal organizations (EPAs) in 1993;
- ▲ Establishment and organization of Boards of Directors and internal management committees at the national hospitals;
- ▲ Finalization, approval, and availability of funds to continue hospital autonomy activities at the national hospitals through the development of hospital sub-projects which use NHSS non-project assistance funds;
- ▲ Appointment of new and enthusiastic management teams at the Niamey National Hospital and the Lamorde National Hospital;
- ▲ Initiation of activities to install a general accounting system at each of the national hospitals through the development of a sub-project which will use NHSS non-project assistance funds;
- ▲ Budget preparation processes developed over the last two years have been implemented for preparation of 1996 budgets;
- ▲ Improvement in revenue collection; and
- ▲ Initiation of activities to decentralize personnel management. National hospitals were expected to assume the role of paying all hospital staff salaries as of January 1, 1996.

Within the non-hospital sector, the MOPH also continues progress toward the decentralization of management systems to the district level, which will permit the nation-wide initiation of cost recovery activities. This progress includes:

- ▲ Finalization and adoption of a national cost recovery policy;
- ▲ Donor contributions of a sufficient quantity of medicines available in country with which to initiate cost recovery activities; and
- ▲ Development and approval of a detailed implementation plan to initiate cost recovery activities on a nation-wide basis scheduled to begin January 1996.

4.0 Needs Assessment

4.1 Hospital Sector Reform

Implementation of management reform and cost recovery at the national hospitals in Niger began in November 1992. Activities to date have focused on: 1) defining the role and responsibilities of the hospitals' governing boards and administrative staffs, 2) improving patient registration and the application of hospital fees, 3) initiating the installation of financial management systems, 4) initiating the installation of personnel management systems, and 5) improving pharmaceutical management. Varying degrees of success in each of these areas have been attained to date.

4.1.1 Policy and Program Issues and Constraints

Progress on the five elements cited above was discussed at a hospital planning conference held in March 1995. The conference was attended by representatives of: the MOPH, the national hospitals, the departmental hospitals, the national reference maternities, and donors. Representatives of each national hospital gave an overview of the progress they have attained to date in management reforms and cost recovery, and discussed the principle issues and constraints confronting them. In addition, summary plans of action were developed to continue management reforms at the national hospitals and to initiate similar reforms at the departmental hospitals and the national maternity reference centers.

Following the planning conference, the MOPH installed new administrative staff at two of the three national hospitals. In addition, the MOPH has decided to slow down the process of hospital autonomy somewhat by delaying the initiation of management reform and cost recovery activities at the departmental hospitals, and focusing instead on continuing these activities at the national hospitals. The MOPH also wants to initiate management reform and cost recovery activities at the newly-built Niamey National Reference Maternity Center.

The PHR team made the following observations concerning the progress towards autonomy and cost recovery at the national hospitals:

- ▲ The central-level of the MOPH continues to need strengthening to use and sustain personnel and financial management systems which will be installed at the hospitals. Simply put, the central-level of the Ministry is not going to support management systems at the district level which is not also available to them.
- ▲ There are conflicting opinions at the central level as to what the role of the Direction de Promotion Sanitaire (DPS) is in relation to the hospitals. The role and responsibility of the Direction de Promotion Sanitaire (DPS) as a regulatory agency needs defining.
- ▲ The roles and responsibilities of the governing boards versus the roles and responsibilities of the hospital administration need to be clarified. In addition, members of the hospital boards are appointed by the MOPH without input from the hospital and with little regard to where board members live and work. As a result, there is little motivation to convene hospital board meetings and when they are convened, they are often very divisive.

- ▲ The national hospitals need to install the accounting systems, which were developed . The financing is in place and a local technical expert has been identified.
- ▲ Initiation of personnel management systems needs to begin immediately, since as of January 1, 1996, the national hospitals are expected to assume the role of paying all hospital staff salaries. The hospitals currently lack the systems to assume this responsibility. Eventually, personnel management responsibilities of the hospitals will be expanded to include hiring and firing, retention, and motivation.
- ▲ Improvements in pharmaceutical management must continue. The national hospitals have been provided very specific recommendations for improving their pharmaceutical management, some of which have be implemented. Baseline indicators to monitor these improvements were established in January 1995.
- ▲ Cost recovery activities should be initiated at the Niamey National Reference Maternity Center. This is a brand new, fully equipped facility which, if adequately staffed, has the capacity to offer high quality service that people would be willing to pay for. This facility has not yet been opened and currently has no staff. Other maternities in Niamey are providing services to a patient population which this facility should be servicing.
- ▲ There is considerable dissatisfaction with the quality of clinical and management support services at the National Hospitals. This dissatisfaction is likely to impede progress towards cost recovery, since people will not be interested in paying for services they continue poor. A concerted effort to improve the quality of care of hospital services therefore needs to accompany cost recovery efforts.

4.1.2 Actions Needed to Complete the Reform Agenda

Legal and institutional framework. The legal documents and administrative decrees adopted in 1992 which established the national hospitals as parastatals (EPAs) need to be revised to reflect the needs identified during the implementation of the EPA process. Thought should be given to the roles and responsibilities of the MOPH, the hospital governing boards, and the hospital administrative staff as identified in these documents. In addition, the composition and selection of the hospital governing boards should be examined to assure selection of the responsible, motivated board members that the hospitals need to ensure success with management reform and cost recovery activities.

Awareness campaigns. Numerous awareness raising efforts need to be conducted. A stakeholder analysis for the national hospitals should be undertaken to. For each stakeholder, such as, a determination of what is to be communicated should be made and an appropriate plan of communication should be devised and implemented.

Team-Building/Quality Management. Team-building and quality assurance concepts and strategies should be introduced to the hospitals, their governing boards, and to the DPS. This approach can be used to create an environment where all workers are dedicated to providing the highest quality of care given the resources available. This would help the various entities involved to better understand their own roles and responsibilities and to make them better communicators. Lack of communication is a significant problem in the MOPH and within the hospitals.

Fee systems. The legal documents finalizing the revised national hospital fee structure need to be adopted by the Conseil des Ministères. Some national hospitals have already started applying the

revised fee structures; those which have not need to start. In the next year, when appropriate cost data is available, the fee structures should be evaluated to ensure that the fees are reasonable in terms of the cost of providing the service and patients' ability to pay.

Financial management systems. The installation of a general accounting system at the national hospitals has been planned for several years. This is a project which has been encouraged by all donors. Financing for the project is available through NHSS counterpart project funds. A local accountant, Mr. Nouhou Tari, has been selected to provide the technical assistance necessary for the installation of the accounting systems and the training of personnel. As of December 1995, the national hospitals had the necessary ministerial authorization to initiate a contract with Mr. Tari. The hospitals need to recruit an accountant from the private sector for Mr. Tari to train. Salary and benefits for the accountant is provided for two years using NHSS counterpart funds. After two years, it is expected that the hospital would pay for the accountant's salary with increased revenues.

Personnel management systems. The hospitals most immediate need is the development of a system permitting them to pay their personnel. This should not be too difficult to design and install. The hospitals currently (and have for years) paid all personnel a monthly bonus, called a *ristourne*. The payment of salaries and *ristourne* should occur at the same time and be incorporated into the same procedure.

Pharmaceutical management. Specific recommendations under NHSS conditions have been provided to the national hospitals regarding the improvement of pharmaceutical management. These recommendations, found in trip reports of Dr. Robert Watt, are very basic procedures designed to improve the accountability of pharmacy management and to ensure continual stocks of essential, generic medicines. These recommendations will be implemented with little difficulty at the Lamorde and Zinder national hospitals. Unfortunately at Niamey National Hospital, certain personnel-related obstacles make implementation difficult. These issues will need to be resolved if implementation is to proceed.

Training activities. On-going training in administration needs to continue at the national hospitals. In addition, training of personnel in basic accounting procedures also must be undertaken. As decentralization of the health sector continues, this need will only increase. There are currently not enough trained personnel in the country to sustain nation-wide decentralization of the health sector. Training modules in health administration and accounting could be developed and installed at the Ecole National d'Administration, the Ecole National de Santé Publique, or both.

