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Assessment of Niger's National Cost Recovery Policy Implementation in the Primary Health Care Sector

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Partnerships for Health Reform

PHR

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Abstract

Under a National Assembly law passed in 1995 and corresponding implementing regulations enacted in 1996, the government of Niger established a new cost recovery policy for primary health care services. According to these legal instruments, the concept of cost recovery is defined as a participatory mechanism for sharing the cost of health care services provided to the local population at public health facilities. Its purpose is to generate additional income from the sharing of health care costs with the local community in order to improve the quality of primary health care. However, attempts to implement the country's new cost recovery policy at the nationwide level have suffered from the unstable political climate, inadequate institutional framework, and lack of leadership within the Ministry of Public Health (MOH). This report presents the strengths and weaknesses of Niger's cost recovery policy for primary health care services and makes recommendations for short- and long-term follow-up activities for the MOH.

Pilot tests on user fees and an annual head tax, implemented with technical assistance from the United States Agency for International Development (USAID)-funded Health Financing and Sustainability (HFS) Project, were used as the basis for developing a financial management system to safeguard revenues and ensure their judicious use by health committees. Drug management procedures were also improved by the installation of a simplified drug management system. Niger has already improved the availability of generic drugs through an ongoing program streamlining procurement procedures, and has trained medical personnel in local health districts in the use of standardized diagnosis and treatment protocols, and essential drugs.

However, Niger's current cost recovery policy for primary health care services ignores two essential issues: income generated by cost recovery mechanisms cannot replace government funding, and means testing policies are needed to protect the poor. In addition to addressing these weaknesses of the cost recovery policy, the MOH needs to implement a major effort to increase the public's awareness of the new policy. All central bureaus and agencies of the MOH need to become more involved in cost recovery activities and help reinforce the goals and objectives of the National Program for the Strengthening of Primary Health Care (PNASSP).

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Acronyms

EDF	European Development Fund
HFS	Health Financing and Sustainability Project
IDA	International Development Assistance
MOH	Ministry of Public Health
NBPCP	National Bureau of Pharmaceutical and Chemical Products
NGO	Non-governmental Organization
PHC	Primary Health Care
PHR	Partnerships for Health Reform
PNASSP	*Programme National d'Appui aux Soins de Santé Primaires* (National Program for the Strengthening of Primary Health Care)
SDSS	*Subvention au Développement du Secteur Sanitaire* (Health Sector Support Grant)
USAID	United States Agency for International Development
WHO	World Health Organization

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Executive Summary

Under a law passed in 1995 and regulations enacted in 1996, the government of Niger established a new cost recovery policy for primary health care services. According to these legal instruments, the concept of cost recovery is defined as a participatory mechanism for sharing the cost of health care services provided to the local population at public health facilities. Its purpose is to generate additional income from cost sharing with the local community in order to improve the quality of primary health care.

The national cost recovery policy for primary health care services was enacted following successful pilot tests in two districts of Niger. These pilots tested user fees in one district and annual head tax coupled with small copayments in another district in primary care facilities, along with an improved supply of drugs, the use of standard diagnostic and treatment protocols, and other quality improvements. These pilot tests, which resulted in an increase in utilization of primary health care (PHC) services, including preventive care, were implemented with financial assistance from the United States Agency for International Development (USAID), under a Health Sector Support Grant, and technical assistance from the Health Financing and Sustainability (HFS) Project.

Cost Recovery Policy Developed

The Partnerships for Health Reform (PHR) Project provided technical assistance in 1996 to the Niger Ministry of Public Health (MOH) for the development and implementation of its new cost recovery policy. This report was the result of a short-term assignment conducted by Health Economist François Diop in December 1996. The purpose of this assignment was to:

- help assess the strengths and weaknesses of the nation's new cost recovery policy
- identify the next series of steps for the implementation of the new policy at the departmental and subregional levels
- identify the steps required to sustain the improvements to the health care system achieved through cost recovery

Attempts to implement new cost recovery policy at the national level have suffered from the unstable political climate, inadequate institutional framework, and lack of leadership within the MOH. The 1995/1996 action plan for the National Program for the Strengthening of Primary Health Care (*Programme National d'Appui aux Soins de Santé Primaires,* PNASSP) called for the implementation of a series of activities by central bureaus and agencies of the MOH, departmental health services and local health districts to introduce cost recovery mechanisms throughout the country. The action plan focused on stepping up efforts to coordinate the various programs and activities implemented by different government agencies and their domestic and

foreign partners at the national level. However, the failure by the implementing committee to undertake this task, and delays in releasing Health Sector Support Grant funds in support of the action plan, undermined the performance of the PNASSP throughout 1996.

Regional Workshops Organized

The main activity scheduled under the PNASSP's action plan was organizing a series of regional workshops (between December 1995 and February 1996) to prepare for the implementation of cost recovery activities in each health department. During these workshops, which were organized with PHR technical assistance, detailed regional and district-level plans for the implementation of the national cost recovery policy were developed. These workshops were conducted in late October 1996, with the last two workshops concluding in December. Thus, the broad outlines of action plans for each region of the country are in place. The next step is to refine and implement these action plans.

Findings on the Strengths and Weaknesses of the New Cost Recovery Policy

The framework created by the cost recovery law for primary health care services passed by the National Assembly, and the implementing regulations issued under the law are two of the main accomplishments of Niger's new cost recovery policy. These two pieces of legislation have given the MOH the opportunity to establish an entirely new foundation for the delivery of primary health care services. The two pilot tests were used as the basis for the development of an income management system to safeguard resulting revenues and ensure their judicious use by health committees. Drug management procedures were also improved by the institution of a simplified drug management system based on these pilot tests.

These accomplishments were paralleled by a noticeable improvement in the availability of essential generic drugs. The National Bureau of Pharmaceutical and Chemical Products (NBPCP) is currently in the midst of an ongoing program to streamline procurement procedures for essential generic drugs and to train medical personnel in local health districts in the use of standardized diagnosis and treatment protocols and essential drugs. The synergy between improvements in drug policy and internal income generation should increase the actual volume of resources available at the district level to sustain improvements in the quality of health care and promote better access to health care services in rural areas.

However, Niger's current cost recovery policy for primary health care services ignores two essential issues: income generated by cost recovery mechanisms cannot replace government funding, and means testing policies are needed to protect the poor. In addition to addressing these inherent weaknesses of cost recovery policy, the MOH needs to initiate a major effort in the areas of public awareness-raising and coordination of efforts. The MOH's central bureaus and agencies

need to get more involved in cost recovery activities in support of the PNASSP's goals and objectives.

Additional weaknesses of the new cost recovery policy are listed below.

- The roles and responsibilities of the different partners in a decentralized health care system (central government, local governments, non-governmental organizations (NGOs), and donor organizations) are unclear. Niger would benefit from a policy framework paper from the MOH on partnerships within the health care sector.
- The MOH should take advantage of the opportunities afforded by the initiation of cost recovery activities to strengthen financial management capabilities at the health district level to help push this decentralization process forward.
- Niger's cost recovery policy for primary health care services and reforms in hospital finance mechanisms will need to be better coordinated under a comprehensive health financing scheme.

