

Policy Paper No. 12

**THE USE OF USAID'S NON-PROJECT
ASSISTANCE TO ACHIEVE
HEALTH SECTOR POLICY REFORM IN AFRICA:
A DISCUSSION PAPER**

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ABSTRACT

This policy paper examines the experiences and effectiveness of using the U.S. Agency for International Development's non-project assistance (NPA) to support health sector objectives in sub-Saharan Africa. Programs in Niger, Nigeria, Kenya, Togo, and Cameroon are summarized. For each country, background is provided on the health sector, and a summary and assessment of specific NPA programs are provided.

The primary focus of the paper is on health finance policy reforms that were promoted through USAID-supported NPA programs. It compares and contrasts country experiences as they relate to NPA. The authors' purpose is to encourage discussion within USAID of the effectiveness of using NPA as a reform tool in policy development and the broader question of how to best support desired health outcomes in Africa.

The paper provides a detailed assessment of three aspects of NPA programming: program development and design, program implementation, and program evaluation. The information sources were limited to official program documentation, and did not include field work. An extensive bibliography on the topics of non-project assistance, policy reform, and health sector policy is included.

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ACRONYMS

CIP	Commodity Import Program
DAC	Development Assistance Committee
DFA	Development Fund for Africa
FHSP	Family Health Support Project
FMG	Federal Military Government
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
GNP	Gross National Product
HAPSS	Health and Population Sector Support Program (Togo)
HFS	Health Financing and Sustainability Project
HHRAA	Health and Human Resources Analysis for Africa Project
IMF	International Monetary Fund
IPC	Interim Program of Consolidation
KHCF	Kenya Health Care Financing Program
KNH	Kenyatta National Hospital
LGA	Local Government Authority
MCH	Maternal Child Health
MOH	Ministry of Health
MOPH	Ministry of Public Health
MOPHSA	Ministry of Public Health and Social Affairs
NHIF	National Hospital Insurance Fund
NHSSG	Niger Health Sector Support Grant
NPHCS	Nigeria Primary Health Care Support Program
P/PHC	Preventive and Primary Health Care
PHCSR	Primary Health Care Subsector Reform Program (Cameroon)
SAL	Structural Adjustment Lending Program (World Bank)
SAP	Structural Adjustment Program
SDA	Social Dimensions of Adjustment Program
TCSP	Togo Child Survival and Population Program
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

At the request of USAID's Africa Bureau and the Health and Human Resources Analysis for Africa Project, the Health Financing and Sustainability Project examined the experiences of the United States Agency for International Development (USAID) using non-project assistance (NPA) to support health sector objectives in sub-Saharan Africa. This paper summarizes the design, implementation, and evaluation experiences of NPA programs in Niger, Nigeria, Kenya, Togo, and Cameroon. All five programs were submitted to USAID; however, only three were authorized.

The overall goal of these programs was to use NPA within the health sector to achieve specific policy reform objectives and to provide financial resources to programs and activities within the sector. The purpose of this paper is to initiate a discussion within USAID of the effectiveness of using NPA as a reform tool in policy development. This will, it is hoped, also promote a discussion of the wider question of how to best support the development of health services and promote desired health outcomes in Africa.

The experiences of the health sector NPA programs are examined using secondary information sources (PAIPS, PAAPS, project reports and documentation, and evaluation reports).

All NPA programs transfer donor resources to a host country to support economic development. The NPA programs in the health sector in sub-Saharan Africa have all been developed as sector assistance programs. Sector assistance programs have two objectives: the direct transfer of financial resources to the host government and the support of sector specific host country initiatives resulting in predefined policy reforms or implementation. Sector assistance programs attempt to define reform agendas that address policy and resource constraints to sector productivity, performance and output.

All of the countries in this study experienced significant declines in their annual GDP growth rates since the early 1980's. Policy reform and development of the health sector in each of the countries has been made more difficult by political instability. In most sub-Saharan Africa countries, the public sector is the primary source of the delivery of health care. This currently leaves many (and perhaps increasing) populations with limited access to services, decreased quality of care, and poor health outcomes. Faced with this decline in services, donor agencies and ministries of health in many countries are attempting to implement reforms and projects in the areas of health finance, primary care services, and planning and management of health care services decentralization. The NPA programs discussed in this paper were developed to support reforms in these areas.

Health services in Niger are provided by the Ministry of Public Health and Social Affairs (MOPHSA), which emphasizes primary health care through vertical disease specific intervention programs. The Niger Health Sector Support Grant (NHSSG) was designed to complement and be implemented in collaboration with other donor (primarily World Bank) efforts in the sector to facilitate policy reform in the following areas: cost recovery, cost containment, resource allocation, personnel, health sector planning, and population policy and resources. The program was judged by evaluators as being too complex for the institutional (including human resources) and fiscal resources available. In addition, funds were not directly transferred to the institutions responsible for the reforms and, due to delays in the accomplishment of certain reforms, were not disbursed within the assigned time frame. However, many of the predefined health sector reforms have occurred since the signing of the grant agreement.

The Kenyan health sector may be divided into three sectors: public, voluntary, and private with the majority of services provided by the public sector. Due to problems in financing the expansion of primary and preventive health care and services to under-served populations, the Kenyan Health Care Financing Program (KHCF) was established. The KHCF program goals are to implement policy reforms in the areas of cost recovery, social financing, and resource allocation. The KHCF was effective in developing, promoting, and implementing many of the defined reforms. However, these reforms were not accomplished without difficulties. The cost-sharing system originally accepted by the Ministry of Health (MOH) was annulled by the President only to be readopted and implemented a year later. Objections arose around the resource allocation algorithms to be applied to primary and preventive services for budget allocation decisions. The implementation of many reforms suffered due to the lack of comprehensive information systems capable of monitoring and evaluating the effects of the reforms.

Both public and private sectors provide curative health services in Nigeria. Due to the economic decline experienced by the country, the quality and quantity of health services has declined. The Nigeria Public Health Care Support Program was developed to support the transfer of responsibilities for the planning, management, and delivery of public health care services from federal to state levels, and redirecting the emphasis from curative to preventive services. The program experienced delays in the disbursement of funds caused by a lack of clear policy objectives. The implementation benchmarks were not completed within the allotted time frame due in part to a lack of sufficient initial analysis and technical assistance.

The Government of Togo (including the health sector) has become increasingly dependent on donor support. The Ministry of Public Health provides the majority of services in Togo. Their goal is to improve and expand service provisions in health facilities country-wide. The Togo Health and Population Sector Support Program (HAPSS) was developed to support the expansion of curative, preventive, and primary care services; improve access to family planning information; increase the availability of essential drugs and contraceptives; and expand recurrent cost recovery mechanisms in the public sector. It was designed to complement the \$15.5 million Togo Child Survival and Population (TCSP) project. The TCSP project was authorized in 1991 but was withdrawn in 1993. As a result, the HAPSS program was not authorized. Nevertheless, several of the program's policy reforms have been instituted by the Government of Togo.

Since 1986 Cameroon has experienced a decline in delivery of health services due to decreases in the Ministry of Public Health (MOPH) budget. The goal of MOPH is to improve the delivery of primary health care services. The Primary Health Care Subsector Reform Program (PHCSR) was established to implement a nationwide primary care program. The PHCSR program was designed to support implementation of recurrent cost recovery activities, develop national standards for delivery of services, and increase the availability of modern contraceptives. The PHCSR program was never authorized by USAID; however, many policy reform changes that were defined by the program have been instituted by the Government of Cameroon.

In order to promote discussion, the lessons learned from experiences using NPA in the health sector in sub-Saharan Africa may be grouped into three areas: program development and design, program implementation, and program evaluation.

Program Development and Design: Before program development and design begins, a background analysis is necessary to allow for an understanding of the policy environment within the country. This analysis should be more detailed than that required for traditional project development. A thorough and honest assessment of existing human resources and institutional capabilities must be included in this

analysis. The development of the NPA reform program must not overlook the institutional reforms and changes that are required to support the policy reforms defined by the program. Sufficient resources must be devoted to promote these institutional reforms as well as the technical policy reforms defined by the program. In all three of the NPA programs implemented in sub-Saharan Africa, the lack of human resources available to support the reform process appeared to have a negative impact on achievement of program mandated reforms within the established time frame. The development of human resources through training should be considered as part of NPA programs.

A more direct linkage between the institution responsible for reforms and the recipient of grant funds may be effective in motivating institutions to carry out program reforms. Programs should be designed to be flexible. Due to unforeseen problems such as political changes and time factors or policies that are made outside of the health sector, NPA policy reform agendas must be adaptable. In the NPA programs that were examined, the specific reform agendas appear to have helped maintain focus and attention on important health sector issues, when faced with these unforeseen problems. Another means of ensuring that policies remain intact is to identify policies that may have high levels of support within the existing institutional framework.

Program Implementation: NPA programs are intended to quickly transfer funds to the host country. However, as found in this study, the disbursement of funds often becomes a significant management burden for the USAID mission and the host country due to cumbersome tracking and administrative requirements imposed on the funds. If additional responsibilities become too burdensome and complicated, enthusiasm for NPA policy reform may diminish. In the countries included in the study, institutional capacity building was an implied objective. In the future, it would appear advisable to develop specific benchmarks for institutional capacity building to be included in the NPA reform agenda. Additional technical assistance resources must also be included in NPA planning, if capacity building objectives are to be met.

Program Evaluation: Direct evaluation of the effectiveness of NPA supported policy reforms in bringing about desired health outcomes is difficult. All of the policy reforms in these countries may or may not have occurred in the absence of the NPA programs. One of NPA's principal roles may be to promote the inclusion of certain policy reforms within a changing national agenda. Some of the health sector policies in these countries may not have remained on the agenda without the efforts of NPA and, therefore, may have never been implemented.

The establishment of direct links between NPA goals of sector policy reform and resource transfer is difficult. Policy reform may not respond to financial incentives as perceived by the NPA framework. Linking people-level impact indicators to specific policy reforms may not be feasible. This is true of not just NPA programs but of efforts to support policy reform in general. Most African countries do not have information systems capable of measuring changes in people-level impact indicators. Even when changes are measured, it is difficult to link those changes directly to policy reforms. It is more feasible to monitor changes in services delivered and utilized as a result of policy reform. The three- to five-year time frame of the programs in these countries appears to be too short for many of the projected outcomes of the studied NPA programs.

Overall, using NPA in the health sector has not been as successful as projected by USAID. The reforms have taken longer than anticipated, building ownership for reforms has been difficult and time consuming, the programs appear to have paid insufficient attention to institutional reform as part of the NPA agenda, and the reforms contained in the programs were, perhaps, too complex.

However, it can be noted that the countries with health sector NPA have made important and significant progress in the development of their health sectors. It may be that NPA has served to promote a number of policy changes and kept health policy issues on the national agendas during periods of instability and transition. USAID should use the experiences of NPA to examine its efforts to support the continued development of the health sector in sub-Saharan Africa.

1.0 INTRODUCTION

The purpose of this paper is to examine and analyze the experiences of the United States Agency for International Development (USAID) in the use of non-project assistance (NPA) to support health sector objectives in sub-Saharan Africa, especially through the achievement of sector-wide reforms of health finance policies. The analysis and discussion of these NPA experiences was carried out by the Health Financing and Sustainability (HFS) Project at the request of USAID's Africa Bureau and the Health and Human Resources Analysis for Africa (HHRAA) Project.

USAID experience in the use of NPA within the health sector is limited compared to that in other sectors (agriculture, education, etc). However, even these limited experiences provide important insight into the application of the NPA mechanism to meeting Agency objectives in the health sector.

To date, health sector based NPA programs have been funded under the Development Fund for Africa (DFA) and implemented in three African countries (Niger, Nigeria, Kenya).¹ In addition, two other countries (Togo and Cameroon) developed NPA components which were intended to be linked to and complement large health sector projects. In these latter instances the projects were accepted but the corresponding NPA components were not authorized.² The experience of health sector NPA in each of these five African countries will be summarized with regard to the design of their programs. Clearly, the experiences of Togo and Cameroon are limited to this aspect of NPA programming. Implementation and evaluation issues will be examined for only the NPA programs in Niger, Nigeria, and Kenya.