Niamey National Reference Maternity. The development of fees based on both costs and the willingness and ability of patients to pay, and the initiation of cost recovery activities at this facility is a high priority of the MOPH. The maternity is in an excellent position to initiate cost recovery, since it has not yet opened. Basic procedures involving patient registration, revenue collection, expense accounting, and budgeting should be developed and introduced at the facility before there is significant patient volume.

Health care resource allocation in Niamey. A resource allocation study within Niamey health care facilities should be undertaken. PHR's assessment found that within Niamey there is considerable duplication of services and unnecessary misappropriation of scarce health care resources. This study could be used as the basis of converting the *Maternité Poudriere* into a district hospital and putting the Niamey Maternity Reference Center into service. This study could also be used as the basis of generating recommendations designed to improve the referral and triage of patients receiving various levels of care within the health care system.

4.2 Financing in the Primary Health Care Sector

After the final evaluation of the pilot tests of cost recovery supported by USAID, the Ministry of Public Health initiated the process of the nation-wide implementation of cost recovery in public primary health facilities. The MOPH has adopted the policy of cost recovery at all public primary health facilities nationwide. Based on the experiences of the pilot tests of cost recovery and the Bamako Initiative and the support of the technical assistance under the NHSS grant, the MOPH has identified many areas where actions will be needed in the coming years in order to enable a coordinated implementation of cost recovery activities throughout the country. Furthermore, the MOPH has developed an institutional framework for the implementation of cost recovery activities and has identified the need to develop a monitoring system for the evaluation of cost recovery performance nation-wide.

4.2.1 Policy and Program Issues and Constraints

The MOPH has developed a national health development plan 1994-2000 (PDS 1994-2000) which is a coherent document of health objectives and strategies. Based on the national plan framework, many districts have already completed, or started developing, their respective health development plan. In the area of cost recovery, nation-wide implementation of cost recovery in the non-hospital sector has been incorporated as a strategy of the national health development. This strategy allows for, or involves, the mobilization of internal resources in order to maintain an equilibrium between demographic growth and resources available to the health sector. In that regard, the national development plan (PDS) for 1994-2000 build from sectoral reforms initiated during the early 1990s with support of the USAID-funded NHSS grant. Cost recovery has been identified as a central component in all district health plans. From the MOPH perspective, implementation of cost recovery activities will be initiated in many health districts starting in 1996 as an integral part of their respective health district development plan. No health district will initiate cost recovery activities without a health district development plan.

There are a number of policy and program issues that need to be addressed in order to effectively initiate and sustain national implementation of cost recovery:

- ▲ Neither national nor district health development plans specify strategies for achieving cost recovery objectives. Since cost recovery is a relatively new policy in the primary health care sector, many district level health personnel, and administrative and traditional authorities are unfamiliar with the central- level Niger health development plan strategies. For example, few district level workers are aware that decentralized management and community participation need to be implemented jointly with the introduction of fees at public primary health facilities. Consequently, regions and districts will need assistance in developing and implementing their health district development strategies related to the cost recovery policy.
- ▲ Although a law on cost recovery for primary health services has been adopted by the Government of Niger, its implementation is hampered by a second law which places the implementation of cost recovery of primary health services under the jurisdiction of local municipalities. Unfortunately, municipal elections to constitute these municipalities are unlikely to take place in the near future. The MOPH is currently attempting to rectify this situation.
- ▲ Similarly, the general population is not well informed of the new cost recovery policies. The MOPH needs to make an effort to broaden and sustain consensus on cost recovery, at the national, regional and local levels, through awareness and educational campaigns.

- ▲ The MOPH is in the process of developing structures and fee levels in the primary health sector that are consistent with health sector objectives and resource constraints. This process needs technical assistance and facilitation. Once it is completed, guidelines for regional and health district managers in setting local tariffs should be developed. The MOPH also needs to define an exemption policy for the poor to be implemented in the primary health sector.
- ▲ Nation-wide implementation of cost recovery will require sustained coordination efforts at the national, regional and local levels in order for fees to be introduced at public health facilities simultaneously with quality improvements. These improvements include the increased availability of essential generic drugs, and training and supervision in the use of diagnostic and treatment protocols.

4.2.2 Actions Needed to Complete the Reform Agenda

The actions identified below have been discussed internally within the Ministry and the inter-ministerial committee which oversees the implementation of cost recovery and had been consolidated in an action plan adopted by the MOPH in November 1995.

Legal and institutional framework. The law on cost recovery needs to be completed by policy decrees and administrative rulings which will specify the mechanisms and institutions for enforcing the law. Moreover, there is a need for these policy and administrative decrees to provide a legal basis for existing district-level health facilities and community-based organizations to be put in place to carry out cost recovery activities in public health facilities.

Awareness campaigns. One of the main challenges that the MOPH will have to face in the coming years will be to sustain the national consensus on cost recovery which developed after the evaluation of the pilot tests and to lay the groundwork for establishing and strengthening community participation. The MOPH will need to launch an information and awareness campaign for political, administrative and traditional authorities, and for local communities. In particular, the population will need to become aware of the introduction of fees, and the effect of cost recovery on the sustainability of improvements in the quality of primary health services.

Fee systems. Failures in coordination of cost recovery activities nation-wide have resulted in a variety of structures and fee levels being implemented in different health districts. This is in conflict with MOPH policy which aims to develop a standardized fee system, with some flexibility. In this regard, the MOPH will need to build from the experience of the HFS pilot tests, the Bamako Initiative, and tariff reforms already enacted in referral hospitals in order to develop a fee structure for health district services which will be tested during a two year period, at the end of which necessary adjustments would be made.

Initial drug stocks. The single most important investment that will be needed for the nation-wide implementation of cost recovery is the establishment of initial stocks of drugs. Many donors have expressed their intention in financing initial drug supplies. Some of these initial stocks are already purchased and are in-country. There is an urgent need to coordinate the establishment and management of this initial stock of drugs at the national level to ensure that all health districts are covered in a timely fashion.

Training activities. In the implementation of its new generic drug policy, the MOPH has made significant steps in the training of health personnel in the use of essential generic drugs following standardized diagnosis and treatment protocols. These two actions have been instrumental in maintaining drug costs at appropriate and low levels at primary health facilities. Training the remainder of health

personnel in the country needs to be completed, and training courses have to be extended to schools that train nurses and midwives. In addition, management systems for tracking drug inventory and cost recovery receipts need to be developed, and health personnel and members of community management committees need training in their use.

Planning at the regional and local levels. Although strategies for district-level implementation of cost recovery have not yet been developed, the regions and districts that participated in HFS pilot tests and the Bamako Initiative have some experience in implementing cost recovery policies. The MOPH needs to build on these experiences and assist other regions and health districts in clarifying their own strategies; identifying intended effects; and developing programs, action plans and budgets for the implementation of cost recovery. This strategic planning process will require sustained and coordinated support from the central MOPH and technical assistance from PHR.

Coordination and monitoring. The implementation of cost recovery nation-wide will involve a number of players, including many central directorates and decentralized entities of the MOPH, other ministries and their decentralized units, non-governmental organizations, and several external partners. Good coordination of the activities of the different players at the national, regional and local levels will be necessary. At the central level, the MOPH needs to reinforce the activities of the inter-ministerial committee which oversees nation-wide implementation of cost recovery. The development of a monitoring system, to be integrated gradually in the health information system (SNIS), is another crucial step.

4.3 Central-level Policy Development and Institutional Strengthening

Important strides have been made in policy development to support health finance and management reforms in Niger during the last four years. Policies now exist that allow national hospitals to begin to function as parastatals with partial financial and management autonomy. Initial steps have been taken to put in place a legal framework for cost recovery of primary health services with the adoption of a law on cost recovery by the National Assembly and the Government in July 1995. New drug procurement policies have already resulted in a substantial shift towards the purchase of essential generic drugs through competitive bidding on the international market. The implementation of overall administrative reforms in Niger simultaneously with the enactment of health sector reforms, such as decentralization, raises new policy and organizational issues for the MOPH. These issues will need to be addressed to facilitate implementation of the national health development plan (PDS) 1994-2000 and to consolidate the health financing reforms into an overall sectoral policy.