Short- and medium-term follow-up activities by the Ministry of Public Health include:

- finalizing the regional action plans, drawing up estimates of corresponding needs
- formulating requests for financing in support of cost recovery efforts in every department throughout the country.

Finalizing the regional actions plans involves:

- mobilization of financing
- legal and institutional framework
- fee setting; training, supervision and management system
- pharmaceuticals
- community participation; worker incentives, and
- monitoring and evaluation

Among the MOH's medium- and long-term concerns are:

- the safety net for the poor; the strengthening of financial management capabilities at the health district

- development of a comprehensive health financing scheme

It should be noted that following a coup in early 1997, USAID assistance to Niger was put on hold and eventually terminated, effectively canceling further involvement by PHR in Niger.

01. Background and Objectives

1.1 Political and Institutional Background

Niger's new cost recovery policy for primary health care services was developed in an unstable political climate. Discussions on cost recovery began in the late 1980's, a period marked by the beginnings of a protest movement demanding a more democratic form of government. These protests eventually prompted the organization of a national conference in 1991, paving the way for the country's first steps towards democracy. The transition period ended in 1993 with Niger's first multiparty elections in which the reigns of power were handed over to a coalition of parties. However, the election process which installed the coalition government failed to put an end to protests. In-fighting within the coalition and the pressure of these social protest movements only served to heighten an already unstable political climate. Political unrest eventually led to the dissolution of the National Assembly, the holding of new elections for the national legislature, and a succession of new administrations. The military coup in early 1996 ultimately put an end to the institutional paralysis produced by this unstable political climate.

This political climate had a tangible effect on the progress of efforts by the MOH to reform Niger's health care system. The decision-making process was stalled by constant changes in the MOH's leadership in which the Minister, the Secretary General and all central bureau chiefs were continuously being replaced by new appointees. However, a reform orientation, combined with a perceived need for internal income generation and for the decentralization of political power in general, helped sustain the momentum of health reforms instituted under the Health Sector Support Grant Project funded by USAID/Niamey.

1.2 Support for Health System Reforms in Niger

Niger's new cost recovery policy was developed as part of the MOH's institutional capacity-building efforts with sizeable inputs of Health Sector Support Grant (SDSS) funds, focusing on its capacity to collect and process health system data, its planning capacity, its capacity to manage strategic drug inventories and its resource management capabilities. Cost recovery in the delivery of primary health care was only one of the reforms contemplated by the MOH under the cost containment and cost recovery components of the SDSS project. In addition to reforms in the primary health care sector, this SDSS project provided for hospital-based reforms, including the restructuring of national hospitals into government-owned service enterprises, vesting them with greater autonomy and strengthening their drug management capabilities. The MOH's cost recovery efforts in the primary health care sector included the implementation of pilot tests of cost recovery mechanisms in a limited number of districts in order to assemble data on the advantages and disadvantages of different health financing mechanisms in the rural areas.

The success of these capacity-building efforts at the MOH led to the crafting of a health development plan for the implementation of health programs and interventions between 1994 and the year 2000. Results of the pilot tests were incorporated into the health development plan, in terms of financing strategies to support primary health care services, as well as community participation and decentralized management strategies for capacity-building at the health district level. Following the evaluation of these pilot tests in June 1994, a National Program for the Strengthening of Primary Health Care (PNASSP) was initiated by the Niger MOH with USAID assistance in support of cost recovery efforts nationwide.

The Ministry of Public Health was the recipient of technical assistance services furnished by Tulane University and Abt Associates Inc. under the Health Sector Support Grant (SDSS) project. Abt Associates provided assistance with cost recovery mechanisms pilot test preparations. Follow-up technical assistance for the conduct and evaluation of these pilot tests was procured through a "buy-in" to the HFS project funded by USAID. Technical assistance activities for the design and implementation of its cost recovery policy were sustained thanks to the technical support furnished by the successor to the HFS project, the Partnerships for Health Reform (PHR) Project. However, the pursuit of technical assistance activities under the PHR project was interrupted by the military coup in early 1996.

1.3 Objectives of the Assignment

This assignment was the third in a series carried out by the same consultant. On his first assignment in November and December of 1995, he helped the MOH frame an action plan for 1995/1996 under the PNASSP. In his second assignment in October of 1996, he assisted in organizing regional workshops in preparation for the implementation of cost recovery activities. The general objective of this latest assignment was to assist the MOH with the implementation of its new cost recovery policy for primary health care services. Its specific objectives were to:

- help assess the strengths and weaknesses of the nation's new cost recovery policy for primary health care services
- identify the next series of steps for the implementation of the country's new cost recovery policy for primary health care services at the departmental and subregional levels
- identify measures designed to solidify accomplishments by cost recovery efforts within the framework of the health care system

02. Cost Recovery Policy for Primary Health Care Services

As part of the implementation process for the Health Sector Support Grant project, USAID supported MOH efforts to initiate pilot tests of alternative financing mechanisms for primary health care services. These pilot tests fueled the ongoing debate over the financing of health care in Niger. The performance evaluation of these pilot tests strengthened the budding consensus that cost recovery policy for primary health care can improve the availability of local health resources and the quality of primary health care. Moreover, organizing these pilot tests afforded the MOH an opportunity to strengthen its institutional capabilities for the financing of primary health care services.

2.1 Policymaking and Implementation

The performance evaluation of its pilot tests of alternative cost recovery mechanisms gave the MOH the opportunity to take the ongoing debate over the financing of primary health care to the national level. The national workshop on the financing of primary health care services, conducted in July of 1994 with USAID assistance, was the final step in the evaluation of its pilot cost recovery efforts. The workshop served as a forum for nationwide discussion of primary health care financing reforms, the ramifications of these reforms for internal income generation purposes, the accessibility of health care services, and capacity-building at the individual health district level. The workshop produced a series of recommendations on advisable reforms to be made by the government of Niger to:

- create an appropriate legal framework for the financing of primary health care services and for community participation in the management of health interventions, and
- strengthen the institutional capacity of the MOH to implement its new primary health care financing and management policy nationwide

2.1.1 The Policymaking Process

The government established a new cost recovery policy for primary health care services under a law passed in 1995 (Law No. 95-014 of July 3, 1995) and corresponding implementing regulations enacted in 1996 (Decree No. 96-224/PCSN/MSP of June 29, 1996). According to these legal instruments, the concept of cost recovery (as it relates to the delivery of primary health care services outside the hospital sector) is defined as a cost-sharing mechanism for sharing the cost of health care services provided at public health facilities with the local population. In this respect, cost recovery is part of the process of the delivery of primary health care services. Its purpose is to generate additional income from the sharing of health care costs with the local community to improve the quality of primary health care.

