Health Sector Reform in Africa: Lessons Learned

Dayl Donaldson

March 1994

Data for Decision Making Project
Department of Population and International Health
Harvard School of Public Health
Boston, Massachusetts

Table of Contents

Executive Summary **1**

Introduction **2**

Nonproject Assistance Programs in the Health Sector **3**
World Bank Health Sector Conditionality 3
USAID Health Sector Grants 4

Factors Influencing Success or Failure of Nonproject Assistance **10**
Environmental Factors 10
Institutional Factors 12
Ministry of Health 13
Design Factors 14

Conclusion **19**

Bibliography **21**

Executive Summary

Since the early 1980s, donors have developed forms of assistance intended to achieve health sector reform by requiring countries' compliance with preset conditions in exchange for a given tranche of funds. The purpose of this paper is to synthesize the lessons learned to date from the design, implementation, and evaluation of this type of program assistance, particularly as it has been applied to the health sectors of African countries.

Seven areas of health program assistance provided by the U.S. Agency for International Development (USAID) have been targeted for reform: cost containment, cost recovery, decentralization, integration, population and family planning, privatization, and resource allocation and management. The number of specific conditions precedent have ranged from four to 60 as against counterpart funds ranging from U.S. $5 to $69 million to be released in three to five tranches.

On average, only 60% of social sector conditions in World Bank assistance are fulfilled, and implementation of USAID health sector reform programs has lagged behind schedule. Reasons identified for the success or difficulty of implementation fall into three categories: environmental factors, design factors, and institutional factors. For example, the probability of a well-managed reform program being successful was only 15% in a country with a poor environment as compared to 82% in a country with a favorable environment. Many institutions are involved in the process of implementing reform, and more attention on developing and managing a reform strategy is required at the beginning of the program. Finally, program design should aim to clarify the relationship between the policy change and the release of counterpart funds. Further, additional attention is required in large programs for the timing and release of the counterpart funds.

Recommendations regarding the future of program assistance as a mechanism for achieving health sector reform suggest that program assistance may not be appropriate in all cases and that a role remains for project assistance. Further, the paper calls for additional work to evaluate the impact of program assistance, as well as to document the process whereby reforms are achieved. Finally, the paper recommends more empirical work on the impact of structural adjustment on health and health sectors to provide a framework for the sector-specific reforms of program assistance.

Introduction

This report aims to synthesize lessons learned to date from the design, implementation, and evaluation of nonproject assistance in the health sectors of African countries.[1] The conclusions of this paper are based on review of project design and evaluation documents as well as on participation in 1992 in midterm evaluations in Niger and Nigeria of health sector NPA programs. The report consists of three parts. First, NPA is described and specific examples of programs in the African region are provided. Then the discussion moves to reviewing the lessons learned regarding factors that contribute to the success or difficulty of implementing these NPA programs. Particular attention is given to the role of data collection and analysis in NPA. Finally, a summary concludes the paper by touching on future prospects for NPA in the health sector.

1/ This paper was presented at the Child Survival Forum in Africa, held March 29-April 2, 1993 at the Meridien Hotel, Dakar, Senegal. The material for the paper was drawn from a longer paper on structural adjustment, sectoral reform, and health, wold-wide (Donaldson, 1992).

Nonproject Assistance Programs in the Health Sector

It has not been documented as to when, and for what reasons, health sector conditionality was first included in donor assistance. However, it is likely that health sector conditionalities initially focused on the commitment of resources (e.g., personnel, local materials, or funds) that would be required for successful implementation of a donor's health project. During the 1980s this focus has evolved in such a way that conditionality intended to impact on the health sector took two forms:

- Health sector conditionality included in an overall economic reform program;
- Health sector conditionality written as part of a specific health sector reform program.

World Bank Health Sector Conditionality

Publically available materials suggest that the World Bank has undertaken health sector reform primarily as part of overall economic reform efforts in a country. Social policy reforms have been included as conditions in 11%, and as actions in 24%, of Bank Structural Adjustment Loans (SALs) and Sectoral Adjustment Loans (SECALs). Data suggest that the trend to include social policy reforms has increased over the decade (Table 1). A review (Nicholas, 1988) of the World Bank's lending for structural adjustment states, "Greater use of sectoral adjustment loans is planned to support the restructuring of social expenditures." Furthermore, there are reports of plans to include sector-specific conditionality in other health projects in West Africa (Hjalte Sederlof, personal communication).

Documentation on a partial list of the World Bank SAL/SECALs with health and population conditions illustrates that these social sector conditions are included in loans attempting to influence policy in such diverse areas as economy-wide economic and financial management, management of public finance and state-owned enterprises, and trade. In addition, the health and social sector conditions are major areas for reform in only about one-third of the sample, and only minor areas for reform in the remaining two-thirds. Whether major or minor, activity had been initiated in the majority of cases (Table 2).

Table 1

Content of Lending Operations

Policy Area	*Share of Loans with Loan-Agreement Conditions in Various Policy Areas (percent)*											*Share of Loans with Actions in Various Policy Areas* (percent)*
	All Countries (183)	*Loan Type*				*EIAL Countries*				*Other AL Countries*		
		SSA (84)	*HICs (64)*	*SAL (73)*	*SECA (110)*	*Hybrid (10)*	*79-85 (55)*	*86-88 (49)*	*89 (15)*	*79-85 (9)*	*86-89 (55)*	
I. Supply-side, growth-oriented policies												
Trade policies	58	58	67	64	55	30	60	69	33	56	55	79
Sectoral policies												
Industry	22	30	16	25	20	10	24	20	27	22	20	44
Energy	15	12	14	21	11	30	15	14	7	22	16	27
Agriculture	45	62	33	56	37	30	44	35	27	89	53	62
Financial sector	31	26	31	40	25	20	16	35	27	44	40	51
Rationalization of government												
Finance/administration	51	57	50	71	38	10	51	53	40	44	55	72
Public enterprise reforms	44	58	34	49	40	40	31	49	33	33	56	65
Social policy reforms	11	13	9	11	11	10	4	20	0	22	11	24
Other	28	42	17	33	25	10	7	27	20	33	51	49
II. Absorption reduction policies												
Fiscal policy	51	69	41	78	34	30	47	51	53	33	58	67
Monetary policy												
(Money supply targets)	16	14	13	14	16	10	7	16	13	11	24	42
III. Switching policies												
Exchange rate	16	18	20	22	13	0	9	18	20	11	22	45
Wage policies	13	23	5	25	6	20	4	8	7	11	29	22