4.3.1 Policy and Program Issues and Constraints

The MOPH has consolidated the cost recovery strategy with related strategies of the national health development plan, decentralization of management of health services and community participation, in a national program for strengthening primary health care (PNASSP). The program serves as a vehicle for central-level support to regional and local levels in the implementation of cost recovery policy, and an instrument for coordinating cost recovery activities in the country. An inter-ministerial committee which oversees the national implementation of cost recovery has been put in place in the MOPH. The committee members include central MOPH directors and representatives of ONPPC, as well as representatives of the Ministry of Finance, the Ministry of Interior, and many external donors. The PNASSP has been attached administratively to the General Secretariat of the MOPH and the office

which has implemented the pilot tests has been designated to coordinate the program and cost recovery activities in the country. These institutional arrangements could allow the MOPH to draw on experiences of its staff with the implementation of cost recovery activities, to mobilize resources from all directorates in their respective areas of responsibilities and technical capacities, and to coordinate the interventions of internal and external partners.

Some progress in improving the strategic management capacities of MOPH personnel and institutional development of the MOPH has taken place over the last decade with multi-donor support. The development of the Directorate of Studies and Programming has helped strengthen planning capacities, and the newly created Directorate of Pharmacy and Laboratories (DPhL) is now playing a major role in the area of drug and pharmaceutical policy. ONPPC is currently being restructured to better manage the procurement and distribution of generic drugs nation-wide. The MOPH has started developing computerized personnel and financial management systems at the central level, and is planning to decentralize these systems at the regional level. The health information system (SNIS) has grown as a key instrument of the MOPH in the area of health planning and evaluation. Building on SNIS capacities and the MOPH experience in monitoring the performance of cost recovery during the pilot tests of cost recovery, the MOPH is planning to develop a data collection and analysis system for monitoring cost recovery performance nation-wide.

Issues that still need to be addressed are described below:

- ▲ As the national hospitals generate resources to recover a larger portion of their respective operating costs, the MOPH plans to use savings at national hospitals to reallocate public resources from the hospital and urban sector towards primary and rural health care. To assure maximal cost recovery at hospitals, the MOPH needs to understand and minimize the degree to which cost recovery in hospitals is constrained by current health finance institutions and mechanisms such as health insurance coverage of civil servants, the scope and coverage of private health insurance, and current exemption policies and practices.
- ▲ In addition to the adoption of new fee systems and improvements in management at national hospitals, the MOPH needs to identify policy reforms necessary to facilitate cost recovery in the PHC setting.
- ▲ The modern private health sector is still at an embryonic stage in Niger, concentrated in Niamey and hampered by many factors such as legal constraints, limited access to credit, and high levels of taxation. The MOPH needs to work with private providers to determine the scope and role of the private sector in the provision of health services in the context of reforms aimed at promoting the equity and efficiency of the health system.
- ▲ Important policy and organizational issues related to decentralization still need to be resolved at the policy level. A complicating factor in decentralization is that there are large disparities in institutional and personnel capacities between the central ministry and the MOPH regional and local levels. Consequently, the formulation and successful implementation of health policies, including health finance and decentralization policies, will depend on the ability of the MOPH to mobilize human resources at the central level in order to support personnel in the regions and health districts.
- ▲ The MOPH needs assistance in developing and implementing the cost recovery monitoring system and to integrate this system into the SNIS.

4.3.2 Actions Needed to Complete the Reform Agenda

Adaptation of policies in the context of on-going reforms. Many of the policy and program issues mentioned above have arisen from experience with implementation of hospital reforms and planning the nation-wide implementation of cost recovery. Efforts to identify constraints and search for solutions are naturally better focused in the course of implementation. This process should include the identification of priority issues, conducting desk-top or field-based studies and then using the results of the studies to inform policy and implementation. In particular, an investigation of the performance of health insurance coverage of civil servants, the scope and coverage of private health insurance, and the impact of these systems on equity of access to public health services should be carried out. Furthermore, for the development of the private sector in the provision of health services to be promoted effectively, there is a need for better knowledge of the constraints which limit the growth of private providers in urban and semi-urban areas. The information compiled from these studies could be complemented by data on the demand for health based on existing household survey data available at the central statistical office. Finally, given the Ministry's priority in the development of health districts, it is necessary to carry out an investigation of the operating costs of health districts not only for budgetary purposes, but also to inform the policy debate over health financing and decentralization.

Strengthening management and information systems and the capacity of the MOPH to use these systems effectively. Significant steps have already been taken in the area of personnel and financial management and work has just beginning on a cost recovery information system. A computerized system of personnel management is under development in the Directorate of Personnel Management and Training, and a computerized financial management system is currently being used by the Directorate of Administrative and Financial Affairs to monitor budgets of sub-projects financed through the NHSS grant. The monitoring system for cost recovery needs to be designed to assist in the identification of constraints and achievements of cost recovery (such as, drug consumption costs and levels of cost recovery at PHC facilities), as well as to provide information on the accessibility of primary health care services and the affordability of these services. The use of these systems should strengthen the capacities of the MOPH to manage the national implementation of cost recovery. For these systems to become effective instruments for policy development and management, however, existing systems need to be upgraded and MOPH staff capacities to use them must be strengthened. Reinforcing the integration of the personnel management system and the health information system could be an efficient strategy to improve the MOPH capacities to use these systems.

Policy dialogue. Policy-makers and health managers who implement national policies need to be aware of key legal decrees which affect the sources, institutions and mechanisms of health financing and management. The MOPH has a responsibility to inform the regional and local levels and various stakeholders in the health sector of these policies, and to foster a dialogue between the central level and these other actors in order to better inform the national policy dialogue on health financing and decentralization. Consultations between levels of the health system and different actors would improve the central-level Ministry's capacity to identify areas where additional reforms are necessary or where additional resources are needed to implement existing policies. An effective strategy may be to hold policy workshops targeted at specific policy-makers and stakeholders in order to broaden the dialogue on health finance and decentralization issues, to assist in the identification of areas where additional reforms will be needed in the health sector, and to assist in the coordination of health sector decentralization. The existing cabinet meetings and inter-ministerial committee on the nation-wide implementation of cost recovery would continue to be effective fora for national level debate over policy and program issues related to health finance and decentralization.

Resolving policy issues related to decentralization. There are a number of critical questions related to the decentralization of the health system that need to be resolved. For example, to what level of the system will decentralization of financial management take place? Which decisions -- such as the ability to establish fee rates and to raise revenues, the determination of exemption from payments, and personnel management decisions -- will be made at which level? Which decisions, if any, will be decentralized to elected local councils, as described in the legal documents of the overall administrative decentralization effort, to health district management teams and health district committees, or to health center management committees, as it is planned in the PDS 1994-2000? What funding mechanisms would be developed as instruments to decentralize financing and management: a block grant to local governments which includes funding for health services, or a global budget for health districts? What criteria and mechanisms regarding resource allocation will be put in place in order to minimize inter-regional and intra-regional inequities which currently prevail in the health system or which may result from decentralization? What will be the linkages between the different levels of the health system -- district health facilities, regional hospitals, and national referral centers -- under a decentralized health system? Finally, what will be the role of the central ministry directorates, the current departmental directorates, and health district management teams under a decentralized health system?

Once the answers to these questions are determined, the MOPH will need to develop tools to aid the process, such as regional and local computerized personnel and financial management systems. A focused and continuous effort must be made on the part of the central level of the MOPH to help build and sustain regional and local capacities to carry out new roles defined under the decentralization reforms.

5.0 Proposed Assistance Under the PHR Project

5.1 Overall Strategy

The overall objective of PHR assistance is to increase access to higher quality health care services within available Nigerian resources. Efforts will focus on continuing management and cost recovery reform activities in the hospital and non-hospital sectors, and continuing institutional strengthening at the central level MOPH. USAID has programmed intensive decentralization activities at the district level through its pending bilateral health project. Consequently, the mission has requested that PHR focus on central-level activities that strengthen decentralization policy and health financing and management at the national level. Together, these efforts are designed to support and encourage the Government of Niger's goals of decentralization of health services.