The government's cost recovery policy for primary health care services was designed with built-in flexibility for adaptation to different socio-economic conditions in local communities throughout the country and to future developments in health financing. Each community has the prerogative of choosing its own cost-sharing method, to be enacted by the corresponding local government with due regard for considerations of equity and for the financial feasibility of corresponding health care services. At the same time, the dynamic policy framework provides for regular adjustments in fees and co-payment rates. The role of the central government in this area is limited to the issuance of guidelines to local authorities regarding ceilings for co-payments and fees locally, leaving the management of revenues generated to the local community. Thus, the income generated by these cost-sharing mechanisms is managed by the local population through community representatives on local health committees, which have complete financial autonomy for the programs.

The MOH has not yet enacted the legal instrument governing the organization and operations of local health committees provided for in the implementing regulations issued under the cost recovery law. Nor has it enacted any provisions regarding the setting of fees. In other words, the legal framework for the MOH's new cost recovery policy for primary health care services needs to be supplemented by additional national legislation to support policy implementation efforts country-wide.

2.1.2 Implementation of the New Cost Recovery Policy for Primary Health Care Services

Attempts to implement the country's new cost recovery policy for primary health care at the national level have been stalled by the unstable political climate. Efforts to establish an effective institutional framework and to coordinate the necessary preparatory work for policy implementation purposes have been hampered by constant changes in leadership within the MOH. Endeavors to coordinate the various activities of the different stakeholders involved have suffered greatly from the political climate, institutional framework, and lack of leadership within the MOH.

2.1.2.1 Institutional Constraints

Preparations for the launching of cost recovery efforts nationwide were initiated against the backdrop of sweeping changes in the MOH's institutional framework. Activities began in late 1993, when the MOH leadership was considering new approaches to managing the country's health care sector. These new approaches were reaffirmed in the preliminary drafts of its health development plan for 1994/2000, which reflected a clear desire to break away from a centralized health management system. If implemented, this would effectively decentralize the health care system and set up a network of local health districts. Thus, preparations for the cost recovery efforts and supporting strategies for the channeling of central government assistance to departmental health services and local health districts to shore up these efforts, have suffered from the uncertainties produced by this shift in emphasis towards greater decentralization within the ranks of the MOH.

Niger's limited experience with cost recovery operations meant the central government needed to provide assistance to departmental health services and local health districts for the implementation of the new cost recovery policy. However, the development of an institutional framework within the MOH to serve as a vehicle for this assistance took far too long. In February 1994, participants at an interim workshop recommended a short-term National Program for the Strengthening of Primary Health Care for the main purpose was assisting departmental officials and health districts, and coordinating cost recovery activities at the national level. The MOH acted on this recommendation in 1995 with its decision to set up the program and place it under the administrative authority of the Office of the Secretary General. With experience gleaned over the previous three-year period, the institutional unit that had been in charge of conducting pilot tests of alternative cost recovery mechanisms was transformed into a program implementation unit with assistance from the SDSS project. In addition, the implementation of cost recovery efforts at the individual health district level was made contingent on the availability of district health development plans.

The action plan for 1995/1996, developed under the PNASSP, was endorsed by the MOH representatives at the central government level, representatives of the Finance and Planning Ministry, and the Ministry of the Interior and National and Regional Development, and by the country's development partners active in the health sector at the November 29, 1995 meeting of the national committee in charge of implementing the country's new cost recovery policy. The plan provided for a series of activities to be conducted by central bureaus and agencies of the MOH, departmental health services, and local health districts for the institution of cost recovery mechanisms in different departments throughout the country. The plan highlighted the need to step up efforts to coordinate the programs and activities of different MOH agencies, and its foreign and domestic development partners active in the health care sector to help coordinate cost recovery efforts nationwide. However, the failure of the implementing committee to undertake this task, and delays in the releasing of SDSS funds undermined program performance throughout the course of 1996.

2.1.2.2 Status of the Cost-Recovery Policy

The status of the cost recovery policy is summarized in Table 1 and can be stated as follows:

Legal and institutional framework

To address inadequacies in the legal and institutional framework for the implementation of cost recovery activities identified in 1995, the program was expected to produce legislation and administrative orders instituting a system of user fees for health care services and initiating cost-sharing mechanisms involving the local community in the financing and management of services furnished by primary health care facilities throughout the country. Achievements to date include:

- the enactment of implementing regulations under Law No. 95-014 of July 3, 1995, and
- the amendment and approval of the MOH order creating the PNASSP

However, while there is a draft administrative order establishing the composition, organization and functions of health and management committees, the MOH has still not issued an order governing the operations of participatory community organizations at the national level.

Awareness-raising

The program recognized weaknesses in community participation and inadequacies in the involvement of local government authorities, traditional leaders and non-governmental organizations (NGOs) in efforts to implement the new primary health care strategy. As a result, the program called for a coherent nationwide awareness-raising campaign and the mobilization of necessary physical and human resources in support of these efforts at the departmental and subregional levels by January of 1996. Given the importance of awareness-raising activities, it was recommended that the MOH form a awareness-raising committee at the national government level to:

- design corresponding communication modules
- develop a awareness-raising handbook
- draft microprogram agreements to be entered into with the media and with nongovernmental organizations, and
- start-up the national awareness-raising campaign

Aside from the publication *Santé des Communautés* (Community Health) distributed under the PNASSP and its arrangements for the televising of cost recovery activities, the MOH has not made much progress in raising awareness.

Training in the use of standardized diagnosis and treatment protocols and essential generic drugs

Efforts designed to provide health care personnel with training in the use of standard diagnosis and treatment protocols and essential generic drugs were to be extended to new health districts and national training centers for paramedical personnel. These training services were to be extended to all health districts over the course of the past year. Wholesale training activities for trainers at national training centers designed to strengthen the curriculum of these training facilities in the area of diagnosis and treatment protocols and essential generic drugs were scheduled from December 23 to December 30, 1996.

Management training

Local health districts have not yet been equipped with financial management systems. The goal was to establish management systems for drugs and income generated by cost recovery mechanisms set up as part of the pilot tests conducted in the districts of Say and Boboye and local health districts in the department of Maradi to safeguard income and improve drug management procedures. These changes have been made and test systems are fully integrated into the national health information system. The training manual has been revised and corresponding management tools have been replicated in four health districts. Thus far, only national and regional level trainers have received any training in this area.

Initial drug inventories

Weaknesses in the coordination of assistance for the establishment of initial drug inventories were reported in 1995. The action plan for the PNASSP was to:

- set up initial inventories of essential generic drugs in all health care facilities involved in the implementation of cost recovery activities, and
- ensure the availability of a detailed blueprint for a restocking system for health care facilities as part of internal management procedures for corresponding cost recovery activities.

With the availability of essential drugs constituting one of the most serious constraints hampering the implementation of the country's new cost recovery policy, it was recommended that the MOH set up a special committee of Ministry representatives and financial backers to coordinate efforts to establish these initial drug inventories. A select committee was formed to oversee efforts to organize inventories of drugs supplied by the World Health Organization (WHO) but, thus far, it has been completely ineffectual.