Source: Based on an analysis of 183 SALs and SECALs to 61 developing countries. Table is reprinted from World Bank (1990).

Notes: Numbers in parentheses are total number of loans. All countries. *All conditions called for in all loan agreements or other actions called for in all Presidents' Report.

Abbreviations: EIAL = early intensive adjustment lending; AL = adjustment lending; SSA = Sub-Sahara Africa; HICs = higher-income country; SAL = structural adjustment loans; SECAL = sectoral adjustment

USAID Health Sector Grants

The U. S. Agency for International Development (USAID) has adopted the alternative approach of including health and population conditionality within health sector projects or program grants. Early USAID conditionality reflected economists' concerns regarding the sustainability of health sector interventions at the end of donor support. For example, the release of funds for country programs supported by the Control of Childhood Communicable Diseases (CCCD) project in the early 1980s was conditional on the development and implementation of efforts to generate sufficient local funds to make CCCD activities self-financing (Dunlop and Evlo, 1988, p.1-2).

By 1992 programs for reform in the health and population sectors had been developed for seven countries: Botswana, Chile, Ghana, Kenya, Nigeria, Niger, and the Philippines; in addition, programs were under design for at least two more countries, Cameroon and Togo. The goals of these health NPA programs generally were to improve both health status and the provision of preventive health and family planning services. Objectives of the programs varied from general statements regarding the reorientation and financing of health systems

Table 2

Structural Adjustment Loans (SALs)

Country	*Economic Financial Mgmt*	*State Econ/Ent Perform*	*Nonfinancial Ministries/Institution*			*Trade Admin Reform*
			Health/ Social Sector	*Population*	*Other*	
Chile II	X	X	m	m, 1	O	X
Chile III	X	X	m, *	O	O	X
Chile TA I	X	O	T, 1	O	O	X
Costa Rica	X	X	m, 1	O	X	X
Costa Rica TA I	X	X	T, 1	T, 1	X	X
Panama I	X	X	M, 1	O	X	X
Panama II	O	X	M, 1	O	X	X
Panama TA I	O	O	T, 1	O	X	X
Uruguay	X	X	M, 1	O	X	X
Uruguay Ta PS Mgmt	X	X	T, *	O	O	X
Gabon	X	X	m, *	m, *	X	X
Ghana ACCRA Rehab TA	O	O	T, 1	O	X	O
Guinea II	X	X	m, *	m, *	X	X
Kenya II	X	O	m, 1	O	X	X
Togo III	X	X	M, *	M, *	X	X
Pakistan TA I	X	X	T, 1	O	X	O

Key: X = conditionality included; O = conditionality not included; M = important aspect of program; m = minor aspect of program; T = technical aspect; 1 = action initiated; * = follow-up report unavailable or incomplete.

Source: Nunberg (1990, p. 30-35).

to more detailed statements regarding the specific aspects of service delivery to be improved. Specific conditions precedent ranged from four to 60 in number per program (Table 3). The programs required policy or institutional reforms and/ or studies in areas such as:

- Cost containment, e.g., implement and monitor use of essential drugs list;
- Cost recovery, e.g., implement new hospital fee system and accounting procedures, or conduct pilot tests of non-hospital-cost recovery;
- Decentralization, e.g. transfer of primary health care facilities and personnel from states to local government areas, or test and implement decen-

Table 3

USAID Health/Population Nonprogram Assistance: Design Aspects and Administrative Plans

Design Features	*Botswana*	*Cameroon*	*Chile*	*Ghana*
Title	Population Sector Assistance	Primary Health Care Subsector Reform Program	Program for Immediate Improvement of Primary Health Care	
Date of PAAD			November 16, 1990	April 25, 1991
Date of PACD				
Original	July 31, 1993			March 31, 1996
Amended				
Recommended				
Goal	To assist the GOB to strengthen effectiveness and efficiency of its Pop/FP programs and services.	To provide the required legal and procedural basis for nationwide implementation of PHC strategy based on decentralized planning, community co-financing, management of health, family planning services.	To improve the quality of the life of the Chilean population.	To increase the demand for and the use of FP methods through expanding capacity of public and private sectors to provide services, supplies, and EIC.
Purpose	Develop nat'l pop policy. • Improve coordination in pop programs. • Improve contraceptive logistics. • Expand IEC services. • Improve delivery/mgmt of MCH/FP services. • Increase trained staff. • Increase GOB FP funding.	• Adopt legal texts for collection/retention of service fees. • Adopt essential drugs, contraceptives list. • Develop/adopt medical standards and service delivery policies for family planning.	• Improve access to PHC, especially rural and urban poor. • Increase capacity for health care problem resolution at the primary level.	• Create environment conducive to implement national FP program through policy reform. • Broaden FP/MCH services provided through regulatory reform.
Policy Reform Areas	Population/family planning	• Financing health services • Integration of FP to PHC		Population/family planning
Number of Tranches	Five	Three	Two	Three
Number of Conditions Precedent	26		Four	19 + subrequirements

tralized planning;

- Integration, e.g., of child survival interventions into a primary health care delivery system.
- Population and family planning, e.g., develop and implement a national population policy, or eliminate customs duties and price controls on contra ceptives;
- Privatization, e.g., permit physicians to have private practices during off-hours;
- Resource allocation and management, e.g., reallocation of personnel by area and type of institution, or reallocation of budget by input category.