PHR activities will take place in a phased approach over a three year period. In the first year, PHR will work with Nigerian counterparts to consolidate on-going management work at the country's three National Hospitals, extend selected systems developed for the national hospitals to the Niamey Reference Maternity Center, and strengthen prospects for cost recovery at the National Hospitals. Project activities will also address simultaneously financing, management, and quality of care issues (including both those perceived by patients, and those identified by hospital management and staff). PHR will use a quality assurance approach in the hospitals, shown to be effective in Niger in the primary health care sector in Tahoua, to advance internal hospital reforms and to improve the quality of services being provided.

In the non-hospital sector, we will consolidate on-going work to implement cost recovery nationwide and lay a base for decentralized management of cost recovery. At the central level, we will focus our efforts on capacity building by undertaking joint investigations with the MOPH and, in some cases, with Planning Ministry counterparts, of particular management and financial reform issues critical to successful implementation of envisioned reforms. The focus of our activities will be on PHC cost recovery policy, completing work on a central and decentralized personnel management system, and developing a base for linking hospital and non-hospital sector reforms in financing and decentralization.

In the second year of assistance, PHR will reinforce Year One activities, and add a field demonstration integrating hospital and non-hospital cost recovery and service delivery. Efforts to strengthen resource allocation and management practices will be to the cost recovery objectives from Year One at National Hospitals. In the third year of PHR assistance, we will work with our counterparts to continue the field demonstration, reinforce other Year Two activities, incorporate findings from studies and technical assistance into national policy, and disseminate findings.

PHR's technical assistance approach will emphasize:

- ▲ *Tools for implementation and analysis*, such as strategic programming, cost and demand analysis, budgeting and accounting systems, fee system design, and quality assurance processes.

- ▲ *Capacity building and training for counterparts, teams, institutions*, which can include in-service counterpart training, short-term courses, study tours within Africa as well as to the US, team-building and group setting of objectives, problem analysis, performance monitoring, horizontal cooperation and information sharing across MOPH units and across ministries and NGOs.
- ▲ *Local field demonstration of what works*, and the use of the findings from the demonstration, as well as from other studies to advance policy development through the joint conduct of studies and field demonstration with local counterparts, consensus-building workshops and policy briefs.

In developing this Country Activity Plan, PHR used the format at USAID/Niamey's Country Strategic Plan 1995 - 2002. This format lists the main objectives of assistance, and under each one, the expected outcomes -- stated in terms of both general "results" and as specific criteria to measure success ("targets"), as well as the activities to be conducted to meet the objective. The overall program of PHR assistance, including all objectives, results, performance measures, and targets, are summarized in *Table 1*.

5.2 Objective 1

Sustained adoption of management practices improving the cost recovery of Niger's three national hospitals and the Niamey Maternity Reference Center.

Result 1.1:

Sufficient cost recovery and cost containment measures in place at the three national hospitals and the Niamey Maternity Reference Center to permit a shift in the national health budget from hospital to preventive and primary health care services by 1998.

Activities:

1. **Annual analyses of the national health care budget** to determine proportion of budget allocated for primary health care activities versus the proportion of budget allocated to the hospital sector. The annual analyses will be undertaken in collaboration with MOPH and MFP personnel. National health budget data will be grouped into the following global categories: national hospital allocations, departmental hospital allocations, reference maternity allocations, central level (MOPH) allocations, departmental level administrative (DDS) allocations, primary care allocations. Within each global category, budget allocations will be grouped into the following sub-categories: personnel, other operating costs, and capital costs. These analyses will permit the MOPH to analyze and determine the success of the health sector reform activities, and to more appropriately allocate their financial resources.

Table 1
Niger PHR Technical Assistance
Summary of Objectives, Results, Performance Measures and Targets

Performance Measures	Targets	Completion Date	Data Source
<p>OBJECTIVE 1 - HOSPITAL SECTOR Adoption of management practices improving the sustainability and quality of Niger's three national hospitals and Niamey Maternity Reference Center.</p>			
<p>Result 1.1 - Sufficient cost recovery and cost containment measures in the place at the three national hospitals and the Niamey Maternity Reference Center to permit a shift in the national health budget from hospital to preventative and primary health care services by 1998.</p>			
<p>A. Proportion of the national health budget (less personnel salaries) allocated to the three national hospitals and Niamey Maternity Reference Center decreases.</p> <p>B. Increased revenue recovery from all sources at the 4 institutions.</p> <p>C. More cost effective use of personnel and financial resources at the 4 institutions.</p>	<p>A. The proportion of the national health budget (less personnel salaries) allocated to primary health care increases from % to %. (exact percentages TBD after initial baseline completed in July 1996)</p> <p>B.1. Revenue recovery at the three national hospitals and Niamey Maternity Reference Center exceeds the amount allocated for non-salary expenses in the national health budget.</p> <p>B.2. Revenue recovery for services to civil servants at the national hospitals and the Niamey Maternity Reference Center increases from % to %. (TBD after baseline)</p> <p>C. More cost effective use of hospital financial and personnel resources. (Exact measures and targets TBD after cost analysis in April 1996)</p>	<p>Dec. 1998</p> <p>Dec. 1997</p> <p>Dec. 1997</p> <p>Dec. 1997</p>	<p>Ministry of Finance and Plan</p> <p>Hospital Data</p> <p>Hospital Data</p> <p>Hospital Data</p>

Performance Measures	Targets	Completion Date	Data Source
<i>Result 1.2 - An increase capacity of national hospital and the Niamey Maternity Reference Hospital administrators to 1) use quality assurance methodologies, 2) manage financial and human resources of their institutions, 3) cover a substantial portion of non-salary costs through cost recovery mechanisms, and 4) implement effective means testing procedures to assure equity in fee charging practices.</i>			
<p>A. Quality management structure and procedures implemented.</p> <p>B. Quality of clinical services increases.</p> <p>C. Increased knowledge of modern methods of hospital administration.</p> <p>D. Ability to measure hospital costs, by service or department.</p> <p>E. Ability to measure hospital revenues, by service or department.</p> <p>F. Ability to determine personnel needs.</p> <p>G. Increased number of national hospitals/reference maternities participating in cost recovery activities.</p> <p>H. Increased cost recovery rates at the 3 national hospitals.</p>	<p>A. Quality assurance (QA) coordinator and council appointed and key staff trained in each of the three national hospitals and reference maternity.</p> <p>B.1. Each facility shows a 25% improvement in clinical management for specific problem areas (to be identified by the QA councils in each facility).</p> <p>B.2. Patient satisfaction increases by 15% each year.</p> <p>C. 12 national hospital and reference maternity administrators participate in administrative preceptorships/study tours in selected U.S. and regional hospitals.</p> <p>D. Installed and operating general accounting systems in three national hospitals of Niger.</p> <p>E. New hospital tariff systems operating at national hospitals.</p> <p>F. Personnel management systems established at all 4 institutions.</p> <p>G. Participation of the Niamey Maternity Reference Center in cost recovery activities.</p> <p>H.1. The cost recovery rate at Niamey Hospital as a proportion of total operating cost less personnel costs increases from 22% in 1996 (budget) to 50%.</p> <p>H.2. The cost recovery rate at Lamordé National Hospital as a proportion of total operating costs less personnel costs increases from 15% in 1996 (budget) to 50%.</p> <p>H.3. The cost recovery rate at Zinder National Hospital as a proportion of total operating costs less personnel costs increases from 11% in 1996 (budget) to 50%.</p>	<p>1 hosp. by July 1996</p> <p>Tisna?</p> <p>July 1996</p> <p>Dec. 1996</p> <p>July 1996</p> <p>July 1996</p> <p>? 1996</p> <p>June 1996</p> <p>Dec. 1998</p> <p>Dec. 1998</p> <p>Dec. 1998</p>	<p>PHR report</p> <p>Hospital Data</p> <p>?</p> <p>Participants' reports from study tour</p> <p>Field Visits</p> <p>Hospital Data</p> <p>Field visits</p> <p>Field visit</p> <p>Hospital Data</p> <p>Hospital Data</p> <p>Hospital Data</p>