The cases of both Botswana and Ghana have been excluded since these NPA programs are designed to primarily address population policy issues and do not include the key health finance policy reforms that are the primary focus of this analysis.

For the three NPA programs which will be the primary focus of this paper, Niger, Nigeria, and Kenya, it is important to note that these programs have been in existence for a relatively short period of time. The longest-standing NPA health program in Africa is that in Niger, which was authorized in 1986. This represents a relatively short time frame to draw conclusions regarding institutional reform and policy reform processes.

¹It is important to note that the NPA program in Niger includes conditionality to promote policy reform within the population sector as well.

²Health sector based NPA programs have also been undertaken in Chile, Philippines and Ecuador. In addition, Botswana and Ghana have developed and implemented NPA programs designed to support objectives in the population sector (Niger's NPA also included population sector objectives).

USAID has attempted to use NPA in the health sector to achieve specific policy reform objectives and to provide resources to programs and activities within the sector as well. The dual goal of NPA to achieve both of these objectives simultaneously is important and serves to distinguish NPA from other assistance mechanisms. This makes NPA an attractive and potentially powerful mechanism capable of promoting wide ranging and fundamental changes within an entire sector or subsector (perhaps beyond those that traditional project mechanisms expect to achieve at similar funding levels). It also makes the design and implementation of NPA complicated, its management time consuming, and evaluation difficult.

NPA potentially provides USAID (and other donors as well) with an effective mechanism to support the development of host country health sectors along a mutually defined path. Alternatively, it may not be prudent or possible to achieve both of these objectives through the use of a single support or funding mechanism. Learning from these experiences may provide program planners with insight necessary to choose the most effective means of achieving sector objectives, especially when those objectives include or are dependent upon significant policy reforms. A discussion of NPA requires USAID to assess its role in supporting the development of health systems capable of demonstrating positive health outcomes. NPA is but one possible means of supporting this process.

Using experiences derived from USAID's NPA health programs in Africa, this paper will:

- ▲ Synthesize lessons learned as they relate to the design, implementation, and evaluation of health sector NPA in Niger, Kenya, and Nigeria (design issues related to proposed NPA programs in Togo and Cameroon have been included in the relevant sections); and
- ▲ Discuss the effectiveness of NPA as a health sector policy development and reform tool, and attempt to formulate recommendations on circumstances under which NPA may be used most effectively.

USAID's desire to examine NPA in the health sector is important if the agency is to continue to play a leadership role in the support of health policy reform in Africa. Examination of NPA's impact in achieving health policy reform also serves to promote discussion and dialogue around issues beyond the individual programs or the specific role or success of NPA in general. These broader issues, while beyond the scope of this paper, relate to:

- ▲ The nature of policy reform and decision making in the African context;
- ▲ The need to encourage policy reform versus a focus only on assistance to program and/or project implementation;
- ▲ The means by which all donors may best promote political interest in policy reform as well as a necessary sense of ownership and commitment;
- ▲ The institutional and human resources which must be in place to undertake policy analysis and reform programs; and
- ▲ The role of donors in the policy reform process.

These questions are clearly relevant to donor efforts to support the development of efficient, quality and sustainable health services. NPA offers important insight into one of the mechanisms used by USAID to promote such development.

2.0 METHODS

This is a comparative study of health sector based NPA programs in Africa to date. It is intended to focus primarily on health finance policy reforms that were promoted through USAID supported NPA programs. The analysis is based on secondary information sources (PAIPS, PAADs, project reports and documentation, and evaluation reports) and examines all three authorized programs and two programs which were developed and submitted but not authorized by USAID.

It represents one of the few attempts to examine all of these health sector programs as a means of examining the effectiveness of NPA programs in supporting policy reform programs. Its main focus is to compare and contrast country experiences as they relate to NPA rather than to describe in great detail each of the country programs or their implementation. Other important and relevant discussions of NPA and health policy reform in Africa have been provided by both Foltz and Donaldson. This analysis is meant to complement rather than replace those.

The principal sources of information for this study were USAID documentation of the NPA programs as well as Agency reports and papers concerning NPA as a funding and assistance mechanism. Unfortunately USAID does not maintain a complete library or repository of all project documentation. Information is scattered between Washington offices and the individual country missions involved. As a result, this paper does not necessarily reflect all relevant documents ever produced on the subject of health sector based NPA in Africa. It must also be noted that many of these sources were not written to provide the basis for policy analysis. They are primarily internal USAID documents intended to define complex environments and reform agendas in terms of "progress" toward goals defined in program documents. As such, they raise questions as to the meaning of "success" and "ownership" within the context of policy reform and development assistance. This paper will use these terms, then, within the context of USAID's efforts to evaluate the ability of the NPA programs to support the institutional and policy reforms defined by the programs.

Additional insight is the result of the personal experiences of the principal author and the HFS project in developing, implementing, and evaluating health sector NPA programs.

The available resources did not permit field work to be carried out as part of the writing of this paper. The authors therefore relied upon the observations, analyses, and opinions of others as found in official program documentation. As a result, it is not always easy to separate the effects of time, place, and person from those of structure, design, and implementation. It is clear that all play a significant role in the ability of any program or project to achieve its objectives. This is not mentioned as an excuse for shortcomings found in the analysis. Instead it is included as an acknowledgment of the limitations of assessing the impact of complex assistance programs through the use of secondary sources.

The difficulties in examining NPA through this method come from the limited number of health sector programs which have been implemented and basic differences in their design (see overview section below). It appears that in many cases the design and experiences of the individual programs are not sufficiently comparable to isolate individual factors affecting the success of a particular program. This complicates the task of relating individual experiences to conclusions about the NPA process. While each of the programs has been evaluated by USAID and external sources according to program specific indicators of "success" (as defined by USAID and the programs themselves), there is no general consensus as to indicators of success for health policy reform programs. The reader is referred to Foltz, "Policy Reform and Non-Project Assistance: Framework for Analysis" for a discussion of this subject.

3.0 BACKGROUND

Non-project assistance that focuses on policy reforms in a single sector such as health is one of several types of NPA. The following provides a brief discussion of the variety of purposes, forms, and implementation mechanisms that NPA may take.

NPA, also referred to as program assistance, is generally characterized by the transfer of donor resources as foreign exchange and/or commodities to support host country economic development. These transfers are often seen as a rapid disbursement mechanism intended to provide balance of payments and budgetary relief to the host country's economy or as a means of supporting the development of a particular sector. Programs of policy conditionality may be attached to such transfer programs so that NPA is often seen as having two basic objectives: direct transfer of financial resources and policy reform.

However, the use of NPA to support host country policy reform is, at times, considered secondary and in general "the basic purpose (of NPA) remains one of support" (DAC, 1986). NPA has been used extensively by USAID in all regions. In 1986 USAID's Development Assistance Committee (DAC) estimated that NPA was "the largest single type of donor assistance" (DAC, 1986).

NPA closely resembles mechanisms employed by other donor organizations to promote host government policy review and reform. The World Bank's Structural Adjustment Lending (SAL) program and the Time Slice Operations funded through the Inter-American Development Bank are examples of such programs. The International Monetary Fund (IMF) also frequently links resource transfers to policy reform conditions. The major similarity between the programs of each of these donors and NPA programs is that all are resource transfer programs driven by meeting conditions precedent linked to a policy reform agenda. The policy reform agendas promoted through these mechanisms are frequently broad economic programs rather than sector specific agendas for reform.

Within USAID, NPA may take several distinct forms:

- ▲ *Cash Transfer/Payment*: A cash transfer is the deposit of foreign exchange funds (dollars) directly into the account of the host government. This transfer is not directly tied to either goods or services. These funds can be used to provide immediate balance of payments and/or government budget support. They are often used as part of stabilization efforts and general economic policy reform programs. Governments can use the funds transferred as foreign exchange to pay for public sector import requirements or can use them to purchase local currency to be used to finance general government expenditures or to finance specific development activities. Cash transfers are considered the "purest" form of NPA since the end use of the transferred funds is only indirectly controlled or programmed by the U.S. government.
- ▲ *Commodity Import (or Support) Program (CIP)*: These programs provide a quick dispersing mechanism in which dollars are made available to the host government in order to finance general import requirements of specified categories of commodities (production inputs rather than consumer goods). The sale of these commodities generates local currencies to be spent in a manner that is agreed upon by both host and U.S. governments. These uses generally involve host government budget expenditures and/or development projects. The degree to which uses of these local currencies are programmed or "projectized" in advance varies by region and country.

- ▲ *Public Law 480, Title I:* Until the law was changed in 1990, USAID had the authority to negotiate highly concessional loans to host countries in order to finance the purchase of U.S. agricultural commodities. These commodities were sold on the local market by the recipient government as a means of generating local currencies. The degree to which Title I agreements required recipient governments to carry out policy, regulatory or administrative reforms, and/or the programming of local currencies for specific uses (often referred to as "self-help measures") varied from agreement to agreement. In 1990, Title I became a market development program administered by the U.S. Department of Agriculture.
- ▲ *Public Law 480, Title III:* Until the U.S. Congress changed the law in 1990, Title III programs resembled Title I (concessional loans to purchase U.S. commodities) but were limited to IDA eligible countries, had much more rigorous "self-help" requirements (including cumbersome procedures for the use of local currency), and permitted forgiveness of debt when those requirements were met. Since 1990, USAID has been authorized to use the new Title III to provide grant assistance to IDA eligible countries to purchase U.S. commodities and requires recipient governments to carry out specific policy, regulatory, or administrative reforms.
- ▲ *Sector Assistance:* Program sector assistance is intended to address policy constraints to sector productivity and output and/or address resource constraints within a specified sector. Like CIPs these programs may involve significant commodity imports and generation of local currencies. Unlike CIPs, however, they generally focus on a single sector and its identified resource and policy constraints. They are justified more often on the basis of the policy constraints and the need for policy reform than the need for resource transfers to the specific sector. An important aspect of this type of program is conditionality. Resource transfer under sector assistance type programs is directly tied to the host government's meeting a predefined series of conditions precedent linked to identified sector policy reforms. Often the resources are divided into tranches which are released periodically (annually), contingent upon the successful completion of the appropriate conditions precedent.

The NPA programs in the health sector in sub-Saharan Africa have all been designed as sector assistance type programs. All specify country agendas for the review and reform of policies within the health sector (the specific policy reform agendas supported by each of the programs will be described below). They differ, however, with regard to the degree of specificity with which the uses of the resources to be transferred are programmed jointly by the host government and USAID. They also differ in the degree to which the NPA programs are directly tied to or combined with "projectized" resources such as technical assistance, commodities, vehicles, salaries, travel, training, infrastructure, etc. to be used in support of the NPA policy review and reform agenda or its implementation.

The "Revised Africa Bureau NPA Guidelines" (USAID 1990) characterize the differences between NPA and project assistance as based upon the specificity with which the end use of USAID funds is defined in advance. "NPA resources are provided in a 'generalized' manner" and "not directly linked to projectized expenditures." This distinction holds true for the health and other sectors.

4.0 EXPERIENCES WITH NPA IN THE HEALTH SECTOR UNDER THE DFA

4.1 OVERVIEW

While each of the NPA experiences in the five countries described in this paper is distinctive and unique, there are attributes and characteristics which the countries share.

From an economic perspective, all of the countries where health sector NPA programs have been developed—Niger, Nigeria, Kenya, Togo and Cameroon—have experienced, since the early 1980s, a decline in their annual GDP growth rates. For example, Nigeria's annual GDP growth rate from 1970-80 was 4.6 percent. In the next decade, 1980-91, this rate declined to 1.9 percent, while the annual inflation rate climbed to 18 percent. Niger, whose growth rate in the 1970s was only 1.7 percent, declined to a rate of -1.0 during the 1980s.