Counterpart funding ranged from U.S. $5.0 million in Botswana to U.S. $69.0 million in the Philippines. Counterpart funds were to be released in three to five tranches following the completion of pre-agreed upon conditionality, over a period of three to five years, or roughly at the rate of one tranche per year. In all cases, decision-making regarding the counterpart funds involved representatives both of government and of USAID. Funding for technical assistance asso-

Table 3 (Continued)

USAID Health/Population Nonprogram Assistance: Design Aspects and Administrative Plans

Design Features	*Kenya*	*Nigeria*	*Niger*	*Phillipines*
Title	Health Care Financing	Primary Health Care Support Program	Health Support Program	Child Survival Program
Date of PAAD		July 15, 1989	July 24, 1986	September 28, 1989
Date of PACD				
Original			December 31, 1991	March 1994
Amended		December 31, 1992	December 31, 1992	
Recommended		December 31, 1994	December 31, 1994	March 1996
Goal	To improve the health status of Kenyas, particularly women and childrern, and to contribute to GOK budget rationalization.	To improve the health status of the Nigerian people.	To assist the GON in provision of services to reduce preventable death and illness, and to reduce the rate of population growth.	To reduce the variance in infant and child mortality rates among and within provinces and regions and lower to corresponding national rates.
Purpose	• To provide sustained increased financial resources for delivery of efficient quality care (curative and preventive).	• To reorient the public health care system from a curative to a preventive focus by expanding PHC.	• To achieve desirable and significant health/population reforms. • To relieve financial constaints to support preventive and promotive CS services.	• To increase the availability and utilization services, particularly to underserved and high-risk groups.
Policy Reform Areas	• Resource allocation • Cost recovery	• Decentralization • Private sector	• Population/family planning • Health planning/information system • Resource allocation/management • Cost containment/recovery	• Child survival (several) • Health planning/information system • Decentralization • Cost containment/recovery • Private sector
Number of Tranches	Three	Two, amended to three	Five	Four, amended to six (?)
Number of Conditions Precedent	23 + subrequirements	18 + subrequirements	60	33 + subrequirements

Abbreviations: PAAD = Program Assistance Approval Document; PACD = Project Agreement Completion Date; GOB = Government of Botswana; Pop = poulation; FP = family planning; PHC = primary health care; IEC = information, education, communication; MCH = maternal/child health; GOK = Government of Kenya; GON = Government of Nigeria; CS = child survival.

Sources: USAID/Botswana (1988); USAID/Cameroon (1991); USAID/Chile (1990); USAID/Kenya (-); USAID/Ghana (1991); USAID/Niger (1986);USAID/Nigeria (1989a/b); USAID/Philippines (1989).

ciated with the grant ranged from zero to U.S. $6.7 million and included both short- and long-term technical assistance. Funds were also included in four of the grants for short- and long-term training intended to increase institutional capability (Table 4).

Table 4

USAID Health/Population Nonprogram Assistance: Design Aspects and Implementation Plans

Design Features	*Botswana*	*Cameroon*	*Chile*	*Ghana*
Technical assistance				
Long-term (person-years)	3 person-years	Not specified.	Type and quantity not specified	Mentioned, specific quantities not given.
Short-term (person-month)	56 person-months			
Training				
Long-term	Mentioned, specific quantities not given.	Not specified.	Not specified	Mentioned, specific quantities not given.
Short-term				
Other donor coordination WRT NPA	Grant implementation not coordinated with projects of other donors.	Coordination of specfiic reformes or activities not described.		Grant implementation not coordinated with projects of other donors.
Funding	DFA	DFA	DA	
Source(s)				
Amount				
LC component	$900,000	$5,000,000	$9,300,000	$3,000,000
TA component	$600,000		$700,000	
Amended amount				
LC component	$3,000,000			$13,000,000
TA component	$2,000,000			
Assoc. Project*				$17,000,000
Counterpart Funds				
Programming	• Jointly programmed by MOH and USAID.	Not specified.		• MOH proposes use, USAID reviews/concurs
Uses	• Provide additional budgetary support to the population sector.	• US $ for imports (US, 899) debt repayment, other • LC for essential drugs, renovate/equip health centers.	• US $ for US imports for health sector. • LC for local costs of restructuring health sector.	• Provide additional budgetary support for FP, MCH, PHC, EPI, CDD, nutrition, guinea worm, IEC, AIDS, national population.

Table 4 (Continued)

USAID Health/Population Nonprogram Assistance: Design Aspects and Implementation Plans

	Kenya	*Nigeria*	*Niger*	*Philippines*
Technical assistance				
Long-term (person-years)	7 person-years	None	12 person-years	16 person-years
Short-term (person-months)	75 person-months	From other projects	40 person-months	40 person-months
Training				
Long-term	10 participants	None	4 participants	None
Short-term	48 participants	None	10 participants	None
Other donor coordination WRT NPA	USAID selected as lead agency in health finance reform.	Grant implementation not coordinated with projects of other donors.	Grant reforms designed for coordination with World Bank health project.	Coordination of specific reforms or activities not described.
Funding				
Source(s)	AEPRP	AEPRP, ESF	DA	DA
Amount				
LC component	$9,700,000	$25,000,000	$10,500,000	$45,000,000
TA component	$5,300,000	$0	$4,500,000	$5,000,000
Amended amount				
LC component		$36,000,000	$10,500,000	$24,000,000
TA component		$0	$6,700,000	$1,000,000
Assoc. Project*	$0	$0	$0	
Counterpart Funds				
Programming	• Jointly programmed by MOF and USAID.	• FMOH proposes use, USAID reviews/concurs.	• MOPH proposes use, USAID reviews/concurs.	
Uses	• Additional budgetary resources for implementing institutions to carry out reforms.	• Items in FY1989 or FY1990 budgets of FMOH or of other agencies.	• Program activities related to reforms. • Recurrent/local cost of USAID/other donor projects.	• US $ for debt servicing or other agreed by USAID. • LC equivalent not required.