Performance Measures	Targets	Completion Date	Data Source
<i>Result 1.3 - An increased capacity of national hospital and the Niamey Maternity Reference Hospital administrators to manage and assure an adequate supply of appropriate pharmaceuticals.</i>			
<p>A. Improved knowledge of modern methods of hospital pharmaceutical management.</p> <p>B. Pharmaceutical inventory/control systems initiated at the national hospitals.</p> <p>C. Increased proportion of hospital pharmaceutical prescribed or in stock at the hospitals which are generic.</p>	<p>A. 4 national hospital and reference maternity chief pharmacies participate in pharmacy management course in Dakar.</p> <p>B. Pharmaceutical inventory/control systems in place at the 3 national hospitals and reference maternities.</p> <p>C. The percent of drugs stocked by generic name at the national hospitals and Niamey Maternity Reference Hospital increases from 0% 1995 to 50%.</p>	<p>TBD based on date of course</p> <p>?</p> <p>Dec. 1998</p>	<p>Participants' reports from study tour</p> <p>Field visits</p> <p>Hospital Data (Drug Inventory System)</p>
<i>OBJECTIVE 2 - Strengthen capacities to implement, monitor, evaluate, and make necessary policy changes regarding nationwide cost recovery in the context of decentralization reforms.</i>			
<i>Result 2.1 - Increased capacity at the central level to strengthen consensus, mobilize resources, monitor and evaluate performance and coordinate the interventions of internal and external partners in support of the national implementation of cost recovery in the PHC sector.</i>			
<p>A. Increased availability of information to the population on cost recovery policy.</p> <p>B. Coordination of tariff systems in the non-hospital sector.</p> <p>C. Coordination of the constitution of the initial drug stocks for health districts.</p> <p>D. Monitoring of cost recovery performance.</p>	<p>A. Sensitization and awareness campaign on cost recovery policy initiated.</p> <p>B. National guidelines on setting tariffs in the non-hospital sector developed.</p> <p>C. Sources of funding of initial drug stocks for all health districts identified.</p> <p>D.1. Data collection system for monitoring the performance of cost recovery nationwide in place.</p> <p>D.2. Use of monitoring data to evaluate cost recovery performance.</p>	<p>March 1996</p> <p>Feb. 1996</p> <p>July 1996</p> <p>Oct. 1996</p> <p>Dec. 1997</p>	<p>Press Releases</p> <p>MOPH documentation</p> <p>MOPH documentation</p> <p>Field visits and reports</p> <p>Field visits and written reports using 5.3.1D</p>

Performance Measures	Targets	Completion Date	Data Source
<i>Result 2.2 - Increased capacity of the MOPH to assist health districts in implementing their health district plans for cost recovery.</i>			
<p>A. Plans for initiation of cost recovery activities at the regional and local levels developed.</p> <p>B. Increased number of health facilities implementing payments at public health facilities.</p> <p>C. Community participation in management of cost recovery receipts.</p> <p>D. Increased recovery of drug costs.</p>	<p>A. Regional and district plans for the implementation of cost recovery activities available for all regions.</p> <p>B. The number of public health facilities implementing payments for health services increase from 66 in December 1995 to 144.</p> <p>C. A health committee installed at every health facility implementing payments for health services.</p> <p>D. 50% of health facilities implementing payments achieve cost recovery ratios for drugs higher than 100%.</p>	<p>June 1996</p> <p>Dec. 1996</p> <p>Dec. 1996</p> <p>Dec. 1996</p>	<p>Plans (MOPH)</p> <p>MOPH report (semestrial progress report from PNASSP)</p> <p>MOPH report (semestrial progress report from PNASSP)</p> <p>From data collection system under 5.3.1D</p>
<i>OBJECTIVE 3 - Strengthen central level strategic management capacities in health financing and decentralization of health services.</i>			
<i>Result 3.1 - Improved policy environment for health services and health financing and decentralization reforms.</i>			
<p>A. Investigations of key health financing and decentralization issues in Niger completed.</p> <p>B. Identification of constraints and weaknesses in implementation of reforms in the cost recovery and cost containment area.</p> <p>C. Increased policy dialogue towards the development of an overall health sector financing policy.</p>	<p>A. Studies completed on the legal framework, third party payment mechanisms, district level operating costs, demand for curative and preventive services and private health sector.</p> <p>B. MOPH evaluates the performance of implementation of hospital reforms and cost recovery in the PHC sector using PHR assisted studies.</p> <p>C.1. MOPH holds Policy Workshop on Health Financing and Decentralization using PHR assisted studies and the evaluation of implementation performance (A above) and develops draft overall health sector policy.</p> <p>C.2. MOH and USAID/Niger identify NPA conditions related to reforms.</p>	<p>Nov.1996</p> <p>Jan. 1997</p> <p>April 1997</p> <p>April 1997</p>	<p>MOPH/PHR reports</p> <p>MOPH Evaluation Report</p> <p>Draft policy documents (MOPH)</p> <p>USAID/Niger</p>

Performance Measures	Targets	Completion Date	Data Source
<i>Result 3.2 - Institutional strengthening and improved capacity of MOPH staff at the central and regional levels to manage personnel.</i>			
<p>A. Computerized personnel management system functional at the central and regional levels.</p> <p>B. Personnel management system integrated with the SNIS.</p> <p>C. Decentralization of personnel management system extended.</p> <p>D. Increased number of central and regional health personnel trained in operating and using the personnel management system.</p>	<p>A. Computerized personnel system fully functional.</p> <p>B. Personnel management system integrated with the SNIS.</p> <p>C. Number of regions with personnel management system extended from 2 (in 1995) to 7.</p> <p>D. 20 MOPH staff members trained at the central and regional levels.</p>	<p>July 1996</p> <p>July 1996</p> <p>Dec. 1996</p> <p>Dec. 1996</p>	<p>Workshop Report MOPH</p> <p>MOPH Reports</p> <p>Field visits</p> <p>MOPH reports</p>
<i>Result 3.3 - Strengthened service delivery systems at the district and referral hospital levels.</i>			
<p>A. More effective referral system in place leads to more rational use of services by target population.</p> <p>B. Implementation of cost recovery accomplished simultaneously with quality improvements.</p> <p>C. The quality of services increases.</p>	<p>A. Use of hospital outpatient services for PHC needs declines from baseline in demonstration site(s).</p> <p>B. Cost recovery activities begin only after drugs supplies available and training in diagnostic and treatment protocols completed in 100% of facilities in demonstration site(s).</p> <p>C.1. Essential drugs and medical supplies routinely available in demonstration site(s)</p> <p>C.2. Percent of visit for which health personnel follow treatment standards increases from baseline.</p> <p>C.3. Supervision visits routinely made in demonstration site(s).</p> <p>C.4. Patient satisfaction with health services increases in demonstration site(s).</p>	<p>Sept. 1996</p> <p>TBD and refined with MOPH after the first year of assistance</p>	<p>MOPH/PHR report</p>
<i>Result 3.4 - Increased access of the poor and vulnerable groups to quality health services.</i>			
<p>A. MOPH evaluates performance of existing exemption policies in the health sector.</p> <p>B. MOPH develops new or revised exemption policies based on evaluation.</p> <p>C. New exemption policies are more accurate than previous policies.</p>	<p>A. Report on performance of exemption policies completed.</p> <p>B. Revised exemption policies developed.</p> <p>C.1. A higher percentage of the poor receive fee exemptions using the new exemption policy in the demonstration site(s) compared to baseline.</p> <p>C.2. The percentage of the poor and other vulnerable groups using essential MCH services increases from baseline.</p>	<p>TBD and refined with MOPH after the first year of PHR assistance</p>	

2. **Execution of budget processes** at the three national hospitals and the Niamey Maternity Reference Center. During the last quarter of each calendar year, technical assistance will be provided to hospital administrators to initiate execution of the budget processes. During the process, year-to-date expense and utilization data will be used to prepare the proposed budget for the upcoming year.
3. **Installation of a general accounting system at the three national hospitals** and training of personnel in its use. Using non-project assistance funds already designated for this activity, technical assistance will be used to coordinate and supervise the installation of the accounting systems at the national hospitals and the training of hospital accounting personnel. These activities will be undertaken in collaboration with a local accountant.
4. **Introduction of accounting practices at the Niamey Maternity Reference Center.** Technical assistance will be provided to assist the maternity with the preparation of procedures and training of personnel which will permit them to install revenue collection procedures and maintain accurate expense data. All systems to be installed will be manual until the maternity has the resources and technical capacity to install computerized systems.
5. **Study of resource (especially personnel) allocation at all Niamey health care facilities** (both primary care and acute care) with recommendations regarding proposed reallocation of services and personnel to assure more cost-effective delivery of health care services within the city.
6. **Establishment of personnel management systems at the three national hospitals and the Niamey Maternity Reference Center.** Technical assistance will be provided to assist hospital administrators to continue developing job descriptions and to formulate internal personnel policies regarding employee recruitment, retention, performance evaluation, and termination.