Economic resources allocated to the health sector have been insufficient to support the delivery of free health services as mandated by national policies in all of the countries. Limited resources within the health sector in the 1980s were increasingly consumed by personnel costs. The lack of overall economic growth and development, especially in the health sector, has been the catalyst for many countries to reform policies in order to expand the financial bases for health service delivery. *Exhibit 4-1* shows several key demographic and economic indicators for the countries studied.

Politically, while all five countries have made attempts at establishing multi-party democratic states, the attempts have not come free of turbulence or unrest. All five countries have experienced a high degree of political instability, with frequent changes of people, policies, and offices. With such fluidity, long-term planning and policy reform processes have been difficult to develop and sustain.

The public sector is the principal force in the delivery of health services in the countries identified. Some countries, such as Kenya, have a relatively mixed public, private, and voluntary health system. Others, such as Niger, have a relatively weak private sector, so the responsibility of health care falls upon the Ministry of Public Health and Social Affairs. Common obstacles within the health sector have been the lack of resources (both human and financial), a focus on curative as opposed to preventive or primary care services, an overly centralized system of planning and management of services, and inefficient and suboptimal allocation of resources within the health sector. The overall effect has been to leave populations with limited access to services, decreased quality of care, and poor health outcomes.

EXHIBIT 4-1
DEMOGRAPHIC AND ECONOMIC INDICATORS

Country	Population (millions, 1991)	Life Expectancy at Birth, 1991	Infant Mortality Rate (per 1,000 live births)	1991 GDP (billions of dollars)	1991 GNP per capita (dollars)	1990 Percent of GDP to health	1990 Percent of GDP to health from public sector	1990 per capita total health expenditure (in dollars)
Niger	7.9	46	126	2.3	300	5	3.4	16
Nigeria	99	52	85	34.1	340	2.7	1.2	9
Kenya	25	59	67	7.1	340	4.3	2.7	16
Togo	3.8	54	87	1.6	410	4.1	2.5	18
Cameroon	11.9	55	64	11.7	850	2.6	1	24

Sources: Infant mortality rates from "1994 State of the World's Children Report," UNICEF; population and economic information from 1993 "World Development Report," World Bank.

The economic, political and health environments in these countries have provided the framework and motivation toward action for donor agencies and ministries of health. Overall policy reform goals focusing on the emphasis of primary care, decentralization, and health finance reform have been central to many donor agendas, including the NPA health programs which are examined in this report. While each of the identified countries—Niger, Nigeria, Kenya, Togo and Cameroon—are unique in their situations, the reform agendas of the health sector NPAs developed for these countries have focused on a limited number of important areas for reform. They are:

- ▲ *Health finance reform:* Each of the reform agendas includes reforms and implementation steps intended to increase the financial resources available for the delivery of health services. Included in this area are reforms to improve the allocation of resources within the health sector as well.
- ▲ *Increased emphasis on primary care:* Several of the programs were developed to support an increased emphasis on services delivered at the primary level. This is intended to increase access and efficiency.
- ▲ *Decentralization of planning and management of health services.* These reform measures are intended to improve health resource allocation decisions and the ability of the health system to respond to local and community needs.

The NPA programs developed for the health sectors in Niger, Kenya, Nigeria, Togo, and Cameroon are summarized in *Exhibit 4-2* below.

EXHIBIT 4-2
SUMMARY OF NPA PROGRAMS

NPA Components	Niger	Nigeria	Kenya	Togo	Cameroon
Program Title	Niger Health Sector Support Grant (NHSSG)	Nigeria Primary Health Care Support Program (NPHCS)	Kenya Health Care Financing Program (KHCF)	Togo Health and Population Sector Support Program (HAPSS)	Primary Health Care Subsector Reform Program (PHCSR)
Authorized	July 1986	July 1989	August 1989	—	—
Funding	\$17.2 million ·\$15 million amended to \$17.2	\$36 million ·\$25 million amended to \$36	\$9.7 million	(\$6 million)	(\$5 million)
Disbursements	\$4.5 million (1992)	\$25 million (1992)	\$4.6 million (1992)		
Monitoring/ Evaluation Component	No formal system; responsibility to technical assistance team	No formal system	No formal system; responsibility to technical assistance team		
Policy Reform Areas	<ul style="list-style-type: none"> ·Cost Recovery ·Cost Containment, especially hospitals ·Resource allocation ·Human resources ·Decentralization 	<ul style="list-style-type: none"> ·Transfer of responsibility for planning, management and delivery of services ·Shift in emphasis from curative to preventive ·Promotion of privatization 	<ul style="list-style-type: none"> ·Cost recovery ·Social financing ·Improved resource allocation 	<ul style="list-style-type: none"> ·Expansion of private sector in delivery of services, drug importation and distribution ·Improved access to family planning information ·Cost recovery 	<ul style="list-style-type: none"> ·Legal foundation for cost recovery ·Creation of national service standards ·Improved access to family planning materials and information
Conditions Precedent	60 (in five tranches)	18 (in three tranches)	23 (in three tranches)	14 (in three tranches)	8 (in three tranches)

5.0 NIGER

5.1 BACKGROUND

After a decade of rapid growth, Niger's economic prospects began to decline in the early 1980s. This was set off by a decrease in the world price for uranium and a number of years of drought. Government expenditures had rapidly risen in the 1970s, with the deficits financed from external sources. During the 1980s, the Government of Niger adopted a number of austerity measures to restrain overall public sector spending under both IMF Standby and World Bank Structural Adjustment programs. Together with the IMF Stand-by Arrangements, the government began an adjustment process under the Interim Program of Consolidation (IPC) in 1984-1985. The IPC provided new policy directions in several areas, including changes in public investment spending, restructuring of state-owned enterprises, and cost recovery measures for public services.

The IPC was complemented on a sectoral level by the USAID Agricultural Sector Development Grant which was authorized in 1984. It was also followed by the World Bank SAC program which was concluded in 1986 and focused on changing expenditures in the social service sector, together with the public enterprise and agricultural sectors. External aid increasingly became an important source of financing for all government operations. By 1991, the government was operating using financing from donors while barely managing to maintain payments of civil servant salaries.

The political shifts toward more democratic forms of government which began in the late 1980s have been encouraging, but have at the same time been a source of significant disruption to the conduct of routine business within the ministries. They have created an environment of uncertainty for those concerned with policy and institutional reform, exacting a high toll on policy and institutional development efforts undertaken during this period.

5.2 HEALTH SECTOR

Health services in Niger are provided almost exclusively by the Ministry of Public Health and Social Affairs (MOPHSA).³ An extensive publicly operated and financed health care infrastructure exists in the country. This includes hospitals in all the departmental capitals, arrondissement level health centers and over 200 rural dispensaries. Niger attempts to provide access to health services to its people through a strategy which emphasizes primary health care which depends heavily on a number of vertical (largely non-integrated) disease-specific intervention programs. The formal system of hospitals, medical centers, maternity units and dispensaries is supplemented by a national program of village health teams, which include volunteer village health workers and traditional birth attendants. Although these teams have been in operation since 1974, their activities and the impact of their presence on the health of the population is largely unknown.

USAID has provided assistance to the health sector in Niger since the mid-1970s and is the major donor to the primary health care program. In 1978 AID initiated the \$15 million Rural Health

³Unlike many other countries in West Africa, the private sector (for-profit, church run and non-profit/NGO operated) is relatively undeveloped.

Improvement Project. RHIP financed the recruitment, training, and supervision of village health teams; training of health cadres; and the construction, repair, and equipment for rural health facilities. RHIP was designed primarily to provide budgetary support to the primary health care (especially the village health team) program and there was little conditionality associated with the provision of resources to the MOPHSA in its design.

Despite the development of a large delivery system infrastructure and supportive health policies, a pre-NPA sector analysis conducted in 1986 identified significant weaknesses in the health care delivery system including:

- ▲ Inadequate management and planning, the lack of integration of economic and financial factors into health plans, and weak central administrative structures and institutions;
- ▲ An imbalance in the allocation of funds between preventive and curative care personnel and material, and between rural and urban populations relative to the stated objectives of promoting primary and preventive care;
- ▲ A lack of integration of existing services and shortage of services in many areas;
- ▲ Inadequate support of personnel, including in-service training, supervision, materials, and supplies;
- ▲ Lack of health care financing policies that address the continued prospects for poor (or even negative) growth in budgetary resources in the near future;
- ▲ Inefficient spending practices and an absence of cost containment measures;
- ▲ Lack of an integrated national health plan, combined with the timely, reliable, and comprehensive information about services, resources, and the population's health status.

5.2.1 The Niger Health Sector Support Grant (NHSSG)

In response to the constraints identified by its analysis of the health sector in 1986, USAID designed and authorized the Niger Health Sector Support Grant (NHSSG) as an NPA program for the health sector. As the first health sector NPA program in Africa, it has the longest history of any of the health sector NPA programs funded under the DFA. Much of the design and mechanisms for implementation were modeled on USAID's experiences with NPA in the agriculture sector in Niger.

In 1986 the original NHSSG grant agreement to provide \$15 million to the health sector over a five-year period was signed. Release of \$10.5 million in tranches over a five-year period was conditioned upon achievement of specified policy review and reform benchmarks ("conditions precedent"). The remaining \$4.5 million was programmed in support of technical assistance and training. An additional \$2.2 million for project assistance was added to that sum when the NHSSG was extended in 1990 (it has since been extended a second time with completion now scheduled in 1995).

The NHSSG was designed to complement and be implemented in close collaboration with other donor efforts in the sector. The most important area of collaboration was the World Bank Health Project, which supports policy reform efforts of the Government of Niger undertaken as part of the Structural Adjustment Credit program.

The NHSSG included numerous benchmarks intended to support and facilitate policy review and reform in the following six areas:

- ▲ *Cost recovery*: implement and increase cost recovery measures for curative services (hospital and non-hospital) in order to improve sustainability of public health services;
- ▲ *Cost containment*: contain unit costs for hospital services and drug purchasing and distribution in order to make more efficient use of available financial resources;
- ▲ *Resource allocation*: reallocate MOPHSA financial resources to promote increased spending on primary and secondary services, and to allow a proportionally larger budget for consumable supplies;
- ▲ *Personnel*: improve management of existing human and material resources, upgrade staff ability to design, implement, and supervise preventive and primary health programs (particularly child survival activities);
- ▲ *Health sector planning*: increase institutional capacity to plan, manage, and monitor health problems and services; and
- ▲ *Population policy and resources*: promote development of national population policies and increase access to family planning services.

5.3 EXPERIENCES

Despite considerable effort on the part of the MOPHSA and the technical assistance provided by the grant, the program has been perceived by evaluators as too ambitious and too complex for the human, institutional, and fiscal resources available. In addition, achievements must be balanced against the much slower than anticipated pace at which grant implementation has moved.

None the less, the Government of Niger has undertaken a number of important health sector reforms as a result of the grant. Most notably these have been in the area of health finance, development of information systems for improved planning, and cost containment for hospital services. It is important to highlight the fact that the program appears to have had a positive impact upon the health policy environment despite several negative process outcomes identified by the evaluators.

Factors which appear to have constrained the grant in achieving its objectives within the original time frame have been documented in two mid-term evaluations. The factors identified by the evaluators may be categorized as chiefly related to the design of the NHSSG itself and institutional constraints associated with implementation of the program.

The evaluators concluded that the nature, number, and structure of the policy reform benchmarks contained in the NHSSG resulted in a great many activities being initiated by the MOPHSA in an uncoordinated manner (the grant identified 60 benchmarks spread out over six policy areas requiring coordination of at least four separate ministries). While the total volume of work carried out was deemed impressive, there was a resulting lack of focus by policymakers and an incomplete understanding of the nature of the reform agenda which the NHSSG defined. The reforms and the resources did not appear closely linked in the minds of MOPHSA policymakers and therefore provided little incentive to undertake the reform package. NHSSG resources were not allocated to the institutions responsible for the reforms so that in the eyes of many (including the evaluators) the connection between "carrot and stick" was not achieved.