Setting of fees for health care services

Inconsistencies in fee-setting procedures in health districts already equipped with cost recovery mechanisms was identified as the main problem in this area. The goal for 1996 was to develop standard fee-setting procedures for health care facilities at the local health district level for the first operating cycle running from January of 1996 through December of 1997. The implementing regulations issued under the new cost recovery law call for the issuance of guidelines on fee levels under a joint order handed down by the MOH and the Ministry of Finance and Planning. Thus, it was decided to set up a special committee to make recommendations in this respect to the MOH and the Ministry of Finance and Planning based on a review of the experience gleaned from pilot tests of alternative cost recovery mechanisms and the Bamako Initiative and of PNASSP data. PNASSP officials have drafted an administrative order in this respect, which has not yet been approved by the MOH.

Supporting services for departmental authorities I: Preparatory work

The main activity provided for under the PNASSP action plan was the holding of regional workshops between December of 1995 and February of 1996. These regional workshops were expected to produce action plans for the implementation of cost recovery efforts at the departmental and subregional levels and requests for financing in support of corresponding implementation activities. The steering committee for the SDSS project spent a great deal of time deciding whether or not to finance these regional workshops. The preliminary version of the PNASSP budget included a line item for the financing of regional workshops, which was later cut as part of the budget approval process. As a result, the necessary financing for these workshops was not obtained until October of 1996, leaving program officials very little time in which to conduct the workshops. The first workshops were held in late October, with the last two workshops in the department of Maradi and Tillabéri concluding on December 20, 1996. The basic outlines for regional action plans are all in place. The next step is to build on the workshops' outputs by fine-tuning these action plans.

Supporting services for departmental authorities II: Implementation

Only two districts, namely the district of Loga in the department of Dosso and the district of Illéla in the department of Tahoua, have benefited from any supporting services furnished to departmental authorities. This assistance, which was scheduled to follow in the wake of the regional workshops, was circumscribed by delays in holding the workshops.

Financing of regional and subregional activities

Efforts to obtain financing for the implementation of cost recovery activities at the region-wide level were stalled by constraints associated with organizing the regional workshops. A number of donors are awaiting the outcome of these workshops to make a decision in regard to the financing of cost recovery activities. The implementation of follow-up activities building on these workshops for the fine-tuning of action plans and the production of requests for financing at the departmental level is crucial for the confirmation of donor financing intentions during the course of the first quarter of 1997.

Monitoring and coordination

The PNASSP has continued to support ongoing internal management efforts in the districts of Say and Boboye. These activities have been supported by the collection and analysis of performance data for corresponding cost recovery mechanisms, and organizing audits producing feedback for general meetings of subregional health committees. As part of this process, the district of Say, which pilot tested a direct financing mechanism or fee-for-service system, also began testing a health plan with annual fees set up as part of an effort to align fee levels with prevailing fees in the department of Maradi. Say's health plan, which requires the voluntary enrollment and prepayment of an annual enrollment fee will need to be evaluated over the course of the next few years to draw conclusions regarding the performance of this type of financing mechanism. The plan's finance mechanism has attracted the attention of many community representatives.

The committee set up by the MOH in the wake of the national workshop on the financing of primary health care services was totally ineffectual throughout the course of 1996. Greater diligence on the part of MOH senior experts and policymaking officials at the MOH in implementing Niger's new cost recovery policy in cooperation with other cabinet ministries and foreign development partners could have helped surmount the obstacles experienced in 1996. Lack of leadership and guidance hampered the start-up of implementation activities and the coordination of cost recovery efforts nationwide.

Table 1
National Program for the Strengthening of Primary Health Care

Action Plan for 1995/1996
Systematic implementation of cost recovery activities associated with the delivery of primary health care services nation-wide level
Status of program activities, December 1, 1996

Strategy	Expected Output	Activities	Status as of December 1996	Comments
▲ Legal and institutional framework	▲ Legislation and administrative orders instituting payments for health care and laying the foundation for community participation in the financing and management of services furnished by primary health care facilities at the country-wide level	▲ Enactment of implementing regulations under Law No. 95-014 of July 3, 1995 ▲ Amendment and approval of the MOH order establishing the PNASSP ▲ Amendment and approval of the MOH order governing the make-up, organization and functions of health and management committees	▲ Decree No. 96-224/PCSN enacted in June of 1996 ▲ MPH Order No. 0068 issued in June of 1996 ▲ Draft version of the order available	▲ For discussion and amendment at regional workshops
▲ Awareness-raising	▲ Coherent awareness-raising program at the nation-wide level, with physical and human resources available for awareness-raising activities at the departmental and subregional levels	▲ Formation of a awareness-raising committee ▲ Design of communication modules ▲ Production of a awareness-raising handbook ▲ Replication of the awareness-raising handbook ▲ Microprogram agreements with the media and NGOs ▲ Training of national-level trainers ▲ Awareness-raising: nation-wide level	▲ Still pending ▲ BI and pilot test modules not properly coordinated ▲ Still pending ▲ Publication on “Community Health”; television coverage (Anfani) ▲ Still pending ▲ Take-off with the publication on “Community Health” and the joint program with Anfani	▲ Legislation still pending at the nation-wide level ▲ Regional authorities are planning to set up regional awareness-raising committees ▲ Financial constraints

Table 1
National Program for the Strengthening of Primary Health Care

Action Plan for 1995/1996
Systematic implementation of cost recovery activities associated with the delivery of primary health care services nation-wide level
Status of program activities, December 1, 1996

Strategy	Expected Output	Activities	Status as of December 1996	Comments
▲ Training in the use of standardized diagnosis and treatment protocols and essential generic drugs	▲ Training in the use of standard diagnosis and treatment protocols and essential generic drugs for personnel at health facilities in health districts not previously covered	▲ Marshaling of follow-up financing for training in the use of standard diagnosis and treatment protocols and essential generic drugs ▲ Training in diagnosis and treatment protocols in health districts not previously covered ▲ Training in diagnosis and treatment protocols at training centers	▲ Scheduled for December 23-30, 1996	▲ No financing available
▲ Management training	▲ Final versions of a management system and corresponding management tools, adequate quantities of high-quality training materials and human resources for training activities in place at the regional level	▲ Fine-tuning/revamping of the management system ▲ Production of a training manual ▲ Replication of the training manual ▲ Replication of management tools ▲ Training of national and regional level trainers	▲ Coordinated with and integrated into the national health information system ▲ Completed ▲ Accomplished in part ▲ Replicated for 4 health districts (for one quarter) ▲ Completed in October of 1995	▲ For national-level training ▲ Financial constraints ▲ Refresher training required
▲ Initial drug inventories	▲ Establishment of initial inventories of essential generic drugs at all health care facilities involved in the implementation of cost recovery activities, detailed blueprint of a restocking system for health care facilities for the internal management of cost recovery operations	▲ Formation of a special committee for the establishment of initial drug inventories: MOH and donor organizations ▲ Fine-tuning of the initial drug inventory component of the cost recovery system	▲ Select committee in place ▲ Still pending	▲ Set up as a coordinating body ▲ The committee is ineffectual