Result 1.2:

An increased capacity within the three national hospitals and the Niamey Maternity Reference Center to: 1) manage the financial and human resources of their institutions, 2) cover a substantial portion of non-salary costs through cost recovery mechanisms, and 3) implement effective means testing procedures to assure equity in fee charging practices.

Activities:

1. Introduce **quality assurance management practices** at the national hospitals and the Niamey Maternity Reference Center. A simple, quality assurance management approach will be developed and presented to hospital administrators. The proposed QA approach will emphasize team-building.
2. Design and conduct **hospital study tours** for directors and administrators of the three national hospitals to visit selected hospitals within Africa in order to observe and discuss their management practices. The Africa regional study tour will visit African hospitals in two or three countries that have achieved a certain level of autonomy. The study tour will be organized and managed by Howard University's International Affairs Center, a PHR subcontractor. Howard University staff will also take part in a study tour for national hospital administrators to U.S. hospitals, that will be funded by the NHSS grant.

3. **Monitor and evaluate the impact of the new hospital fee system.** As cost data by department becomes available with the installation of the accounting systems, the data and utilization of services will be analyzed to assure that the tariff system reasonably reflects the actual cost of providing the service.
4. **Propose and develop a fee structure for the Niamey Maternity Reference Center.**
5. **Assess the effectiveness of the current systems to identify the indigent.** Technical assistance will review the current systems the national hospitals have in place to identify the indigent to exempt them from paying fees. PHR will propose modifications to the current means testing procedures, as necessary.
6. **On-the-job training in the use of budgeting, financial management, and patient record systems for improved hospital resource management.** Periodic training will be provided to hospital administrators to support the installation of various management systems. The training will be informal and conducted in the work place, to complement the formal training to occur when the various systems are actually installed.

Result 1.3:

An increased capacity of national hospital and the Niamey Maternity Reference Hospital administrators to manage and assure an adequate supply of appropriate pharmaceuticals.

Activities:

1. Participation of pharmacists from the four hospitals in the **pharmacy management course in Dakar, Senegal.**
2. **Assistance in establishing modern pharmaceutical management practices at the four hospitals** to increase the efficient use of pharmacy resources. Technical assistance will be provided to the hospital pharmacists by a pharmaceutical management consultant to continue implementation of the recommendations provided during the last two years.
3. **Assistance in monitoring and evaluating pharmacy management** at the national hospitals and Niamey Maternity Reference Center.

5.3 Objective 2

Strengthen capacities to implement, monitor, evaluate, and make necessary policy changes regarding nation-wide cost recovery in primary health care facilities in the context of decentralization reforms.

Result 2.1:

Increased capacity at the central level of the MOPH to strengthen consensus, mobilize resources, monitor and evaluate performance and coordinate the interventions of internal and external partners in support of the national implementation of cost recovery in the primary health care sector.

Activities:

1. **Assistance in conducting information and awareness campaign.** The purpose of the information and awareness campaign is to strengthen the consensus on cost recovery policy issues nation-wide and to lay the ground for setting up health committees at all primary health facilities. Health committees are a key part of the community participation strategy to be implemented with cost recovery activities. Assistance in this area will consist of providing support to the information and awareness committee to be put in place at the central level of the MOPH. Activities will include the development of information and communication materials on cost recovery policy issues, development of contractual arrangements with national and regional media organizations, and development of national and regional plans of the awareness campaign. This activity should be implemented during the first quarter of 1996.
2. **Fee setting.** The purpose of this activity is to develop national guidelines on setting fees for health services in the non-hospital sector. A tariff committee will be put in place at the central level of the ministry. The objectives of the committee is to make recommendations to the MOPH on the scope, structure and levels of fees for health district services. Assistance to be provided in this area includes support to the tariff committee in reviewing the results and policy implications of the pilot tests of cost recovery, the Bamako Initiative experience, and cost recovery experiences in the health districts of Gaya and Téra. Assistance will be provided to the MOPH in finalizing a policy document setting tariffs in the non-hospital sector. This activity should be implemented during the first quarter of 1996.
3. **Assistance in accessing needs for initial drug supply to health districts for the initiation of cost recovery.** The purpose of this activity is to ensure that initial drug needs for the implementation of cost recovery and sources of funding of the initial stocks are identified for all health districts in the country. It is planned to set up an initial drug stock committee at the Ministry of Public Health for that purpose. Continued assistance will be provided in finalizing plans for the acquisition, management, and the supply of drugs to public health facilities. The input from a pharmaceutical management specialist may be required for this activity.
4. **Monitoring cost recovery performance.** The purpose of this activity is to strengthen the MOPH institutional capacities to monitor and evaluate the national implementation of cost recovery policy in the non-hospital sector. Initial steps in designing a monitoring system began under the NHSS grant. Instruments used in the monitoring cost recovery performance in the pilot test districts and the collaboration between central and departmental institutional units required to develop the national monitoring system have been tested in the Bamako Initiative project area. Additional technical support is required to consolidate the monitoring system design and to (articulate its implementation) with the decentralization of the national health information system. Activities in this area will begin during the third quarter of 1996 and will be continued during 1997.

Result 2.2:

Increased capacity of the MOPH to assist health districts in implementing their health district plans for cost recovery.

Activities:

1. **Assistance in planning the implementation of nation-wide cost recovery.** The purpose of this activity is to assist the MOPH to develop regional and local programs and action plans for the implementation of cost recovery strategies. In the process, the MOPH will develop and hone skills in using strategic programming tools as instruments for the implementation of other strategies of the national and district health development plans. This process has already been initiated under the NHSS grant with the development of the national program for strengthening primary health care. Continued support by the MOPH will be provided to the regional and district levels through cost recovery planning workshops at the regional level, with PHR assistance. The MOPH will assure that regions subsequently complete planning exercises through workshops with the district level.
2. **Coordination of cost recovery and quality improvements.** Since the success of cost recovery depends on simultaneous improvements in the quality of care of district health services, the MOPH needs to ensure that quality improvements, particularly an adequate drug supply and training and supervision in the use of diagnostic and treatment protocols, are coordinated and phased in with cost recovery activities. Approximately half of the districts have been trained in the use of diagnostic and treatment protocols. The MOPH has requested additional NPA monies to continue this training to cover the entire country. The Coordinating Committee for Cost Recovery will work with other divisions of the MOPH to monitor the initiation of all three activities (cost recovery, provision of drug supplies, and the use of diagnostic and treatment protocols) to ensure that all facilities that begin cost recovery activities are also prepared to implement these quality improvements.
3. **Monitoring performance of reforms.** PHR will work with the MOPH to establish a monitoring and supervisory system to review the impact of reforms on a quarterly basis using data generated from the cost recovery data collection system. In this way, the MOPH at the central level can identify regions that may need more targeted assistance to achieve their objectives for cost recovery. The MOPH will then, in turn, assist the regional level to use this same information source to pinpoint and provide targeted assistance to districts identified as trouble spots. PHR will review progress with the central level of the MOPH on a quarterly basis.

5.4 Objective 3

Strengthen central-level strategic management capacities in health financing and decentralization of health services.