The delays experienced in meeting reform agenda benchmarks has meant that the financial resources have not been released to the MOPHSA according to the original time line. Less than \$5 million of the \$10.4 million allocated has been released after eight years (1986-1994). The original time line anticipated the disbursement of the entire \$10.4 million within a five-year period (1991). As a result of these delays (and others brought about by the de-certification of the institution responsible for the allocation and tracking of funds for the Government of Niger) the economic impact of the grant has, clearly, been significantly reduced. It was noted by the evaluation that complicated and unclear directives for the development of subgrants for the use of the NHSSG counterpart funds contributed to the lack of economic impact of the grant.

Institutional weaknesses identified during the evaluations have plagued the NHSSG as well. The MOPHSA has never allocated a sufficient number of qualified and capable personnel to assist in undertaking grant activities. This is most likely a function of a lack of ownership for the reform agenda and an absolute lack of personnel capable of the analytic work required to achieve many of the NHSSG benchmarks.

The secretariat established by the Ministry of Planning to execute and track the disbursement of NHSSG funds was deemed inadequate and decertified by USAID. Additionally, USAID found that it did not have sufficient resources to adequately monitor grant activities.

Linkage of NHSSG reform conditionalities to those of the World Bank program proved to be problematic. The MOPHSA was not able to undertake the activities required by the World Bank within the original time frame. As a result, several NHSSG activities were held hostage and were not able to be completed, thus holding up the eventual disbursement of NHSSG funding.

6.0 KENYA

6.1 BACKGROUND

Kenya's early economic expansion period, 1963-1980, was among the greatest in Africa. Real GNP grew by over 6 percent annually and real GNP per capita grew at an annual rate of over 3 percent. The early 1980s were marked by substantial economic declines with real per capita growth of minus 0.2 percent per year and a (current) deficit of over 12 percent of GDP. The latter half of the 1980s marked a recovery period, with Kenya's economy achieving a growth rate of about 5 percent per year. The overall performance of the economy has been relatively strong since the recovery in the mid-1980s: agricultural, manufacturing, service, and tourism sectors have grown and performed well. However, the overall strong economic performance has been accompanied by rapid population growth, rising aggregate demand, and inflationary pressures.

In 1985 the Government of Kenya initiated its Budget Rationalization Program to control and restructure public expenditures. The thrust of the budget rationalization called for controls on overall spending and policy reforms to change the composition of government spending (e.g., addressing imbalances between wage and non-wage expenditures). However, progress in improving the composition of public expenditures was very slow and government employment continued to grow. In addition, these budgetary constraints adversely affected and magnified the recurrent cost financing problem of the health sector by limiting resources available to the sector.

Following the sudden fall of coffee and tea prices and the resulting terms of trade deterioration in 1987, together with expansionary fiscal and monetary policies, serious macroeconomic imbalances emerged. Widespread economic stabilization became essential, and in early 1988 the Government of Kenya received IMF assistance in the form of an 18-month stand-by arrangement and a three-year Structural Adjustment Facility to support stabilization efforts.

Efforts to move Kenya toward a multiparty, truly democratic state have dominated the political environment since the late 1980s. Parliamentary elections were held in 1988 and late 1992. Presidential elections were held in late 1992. Civil unrest, strikes, and demonstrations were associated with these attempts at political transformation. Violent ethnic disputes have occurred frequently during the last three years, especially in Western Kenya.

6.2 HEALTH SECTOR

The Kenyan health sector can be divided into three sub-sectors: public, voluntary, and private. The public sub-sector comprises the government and municipal health services. It provides about 70 percent of hospital beds and employs the majority of doctors, clinical workers, and nurses. The voluntary sub-sector consists of the church-related health services and the health activities of other non-government organizations and provides about 20 percent of hospital beds. The private sub-sector includes medical services provided directly by private companies to their employees and through the "market" by private health institutions, fee-for-service medical practitioners and pharmacies.

The Government of Kenya has placed a high priority on health and the Ministry of Health (MOH) is the dominant institution in Kenya's health care system. The health sector's share of the total government budget during the last half of the 1980s averaged 8 percent. Real government expenditures for recurrent costs of health services rose at an average annual rate of 2 percent from 1985-1990. This growth rate, however, was not sufficient to keep pace with high population growth and demand for services. This, in conjunction with the need for fiscal restraint and problems with health financing, imposed severe constraints on the Government's ability to finance expansion into under-served areas, and for strengthening preventive and primary health care (P/PHC). It has led to cutbacks in spending for drugs, consumables, maintenance, and medical equipment. Meanwhile, personnel costs continued to rise. Spending is concentrated on urban hospitals.

Background analyses of the health sector carried out as part of the development of the KHCF program in 1989 identified the following as constraints to the delivery of health services in Kenya:

- ▲ An excessive concentration of budgetary resources on hospital-based care (and other secondary and tertiary services), as compared to preventive and primary services; wage versus non-wage expenses; and capital versus maintenance outlays has resulted in a decline in the quality of public health services.
- ▲ Current government resources are insufficient to provide free services to the entire population as stated by MOH policy. The MOH has experienced great difficulty in controlling the costs of complex and acute care services due to a the lack of consistent health care financing policies to address recurrent budget constraints.
- ▲ Inadequate public/private sector coordination for the delivery of services exists.
- ▲ The central delivery system for primary and preventive services is weak due to inadequate financial resources and program supervision, and overly centralized (yet weak) planning and management.

6.2.1 Kenya Health Care Financing Program (KHCF)

In response to the constraints described above, the Kenyan Health Care Financing (KHCF) Program was developed and authorized in 1989 to be a policy-based resource transfer program. Its purpose is to support implementation of policy reforms that provide sustained, increased financial resources for the delivery of efficient, high quality primary, preventive, and curative services. The policy reforms included in the program are designed to foster the reallocation of financial resources within the health sector in favor of primary and preventive services, and to improve all services by increasing the overall financial resources available to the health sector, made possible by cost sharing and improved efficiency.

The KHCF program is designed to work with three institutions in achieving the implementation of the reform package: the Ministry of Health (MOH), Kenyatta National Hospital (KNH), and the National Hospital Insurance Fund (NHIF). The program defines yearly benchmarks for each institution and grant funds are released in tranches to the treasury as each group of benchmarks is completed. In this way, institutions are not held hostage by the lack of progress toward reform by other participating institutions (a criticism made by evaluators of the NHSSG). In total, the number and complexity of the benchmarks contained in the grant agreement is substantial. A total of 23 benchmarks (some of which contained secondary sub-requirements) were developed and assigned among the implementing institutions. Program funds were to be released to each institution in three tranches.

The program provides \$9.7 million in direct program support to the three institutions, conditioned upon achievements of the agreed upon benchmarks. Under the project component, \$5.3 million was budgeted for technical assistance, training, and commodities required to meet the policy reform benchmarks.

The program was designed as the first step in a longer-term, multi-donor effort to support health sector reforms in Kenya. The KHCF program supports implementation of key policy actions related to cost sharing (fee for service) and to assist the MOH and other donors to define a broader reform program expected to be implemented over a 10-15 year period.

The three main elements of the KHCF reform program are the initiation of:

- ▲ *Cost recovery* through direct patient user fees for curative services at all levels of publicly financed health facilities (with special attention paid to KNH);
- ▲ Increased levels of *social financing* (primarily achieved through increasing the level of insurance claims at government facilities); and
- ▲ *Improved allocation* of financial resources to improve quality and availability of services (especially primary care services).

Specific steps intended to provide a framework for these reforms constitute the benchmarks to which the disbursement of grant funds is tied. The funds are released directly to the Government of Kenya as general budget support, under the condition that government budget support is maintained at least at a constant level.

6.3 EXPERIENCES

The 1992 mid-term evaluation concluded that the KHCF Program has generally proven to be an effective means to promote and develop the Government of Kenya's capacity to define and implement health sector policy reforms. The systems being implemented appear well designed and feasible and the overall goals of the program are being accomplished. In this case, the combination of NPA and project technical assistance appears to have formed an effective package by which important policy reforms have been developed and implemented. Commitment to the reform agenda by the MOH appears high and cost sharing has had an apparent impact on the quality of care and availability of resources where it has been implemented.

The successful implementation of the MOH "cost sharing" program has not been without difficulty, however. The most obvious of these was apparently due to the lack of a broad consensus on the need and importance for cost sharing prior to its implementation on a nationwide basis. The population and MOH employees were ill prepared for the imposition of fees-for-services in publicly financed facilities. Essential accounting and management systems were not in place and no means to monitor and evaluate the system had been developed. A political decision by the President overturned the MOH policy and cost sharing was scrapped less than 12 months after its imposition. Much time and energy were lost before a modified cost sharing program could be re-imposed through a phased process starting at KNH and seven district level hospitals and working its way down through the remaining levels of the Kenyan health system.

The MOH has had difficulty in meeting KHCF targets for the reallocation of budgetary resources toward preventive and primary care services due to its large wage bill. Salaries consume upwards of 70 percent of all budget expenditures. The remaining resources are not great enough to allow for the magnitude of reallocations called for under the KHCF program reforms. Debate occurred around the development and application of appropriate algorithms for the analysis of the MOH budget in order to allocate expenditures between preventive and primary services and "other." Without consensus as to the means by which budget analysis is performed, improvements in resource allocation will be difficult to achieve. Despite the debate, the MOH was, for the first time, analyzing its budget and attempting to bring about a greater coherence between stated policy and resource allocation decisions (whatever the algorithm employed). This was seen by evaluators as a positive development.

The lack of a comprehensive data collection and analysis system capable of providing information necessary for planning and monitoring program implementation represents another important institutional weakness affecting the KHCF program. The KHCF program was slow to develop and implement its own monitoring and evaluation systems in hopes that these needs could be effectively piggybacked onto a more comprehensive health and management information system. This proved unfeasible and the program was forced to develop its own independent reporting and tracking system to monitor cost sharing revenues and expenditures at all levels.

Other institutional weaknesses have also plagued the KHCF program reforms. For example, the mid-term evaluation identified the lack of ability and the human resources required to carry out a number of operations basic to the operation of a health insurance system as limiting the NHIF's ability to implement its set of policy reforms. The MOH's capacity in the area of financial, economic, and health policy analysis are limited. The KHCF reform program faced competition from other donor programs and activities for the attention of the limited MOH personnel involved in policy reform and implementation.

7.0 NIGERIA

7.1 BACKGROUND

The Nigerian economy has been in crisis since the 1980s. In less than a decade, per capita income has fallen from more than \$1,000 in 1980 to \$340 in 1991. The principal cause of this decline has been the progressive weakening in the international oil market since the early 1980s. The resulting economic crisis was intensified by the inappropriate economic policies that prevailed during the 1970s oil boom, which led to large balance of payments deficits and mushrooming fiscal problems.

In mid 1986, the Federal Military Government (FMG) embarked on a far reaching and comprehensive Structural Adjustment Program (SAP). The centerpiece of this program has been the adoption of a substantially market-determined exchange rate system. Other key elements included: elimination of import licensing regimes, abolition of commodity market boards, liberalization of rules governing foreign investment, and revision of import tariff schedules.

Implementation of the SAP by the Government of Nigeria has been generally good and the economy's supply response encouraging. The impact of adjustment has, however, been severe on certain groups. Conventional wisdom is that urban dwellers, civil servants, employees of parastatals, and the middle class have been the most negatively affected by the adjustment process. Consumer prices in Lagos rose 70 percent over the 12-month period ending June 1, 1989. Prices of staples on which the poor depend most have increased the greatest. Despite a lift of the wage freeze in 1988, real purchasing power had been reduced for most workers by accelerating inflation. Local industries and entrepreneurs whose manufacturing and trade depend on external inputs have also been seriously affected by SAP. Unemployment rates, estimated at 20 percent, remained despite the SAP. Foreign investment remained sluggish and capital inflows depressed.