Table 1
National Program for the Strengthening of Primary Health Care

Action Plan for 1995/1996
Systematic implementation of cost recovery activities associated with the delivery of primary health care services nation-wide level
Status of program activities, December 1, 1996

Strategy	Expected Output	Activities	Status as of December 1996	Comments
▲ Setting of fees for health care services	▲ Standard fee-setting system for the use of health care facilities in local health districts for the initial operating cycle running from January of 1996 through December of 1997	▲ Formation of a committee on fee setting procedures	▲ Still pending	
		▲ Design of a provisional fee-setting system	▲ Draft version of the order available	
		▲ Submission to the implementing committee	▲ Still pending	▲ The committee is ineffectual
		▲ Issuance of opinions by the Ministry of Finance and Planning, the Ministry of the Interior and National and Regional Development and other interested cabinet ministries	▲ Still pending	
		▲ MOH order on fee-setting procedures for health care in local health districts	▲ Draft version of the order available	
▲ Supporting services for departmental authorities I: Preparatory work	▲ Departmental action plan for the implementation of cost recovery efforts outlining supporting activities for departmental health services and scheduled activities in different health districts ▲ Request for the financing of cost recovery activities at the departmental level for the two-year period 1996/1997	▲ Holding of workshops for the framing of departmental action plans	▲ 6 out of 8 concluded: last 2 to be concluded by December 20	▲ Start-up delayed due to a shortage of funding
		▲ Fine-tuning of departmental and subregional action plans	▲ In process	
		▲ Calculation of financing needs for 1996/1997	▲ Agadez and Tahaoua	▲ Estimates for the other regions still need to be finalized
		▲ Production of preliminary requests for financing	▲ Still pending	▲ Pending completion of the two previous activities
		▲ Submission of preliminary requests for financing to the Office of the Minister of Public Health	▲ Still pending	
		▲ Acceptance/review of preliminary requests for financing	▲ Still pending	
		▲ Submission of final requests for financing to the Office of the Minister of Public Health	▲ Still pending	

Table 1
National Program for the Strengthening of Primary Health Care

Action Plan for 1995/1996
Systematic implementation of cost recovery activities associated with the delivery of primary health care services nation-wide level
Status of program activities, December 1, 1996

Strategy	Expected Output	Activities	Status as of December 1996	Comments
▲ Financing of regional and subregional activities	▲ Preliminary statement of financing needs to enable the MOH to identify prospective sources of financing ▲ Availability of necessary financial resources to departmental health services for the financing of cost recovery activities within the department in question	▲ Consolidation of committee work ▲ Submission of a first draft to the Office of the Minister of Public Health ▲ Acceptance, suggestions, changes to statement ▲ Adjustment of preliminary estimates ▲ Identification of sources of financing ▲ Acceptance and review of preliminary departmental financing requests ▲ Approval of departmental requests ▲ Submission of final departmental requests to prospective donors ▲ Confirmation of departmental financing	▲ Still pending	▲ Contingent on the completion of previous activities ▲ The implementing committee is ineffectual
▲ Supporting services for departmental authorities II: Implementation	▲ Implementation of cost recovery activities at the departmental level and in corresponding health districts	▲ Bolstering of implementing activities	▲ Loga, Illéla health districts	▲ Stalled by shortages of funding for management training and awareness-raising

Table 1
National Program for the Strengthening of Primary Health Care

Action Plan for 1995/1996
Systematic implementation of cost recovery activities associated with the delivery of primary health care services nation-wide level
Status of program activities, December 1, 1996

Strategy	Expected Output	Activities	Status as of December 1996	Comments
▲ Monitoring and coordination	▲ Oversight of the implementation process for cost recovery activities. Identification of bottlenecks hampering cost recovery efforts at the nation-wide level and search for solutions. Coordination of activities initiated by different development partners and strengthening of program complementarities	▲ Quarterly progress reports ▲ Quarterly meetings of the implementing committee ▲ Audits	▲ Concluded ▲ Still pending ▲ Concluded in 24 comprehensive health care facilities in Say, Boboye and Maradi	▲ The implementing committee is ineffectual

03. Strengths and Weaknesses of the New Cost Recovery Policy

The Ministry of Public Health has made tangible progress in the implementation of its new cost recovery policy for primary health care services since organizing the national workshop on cost recovery policy in Kollo in November 1989. Notable accomplishments include the preparation, introduction and evaluation of pilot tests of alternative cost recovery mechanisms, and the implementation of the Bamako Initiative. The ability of the Ministry of Public Health to capitalize on these accomplishments to extend cost recovery efforts to the national level has been undermined by the unstable political climate and institutional framework over the past four years. The resulting delays in and poor coordination of cost recovery activities have prevented the MOH from correcting weaknesses in its cost recovery policy as currently designed.

3.1 Strengths

Two of the main accomplishments of the country's new cost recovery policy are the framework created by the cost recovery law for primary health care services passed by the National Assembly and the implementing regulations issued under the law. These two pieces of legislation gave the MOH the opportunity to establish an entirely new foundation for the delivery of primary health care services in Niger. The financial independence of participatory community organizations and provisions for the independent management of income generated by cost recovery mechanisms for primary health care services at the local community level:

- provide a window of opportunity to strengthen mutual trust between community health care workers and the local population, and
- to get local communities fully involved in the management of health care activities, including community participation in all aspects of the identification of health problems, the search for appropriate solutions, and the mobilization of local resources through representatives on local health committees.

In sum, *the environment created by this new legislation has allowed the MOH to revitalize Niger's primary health care system with the full participation of corresponding stakeholders, namely residents of urban fringe and rural communities*.

The *Ministry-wide increase in institutional capabilities in cost recovery policy is another accomplishment*. There are important lessons to be drawn by the MOH from its pilot tests of cost recovery mechanisms and from the Bamako Initiative for the framing of strategies for the systematic institution of cost recovery procedures at public health care facilities. The MOH currently has the resource persons it needs for the use of strategic planning methods to help individual departments and health districts plan corresponding cost recovery activities. Health care personnel involved in the implementation, monitoring and evaluation of these pilot tests and the

Bamako Initiative have gained a wealth of experience which can be used for developing implementing strategies for the cost recovery efforts. They know how to convert these strategies into specific activities, and can anticipate the ramifications of these activities for the delivery and management of health care services. The experience gleaned by these health practitioners is an important asset for the planning and implementation of cost recovery efforts at the national level. Organizing the regional workshops was the first step in the transferring of this knowledge and experience to departmental authorities and local health districts.