Notes: *Bilateral or multilateral, information unknown or incomplete for some countries

Abbreviations: WRT = with respect to; NPA = nonprogram assistance; DFA = Development Fund for Africa; DA = development assistance; MOH = Ministry of Health; USAID = U.S. Agency for International Development; LC = local currency; FP = family planning; MCH = maternal/child health; PHC = primary health care; EPI = Expanded Program on Immunization; CDD = control of diarrheal disease; IEC = information, education and communication; AIDS = acquired immune deficiency syndrome; MOF = Ministry of Finance; FMOH = Federal Ministry of Health; MOPH = Ministry of Public Health; FY = fiscal year.

Sources: USAID/Botswana (1988); USAID/Cameroon (1991); USAID/Chile (1990); USAID/Kenya (-); USAID/Ghana (1991); USAID/Niger (1986); USAID/Nigeria (1989a/b);

Factors Influencing Success or Failure of Nonproject Assistance

Many criteria may be used for evaluation of health sector reform efforts. One might simply determine the level of success by examining the percentage of conditionality fulfilled. This approach, adopted in one World Bank study, revealed that, with respect to the total fulfillment of social sector conditionalities, countries' performance lags behind all other policy reform areas except wage policy. Specifically, only 59% of social policy conditions were fully implemented, and only 55% of critical actions were fully implemented, whereas in other areas implementation rates were as high as 79%. However, partial fulfillment of social policy conditionality and critical actions reached levels at or above performance in other policy areas (Table 5). This information suggests that the required changes in social policies may be particularly difficult to achieve, at least in their most complete form, either for reasons of social resistance and/or because of the difficulties of implementing reforms in large service delivery systems.

Alternative approaches to evaluating NPA have addressed not only the question of performance in meeting conditions precedent, but have also attempted to address questions related to why a program has been successful or why it has failed. To date evaluations have been conducted for four of the seven grants, i.e., those in Kenya (Setzer et al., 1992), Niger (Foltz et al., 1992), Nigeria (Taylor and Donaldson, 1992), and the Philippines (Abella et al., 1991). The following section is based principally on the key lessons learned from the evaluations for the NPA programs in Africa. Factors found to influence the success or failure of health sector NPA have been grouped under three headings:

- Environmental factors;
- Institutional factors;
- Design Factors.

Environmental Factors

It must be recognized that policy reform is difficult to achieve in an environment going through rapid political and economic change.[2] This point is well illustrated

2/ There would appear to be no single signed relationship between political and economic crisis and success at achieving reform. Some policy refrom may come about more quickly in times of crisis, whereas institutional reforms may be difficult to achieve under circumstances of political upheaval and change.

Table 5

Implementation of conditions (percent at final tranche release)

	In All Loan Agreements/a		SALs	SECALs	HICs	SSA	Critical Actions/b	
	Fully Implemented	At Least Substantially Implemented	At Least Substantially Implemented	At Least Substantially Implemented	At Least Substantially Implemented	At Least Substantially Implemented	Fully Implemented	At Least Substantially Implemented
I. Supply-side, growth oriented policies								
Trade policies	62	85	79	88	87	84	56	82
Sectoral policies								
Industry	72	92	90	92	100	96	53	65
Energy	69	80	70	84	79	67	72	80
Agricultural	62	81	86	80	88	75	49	74
Financial sector	73	89	94	83	97	80	79	92
Rationalization of government								
Finance/administration	63	81	79	83	85	85	54	68
Public enterprise reforms	66	80	77	78	90	71	67	77
Social policy reforms	59	91	67	92	93	75	55	82
II. Absorption reduction policies								
Fiscal policy	74	82	81	85	93	84	72	89
Monetary policy (money supply targets)	67	83	0*	91	100*	50*	61	89
III. Switching policies								
Exchange rate	75	85						
Wage policy	45	91						
Total								
Loan agreement conditions/c	66	84	83	84	89	80	67	83
All conditions or actions/d	57	77	73	80	82	75	60	79

Source: Based on an analysis of 97 SALs and SECALs in 32 developing countries. The sources of information on implementation were mainly supervision reports, tranche release documents, and, where available, Project Completion Reports and Program Performance Audit Reports. Table is reprinted from World Bank (1990).

a. The data on implementation indicate the extent to which a condition or action was fulfilled at final tranche release. A total of 1015 legal conditions were graded on implementation.

b. Critical actions are so identified because Bank staff designing the operation put particular emphasis on them and because they were expected to make a significant contribution to adjustment in a short time. A total of 494 actions were coded as critical, of which 303 appeared as conditions in the loan agreements.

c. The implementation rate of conditions that appear in the loan agreement.

d. Average implementation of actions which appear in the President's Report or conditions in the loan agreement. A total of 2231 actions were graded on implementation.