These effects explain why the public has become increasingly disenchanted with both the real and perceived results of SAP. This led to violent and overtly anti-SAP riots in various cities. In response, the FMG instituted a number of short-term measures intended to mitigate the negative effects of SAP. The international donor community (particularly IMF and World Bank) have remained actively committed to supporting Nigeria's adjustment efforts.

During the same time period, Nigeria's repeated attempts to institute a lasting democratic government have failed. A succession of democratically elected leaders have been overthrown by military-backed coups. The lack of permanent governing institutions which are responsive to the needs of the population has most certainly taken a toll on the country's ability to pursue a consistent path of policy development and implementation.

7.2 HEALTH SECTOR

Economic decline and implementation of SAP have had a negative effect on the ability of the government to deliver health services. As in most other sectors, government health expenditures in real terms have been reduced, in large part through wage freezes and the cessation of capital construction and equipment purchase. Other non-personnel costs, such as travel, supplies, maintenance, and equipment have been virtually eliminated. The overall result has been a decline in the quality and quantity of health care services, especially preventive services. One response to this decline has been the imposition of user fees for curative services delivered in government facilities.

Health services in Nigeria are delivered through the public and private sectors. The public sector is managed by the Federal, State, and Local Governments (LGAs). The private sector delivers the majority of health services in Nigeria and consists of privately run Western-style facilities owned by individual practitioners and a large, informal, traditional subsector (which includes traditional healers and birth attendants).

The model Local Government Authority (LGA) program was initiated in 1986 to reorient and improve primary care services at the LGA level through improved supervision, increased local management, and the provision of locally managed grants for the rehabilitation and purchase of existing facilities, equipment, supplies, transport, and training. Under this program, the LGA was designated as the functional unit for the administration of all primary care service delivery. The states in turn supervise the LGAs while the federal government provides policy guidelines and strategic support to both LGAs and states. The FMG also retains the overall responsibility for monitoring and evaluation of the primary care program.

Fifty-two LGAs were chosen to be used as model primary care service delivery implementation sites. Refinements in the primary care model, based on the experiences of these 52 LGAs, were to be made and implementation expanded to the remaining LGAs.

The model LGA program experienced a number of difficulties in implementation including:

- ▲ Weak management capacity due to lack of adequate human resources and insufficient preparation of LGAs to assume full managerial responsibility for health services;
- ▲ Overly bureaucratic systems of control resulting in delays in start up and implementation of the program;
- ▲ Lack of cohesive organizational framework for delivery of health care at the LGA/PHC level;
- ▲ Low levels of sustained community participation; and
- ▲ Shortage of funds to purchase needed materials and drugs.

To address these problems, in 1988 the FMOH developed *The National Health Policy and Strategy to Achieve Health for All Nigerians*. The document outlines two major policy directions for the health sector:

- ▲ A renewed emphasis on primary and preventive services over curative health care; and
- ▲ Rationalization of health care financing.

To implement these policies, the FMOH initiated the model LGA/PHC program, which calls for decentralization of control, and provides support for the local management and delivery of services. LGAs see these policies as responding positively to the direct and immediate health needs of the population, and in providing opportunities for communities to become involved in decisionmaking, planning, and implementation of activities affecting their own health. Prior to implementation of the LGA/PHC program, basic primary health services were largely delivered through and by NGOs and vertical programs. The program has provided an umbrella under which these services are delivered in an integrated framework coordinated and supervised at the LGA level.

The National Policy and Strategy statement also reflects a basic commitment to move toward cost recovery for curative health care and drugs at all three levels of the health system. Preventive and primary health care continue to be subsidized, but cost recovery theoretically increases resources available to the entire government health sector, allows for increased spending on underfunded programs, encourages greater efficiency and better quality services, and increases access to services for the poor.

7.2.1 The Nigeria Primary Health Care Support (NPHCS) Program

In January 1989, USAID authorized \$25 million to support the structural adjustment program of the Federal Military Government through an NPA program targeted to support the health sector.

Despite stated policies which placed the responsibility for the planning, management and delivery of primary health care services at the level of the LGA, the process of actually transferring responsibility from state governments had been slow. The NPHCS program was designed to accelerate this transfer of responsibility. Since the FMOH lacked sufficient budgetary allocations to effect change and expand the effort nationwide, NPA was chosen as the most efficient means of providing support to this process.

The original NPA program agreement, signed in August 1989, anticipated the disbursement of two tranches of \$15 and \$10 million to the FMOH to support the implementation of its stated policy reform objectives. Specifically two areas of reform were targeted for support under the program:

- ▲ The *transfer of responsibility for the planning, management, and delivery of primary care services* from the federal and state levels to the LGAs. This key reform was to come about as the result of a FMOH directive requiring the state government to give control of the lower levels of the PHC system to the LGAs.
- ▲ A *shift in emphasis from curative to preventive services* at the primary care level.

To support these reform objectives, program funds in the form of supplemental budgetary allocations to the LGAs were directed to pay for local training of personnel, assuring the availability of adequate equipment and expendable supplies, and the management of drug revolving funds.

It was anticipated that the NPHCS Program would be completed by the end of 1990, with the disbursement of the second tranche of funds contingent upon proof of progress toward the program policy reform objectives. One month after its signing, the program was amended. The amendment served to increase total funding to \$36 million through the inclusion of a third tranche of funds to be disbursed before the new end-of-program date in late 1992. In return, conditions precedent were added to the program to support policy reforms aimed at:

- ▲ *The promotion and acceleration of the privatization of health services.*

Under the program, no funds were allocated by USAID for "projectized" elements such as training and technical assistance.

7.3 EXPERIENCES

The reform process intended to trigger the disbursement of program funds has proceeded more slowly than anticipated, and by mid-1992 the second tranche had not been released. It is possible that the third tranche will be deobligated by USAID rather than disbursed in conjunction with an extension of the end-of-program target date.

The delays in the disbursement of funds have come despite the fact that the NPHCS program did not require the review or development of new policy initiatives. The program sought to merely accelerate a policy initiative that had stalled due to lack of financial support. Despite this indication of apparent FMOH ownership for the reform agenda, implementation benchmarks set by the program were not completed within the time frame and the mid-term evaluation characterized Nigerian involvement in the program as suffering from "benign neglect."

A lack of thorough analysis in the development of the program has been cited as partly at fault for implementation delays. The entire mechanism was developed in order to provide a means for the rapid transfer of resources to the Government of Nigeria.

A lack of consensus over the means of achieving policy objectives in the area of increased privatization of services also caused delays that resulted in funds not being transferred according to the original time frame. The mid-term evaluation concluded that the impact of the NPHCS program in this area was unclear.

The lack of a technical assistance component tied to the program created difficulties for its implementation. USAID/Lagos did not have the technical resources to monitor progress made against the policy reform agenda. The lack of a technical assistance team (or resources for short term assistance) meant that all program monitoring efforts were based upon FMOH reporting and information systems.

The shift of resources from curative care to preventive services has been difficult. The continued economic crisis has meant that government allocations to the health sector have remained depressed with a greater percentage of resources going to pay personnel costs. The mid-term evaluation painted an unoptimistic picture for improvements in budget allocations in the near future.

8.0 TOGO

8.1 BACKGROUND

Togo experienced substantial macroeconomic imbalances in the late 1970s and early 1980s. These imbalances resulted in an acceleration of inflation, a slow down in export growth, a large increase in the current account deficit, and relatively sharp drops in GDP. Faced with deterioration of the economic and financial situation, in 1983 the Government of Togo initiated the first of a succession of four Structural Adjustment Programs (SAP). Togo had one of the most successful SAP in Africa and economic performance initially improved.

Between 1986-87, Togo's terms of trade declined as the world prices for its main exports fell sharply, causing a substantial decline in budget revenues. Starting in 1990 the economy contracted, the overall public sector deficit deteriorated, and exogenous shocks led to a further deterioration of Togo's internal and external financial situation. Domestic riots, mass civil disobedience, and demands for political change in 1991 further weakened the economic and political stability of the country. Despite the resulting deterioration in internal and external economic conditions, Togo's Transitional Government of National Unity has made serious efforts to improve the fiscal situation and to continue the structural adjustment program.

Per capita GNP levels are low (\$410 in 1991). Combined with the current rate of population growth (greater than 3 percent per year) substantial increases in output are required each year just to keep living standards from declining further. Unemployment and under-employment are serious and growing problems. Despite government efforts, the growth of expenditures on education and health services has been limited by budgetary constraints imposed by the adjustment process and rapid population growth.

The political situation has continued to create uncertainty within the public sector. The Transitional Government attempted to address a number of policy concerns during a series of "Etats Generaux" (policy forums which were organized on a sector by sector basis) in 1992. The failure of the elections to produce a recognized democratic government, however, has meant that many of the policies developed have not yet been implemented. An extended strike by civil servants in 1993 resulted in an even further deterioration of services within the health sector. The political situation has also brought about a decline in donor assistance.

8.2 HEALTH SECTOR

Government spending in the health sector over the period of 1982-1991 has remained low. Health expenditures were anticipated to equal 7 percent of government spending (recurrent and capital) in 1992. The Government of Togo has become increasingly dependent on donor support for investment expenditures in all sectors. Donor support to the health sector in 1989 totaled over 5 billion FCFA which was equivalent to 96 percent of government budget allocations (both recurrent and investment) in the health sector.

The majority of health services in Togo are financed and delivered by the Ministry of Public Health (MOPH). The MOPH has made significant efforts to expand and improve service provision in health facilities throughout the country with the support of WHO, UNICEF, UNFPA, USAID and the World Bank. Despite significant gains, many constraints exist including:

- ▲ Lack of articulated, coherent, and operational policies, plans, and strategies in the health and population sectors;
- ▲ Administrative fragmentation, lack of coordination among vertical programs, excessive centralization of decision making in Lomé, and insufficient resources and support for management and supervision at the prefectural level;
- ▲ Limited competence in budget management resulting in inadequate planning of available financial resources;
- ▲ Stagnant levels of national funding for the health sector, and inappropriate allocation of available resources in favor of the hospital sector and personnel costs (80 percent of recurrent expenditures are consumed by the MOPH wage bill);
- ▲ Growing and unmet needs for family planning and family health services; and
- ▲ Importation of high-cost French brand name drugs by TogoPharma, the sole legal supplier of drugs and pharmaceutical supplies to both public and private sector facilities.

The MOPH suffers from an over-centralized administrative structure. This is compounded by the organization of services as a series of vertical programs which are at best loosely coordinated or integrated. The numerous donors supporting MOPH activities bear some responsibility for this situation by providing separate budgets and technical assistance for vertical programs, with little built-in incentive or support for integration. Donor support to the MOPH is not coordinated either by the MOPH or the donors themselves. A lack of management and financial information systems and skills at the prefectural level further reduces the capacity of the health system to respond to different epidemiological situations and resource allocation problems (personnel, materials, drugs, etc.) at the local level.

During the last ten years real per capita recurrent budget expenditures in health have declined by approximately 20 percent. This has resulted in a shift in recurrent budget allocation toward salaries. Over half of the MOPH budget outside of Lomé goes to the regional and prefectural hospitals, leaving little support for primary health care programs and essential supplies, equipment and maintenance of lower level facilities.

8.2.1 Togo Health and Population Sector Support Program (HAPSS)

The HAPSS program was developed and submitted for authorization in 1992, utilizing an NPA approach based upon USAID belief that the principal constraints to health care delivery in Togo are most clearly confronted through support for policy reform and implementation as a complement to traditional support in the form of institutional strengthening and provision of financial resources, technical assistance, and commodities. The HAPSS program provided a mechanism by which USAID encourages the Government of Togo to undertake policy reforms which facilitate:

- ▲ *Expansion of private delivery of curative and preventive and primary health care services through the removal of legal, administrative, and financial barriers to private sector health practice;*

- ▲ Increased availability of essential drugs and contraceptives through the *private importation and distribution of essential drugs and contraceptives*;
- ▲ *Improved access to family planning information and services* by removal of existing legal barriers; and
- ▲ *Expansion of recurrent cost recovery in the public sector* for primary care services, essential drugs, and contraceptives.