The experience gleaned from the pilot tests and the Bamako Initiative was also used in the development of management and monitoring systems for these cost recovery activities. More specifically, the two pilot tests were used as the basis for the development of a income management system to safeguard resulting revenues and ensure their judicious use by health committees. Familiarity with the current system is the first step toward the development of a more sophisticated financial management system. Likewise, based on the pilot tests, drug management procedures were improved by the introduction of a simplified drug management system. The MOH considers these management systems and the personnel training manual developed in conjunction with PNASSP officials important assets. By the same token, the experience gained from the pilot tests and the Bamako Initiative was used for the development of tools designed to monitor the operations of health care centers. These monitoring tools are currently being used under the PNASSP to collect data on the use of drugs and income to supplement the statistical data compiled by the national health information system. This data is extremely useful in establishing drug needs at community-based health care facilities. The computerization of this data base has made it easy for the PNASSP to monitor the performance of cost recovery mechanisms at individual health care facilities, as well as the consumption of essential drugs. These tools are the main inputs for a capacity-building process designed to strengthen the management capabilities of local health districts and comprehensive health care facilities, fostering further decentralization of the health care system and increasing responsibility to health district managers and participatory community organizations.

These accomplishments were paralleled by a tangible improvement in the availability of essential generic drugs. The National Bureau of Pharmaceutical and Chemical Products (NBPCP) is currently implementing a program for streamlining procurement procedures for essential generic drugs and training medical personnel in local health districts in the use of standardized diagnosis and treatment protocols and essential drugs. The synergy between improvements in drug policy and internal income generation should augment the actual volume of resources available at the health district level to sustain improvements in the quality of health care and promote better access to health care services in rural areas.

However, attempts to capitalize on these achievements with a view to improving the performance of the health care system will need to address certain weaknesses in the design and implementation of the country’s new cost recovery policy.

3.2 Weaknesses

The new cost recovery policy for primary health care services includes both internal and external weaknesses. Internal weaknesses are associated with the policy design and implementation

process in its current form. External weaknesses are associated with the alignment of current cost recovery policy with efforts to decentralize Niger's health care system and with health financing efforts in general.

3.2.1 Internal Weaknesses

The current cost recovery policy for primary health care must deal with four limitations. The first is that the cost recovery policy is but one component of a more comprehensive health care financing policy; by itself it cannot replace government funding. Attention should now be directed to how to develop, and implement, a comprehensive set of health care financing options that will ensure greater sustainability and higher quality health care.

The second limitation is that few controls exist over how revenues generated from cost recovery are allocated and spent. Current cost recovery legislation contains no provisions regarding the incremental nature of the revenues produced at the local level vis-a-vis government funding. The MOH needs to take steps to ensure that national government equipment and drug grants *to local health districts are not supplanted by the income generated by cost recovery mechanisms at the health district level*.

The third limitation of the cost recovery policy is that means testing policies are inadequate to ensure protection of the poor. The current policy documents on cost recovery pay little attention to means testing policies that would ensure protection of the poor. The implementing regulations simply provide that local governments should have due regard for equity considerations in selecting a financing mechanism and in the establishment of corresponding fee levels. This is neither an explicit nor an adequate provision. In addition to sustaining the national government grants, the MOH should see to the introduction of effective means testing mechanisms to ensure that health care remains accessible to the poor (i.e., the indigent) and to certain patient groups.

The fourth problem to be addressed is the issue of knowledge and understanding of the cost recovery policy. The MOH needs to initiate a major effort in the areas of public awareness-raising, and to coordinate support for the policy implementation process. The need for stepped-up awareness-raising efforts and better coordination has been heightened by recent changes throughout the government and within the ranks of the MOH, at the national and departmental levels. If cost recovery efforts are to continue to be part of the government agenda, the MOH must ensure that policy-level officials are apprised of the importance of the cost recovery policy objectives and of the policy instruments at its disposal. Furthermore, if the MOH is to gain the support of other ministries, such as the Ministry of Finance and Planning and the Ministry of the Interior in general, and of local agencies and authorities (e.g., heads and deputy heads of departmental governments, departmental planning commissioners, district planning officials), it must step up current awareness-raising efforts, as well as the coordination of corresponding activities. Aside from its obvious role as a steering committee, the national committee for the implementation of Niger's new cost recovery policy was designed to serve as a coordinating body, both within the ranks of government and for the MOH's outside development partners. However, thus far, operations of the national committee for implementation have been ineffectual.

Furthermore, the MOH has been unable to mobilize and involve central bureaus and agencies in its policy implementation efforts, which was the main reason for placing the PNASSP under the direct authority of the Office of the Secretary General of the MOH. The PNASSP coordination and monitoring unit is an important MOH asset for the implementation of cost recovery activities, but cannot handle all activities by itself. All central bureaus and agencies of the MOH need to get more involved in cost recovery activities and to help support the goals and objectives of the PNASSP within their respective spheres of competence.

3.2.2 External Weaknesses

Niger's new cost recovery policy for primary health care services is laying a whole new foundation for decentralizing the nation's health care system. The main elements of this decentralization include local finance, the establishment of decentralized resource management centers, and community participation. However, the roles and responsibilities of the different partners in a decentralized health care system (i.e., the role of central government, local governments, local communities and other development partners, such as NGOs and donor organizations) are still unclear. This makes it difficult to set specific targets for cost-sharing mechanisms at the local level. The changes instituted in fee-setting procedures in the department of Maradi and the districts of Say and Boboye, for example, were the result of uncertainties in regard to the specific objectives of corresponding cost recovery mechanisms. Should the community recover 50 percent or 100 percent of drug and management costs? The MOH needs to fill this institutional void with a policy framework paper (e.g., on partnerships within the health care sector).

Moreover, the main financial resources, which will need to be managed by local health districts over the course of the next few years (pending a more extensive decentralization of financial management functions at the district level), will be the revenues generated by cost recovery. Thus, the MOH should take advantage of the opportunities afforded by the implementation of cost recovery activities to strengthen financial management capabilities at the district level to promote the decentralization process.

Furthermore, the new cost recovery policy has not been properly coordinated with prevailing policies in hospital establishments and in the private health care industry. This is due, in part, to parallel reform efforts within the hospital sector. Thus, the country's cost recovery policy and ongoing reforms in hospital finance mechanisms will need to be better coordinated under a comprehensive health financing scheme. Under this scheme, program planning for the health care system is focused mainly on primary health care services and coordinated with ongoing structural reforms (independent hospital management, establishment of district hospitals, etc.) and the participatory capacity of different population groups (i.e., their ability to pay).

04. Follow-Up Activities

The Ministry of Public Health has made substantial progress in the design and implementation of its cost recovery policy for primary health care services despite the prevailing political climate and institutional framework over the course of the past few years. The accomplishments outlined above need to be reinforced, with special efforts to extend the scope of ongoing reform efforts to the national level and revitalize the primary health care system by placing it on a more solid footing. Accomplishing this will require the implementation of short and medium-term programs for the systematic institution of cost-sharing mechanisms in health districts throughout the country. In addition, specific initiatives will need to support these achievements as part of broader-based efforts to decentralize the health care system and improve health financing.

4.1 Short/Medium-Term Follow-up Activities by the Ministry of Public Health: Implementation

4.1.1 Regional Action Plans

The purpose of the regional workshops for the implementation of cost recovery activities was to furnish information to and heighten the awareness of local authorities (namely, government officials, traditional leaders and health authorities) regarding the country's new cost recovery policy. In addition, the workshops were intended to familiarize authorities with the strategies being used to coordinate policy implementation efforts and to help them formulate action plans within their respective jurisdictions. The output from the workshops conducted thus far (in 6 out of 8 regions, with the last two workshops presently underway) has been more than satisfactory. Certain regions have developed highly detailed action plans. The next step is to finalize these regional action plans, draw up estimates of corresponding needs, and formulate requests for financing in support of cost recovery efforts in each department throughout the country.