Result 3.1:

Improved policy environment for health services and health financing and decentralization reforms.

Activities:

Activities in this area are directed towards fostering a policy dialogue on health financing and decentralization as well as on strengthening MOPH institutional capacities through technical support of policy analysis by MOPH institutions and staff responsible for the implementation of specific policy reforms. Implementation of the activities will emphasize the use of local expertise and MOPH collaboration with other governmental and non-governmental institutions in the identification of and the search for solutions to health financing and decentralization problems. These activities will also contribute to the objectives on institutional strengthening and personnel capacity-building. All of the investigations described below will be carried out by a team of MOPH personnel, and in some cases Planning Ministry and MOPH personnel, paired with outside PHR technical experts, in order to ensure that these investigations are relevant to the Niger context and to build in-country capacity to carry out similar types of studies in the future.

1. **Study of the legal framework for health finance and management.** The purpose of this activity is to assist the MOPH in identifying areas where legislative reforms or policy and administrative measures would be needed, or areas where additional financial and human resources would be required, in order to improve the policy and institutional environment of health financing and the decentralization of the management of health services. A comprehensive study of laws and decrees that affect sources and mechanisms of health finance, and that define the functions of fund holding institutions will be undertaken. This investigation will be implemented during the first year of the assistance plan and a report prepared by June 1996.
2. **Study of the performance of third-party payment mechanisms.** The low coverage and poor performance of third-party payment mechanisms (i.e. insurance) are major constraints to cost recovery, particularly in the hospital sector. Given the relative share of hospital funding in the public health budget and the national health development plan strategies of reallocation of health resources from hospital-based curative services to primary health care based preventive services, particular attention will be focused on the sources and mechanisms of hospital care financing. In that perspective, an investigation of existing third-party payment institutions and performance will be undertaken. The scope of the investigation will include: the health care benefit system which covers civil servants and their dependents (*imputations budgetaires*), the *conventions de soins* (employer-based private insurance) programs, and other private health insurance programs. This study will be implemented during the first year of the assistance plan and a report will be prepared by September 1996.
3. **Study of operating costs of health districts.** The design and successful implementation of health financing and decentralization reforms under the Niger national health development plan will depend largely on improved knowledge of health district operating costs. The purpose of this investigation is to fill that information gap. Particular attention will be focused on the recurrent cost implications of district hospitals which are planned to become the first referral institution in the health district delivery system. The methodology of the study will build from cost studies undertaken under the NHSS grant and will be based on a small sample of health districts where district hospitals will be operational in 1996. The study report will be completed by November 1996.
4. **Study of the demand for health services.** A few demand studies have been undertaken under the NHSS grant. The scope of these studies, however, has covered mostly primary health services. The patterns of demand for hospital care, the use of health services, and private health related expenditures in urban areas are not well known. Both the success of hospital reforms and the promotion of the private sector in the provision of health services

will depend largely on the patterns of demand for health services in urban and semi-urban areas. The purpose of this study is to fill the information gap on the demand for health services in general, and the demand for health services in urban areas in particular. PHR will provide assistance to a team of both MOPH and Planning Ministry staff. The investigation will be based on data generated under the national household survey conducted in 1994 by the statistical office of the Planning Ministry which was based on a national sample of 4,000 households, including approximately 2,400 urban households and 1,600 rural households. A report will be available by June 1996.

5. **Review of constraints on the development of the private sector.** Building on existing studies conducted by USAID/Niger on the scope and role of private providers in the health sector, this investigation will assist the MOPH in identifying areas where actions will be needed for the effective promotion of the development of private practices in the health sector. This review will complement studies on the performance of third-payment mechanisms and the demand for health services in urban and semi-urban areas by identifying legal, administrative and financial constraints for entry in the modern health market. It will incorporate the legal framework review described under Activity 1 above and some private provider perspectives obtained through provider interviews and/or focus groups. This study will be completed during the first year of the assistance plan and a report finalized by November 1996.
6. **Evaluation of the implementation of on-going reforms.** Since 1992, the MOPH has initiated important reforms in the hospital and non-hospital sectors. The purpose of this evaluation is to identify organizational and managerial constraints that impede the effective implementation of these reforms, to assess the success of cost recovery in terms of revenue generation and quality improvements, and to evaluate the impact of cost recovery on the population. The evaluation will assess the influence of various stakeholders on the implementation of reforms, the coherence of health finance reforms and other health policies pursued by the ministry, and administrative arrangements within the central MOPH, including the role of central directorates in implementing the reforms. The evaluation will also assess managerial capacity at the hospitals and health districts implementing reforms to generate revenue and to improve the quality of services. Investigations will also include surveys to assess the impact of cost recovery on the local population and ability to pay. This evaluation will be conducted at the end of each year of PHR assistance.
7. **Policy workshop on health finance and decentralization reforms.** Findings from experience, studies and reviews conducted during the first year of the PHR assistance plan will be compiled and subsequently reviewed at a national workshop on health financing and decentralization reforms in the health sector. The workshop objective will be to clarify and elaborate policy issues and constraints in the areas of health finance and decentralization as they affect the implementation of the national health development plan. In addition, workshop participants will outline alternative courses of actions that the MOPH should consider in order to: 1) improve the policy environment of on-going reforms and 2) better support regional and districts to implement a health financing and decentralization reform. Recommendations for NPA conditions will be formulated at the workshop, in collaboration with the MOPH and USAID/Niger. This workshop, which will include various policy makers and stakeholders from multiple levels of the health system, will be organized early in the second year of PHR assistance.

8. Development of policy and identification of NPA conditions. Building on the first year activities in the area of hospital reform and the nation-wide implementation of cost recovery in the non-hospital sector, and the policy debate on health financing and decentralization issues, this activity will focus on assisting the MOPH to formulate an overall health sector finance and decentralization policy. Technical assistance will be provided in areas identified at the MOPH policy workshop on health financing and decentralization reforms described above. Technical assistance will also be provided in identifying and supporting areas where non-project assistance will be instrumental in advancing additional reforms or reinforcing existing policies to improve the institutional environment of the implementation of the national health development plan.

Result 3.2:

Improved capacity of MOPH staff at the central and regional levels to manage personnel.

Activities:

1. **Assist in upgrading the MOPH personnel management system.** The purpose of this activity is to upgrade the existing computerized personnel management system at the DF/GP. The activity will include assessing the completeness of existing personnel files, adapting personnel system files to the Ministry's personnel management needs, adapting computer programs relative to DF/GP capacities in order to facilitate their use, and integrating the personnel management system to the national health information system (SNIS).
2. **Training of MOPH staff in the use of the personnel management system.** This activity is a continuation of on-going work under the NHSS grant. A procedure and training manual will be developed jointly by a consultant and the national health information system staff. All technical staff at the DF/GP and the national information health system directorate (DSNIS) will be trained in the use of the personnel management system. Additional training will be provided to a core team of DF/GP and the DSNIS staff who will serve as national trainers and supervisors for the decentralization of the personnel management system at the regional level.
3. **Assistance in decentralizing the personnel management system to all regions in the country.** An assessment of the operation and use of the personnel management system at the two testing regions, Dosso and Tahaoua, will be completed by a consultant. An action plan will be developed before the end of the first quarter of 1997 jointly by the consultant, the DF/GP and the DSNIS to extend the installation and operation of the personnel management system to all regions in the country.

Result 3.3:

Strengthened service delivery systems at the district and referral hospital levels.

As components of the implementation of the national health development plan and health district development plans, continuing hospital reforms, the transformation of rural dispensaries and medical posts into integrated health centers, and the emergence of district hospitals will change significantly the health delivery and referral systems in Niger

Activities:

1. **Demonstration project.** In collaboration with the MOPH, PHR will design and implement a field project to demonstrate the effectiveness of financing, management and referral reforms developed during the first year of PHR assistance on health service delivery. The intent is to link policy development with service delivery realities and pull together the work on hospital and PHC financing, referral, quality, planning and service delivery. The demonstration project will cover one national hospital and two health districts, one rural and one urban. The exact issues to be addressed will be determined in collaboration with the MOPH. One possible issue to be addressed concerns how to channel appropriate, cost-effective health service utilization (i.e., for preventive rather than only curative services) and at the appropriate levels of the system, using integrated tariff structures and levels, including fee waivers and penalties and quality improvements. The relevance and utility of financial and administrative reforms at the local level might also be addressed. Finally, the demonstration project will likely address the effectiveness of coverage of indigent care by the budgets of rural and urban municipalities. Performance measures and targets identified in *Section 6, Table ()* should be viewed as illustrative, since these will need to be finalized with the MOPH and tailored to key issues which will arise from the results of the first year of PHR assistance.
2. Quality.