These reforms were identified and developed in direct support of current MOPH public sector programs and stated priorities.

The design of the HAPSS program was based upon USAID/Togo's extensive experience and lessons learned in the health sector and was designed to complement the major \$15.5 million Togo Child Survival and Population (TCSP) project by targeting key policy constraints to improve performance in the sector. Originally a NPA component was proposed for the TCSP, but due to time pressures the TCSP project was authorized in 1991 without the intended NPA component. HAPSS was developed and submitted for authorization the following year as a separate, stand-alone NPA program.

In tandem with the TCSP project, the HAPSS program was intended to serve as USAID/Togo's primary vehicle for assisting the Government to translate its objectives and strategies into policy actions and implementation plans. It identified reforms that would eliminate apparent policy constraints that restrict expansion of access to primary health care and limit the availability of essential drugs and contraceptives to the private and public sectors. The reform benchmarks contained in the HAPSS program required changes in laws and regulations that presently restrict access to primary health care goods and services both in the public and private sectors. The HAPSS program defined three sets of benchmarks to be met over a five year period (corresponding to the TCSP). A total of \$6.0 million in central budget support (not tied or targeted to the MOPH budget) was to be disbursed in three tranches linked to completion of the policy reform benchmarks.

8.3 EXPERIENCES

The TCSP was authorized in 1991. Before a contract to provide the required technical assistance could be signed, support for the project was withdrawn largely for political reasons in 1993. The HAPSS was submitted for authorization in 1992. Authorization was denied due to the same political concerns that led to the cancellation of the TCSP project.

Despite the lack of a signed agreement (or NPA financial incentives to carry out the HAPSS reform agenda) several of the policy reforms contained in the HAPSS were carried out by the Government of Togo. The most notable reform has been the government's decision to license private importers of drugs and pharmaceutical supplies.

9.0 CAMEROON

9.1 BACKGROUND

Cameroon experienced relatively rapid economic growth throughout the 1970s and into the mid-1980s. During this period, GDP increased at an average annual rate of 5.2 percent. The substantial expansion of oil production beginning in 1978 further accelerated this growth to 9 percent annually from 1981 to 1986. Per capita income at that time reached approximately \$800.

Since 1986, the Government of the Republic of Cameroon has endured an economic recession and financial crisis, which has resulted in an estimated 21 percent decline in GDP. The recession was mainly due to steep reduction in world prices of cocoa, coffee, and oil, which drastically reduced export earnings.

Beginning in 1988, the Government of Cameroon began discussions with the IMF and the World Bank regarding stabilization and structural adjustment of its economy. With the support of a Stand-By Arrangement in 1988 and a Structural Adjustment Loan in 1989, Cameroon began to undertake actions aimed at: curtailing public expenditure growth; strengthening revenue collection; liberalizing the trade regime; liquidating, privatizing and restructuring the parastatal sector; and reforming the civil service.

The economic crisis led to a significant reduction in per capita income and the private consumption of goods and services. In addition, the Government had seriously reduced the allocation of resources to the social sectors including health and education. The economic crisis and resulting adjustment programs also had a negative impact on employment and standard of living. In response, the Government, in collaboration with multilateral and bilateral donors, developed the Cameroon Social Dimensions of Adjustment Program (SDA). This program has been an effective mechanism to mobilize donor funding in the areas of health, population, education, employment, and women in development.

During the late 1980s and early 1990s, political and civil unrest have reoccupied the Government of Cameroon. There have been numerous general strikes and movements aimed at the establishment of multi-party democracy and constitutional reforms. Presidential elections were held in 1992.

9.2 HEALTH SECTOR

Cameroon's ongoing economic recession has particularly affected the health sector. The Ministry of Public Health (MOPH) budget has registered a sharp decline since 1986. In 1988, MOPH funding was reduced by 50 percent, causing an almost complete cessation of service delivery. As a result of this reduction, the supply of drugs virtually ceased, utilization rates and confidence in the system deteriorated, and personnel were poorly motivated because they received no support. While the health budget has been partially restored, serious problems persist in the delivery of services, and personnel costs consume a high percentage of total resources.

The MOPH has taken action to improve the delivery of primary health care services. In 1989, the MOPH conducted a national assessment of the existing primary care program(s) and developed a revised strategy which stresses community involvement, co-management of health facilities, community co-financing of services, and full integration of all interventions. This new strategy, documented in "Reorientation of Primary Health Care in Cameroon," follows closely with UNICEF's Bamako Initiative and WHO's three-phase strategy for the development and delivery of primary care services.

The redefined strategy has been implemented in pilot zones and has shown positive results. By 1991, however, a number of important policy constraints had been identified which limited the effective, nationwide implementation of the new strategy.

The principle constraints identified by the MOPH and USAID to the implementation of the redefined primary health care strategy at that time (1991) were:

- ▲ Cameroonian finance law does not allow the collection of fees for service at sub-divisional hospitals and health clinics.
- ▲ Cameroonian finance law does not permit facilities to retain income generated from cost-recovery activities.
- ▲ The MOPH's framework for revenue sharing by employees does not include paramedical personnel and does not include incentives for non-revenue generating activities such as supervision, management, and outreach activities.
- ▲ There is no legal basis for the election and operation of community health committees.
- ▲ The essential drug list does not include modern contraceptives.
- ▲ Family planning, service delivery policy, and family planning medical standards need to be developed and followed.
- ▲ The national drug procurement system has ceased to function effectively resulting in no legal alternative mechanism for drug procurement.
- ▲ Access to contraceptives from private pharmacies is limited by high prices.

9.2.1 Primary Health Care Subsector Reform (PHCSR) Program

In 1991 USAID and the MOPH developed the PHC Subsector Reform Program to provide the required legal and procedural basis for the nationwide implementation of a primary care program based on the MOPH's redefined strategy. NPA had been used effectively in the agriculture and economic development sectors in Cameroon during the 1980s.

The reform agenda was defined to assist the MOPH in providing a legal foundation for the nationwide implementation of the redefined primary health care strategy and promote the integration of family planning services into this program. The PHCSR reform agenda was packaged into an NPA program to directly support the implementation of USAID/Cameroon's other two bilateral health projects: the MCH/CS Project which assists the MOPH to implement the redefined strategy in Adamaoua and South Provinces, and the Family Health Support Project (FHSP) which assists the MOPH to integrate child spacing and related maternal health interventions in the reoriented primary health care program in the provinces. The NPA activity was designed to:

- ▲ *Provide a firm legal foundation for community-managed cost recovery activities;*
- ▲ *Provide national standards for delivery of family planning and maternal health services;*
and
- ▲ *Make modern contraceptives readily accessible to the population by including them in the national essential drugs program.*

The PHCSR program called for the disbursement of a total of \$5 million to the Government of Cameroon in three tranches over a period of three years. It was anticipated that the funds would be used directly by the MOPH to support the continued implementation of the redefined primary care strategy throughout the country.

9.3 EXPERIENCES

The PHCSR reform program was never authorized by USAID. Instead, USAID chose to direct its attention to more fully supporting the implementation of the reoriented primary care strategy in South and Adamaoua provinces (SESA) and strengthening the delivery of family planning services throughout the country (FHSP).

Despite the lack of an NPA-based incentive for policy reform, a number of the legal changes in support of cost recovery and the redefined primary care strategy that were defined by the PHCSR have been made by the Government of Cameroon.

10.0 SUMMARY OF LESSONS LEARNED

The health sector NPA programs which have been developed and implemented (and summarized above) in sub-Saharan Africa represent a wide range of experiences. Each of the countries involved has made important policy reforms since 1986, when the Niger Health Sector Support Grant (NHSSG) was developed (the first of the three). NPA programs have in some way supported many of those reforms. None of the programs was able to demonstrate proof of meeting all of its conditions precedent within its original time frame. All of the programs, however, should be considered qualified successes based upon the progress that has been made.

In Togo and Cameroon, reform agendas were developed during the design of NPA programs but never linked to the economic incentives that would have been made available had the NPA programs actually been authorized. None the less, several of the reforms contained in the programs have been carried out in both countries. The mere fact that developers were able to engage policymakers in a review of the reform process and help focus on priorities and constraints may have influenced their actions.

While each country presents a unique environment and story, a number of common threads run through the experiences summarized above. As such, they represent lessons that USAID should study in the use of the NPA mechanism to support health sector policy reform. Consideration of these lessons is important if USAID is to continue to support the development of rational, sustainable health systems in Africa.

Despite our ability to learn from these experiences, a multitude of questions remain. There are still a number of issues related to NPA for which the only lesson learned is that there is no set or formula answer available. These issues will be identified and discussed in following section.

The issues and lessons learned from current NPA experiences in Niger, Kenya, Nigeria, Togo, and Cameroon will be grouped as they relate to issues of: *Program Development and Design*, *Program Implementation*, and *Program Evaluation*. Despite a certain amount of overlap among these categories, it is hoped that this discussion may assist developers and planners when they consider health sector assistance efforts and mechanisms.

10.1 PROGRAM DEVELOPMENT AND DESIGN

- ▲ *Extensive background analysis is required so as to have an adequate understanding of national policy review and reform mechanisms.*

The preliminary background analysis required to develop an NPA program exceeds those required for traditional project development. The need for additional background analysis is clearly recognized by USAID guidance on NPA program development. National policy mechanisms and priorities are often not clearly stated and available to the designer on request. While the desire may be to write detailed benchmarks to mark progress along the reform path (this makes the role of USAID easier when deciding whether sufficient progress has been made to permit disbursement or transfer of program funds), it is extremely difficult to do so without an in-depth understanding of the issues and environment implied by such benchmarks. There may be an inherent conflict between NPA's label as a quick disbursement mechanism and the slow and analytic process required for its development.

The Nigeria NPA experience suffered because, in the eyes of its mid-term evaluators, it had not benefited from sufficient background analysis. USAID had a long-standing relationship with the MOPHSA in Niger; however, long years of project implementation experience did not provide direct insight into the identification of policy reform priorities or mechanisms. A great deal of analysis was necessarily conducted as part of the NHSSG design process. None the less, the reform agenda that was developed has proven to be, in some instances, overly complicated and ambitious given the institutional and human resources available. The NPA program in Kenya was the end result of at least seven years of dialogue and analysis of health finance issues with many donors in that country.

The policy reform mechanisms and environments in African countries are complex, as they are elsewhere in the world. Frequent and unforeseen political and personnel changes complicate efforts to undertake fundamental changes that may take years to adopt and implement fully. Ownership and consensus are difficult to develop and/or ascertain when people and issues change frequently.

- ▲ *Limited institutional and human resources in many countries complicate NPA's ability to define a reform process, especially one which is based on research and analysis.*

A more thorough analysis than has been done in the past of the institutional and human resource environment must be undertaken if NPA designers are to develop feasible and reasonable expectations (in terms of time and complexity) for policy reforms. In all three countries where NPA was implemented, it appears that designers overestimated both the quantity and quality of human resources that would be devoted to supporting the reform process.

NPA designers also apparently overestimated the institutional capabilities of many of the participating institutions to take a leadership role in guiding the reform process. This has been especially true in those instances where the identified reforms have required action or participation of ministries other than health.

The results of an assessment of institutional capacity to undertake complex, analytic reform programs should guide NPA developers in evaluating the need for complementary technical assistance.

- ▲ ***It may be difficult to define, in advance, a complex reform process in terms of measurable and quantifiable conditions precedent which capture the spirit of the desired reforms.***

Policy is made and changed for many reasons, not all of them completely analytical in nature. This is true in the United States and developed countries as well as developing countries. The policy agendas and priorities for a given sector may not be either well developed or articulated. The agenda and priorities may be set completely outside of the health sector itself (evidenced by the political decision made by the President of Kenya to eliminate cost sharing without consulting personnel within the health sector). Frequent political and personnel changes in many African countries make it difficult to design a long-term strategy for policy reform and implementation that will remain valid.