Under these conditions, the MOH should not make the implementation of cost recovery efforts in any health district contingent on the availability of a district health development plan. The institution of cost recovery procedures at all public health care facilities throughout the country is a constant, mandated by law. The MOH should seize on the opportunity afforded by the formation of district health committees to get them actively involved in health care activities early on, namely in the framing of corresponding district-level health development plans.

4.1.2 Finalizing the Regional Action Plans

The MOH in general and, more specifically, the Minister of Health, the Secretary General, health agencies at the central and departmental government levels and PNASSP officials, will need to make a special effort to sustain the enthusiasm shown by local government officials and health authorities and traditional leaders in the course of the regional workshops for the implementation of

cost recovery activities. All regions throughout the country expect to begin implementing the provisions of the country's new cost recovery legislation and initiating corresponding activities beginning in early 1997. A special effort will need to be made in the following areas:

- mobilization of financing
- legal and institutional framework
- fee setting
- training, supervision and management system
- pharmaceuticals
- community participation
- worker incentives, and
- monitoring and evaluation

Mobilization of financing

The fine-tuning of regional action plans should result in the production of requests for financing for planned cost recovery activities. To accomplish this, the MOH and its departmental health services should be prepared to organize meetings of development partners active in each region to confirm the intentions of its different partners to finance the implementation of cost recovery activities, coordinate corresponding supporting activities, and pinpoint areas for the pursuit of fund-raising efforts. There are a number of ongoing development projects at the local health district level which could lend their support to cost recovery activities within the district in question and the supervisory authority at the regional level (the PASSP project, Project Health II funded by the IDA, the Bamako Initiative sponsored by UNICEF, etc.). However, not all districts throughout the country are served by such projects. The success of cost recovery efforts in these districts will be contingent on overcoming constraints regarding the coverage of necessary training activities, the formation of health committees, the establishment of management systems, the marshaling of initial drug inventories, and the strengthening of monitoring and supervision procedures. The Ministry might want to consider using European Development Fund (EDF) budgetary aid in surmounting these obstacles to extend the scope of its short and medium-term policy implementation efforts.

Legal and institutional framework

The regulations issued under the cost recovery law for primary health care services recognizes health committees as the community organizations in charge of the management of revenues generated by cost-sharing mechanisms for the sharing of primary health care costs with the local population. Furthermore, the same piece of legislation provides that these health committees have complete financial autonomy. The MOH needs to issue an administrative order containing provisions regarding the make-up and operations of health committees to strengthen the legal framework for these committees (see the section on community participation).

In keeping with the provisions of the regulations issued under the cost recovery law for primary health care services, the MOH should also take immediate steps to hand down an order establishing a scale of fees for the use of local health districts. The immediate issuance of such an order would furnish health districts with central government guidance as called for in the implementing regulations issued under the cost recovery law (see the following section on fee setting).

Fee setting

A special effort should be made to establish coherent fee-setting procedures for district hospital services in line with service delivery costs and to strengthen the patient referral system. The MOH should set up a technical committee in charge of designing the fee-setting system for district hospitals. In its initial phase, the fee-setting system could simply furnish guidance and ensure consistency with current fee-setting procedures at hospital establishments. This initial phase of the fee-setting process, the recommended length of which is two years, should include organizing cost studies for district hospital services. The fee-setting system would be adjusted accordingly in phase 2 of its implementation process based on the findings emanating from these studies of district hospital service costs (see the section on monitoring and evaluation).

Training, supervision and management system

All scheduled training for prescribing health care personnel in the use of standardized diagnosis and treatment protocols and essential generic drugs was concluded over the course of the past year. However, medical personnel will require follow-up supervisory training. A special effort will need to be made to furnish training in income and drug management procedures in health districts preparing for the institution of cost recovery mechanisms. Health care personnel as well as management committee members will require management training as defined in preliminary departmental action plans. National-level trainers trained back in 1995 will need to attend a refresher session (organized under PNASSP) to enable them to effectively assist in training activities implemented at the regional level. The MOH will need to ensure the necessary synchronization of national, regional and subregional training activities for the establishment of management systems and the implementation of cost recovery efforts. Moreover, PNASSP officials will need to make sure that corresponding regional action plans provide adequate resources to help strengthen the supervision of cost recovery activities throughout the first year of their implementation period.

Pharmaceuticals

A number of development partners active in the health sector have indicated their intention of financing the cost of initial drug inventories, either at the national level or within their respective program areas. A special endeavor will need to be made to coordinate efforts to set up initial drug inventories, both to ensure the timely availability of initial drug supplies in all health districts and to prevent duplication of effort. The plan calls for the formation of a committee devoted specifically to the coordination of drug supplies. Thus far, the select committee in charge of the coordination of drug inventories set up by the WHO has been totally ineffectual. The MOH might want to consider the following options in this respect:

- It could re-energize the present committee set-up by extending its scope to include operations of other development partners to ensure the effective coordination of efforts to obtain initial drug supplies for the implementation of cost recovery activities.

- It could support efforts by the NBPCP to set up an official monitoring structure for essential generic drug supplies within the framework of this agency, including operations by the MOH and its development partners, extending its authority to the establishment of initial drug inventories for the implementation of cost recovery activities.

The second option would appear to afford longer-lasting solutions, given the need to strengthen the procurement system to ensure the availability of affordable drugs at the national, regional, and subregional levels.

Moreover, the NBPCP is planning to extend its network of "discount" pharmacies, or low-cost drug dispensaries, to all health districts throughout the country. According to the NBPCP management, these "discount" pharmacies are to be gradually reorganized into subregional warehouses for pharmaceutical products to be run by the district management team in line with progress in the implementation of cost recovery activities and the establishment of local health districts. PNASSP officials will need to ensure that corresponding departmental action plans are duly coordinated with this NBPCP program.

Community participation

The proposed administrative order drafted by PNASSP officials for discussion within the framework of the regional workshops needs to be finalized, incorporating any justifiable changes emanating from discussions at these workshops, with a view to strengthening the legal and regulatory framework for the implementation of cost recovery efforts. As currently drafted, the order contains no provisions regarding to the term of office of local health committee members. As a result, the local community has no way of expressing its approval or disapproval of the actions of health committee members. Accordingly, the proposed order should include provisions for the replacement of members of local health committees. For example, Senegal health committee members are replaced every two years. A two-year term of office in Niger may be somewhat short within the context of a development period in which corresponding health committees need time to fully carry out their mandate. Since the implementing regulations issued under the cost recovery law establish these health committees as an extension of corresponding local councils, one suggestion is to align procedures for the replacement of health committee members with provisions for the replacement of local councilmen.