* Less than five observations in these cells.

by Niger, where virtually all government and program activity ceased during a National Conference (July-November 1991) that defined the steps to be undertaken during a transition to democratic elections. Other factors influencing the success of health sector NPA in Africa were drought, overall decline in the macroeconomic situation, and opposition of political groups to user fees and privatization reforms (Table 6). The importance of a program environment conducive[3] to the success of NPA programs is borne out in findings of an evaluation of agriculture sector reform grants (Tilney and Block, 1991). This study found that a reform program had only a 15% chance of success if the program environment was poor even though program management was good, but that the probability of success increased to 82% if the program environment was favorable (Table 7).

3/ For purposes of the study cited, good or favorable project environment includes support of influential policy-makers, well-trained host agency staff, consistent and long-term aid program, and coordinated donor support.

Table 6

Logit Simulations of Policy Reform Success

Scenario	*Probability of Success*	*Confidence Interval*
Good management and good environment	.82	(.64, 1.0)
Poor management and good environment	.44	(.21, .68)
Good management and good environment	0.15	(0, .32)
Poor management and good environment	0.03	(0, .11)

Note: The estimated coefficients from the Logit model of policy reform are: Logit (Prob[policy reform success]) = -3.492 + 1.7535*(Project Management) + 3.2593* (Project Environment), n = 17

Source: Tilney and Block (1991, p. 14).

Institutional Factors

Just as the study cited above (Tilney and Block, 1991) demonstrated the importance of environmental factors to the success of NPA, it also demonstrates the importance of good program management for NPA success. NPA programs operating in a good environment with good management had a nearly 40% higher chance of success than programs with poor management. NPA program management usually involves many groups: the Ministry of Health (and other-government institutions), USAID, the technical assistance team, and other donors. However, to date, political and/or institutional analyses to develop health reform strategies have been either inadequate or nonexistent during program design. Use of guides such as *Guidelines for Mapping Decision-Making Processes* (Reich, 1992) is encouraged for the design of future health sector reform programs[4] to aid in the development of understanding of institutions and their decision-making processes.

Table 7

Evaluation of Health Sector NPA: Environmental Factors

- Drought
- Macroeconomic problems, e.g., decline in government budget
- Political changes related to democratization and decentralization
- Resistance of political groups to policies, e.g., user fees and privatization

4/ Other useful guidance appears in the *AID Guidelines for Non-Project Assistance Handbook 4, Institutional and Social Analyses.*

Ministry of Health

Continuity in the senior management of the Ministry of Health contributes to the success of health sector NPA. During the period of the Primary Health Care Program in Nigeria, there was a single Minister of Health and a single special assistant for primary health care who oversaw implementation of the program. In contrast, Niger's Ministry of Health had five Ministers and three Secretary Generals. In the latter case considerable time had to be spent reintroducing the grant and developing support for its implementation. Committees responsible for wider coordination of grant activities were either not formed (Niger) or not provided with adequate staff or operating funds (Kenya). Finally, all of the staff posts in a Planning/Studies unit in Niger were not filled, making it impossible to transfer skills or for some tasks to be carried out.

U.S. Agency for International Development

Initially, it was assumed that NPA programs would require less input from USAID staff than was generally required for health projects. It has been found that this is not the case and that NPA programs do have technical and administrative burdens. In Kenya, Niger, and Nigeria, USAID staff played a key role in catalyzing activities under the grants. Thus, prolonged absence of USAID personnel during grant implementation can result in a slowing of progress.

Technical Assistance

The placement of the technical assistance team within the Ministry of Health is important for the success of an NPA grant. In Nigeria the grant was implemented under a Special Assistant to the Minister for primary health care. In Kenya, the Minister oversaw major policy decisions related to the grant and technical assistance related to senior and mid-level personnel in the three implementing institutions. In contrast, the grant in Niger was implemented under a newly created Direction of Planning and Studies, which also benefitted significantly from the counterpart funds released. Other Directions in the ministry that were implicated in the full implementation of the grant did not fully participate or support the implementation of the grant.

Long-term technical assistance was used in the Kenya and Niger grants to carry out actions would lead to the completion of conditions precedent. While in some cases the technical assistance was necessary from a technical point of view, in other areas it merely substituted for effort on the part of a government employee. This lack of government involvement also reduced the possibilities for transfer of skills and institutionalization. In addition, technical assistance, which was more junior in experience, was generally less successful in promoting

policy or institutional change, a process which requires more than technical skill.

Careful consideration should be given to the appropriateness of using short-term technical assistance; unless it is provided on a regular and repeating basis the consultants are unlikely to develop the necessary understanding of technical issues and political processes to know what to recommend, nor to have developed the necessary personal relationships through which to influence policy-makers. Further, it is unclear whether short-term technical assistance is adequate to bring about institutional and/or administrative changes (e.g., institution of user fees and installation of a hospital financial management system), especially when the number of national staff with advanced training andexperience are limited. Regarding institutionalization, further investment in long-term training would facilitate the transfer of skills through later on-the-job training.

Donor Coordination

Donor coordination is important in sector adjustment programs when more than one donor is attempting to influence policy in a given area. A good example of the problems than can result is Niger, where the progress of USAID's program was tied to progress in the World Bank's program. Delays in implementation of the World Bank's program due to lack of technical assistance ultimately led the USAID program to carry out activities in the Bank project. Another example is the joint effort of USAID, the World Bank, UNICEF, and several European countries in trying to influence the government of Niger policy on cost recovery for drugs. Until a Comite Pilotage was developed to set up terms for a pilot study comparing different schemes, the sometimes conflicting efforts of the different donors led to inaction in terms of policy on the part of the Ministry of Health. Another mechanism that facilitates donor coordination is the designation of one donor to have a lead role in a given policy area. This mechanism is being tried in Kenya where USAID has the lead role in issues related to health care financing. The evaluation of Kenya's NPA reported a significant level of effort to achieve donor coordination and an acceptable level of success. Thus, development of specific mechanisms to ensure donor coordination is recommended (Table 8).