Result 3.4:

Increased access of the poor and vulnerable groups to higher quality health services.

Activities:

1. **Study of the performance of policies to exempt the poor and vulnerable groups from paying fees for health care.** As health finance reforms are reinforced in Niger and cost recovery mechanisms become more prevalent in all levels of the health system, the MOPH will have to face policy issues related to the performance of exemption policies in general, exemption policies targeted to the poor in particular. The purpose of this study is to investigate the scope, coverage and impact of existing exemption policies in the health sector in order to assist the MOPH to identify areas where reforms will be needed to: 1) promote access of health services to the poor and other vulnerable social groups in the context of ongoing health finance reforms, and 2) promote equity through targeting and subsidy policies. Data will be collected from at least one hospital and several PHC facilities. Demand surveys already undertaken under the NHSS grant will serve as an additional data source.
2. **Assistance in revising existing exemption policies.** The current exemption policies were adopted in the early 1960s when most health services were provided free of charge. Recent hospital reforms, including the introduction of user fees, and implementation of cost recovery in primary health facilities could result in reduced financial access of quality health services for the poorest segments in urban and rural areas. The MOPH will consequently need to tailor the exemption policies to the new health finance environment, the overall administrative decentralization project, and the current social and economic conditions in order to promote true equity in the health system. PHR will provide assistance to the ministry in redesigning exemption policies in the health sector.

3. **The testing of revised exemption policies in demonstration sites.**

6.0 Evaluation Plan

PHR is committed to serious evaluation of progress towards the achievement of objectives set out at the beginning of project activities. Section 5.0 describes proposed assistance under the PHR project and indicated performance measures and targets for PHR activities. PHR will measure and track achievement of our results through the analyses of existing MOPH and Ministry of Plan data, the analysis of hospital and facility level data, periodic reports from the MOPH and field visits. The emphasis will be on using existing data sources or integrating new essential information for tracking progress into existing information systems, rather than creating new vertical information systems. For example, PHR intends to assist the MOPH to develop of a monitoring system for cost recovery which will be gradually integrated into the national health information system. This monitoring system will allow national, regional and local authorities to identify bottlenecks in the implementation process, to help make necessary corrective actions on a timely basis and to evaluate the performance of cost recovery. performance. Such a monitoring system could become instrumental, for example, in the periodic adjustment of tariffs. Data sources include the Ministry of Public Health (drug inventory system, semestrial progress reports of the PNASSP, workshop reports, etc), Ministry of Plan budgetary data, hospitals and PHC facility data, and special household surveys. Attached is a table which summarizes the results we expect to achieve, targets, anticipated dates of completion, and data sources.

7.0 Management Plan

7.1 Proposed Staffing

The Partnerships for Health Reform Project has recommended to USAID/Niamey that the MOPH identify a counterpart within the Ministry who will oversee all PHR project activities and serve as the main liaison between the Ministry and the project. In addition to this person, PHR proposes the following in-country and home-office staff, who will be funded under the field support funds provided to the project by USAID/Niamey.

7.1.1 In-Country Staff

Chief Technical Advisor A Health Economist with considerable experience in designing and implementing financial management and cost recovery systems and programs in Africa will be required to carry out the financial and management and economic analysis activities that will take place at the hospitals and primary health care sectors, as well as at the central level. PHR proposes that this individual spend 50% time on the project, including one continuous month every quarter in Niger. As the primary health economics/financial management advisor to the MOPH for the project, this individual will:

- 1) Provide technical assistance to the three national hospitals and Niamey Reference Maternity Center in developing budgets, monitoring the fee structure and cost recovery performance of the hospitals (and developing the fee structure in the case of the Niamey Reference Maternity), and in general, improving the financial management of the hospitals;
- 2) Assist in annual analyses of the national health budget to determine changes in allocation between hospital and PHC sectors, and conduct resource allocation study for Niamey health facilities;
- 3) Provide technical assistance to the MOPH on all PHC financing activities, including helping to organize regional planning workshops, reviewing performance of past cost recovery experiences in Niger, and assisting in design and evaluation of the sentinel cost-recovery data collection system at the district level;
- 4) Provide technical assistance for all finance-related institution strengthening activities at the central (MOPH) level and provide technical and managerial oversight for the seven field studies to be conducted under Objective 3;
- 5) Provide continual on-the-job training to the MOPH counterpart in conducting financial/economic analyses, designing and conducting field studies, analyzing cost recovery performance, and other economic/financial-related activities.

PHR proposed Dr. Francois Diop for this position. Dr. Diop, a health economist with a Ph.D. from Johns Hopkins University served as the Resident Advisor for the Health Finance and

Sustainability (HFS) Project -- the predecessor to PHR -- in Niger from November 1992 to August 1994. In that role, he provided technical assistance in the design, implementation, and evaluation of the cost recovery pilot tests that took place in two health districts, the success of which led to plans for the national implementation of cost recovery. Dr. Diop has more than 14 years experience as a researcher, economist, and program evaluator in the fields of health and population in Africa. He will be based in Dakar, Senegal, and will spend one month out of every three in Niger.

Hospital Management Specialist

In-Country Administrative Support PHR proposes that a full-time local administrative assistant be hired under the project to provide administrative support to Dr. Diop and to the short-term consultants who will be providing considerable technical assistance throughout the three years of project activities. This individual, who will be located in the PHR field office, will be required to have strong word processing and computer skills, strong inter-personal skills, accounting/book-keeping experience, and should ideally be conversant in English as well as French.

In-Country Short-Term Consultants PHR will make maximum use of local talent for the provision of technical assistance, especially in conducting the proposed field studies to assist the Ministry in policy development (Objective 3). All seven studies will be conducted by local consultants, with technical and managerial oversight from Dr. Diop.

7.1.2 US-Based Staff

The US-based staff will consist of:

- ▲ Dr. Charlotte Leighton, the PHR Deputy Director for Technical Direction. Dr. Leighton, a health economist, has more than 13 years of experience assisting African countries (including Niger and the CAR) in developing and implementing health finance reforms.
- ▲ Dr. Katherine Krasovec
- ▲ Denise DeRoeck will be the Operations Officer responsible for managing Niger activities from the home office. She will serve as the main backstop to the in-country Chief Technical Advisor (Dr. Diop); assist in recruiting and fielding short-term consultants; liaise between USAID/Niamey USAID/Washington, and PHR; and provide overall managerial and administrative support to the project.
- ▲ Other administrative and financial support as needed.

Expatriate Short-Term Consultants In addition to local consultants, PHR will use expatriate specialists to provide a considerable amount of technical assistance on a short-term basis. PHR will try to use the same experts over the three year period in order to provide continuity, and it will focus on using the staff of its partner firms instead of consultants, whenever possible. The project will also place priority on using experts who have experience in Niger or other parts of West/Central Africa.

7.2

Local Office

PHR proposes that USAID/Niamey request the MOPH to provide an office within the Ministry to serve as the field office for the project. One possible space is the office of the Niger Health Sector Support Grant, which will end in March 1996. Although the establishment of a separate office/apartment for the project may save some lodging costs, PHR feels that housing the project within the Ministry will be critical in establishing and maintaining close collaboration with the MOPH counterpart and other Ministry personnel, and in carrying out the institution-strengthening activities of the project.

The PHR field office will be staffed by a local administrative assistant. The office will be equipped with a laptop computer, printer, and photocopying machine. The PHR Operations Officer will make a field visit early on in the project to recruit, hire and train the Administrative Assistance, help set up the field office, and assist in the procurement of office equipment.