Furthermore, the MOH needs to make provisions for entering into cooperative arrangements with local NGOs to train and strengthen the skills of committee members. It will not be an easy task for district managers to provide adequate supervision for technical operations while, at the same time, lending needed support to local health committees. There are numerous NGOs with years of experience in the operation of community development projects in rural settings, offering comparative advantages as providers of supporting services for local health committees which need to be encouraged to serve in this capacity under microprograms initiated at the departmental and health district levels. This type of support could help get local health committees actively involved in health development efforts at the district level in areas other than merely overseeing the management of income generated by corresponding cost recovery mechanisms.

Worker incentives

The matter of worker incentives is a recurring problem. The MOH needs to study this issue and institute an incentive policy for health care personnel at the local health district level, to be backed up by subregional health committees with income generated by cost recovery mechanisms. The MOH could use performance evaluation criteria, such as improvements in the quality of health care, vaccination coverage levels, and coverage levels for prenatal care, as an incentive for health care personnel to step up their efforts in areas with the greatest impact on health conditions. To accomplish this, the MOH need only furnish local health committees with guidance and assistance in implementing these recommendations. It is important that the MOH anticipate local initiatives to ensure that they are in line with national public health objectives.

Monitoring and evaluation

The MOH needs to revitalize the national committee for the implementation of its cost recovery policy to ensure that the policy implementation process is diligently steered in the right direction and that operations undertaken by the numerous stakeholders involved are all duly coordinated. It is essential that the MOH's different development partners, including its domestic and foreign partners, be apprised of all activities, both to prevent overlapping and to promote synergy and to accentuate program complementarities at all levels. It is recommended that the national committee meet every three months to review quarterly program reports, identify bottlenecks hampering the policy implementation process, and seek solutions to problems. The pursuit of the objectives of the PNASSP could be supported by the formation of a committee within the MOH comprised of representatives from the Office of the Secretary General and other central bureaus and agencies. The purpose of this committee would be to coordinate MOH efforts and strengthen the strategic elements of the program implementation process (awareness-raising, new systems, training, means testing policies) at monthly meetings.

In keeping with the provisions of the implementing regulations issued under the cost recovery law calling for necessary adjustments in fee schedules in line with the real cost of service delivery, the ability to pay of corresponding local communities, and the need for continuing improvements in health care, the MOH needs to strengthen fee-setting procedures in general and, more specifically, procedures for the regular adjustment of user fees by setting up a data collection system for the use of individual health care facilities. It could build on the national health information system and the drug and income management tools furnished in connection with the implementation of cost recovery activities to establish a monitoring system for corresponding cost recovery mechanisms and essential generic drug supplies as a source of regular data to serve as the basis for the adjustment of user fees (see the MSP/DEP/BCS report of July of 1995 on the performance of cost recovery mechanisms instituted under the Bamako Initiative in the department of Maradi).

4.2 Medium/Long-Term Follow-Up Activities by the Ministry of Public Health

4.2.1 Development of a Safety Net for the Poor

The MOH needs to make a special effort to frame an explicit means testing policy for health care services furnished outside the hospital sector under the provisions of the cost recovery law for primary health care services. To accomplish this, it needs to pinpoint one or two districts where cost recovery mechanisms are already in place (districts with fee-for-service systems) in which to

evaluate current means testing mechanisms and test different options. In contrast to existing means testing mechanisms, these alternative measures should be based on explicit eligibility criteria consistent with the country's public health objectives. The presumption is that means testing mechanisms, under which eligible patients would be identified by corresponding health committees, would be easier to institute and operate in rural Niger. The findings from these monitoring efforts should facilitate the framing of an explicit means testing policy to be incorporated into corresponding cost recovery mechanisms in place of its current "laissez-faire" policy.

4.2.2 Strengthening of Financial Management Capabilities at the Health District Level

Thus far, the volume of resources managed directly by local health districts has been extremely limited. However, given the wide range of programs initiated by different development partners at the district level, management capabilities will need to be strengthened. Future decentralization of the nation's health care system will depend in part upon management practices designed to ensure the efficient use of available resources in furtherance of district health objectives. The MOH needs to strengthen its cooperation with different development partners (such as the Belgian cooperation agency, for the establishment of an administrative and financial management system at the local health district level with built-in procedures for the management of income generated by its new cost recovery policy. It also needs to take advantage of the opportunity afforded by the implementation of cost recovery mechanisms, which are expected to generate substantial financial resources at the district level, to develop and test a financial management system at this level.

4.2.3 Development of a Comprehensive Health Financing Scheme

The MOH needs to initiate special information processing efforts to support the consolidation of its primary health care and hospital financing policy within the framework of a comprehensive health financing scheme. To accomplish this, it will need to improve the availability of data on prospective sources of health finance, including governmental bodies (the central government, government enterprises, local governments and foreign aid) as well as private sources (private enterprises, health plans, insurance plans) and individual households. It will also need to expand available data on mechanisms for allocating resources to different health care providers (line items under the central government budget, local government line-item and operating budgets, reimbursements under insurance and health plans, user fees, etc.), as well as on service delivery costs at different levels of the health care system. This information could be used by the MOH for the formulation of different options and strategies fostering the development of a comprehensive health financing scheme. Some possible strategies include:

- complementary income-generating strategies to improve the equity of health financing mechanisms
- bona fide partnerships to shore up investments in the health care sector
- strategies designed to help improve the efficiency of the health care system (from the standpoint of the allocation and use of corresponding funding)

- and provisions fostering more equitable access to health care services

4.3 Follow-Up by USAID

With the conclusion of the regional workshops sponsored by USAID, the policy implementation process has entered a new phase, where each region of the country is equipped with an action plan and most expecting to start-up activities over the course of 1997. In other words, a transition process is well underway, with the focal point for corresponding operations shifting away from the national MOH down to the regional and local health district levels. Forthcoming support for this transition process at the central government level over the course of the next new months will be crucial to its outcome. The country's departmental authorities will require two types of central government assistance, namely:

- a joint commitment by the central government and its development partners to furnish necessary support through the financing of corresponding implementing activities, and
- technical assistance from the MOH for the start-up of corresponding action plans.

The Office of the Secretary General and the PNASSP unit will need to play a leading role throughout the transition process.

Accordingly, USAID will need to uphold its commitment to the MOH to support this transition process through continual high-level cooperation with the Niger Ministry and donor organizations, such as the European Community, UNICEF, the World Bank, and the WHO, in regard to the country's new cost recovery policy. Moreover, the efficient operation of the PNASSP over the next few months would help propel these donor efforts to the next level, namely, the actual start-up of cost recovery operations at the regional level. To this end, USAID will need to continue to lend its support during the change-over in PNASSP financing. Options currently under consideration include the provision of financial aid to the PNASSP by the European Development Fund to support technical assistance activities initiated at the central government level for departmental and health district authorities as part of the program implementation process. USAID will need to continue to make financial aid available during this transition period until other financing arrangements can be made (with the EDF for example). This aid would be limited to the payment of salaries for PNASSP contract personnel.

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