NPA should attempt to induce specificity into the reform process by asking host governments to agree upon priorities and measurable steps along the path. This dialogue is a positive step, even if ultimately it does not lead to an NPA program (Togo, Cameroon). At the same time it would seem prudent and perhaps necessary to allow for flexibility in the process. This must be done unless the outcomes are all known in advance. This is infrequently the case. The balance between the appropriate amounts of both specificity and flexibility is difficult to achieve and perhaps the key to the development of effective NPA supported reform programs.

In Niger, NPA designers attempted to balance these two apparently contradictory needs with respect to cost recovery for non-hospital curative services. NPA benchmarks required pilot tests of various methods leading to the nationwide adoption and implementation of a single cost recovery method for the health sector. The progress in the design and implementation of the pilot studies provided USAID and the MOPHSA with measurable benchmarks but did not impose or suggest any particular cost recovery mechanism. The tests have been successfully completed (with assistance of the HFS Project) and the President has declared that a cost recovery mechanism will be adopted and implemented nationwide.

The difficulty of predicting the steps and time required to build consensus and ownership around a given reform (or set of reforms) must be noted. In Niger it has taken many studies, much debate, and a series of workshops in order to arrive at the point of national adoption of a single method for cost recovery for non-hospital services. The greater than anticipated amount of time required to accomplish these significant reforms should not be a signal of failure for either Niger or the NHSSG.

- ▲ ***The goals and objectives of NPA appear best served when combined with standard elements of project assistance.***

Given the many institutional and human resource difficulties faced by many Ministries of Health in Africa, it may be unreasonable to expect them to carry out extensive and complicated analytic work in support of policy reform programs without providing for technical assistance to support the process at the same time. If long-term goals of capacity and institution building are to be accomplished, training is required. Both technical assistance and training should be included as part of a "projectized" adjunct to the NPA program.

The transfer of untargeted funds to a ministry may not be the most effective means to ensure the implementation of new policies. If NPA funds are intended to be spent in support of policy implementation then a more project-oriented approach which has a higher degree of specificity of their end use may be required. In all three cases examined, the NPA grant funds did not provide an effective means for the implementation of revised policies (in two cases because the funds were either not available or slow in coming, in another, due to apparent lack of interest on the part of the implementing institution).

- ▲ ***What is the framework required to make grant funds an effective incentive for policy reform? Is it necessary to link reform with monetary reward? Do grant funds provide a real incentive to host country institutions to undertake policy reform measures?***

The mid-term evaluation(s) of the NHSSG conclude that the reform process was impeded because of the lack of a direct linkage between the institutions responsible for the reforms and the recipients of grant funds. The carrot and the stick were, in the eyes of the MOPHSA, effectively disconnected. None the less, reform continued, albeit at a much slower pace than outlined in the program agreement. It would be pure conjecture to suggest that a more direct linkage would have provided sufficient incentive to proceed more rapidly (or decisively) with the reform process.

Many of the delays incurred in meeting NHSSG conditions precedent were (according to the same evaluators) due to a combination of institutional weaknesses in policy analysis and planning, lack of human resources to undertake the many activities required by the benchmarks, and a lack of commitment to certain aspects of the reform package. The NPA reform agenda in Niger contained several reforms that appear to be unfeasible within the current political and social context of the country. The benchmarks associated with health manpower planning and allocations will, in all likelihood, remain unmet over the course of the program. As a result, the disbursement of funds to the MOPHSA remains blocked, despite significant reforms and progress made in other areas included in the grant. The financial incentives contained in the grant did not (and in all likelihood will not) produce the overriding incentive for the reforms which did and did not take place.

The Nigerian MOPHSA continues to make progress in the areas of hospital autonomy and cost recovery for non-hospital curative services, despite the fact that no grant funds are likely to be disbursed as a result of failure to meet other benchmarks. In fact, the MOPHSA has sought support from another USAID mechanism (the Health Financing and Sustainability Project) to carry out the pilot test of the cost-recovery mechanism that is called for by the NHSSG. These tests are clearly a step in the reform process and the MOPHSA is dedicated to carrying them out with or without a financial "carrot."

In Nigeria, funds were made directly available to the FMOH to allow for the implementation of its stated policy promoting the transfer of programmatic responsibility to the LGA level. The decision to transfer responsibility was made prior to the authorization of the NPA program. Clearly, NPA funds did not, then, provide any incentive to the reform process. They should have provided the means by which the new policy could be put into action. Response to the availability of the NPA process was characterized as one of "benign neglect." Clearly the availability of resources to proceed with implementation was not the only obstacle to overcome.

The availability of funds to the MOH in Kenya did not appear to be an effective incentive to any of the institutions responsible for the reform package. They certainly did not deter the President of Kenya from overruling the MOPH and rescinding one of the most important of the KHCF reforms, cost sharing.

- ▲ ***The health policy reform process must be seen in terms of the ongoing political and social evolution of the country. NPA's biggest role may be in keeping defined policy issues on the national agenda, despite a changing political environment.***

The African political and social landscape is changing rapidly. The changes taking place may rival those which occurred in the early 1960s when most countries became independent. In such a fluid environment, policies and priorities may change rapidly as well. The presence of a defined policy reform process contained in an NPA agreement may serve as a means of keeping certain issues on the agenda in spite of these changes. This is an important effect of NPA agreements. Other forms of assistance may serve this same purpose as well.

NPA allows USAID to sustain a detailed and consistent dialogue with host governments as to their specific policy priorities for the health sector as a whole. In Niger there have been two changes of government and more than six different Ministers of Health. The presence of the NHSSG policy reform agenda has allowed USAID to continue to raise the question of progress toward agreed upon objectives despite the changing scenery. Niger has, in fact, held to many aspects of the NHSSG agenda and significant policy changes continue to occur. USAID has modified the agenda slightly as the result of evaluation activities. This is an effective use of flexibility to allow for change while maintaining a steady course.

In Kenya the elimination of cost sharing for apparently political reasons despite the presence of the KHCF program was the cause of considerable discouragement among USAID and MOH policymakers. The presence of the KHCF program, however, provided the MOH with the incentive to develop a strategy that resulted in the reintroduction of a modified cost sharing program. This modified program has been successfully implemented nationwide.

In both of these instances, it appears that NPA allowed USAID to maintain a consistent policy dialogue with the host country governments. In doing so, it would appear that it was able to promote reform despite a changing and unpredictable environment.

- ▲ ***NPA appears more successful in supporting reforms for which there is a high level of pre-existing national ownership.***

This lesson raises the question as to the absolute necessity of NPA. It is possible (if overly cynical) to interpret USAID's experience with NPA to teach us that most host governments will proceed with the development of the policies they want, and USAID through NPA (or other mechanisms) may have little influence on that process. Taken one step further, we can ask why USAID should pay countries to do what they would (and should) do anyway. Success in this context is taken as the program's ability to transfer funds to the host government within the defined time frame based on mutually agreed upon measures of meeting program benchmarks.

The first task before NPA designers, then, is to identify those policies for which there is a high degree of interest and support within the existing institutional framework (i.e. "ownership"). The second task is to identify the existing constraints to their adoption and/or implementation. If it is possible to identify these constraints, then NPA (at its best) may be seen as a mechanism capable of performing two services:

- △ Facilitation of broad-based discussion around those constraints and the strategies to overcome them.
- △ Provision of resources in a timely manner to assist in the implementation of the identified strategies aimed at overcoming the recognized constraints (i.e. more targeting of NPA resources to specific activities).

Instead, the NPA experiences that were examined appear to have attempted to define not constraints to policy reform, but the process for reform and even the new policies which must be adopted. By doing so, designers may have (inadvertently) imposed either processes or solutions that preclude "ownership" and, therefore, implementation.

▲ ***Can NPA satisfy its two objectives of sector policy reform and financial impact? Must these two objectives be linked?***

The allure of NPA is quite seductive in its promise of high impact in return for relatively small amounts of money and a "light" management burden upon the Mission. Given such expectations, is it possible to succeed when the complexity of the task at hand is understood? Both NPA objectives of support to policy reform and financial impact are justifiable. Linking the two together, however, may not be the most effective mechanism to accomplish either. The experiences described in this paper indicate that the linkage has not worked effectively. The policy review and reform process may not (despite any of the rationales provided about offsetting implementation costs, etc.) respond to financial incentives as contained within the NPA framework.

NPA has been a participant in significant health policy reform efforts in both Niger and Kenya (NPA in Nigeria merely paid for the implementation of adopted reforms, an alternative model worth consideration). It is questionable as to whether it has actually driven or leveraged the process in either Niger or Kenya (as opposed to supporting the process). It has kept reform on the agenda within a changing political environment.

- ▲ ***Is policy reform, as generally structured by NPA (e.g., conditions precedent, benchmarks, national policy statements, legal and regulatory changes), necessary? Should donors support the implementation of new policy measures without requiring a formal statement of policy? Is the support of de-facto reform more efficient and satisfying?***

Many countries have begun (with the support of UNICEF and the Bamako Initiative, for example) to implement policy reforms in the area of cost recovery and community participation. These are reforms that are analogous to those supported under the NPA programs in Niger and Kenya. In certain cases, this has taken place without the benefit of formal policy declarations or legislative changes (especially when initiated as pilot tests in a defined region or area of the country). These changes have also taken place in the absence of financial incentives to adopt the policies (UNICEF does provide resources to facilitate the implementation of reforms in many countries).

This discussion raises the question as to how to best define and support policy reform packages. The need to define measurable benchmarks (as with NPA) that trace the reform process in advance may lead us away from providing support to key issues related to implementation. This, at its worst, leads to "empty reform," where a number of important changes have been made on the books but lack the support for their implementation.

- ▲ ***The three- to five-year time frames contained in the NPA experiences to date appear to be too short to permit the number and magnitude of policy reforms contained in them.***

All of the health sector NPA experiences in Africa have required far greater time to achieve policy reform benchmarks than was anticipated by program designers. It is clear that the expectations of designers were overly ambitious. The time required to achieve ownership and consensus in a rapidly changing political environment was underestimated. The time required to carry out necessary analytic work was also underestimated.

The clear lesson to be learned is that the major policy reforms that were contained in these NPA programs take time and patience to come about. The time frames required to reform policies and especially institutions, as contained in the NPA programs, were underestimated. Given the many variables that are implied by the policy and institutional reform equation, it is understandably difficult to predict that given changes can occur within a three- to five-year program period. It is also possible that such a short time frame may be insufficient to bring about such major change. It may be prudent for USAID to reevaluate the time frame contained in NPA programs and allow for a longer period in which to bring out reform.

The reforms in health finance contained in the Niger and Kenya NPA program required a significant amount of analytic work before the actual reforms were ready (this is an ongoing process in Niger). The time required to build consensus and ownership on both process and outcome is difficult to estimate in advance. It must be remembered that the reforms under discussion represent major policy changes and a significant departure from previous policies. It is also difficult to portray that process in terms of discrete and measurable/verifiable benchmarks.

10.2 PROGRAM IMPLEMENTATION

- ▲ *USAID should not underestimate the management burden associated with NPA. This burden increases as layers of administration and tracking are added to disbursement mechanisms. Complex policy reform agendas add to the management burden by imposing considerable demands on the Mission to monitor host government progress against those agendas. It should be remembered that this management burden is also shared by the host government institutions involved in the program and may serve to diminish enthusiasm for the NPA policy reform agenda.*

NPA is intended to be a mechanism for the quick disbursement of funds, as a means of providing budgetary support to a national treasury or sector. The end use of the funds is not (or is only loosely) defined, and little tracking of the end use of the funds is anticipated. As such, it should incur minimal management demands on the Mission involved. As the health sector NPAs described here have departed from this original "management lite" approach and imposed additional complexity in requirements for the use of grant funds, or complexity in the policy reform agendas they contain, the management burden has increased substantially.