Design Factors

Tranches and Conditions Precedent

The design of some programs has been overly ambitious in terms of the number of policy areas and policy/institutional reforms to be carried out. The fulfillment of some conditions precedent did not necessarily achieve any policy or institutional reform (e.g., completion of a study). For example, the Niger Health Sector Support Grant included six different reform areas with over 60 different condi-

Table 8

Evaluation of Health Sector NPA: Institutional Factors

MOH	*USAID*	*Technical Assistance*	*Donor Coordination*
• Continuity at ministerial and secretarial level. • Creation and financing of project committees.	• Prolonged absence of USAID staff should be avoided. • Technical and administrative requirements should not be underestimated.	• Placement of TAT high within MOH. • Recruitment of senior long-term TA.	• Coordination vital where: - NPA linked to progress in other donor projects. - Several donors active in a policy area.
• Appointment of personnel to new divisions and units.	• USAID staff involvement can catalyze policy and institutional reforms.	• Policy experience desired for chief-of-party. • Short-term TA not best suited to bring about administrative or institutional reforms.	• Donor coordination can take the form of: - A donor takes the lead role for a policy area. - MOH and donors form coordinating committee

Abbreviations: TAT = technical assistance team; MOH = Ministry of Health; TA = technical assistance; NPA = nonproject assistance

tionalities. Achievement of reform in some areas (e.g., cost recovery[5] or reallocation of manpower) is inherently more difficult than in other areas (e.g., development of a population policy). Counterpart funds may be limited in amount relative to the political costs and scope of the reforms proposed. Prioritization of the areas for reform was recommended, as experience in Niger suggested that it was only possible to work on two or three policy areas at any one time[6]. To the extent that this is true, the inclusion of conditionality related to many policy areas within the same tranche results in slowing the pace of reform to the rate of progress of the slowest element of the tranche. Separation of policy areas into different tranches would facilitate the progress of reform in any particular policy area.

Counterpart Funds

Experience with counterpart funds has taught several major lessons. First, counterpart funds may comprise a significant portion of the recurrent budget of Ministries of Health. In Niger, the tranches, had they been released on an annual basis, would have been equivalent to about 10% of the overall recurrent budget, or 20% of the nonpersonnel recurrent budget of the Ministry of Health. (About 30% of the counterpart funds released in the first tranche were provided to service delivery programs such as the Expanded Program on Immunization.) Released as they were on an ad-hoc basis, however, they introduced a significant level of fluctuation in the recurrent resources available to the Ministry of Health and thus did not promote the development of rational program planning. InNigeria, the *naira* equivalent of the first tranche was equivalent to about 20% of the Ministry of Health's 1991 recurrent budget, and 17% of the Ministry's combined capital and recurrent budgets. Thus in both cases, each tranche of

5/ The difficulties in implementing cost recovery are not unique to the health sector. A World Bank study reviewing the experience with cost recovery conditionality in 48 irrigation projects found that over two-thirds of the projects had not complied with cost recovery conditionality, and where initiated that the proportion of operations and maintenance costs recovered ranged only from 15% to 45%.

counterpart funds represented a significant increase in the budgetary resources available to the Ministry of Health. Improvement in the absorption of these funds and sustainability of the programs/activities funded could have been facilitated through additional USAID involvement in setting general guidelines for allocation of funds and in review of the Ministry of Health's proposed allocations.

Procedures for the allocation of the counterpart funds varied. In Nigeria decisions about which program areas would obtain funds and the level of funding were simply made by an internal committee of the Ministry of Health. In Niger, on the other hand, programs wishing to obtain counterpart funds were required to prepare detailed proposals and budgets, and decisions were then taken by a committee not exclusively made up of representatives of the Ministry of Health.[7] In this sense, the Niger mechanism treated the decision-making process as if the proposals were competing against each other for investment funds. However, the large bulk of funds were used to fund recurrent costs of the projects. In this case, some emphasis should have been placed during the proposal writing stage on defining how the activity would be continued in the absence of counterpart funds. In addition, the management of counterpart funds in Niger was linked to a Secretariat mechanism used for the Agricultural Sector Development Grant I (ASDG I). Decertification of the Secretariat, due primarily to problems with the ASDG I, delayed release of health sector funds by over a year. Linking of a mechanism for the release of health sector grant funds with that used for other grants is thus not recommended.

Neither decision-making mechanism seemed to recognize the benefits of linking the reward of counterpart funds to the department that had achieved policy or administrative reforms. While hospital reforms were included in the design of both the Niger (cost recovery) and Nigeria (privatization) programs, to date counterpart funds have not been allocated to hospitals in either program, and in both programs hospital reforms have lagged in implementation.

Finally, the health sector grant in Nigeria did not serve as an efficient mechanism for providing quick disbursing foreign exchange for balance-of-payment support.[8] The grant's designers foresaw the release of first-tranche funds in late 1989 and second-tranche funds in early 1990. However, delays in meeting first-tranche conditionality did not permit first-tranche disbursement until July 1990, and the second tranche was not released until the latter half of 1992, or two years later than anticipated. This experience demonstrates the problems of trying to link funds intended to provide quickly disbursing balance-of-payment support with a program related to the inherently slower processes of policy and institutional change. In the future, when designers wish to provide balance-of-payments support, other mechanisms other than NPA may permit quicker release of funds. (Note, for example, that programming of Economic Support Funds does not require achievement of policy/institutional reform.)

6/ Criteria for prioritization among policy areas and specific reforms should be developed. Selection of reforms in the area of health financing and cost recovery might be based on criteria such as the level of revenue generation, degree of cost savings, or political and administrative feasibility.