In the case of Niger, the NPA design imposed a complicated (and ultimately problematic) institutional structure that required the collaboration of several ministries and the USAID mission to program and track NHSSG funds after disbursement. This was intended to target those funds toward Mission priority programs in the area of primary care and child survival. This mechanism, however, proved to be cumbersome, time consuming and, in the final analysis, ineffective in facilitating the flow of funds. The process suffered from a lack of clear definition of the desired uses for the funds and the procedures by which they were to be allocated. The accounting procedures and capabilities of the institutions involved were inadequate, and the secretariat created to facilitate transfer of funds, was decertified by USAID. The operation of the secretariat, procedures for the allocation of funds and tracking use of funds consumed considerable amounts of time and energy within the Mission. In the end, these problems limited the budgetary impact of the NPA program.

The mechanisms employed for the transfer of NPA funds in Kenya and Nigeria were less burdensome. In Kenya, some time and effort (and consultation with host government) was required to establish the methodology by which the Government of Kenya would demonstrate to USAID that grant funds had increased the level of budget support to the Ministry of Health. The concept of additionality of NPA funds to existing health resources, compared to substitution, was a key facet of the KHCF program design.

The three NPA programs described here all contain complex policy reform agendas. It has been necessary for USAID missions in each of the three countries to expend considerable effort to monitor host government progress toward meeting the policy reform benchmarks. In all three cases this has required much more effort than anticipated by the Mission. In Niger and Kenya much of this burden was/has been transferred to the technical assistance team. The team's participation in assisting USAID to monitor host country success toward meeting benchmarks has had a generally negative impact on the position, role, and effectiveness of the technical assistance team as resources to the Ministry of Health. In Nigeria, where there were no technical assistance resources available, the monitoring of FMOH progress by the USAID mission proved to be problematic.

The complexity of the policy reform agendas involved in these programs must also be viewed in terms of the capacity of the host country institutions involved. The reform agendas in both Niger and Kenya, however elegant, were beyond the institutional capabilities of the ministries involved in the given time frame. The ministries were unable to commit sufficient human resources to respond to the managerial and technical burden imposed by the programs. This served to create frustration and delays. With delays, the link between reform efforts and grant funds (carrot and stick) becomes less tangible.

▲ ***How does NPA build institutional capacity for policy review and reform while satisfying the need for policy reform progress?***

Institutional capacity-building was an important, but perhaps neglected, objective of each of the NPAs examined. While PAAD language indicates the need to build such capacities, the emphasis clearly fell on the accomplishment of deliverables and the meeting of the conditions precedent, in hopes of making program funds available in a timely fashion. In the arena of implementation, USAID and the host institutions involved have tended to become focused on the benchmarks and the reforms they represent. This focus was communicated to the technical assistance teams in both Kenya and Niger who then, understandably, put activities aimed at accomplishing benchmarks above capacity-building.

It may be desirable or necessary in the design of future NPA agreements to develop benchmarks for institutional capacity-building. These would be given equal weight and importance with the reform benchmarks. They would serve as a reminder to Ministry, USAID, and technical assistance team of the importance of this aspect of the NPA program. This would serve to make NPA more than a "money for policy" transaction. The inclusion of such benchmarks would mean that the time frame required for a given set of reforms may almost necessarily need to be extended to accommodate the need to build capacity along the way. The additional time required is justifiable in terms of both ownership and sustainability. USAID must also commit sufficient technical assistance resources to capacity-building efforts.

10.3 PROGRAM EVALUATION

▲ ***It appears difficult to measure the absolute success of NPA in promoting policy reform. How do we judge the effectiveness of NPA in a complex policy reform environment?***

The NPA programs described in this paper exist within complex and changing environments. It appears difficult to unravel the exact role played by NPA programs in supporting or encouraging any reforms made during a given period. In as much as the reform agendas are developed collaboratively with host governments (the need for "ownership"), it is conceivable that any or all of the reforms might have taken place without an NPA program in place. In the case of Nigeria, NPA provided the financial resources necessary to implement a policy reform which had already been adopted. In all three cases, significant and important reforms, outlined in the NPA programs, have taken place.

The experience of Cameroon and Togo are of interest. Important and controversial reforms that had been included in an NPA program proposal were carried out even though the NPA program was not authorized by USAID. Many countries in West and Central Africa are undertaking similar policy reform programs without NPA assistance. In all of these countries, both with and without NPA, many donors are promoting change as well. The attributable role of NPA in promoting or facilitating change in such a complex and crowded environment is difficult to determine.

One of NPA's principal roles may be to keep certain policy reform issues on the national agenda despite the complexity of the environment. There have been more than six Ministers of Health in Niger since the original signing of the NHSSG. There have been two complete changes of government during that period as well. Despite this, much of the policy reform agenda defined by the NHSSG agreement has continued to move forward. The speed of the reforms has been much slower than anticipated, but progress continues to be made, and the existence of the NPA agreement allows USAID to refocus ministry attention on a set agenda.

Policy reform is not an experimental endeavor with experimental and control situations. It is difficult to ascertain what would have occurred in Niger, Kenya, and Nigeria without NPA. It may not be possible to effectively measure or assess the relative (or attributable) contribution of NPA to the reform of health policies in the current African context.

- ▲ ***It may not be possible to develop people-level impact indicators linked to the transfer of funds under NPA. It is almost certainly impossible to attribute changes in people-level indicators to general budgetary support provided under NPA. It may be possible to link the implementation of certain programs or activities to those funds. The link between those activities and programs and people-level impact is also difficult to establish.***

Despite considerable effort and donor support, most African countries do not currently possess comprehensive health information systems capable of providing information on people-level impact indicators (morbidity and mortality). Information on less quantifiable indicators of quality and access to health care are not available and difficult to interpret. This makes the evaluation of interventions using people-level indicators troublesome from the standpoint of data availability. Many projects are forced to develop costly, independent information systems for management and evaluation.

Methodologically, the attribution of people-level impact to any health intervention is difficult. In the case of interventions consisting of general budgetary support, it is indirect at best. While it may be shown that per capita expenditures of health services have risen, this is a great leap of faith away from demonstrating positive change in health and other people-level impact indicators. We may, however, be able to demonstrate a link between resources, services, and utilization.

In the case of Niger, the link between the transfer of funds and impact may be more easily discerned due to the expressed targeting of funds to primary health and child survival programs within the MOPHSA (of course this targeting does not come without an administrative price). In most cases NHSSG funds contributed only partial support to various MOPHSA programs. The apportionment of direct impact to any of these individual MOPHSA programs is difficult.

In the other examples studied where NPA funds were released to the host country government as untracked budgetary support, the direct link to people-level indicators is problematic. It must be remembered that attribution of direct impact is difficult to establish with most health projects that are not designed and implemented to include a rigorous research and evaluation component.

- ▲ ***It appears difficult to define people-level impact indicators for many of the policy reforms supported under health sector NPA to date. The success of NPA supported policy reforms in bringing about positive people-level outcomes is difficult to establish.***

The evaluation of the success and impact of policy and policy reform efforts is particularly difficult. While we can easily track changes in policy and even changes in programs and service delivery based upon new policy, it is, for reasons discussed above, often difficult to directly attribute any of those changes to measured change in impact indicators such as morbidity and mortality.

The path from policy to implementation to impact is complex and there are many intervention points possible along the way. There are also a myriad of other factors which feed into such a path. All of these factors determine, to some extent, measured changes in impact indicators (if systems exist to allow for the measurement of changes in this type of indicator).

It may be more feasible to monitor changes in services delivered or utilized (improved quality and/or quantity) as a result of policy reforms. This would be equivalent to a process type evaluation rather than an impact evaluation. Information systems generally exist that permit collection of data on these types of indicators, as opposed to morbidity and mortality outcomes. Positive changes in indicators of quantity and/or quality of services give us faith, if not proof, in the impact of reforms.

The evaluation of NPA programs should attempt to trace the model upon which NPA has been developed. That model suggests that NPA benchmarks lead to policy reforms. These reforms in the health sector have generally been concentrated in the areas of: health finance, increasing financial resources to the health sector, decentralization, and increased emphasis on primary care services. These reforms, along with the financial resources generated through NPA, lead to increased and more rational use of resources within the health sector. It is then possible to link the increased availability of resources to improvements in the quality and quantity of services delivered. While quality of services is difficult to quantify and measure, it is possible to track changes in the quantity of services delivered in most circumstances. The link between services delivered and improvements in health is difficult to directly attribute.

11.0 CONCLUSIONS

The experiences with NPA in the health sector in sub-Saharan Africa have not lived up to all of the expectations held by their designers, host country institutions, or USAID. The reforms have come much more slowly than intended. The building of ownership and consensus necessary to undertake some of the targeted reforms has taken more time than anticipated. Some of the proposed reforms have proven unfeasible, even when linked to the financial incentives of NPA.

The reforms that the health sector NPAs have supported have proven complex. The process by which policy is made has proven difficult to predict in advance and in all of the countries examined has taken place within a rapidly changing political and social context. The institutional and human resources available to drive a reform process heavily dependent on studies and analysis (as the NPAs have been) have proven weak, and sufficient resources and time to build that capacity were not anticipated in the original designs and time lines developed. Capacity building takes time.

The NPA experiences in the health sector in sub-Saharan Africa have not been failures. Nor have they proven unqualified successes. NPA has contributed to positive and significant health sector policy changes in the countries with programs. The NPA programs have kept key questions related to the finance, delivery, and management of services on the agenda during turbulent and changing times.

For example, in Niger and Kenya significant changes in health finance have occurred as part and partner to NPA programs. The changes, when fully implemented, will result in a substantial increase in the resources available to the health sector in those countries. The presence of those NPA programs most certainly influenced the content and direction of those changes. The importance of what has been accomplished in those countries must not be overlooked, despite the apparent frustration of evaluators over the pace at which changes have occurred.

The NPA programs examined provide insight into the mechanisms of health policy reform in Africa. It is a slow, complicated process. The environment and priorities change rapidly and unexpectedly. NPA has given USAID in the three countries where it has been tried a vehicle to maintain an ongoing and consistent dialogue around health priorities. NPA has provided resources to implement programs based on some of those priorities. The sustainability of service delivery and other activities supported through NPA has been enhanced through their linkage to basic policy reforms.

Given all of the potential difficulties in supporting reforms, a case might be made that the processes involved are too complex and time consuming, and assistance should be targeted directly to project assistance where the measurement of people-level impact is more easily measured. Inputs and outputs are more easily identified and the linkage to indicators of impact is easier to establish.

Based upon NPAs accomplishments, frustrations, and progress, as described in this paper, a discussion of how USAID can and should support policy reform in Africa is justified. Within such a discussion, the role and best uses of NPA begin to emerge. It may be that NPA is best used to support certain types of reforms or that a country must be at a certain stage in the reform process before NPA can

be most effective. These discussions take place only after affirming the underlying premise that: *Donor efforts to promote the development of effective, efficient, and sustainable systems for the delivery of quality health services in Africa should include a component which includes support for basic policy reform.*

If this assumption is true, then USAID must reflect upon whether NPA is the most effective tool to support such reforms. NPA is expensive and labor intensive for all involved. It is not "management light" nor a method for quick and easy transfers of funds. It should probably be combined with technical assistance resources and the time line for reform must account for the need to build capacity though the reform process.

If NPA is to be effective its designers must attempt to better understand the policy reform process and correctly identify national priorities and constraints which exist within that process. The difficulty of this task must not be underestimated. NPA should not attempt to support reforms for which there is no sense of consensus/ownership, or for which the constraints to reform are not clearly understood. Lack of information is often, incorrectly, identified as the single major constraint to reform.

It may be unwise to attempt the design of a health sector NPA in a country where there is not a long-standing USAID presence. This presence must have resulted in the development of insight into priorities and process within the policy arena. It must understand the limits of the Ministry of Health to change policy and the dynamics of policy reform at the national and political level.

The results of an assessment of institutional capacity to undertake complex, analytic reform programs should guide NPA developers in evaluating the need for complementary technical assistance. The results of this analysis should be reflected in the content and timing of the reform agenda. Strengthening institutions should be seen as a major objective of NPA programs and the necessary time and resources must be committed if this is to be accomplished.

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