Policy Studies

Policy studies can play a role in the identification and assessment of policy options as well as in development of consensus and ownership of a decision regarding which option to implement. To the extent that Ministries of Health and donors are accountable for the impact of any reform implemented, the conduct of a study during design or implementation of a program helps to facilitate the development of consensus over the option to be implemented, and understanding of the consequences of its implementation. For example, the Nigeria Primary Health Care Support Program included significant policy reforms with respect to the decentralization of health services. To a considerableextent these reforms were included because they had already been decided upon by the Government of Nigeria, but the program played a key role in obtaining special allocations of funds for the policy's implementation. However, support for the decentralization policies was included in the program without study of the consequences of decentralization, and issues such as the financial sustainability of local government authority-based services soon required attention. Also, the Nigeria program failed to include study of the policy of private practice for physicians prior to calling for its implementation. Thus there was no opportunity to defuse resistance to the policy through study of the actual issues involved.

The importance of studies to the success of NPA in the health sector is borne out by a finding in the Kenya Health Care Financing Program. Studies carried out during the decade prior to the program were deemed critical to developing consensus for the policy reforms of that program. On the other hand, the experience of the Niger Health Sector Support Grants suggests that the conduct of studies can be carried to an extreme. For example, the disaggregation of hospital issues into a number of small studies may have slowed reform by increasing the number of approvals for scopes of work, consultants, and draft reports. Further, the large number (23) of hospital studies and papers developed by the technical assistance team made it difficult for policy makers to review or consider the recommendations and implementation plans. Organization of studies into fewer studies with larger scope may have provided greater visibility and facilitated earlier progress to implementation (Table 9).

7/ Allocation of first-tranche counterpart funds in the Niger program was as follows: secretariat support, 20%; information system and studies support, 40%; disease contral, 15%; nongovernment organizations, 20%; other, 5% (Foltz et al., 1992, Table 2). Allocation in the Nigeria program was as follows: primary health care support, 65%; grants, 18%; support to family planning and AIDS, 17% (Taylor and Donsldon, 1992, p. 5).

Table 9

Evaluation of Health Sector NPA: Design Factors

Tranches and Conditions Precedent	*Counterpart Funds*	*Studies*
• Expectation too ambitious for time available.	• More attention to the programming of counterparts funds timing and is needed.	• Studies are important to identify possible courses of action and their consequences.
• Achievement of reform in some areas is inherently more difficult than reform in others.	• Links between the fulfillment of CPs and the receipt of counterpart funds needed to be strengthened.	• Studies may help to build consensus around a policy or course of action.
• Coupling of policy areas within tranches slows progress in any given area.	• NPA programs generally operate slower than initially designed and, thus, may not be the best way to provide rapidly dispersing balance-of-payments support.	• Conduct of fewer, larger studies gain more attention and permit earlier action by decision-makers.
• Fulfillment of CPs does not necessarily result in reform.		

Abbreviations: CPs = conditions precedent

8/ Design acknowledged that "The Nigerian macroeconomic situation is both the justification for the program and a major influence on the design." Specifically, the U.S. government at a meeting of the London Club in 1989 had pledged US $25 million of rapidly disbursing aid to fill a foreign exchange financing gap."

Conclusion

This paper has attempted to review the experience of donors and countries in the design and implementation of programs to reform health sector policy, structure, and financing in developing countries. Evaluation of these experiences suggests that the completion of health sector reforms is more difficult than that of reform in other sectors. Reasons for the specific difficulties of health sector NPA have not been delineated, but likely they relate to the fact that health programs often affect many or most interest groups in the society and that access to free health services is often regarded as a right. In addition, many reforms require more than merely a statement or restatement of policy; they often require the alteration or creation of administrative practices and institutional structures. However, it appears that within a favorable environment, and in conjunction with reasonably stable institutions, NPA programs concentrating on reform in two or three areas and linking counterpart fund awards to reform are likely to succeed.

Regarding NPA, at least two areas remain for further development. First, efforts to date to evaluate the impact of NPA programs in the health sector have been limited, in part because the evaluations conducted have been midterm evaluations focused on completion of conditions precedent. For example, questions about how the distribution of health services, or how the burden of health financing, have changed as a consequence of the implementation of NPA remain to be answered. A second related area for further inquiry relates to illuminating the process of health policy reform. Midterm evaluations may contain some process information but do not provide the kind of case study information about actors and institutions and health reform that would illustrate which aspects of the reform processes work and which aspects do not work.

Finally, there is a need for more empirical information about the relationship between economy-wide structural adjustment and health or the health sectors. The 1980s has been a decade of difficult economic circumstances for many developing countries, particularly in Africa. To address these problems, the countries have often undertaken programs of structural adjustment financed by the World Bank. While relationships between adjustment policies and the health sector and health status have been sketched out in general terms, insufficient empirical work has been done to determine the actual direction and magnitude of the impact of different structural adjustment policy packages on the health sector. Without such analyses, donor policies for stabilization and structural

adjustment are made with incomplete consideration of their effects on the health sector and on health. Further, it is more difficult to develop short-run health programs to assist those most affected and to develop medium- and longer-term reform programs (e.g., NPA) that are sensitive to the different health needs and resources of population subgroups.

Bibliography[9]

Abella, C., Tau, J., Hirschhorn, N. 1991. *Child survival program (Philippines) midterm evaluation.* 56 p. plus appendices.

Banque Mondiale. 1991. *Aide memoire, Project Sante (Credit 1668-NIR).* Mission de Supervision, 10 au 22 Novembre 1991.

Block, S. 1988. *Agricultural policy reform in Niger: the agriculture sector development grant.* APAP staff paper no. 17. Cambridge, MA: Abt Associates. 27 p.

Bourguinon, F., de Melo, J., Suwa, A. 1991. *Distributional effects of adjustment policies: simulations for archetype economies in Africa and Latin America.* World Bank Economic Review 5(2):339-366.

Cohen, J.M., Grindle, M.S., Walker, S.T. 1985. *Foreign aid and conditions precedent: political and bureaucratic dimensions.* World Development 13(2):1211-1230.

Diop, F., Hill, K., Sirageldin, I. 1990. *Economic crisis, structural adjustment and health in Africa.* Presented at World Bank Seminar, April 23, 1990. 35 p. plus tables.

Donaldson, D. 1992. *Structural and sector adjustment and the health sector, a review.* Unpublished manuscript.

Dunlop, D.W., Evlo, K. 1988. *A comparative analysis of CCCD project health care financing activities.* Report for the Resources for Child Health Project (REACH). Arlington, VA: John Snow, Inc. 34 p. plus annexes.

Foltz, A.M., Donaldson, D., Ba, B. 1992. I*nterim evaluation Niger health sector support project.* Boston: John Snow, Inc. 34 p. plus annexes.

Grindle, M., Thomas, J. 1991. *Public choices and policy change, the political economy of reform in developing countries*. 222 p.

Jolly, R. 1991. *Adjustment with a human face: a UNICEF record and perspective on the 1980s.* World Development 19(12):1807-1823.

Kanbur, R. 1991. *Projects versus policy reform.* Proceedings of the World Bank Annual Conference in Development Economics, 1990. Washington, D.C.: World Bank. p. 397-414.

9/ This bibliography lists references cited in the text as well as additional material that may be of inerest to the reader.

Kerst, E. 1991. *Lessons learned in the design of sector grants in Niger*. U.S.Agency for International Development/Niger. 43 p.

Korte, R., Richter, H., Merkle, F., Görger, H. 1992) *Financing health services in sub-Saharan Africa: options for decision-makers during adjustment.* Social Science and Medicine 34(1):1-9.

Lieberson, J.M. 1991. *AID economics policy reform programs in Africa, a synthesis of findings from six evaluations.* Washington, D.C.: U.S. Agency for International Development, Center for Development Information and Evaluation. 33 p.

Nicholas, P. 1988. *The World Bank's lending for adjustment an interim report.* Washington, D.C.: World Bank. 55 p.

Nunberg, B. 1990. *Public sector management issues in structural adjustment lending.* Discussion paper no. 89. Washington, D.C.: World Bank. 76 p.

Paul, S. 1990. *Institutional reforms in sector adjustment operations, the World Banks's experience.* Discussion paper no. 92. Washington, D.C.: World Bank. 65 p.

Reich, M. 1992. *Guidelines for mapping of decision-making processes.* Boston: Harvard School of Public Health, Data for Decision Making Project. 13 p. plus tables.

Rozell, C. 1990. *Revised Africa Bureau NPA guidance.* Washington, DC: U.S. Agency for International Development, Africa Bureau. 29 p. plus appendices.

Sederlof, H. 1987. *Personal communication from Hjalte Sederlof,* World Bank.

Setzer, J., Leighton, C., Emrey, R. 1992 *Kenya health care financing program and project,* midterm evaluation report. Bethesda, MD: ABT Associates. 86 p. plus appendices.

Taylor, R., Donaldson, D. 1992. *Nigeria primary health care support program,* project status and evaluation report. Boston: Harvard School of Public Health,Data for Decision making Project. 39 p. plus annexes.

Tilney, J., Block, S. 1991. *USAID Efforts to Promote agricultural policy reform and institutional development in developing countries: lessons for design and implementation.* Cambridge, MA: ABT Associates. 24 p. plus appendix.

U.S. Agency for International Development, Africa Bureau. 1991. *Beyond policy reform - a concept paper.* Department of State cable. Washington, D.C.: U.S. Agency for International Development.

U.S. Agency for International Development/Botwana. 1988. *Botswana population sector program assistance.* Report no. 633-0249. Botswana: U.S. Agency for International Development.

U.S.Agency for International Development/Cameroon. 1991. *Cameroon primary health care subsector reform program.* Program assistance approval document no. 631-0087. Cameroon: U.S. Agency for International Development.

U.S. Agency for International Development/Chile. 1990. *Chile program for immediate improvement of primary health care.* Program assistance approval document no. 513-0350. Chile: U.S. Agency for International Development.

U.S. Agency for International Development/Kenya. Undated. *Kenya health care financing program.* Program assistance approval document no. 615-0245. Kenya: U.S. Agency for International Development.

U.S. Agency for International Development/Ghana. 1991. *Ghana family planning and health program.* Project paper and program assistance approval document no. 641-0118. Ghana: U.S. Agency for International Development.

U.S. Agency for Internatonal Development/Niger. 1986. *Niger health sector support program.* Program assistance approval document no. 683-0254. Vol. I. Text and statutory annexes; Vol II. Technical annexes. Niger: U.S. Agency for International Development.

U.S. Agency for International Development/Nigeria. 1989a. *Nigeria primary health care support program.* Program assistance approval document no. 620-0003. Nigeria: U.S. Agency for International Development.

U.S.Agency for International Development/Nigeria. August 15, 1989b. *Nigeria primary health care support program.* Program assistance approval document no. 620-T-601. Nigeria: U.S. Agency for International Development.

U.S. Agency for International Development/Philippines. 1989. *Philippines: the child survival program.* Program assistance approval document no. 492-0406.Manilla: U.S. Agency for International Development.

Wolgin, J. M. 1990. *Fresh start in Africa: AID and structural adjustment in Africa.* Washington, DC: U.S. Agency for International Development. 52 p.

World Bank. 1986. *Staff appraisal report,* Niger Health Project, Washington, D.C.: World Bank, 66 p.