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PROJECT PERFORMANCE ASSESSMENT REPORT

WHAT WORKS

NIGER

Ownership, Capacity, Results Focus and Accountability:

Lessons for Enhancing the Bank's Program Approach to Health and Population

Report No. 106254
JUNE 28, 2016

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PROJECT PERFORMANCE ASSESSMENT REPORT

NIGER

INSTITUTIONAL STRENGTHENING AND HEALTH SECTOR SUPPORT PROJECT
IDA CREDIT 41410

MULTISECTOR DEMOGRAPHIC PROJECT
IDA GRANT H3090

June 28, 2016

IEG Human Development and Economic Management
Independent Evaluation Group

Currency Equivalents (annual averages)

Currency Unit = CFA Francs BCEAO (CFAF)

2007	US$1.00	CFAF 498.22
2008	US$1.00	CFAF 425.24
2009	US$1.00	CFAF 476.43
2010	US$1.00	CFAF 475.36
2011	US$1.00	CFAF 477.90
2012	US$1.00	CFAF 491.08
2013	US$1.00	CFAF 506.13
2014	US$1.00	CFAF 482.24

Abbreviations and Acronyms

AAA analytic and advisory activities
AAP Annual Action Plan
AECID Spanish International Cooperation Agency for Development
AF additional financing
AFD French Development Agency
AfDB African Development Bank
AIDS Acquired Immune Deficiency Syndrome
ANC antenatal Care
AWP Annual Work Plan
CAS country assistance strategy
CPR Country Partnership Strategy
CPS country partnership strategy
CSR country status report
DCA Development Credit Agreement
DHS Demographic and Health Survey
DP development partner
GAVI Global Alliance for Vaccines and Immunization
GDP gross domestic product
HIPC heavily indebted poor country
HIV human immunodeficiency virus/acquired immunodeficiency syndrome
ICR Implementation Completion Report
IDA International Development Association
IEC information, education, and communication
IEG Independent Evaluation Group
ISHSSP Institutional Strengthening Health Sector Support Project
M&E monitoring and evaluation
MDG Millennium Development Goals
MDP multisector development project
MHP minimum health package
MMR maternal mortality rate
MoH Ministry of Health
MoP Ministry of Population and Social Affairs
MTEF medium-term expenditure framework
NGO Nongovernmental organization
NHDP National Health Development Plan
PAD Project Appraisal Document
PDO Project Development Objective
PDES Plan for Economic and Social Development
PDS Plan de Développement Sanitaire
PHRD Policy Human Resource Development
PPAR Project Performance Assessment Report
PRS Poverty Reduction Strategy
PRSP Poverty Reduction Strategy Paper
RSRC Rural and Social Policy Credit
SDR special drawing rights
STI sexually transmitted infection
SWAP sectorwide approach
TFR total fertility rate
TTL task team leader
UN HDI United Nations Human Development Index
UNFPA United Nations Population Fund (formerly United Nations Fund for Population Activities)
UNICEF United Nations Children's Fund
WHO World Health Organization

Fiscal Year

Government: FY 07–FY 14

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Contents

This report was prepared by Michael Azefor. The report was peer reviewed by Antonio Giuffrida and panel reviewed by Soniya Carvalho. Aline Dukuze provided administrative support.

Boxes

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Principal Ratings

Institutional Strengthening and Health Sector Support Project (P083350)

	ICR[a]	ICR Review[a]	PPAR
Outcome	Satisfactory	Moderately Satisfactory	Moderately Satisfactory
Risk to Development Outcome	Significant	Significant	Significant
Bank Performance	Satisfactory	Moderately Satisfactory	Moderately Satisfactory
Borrower Performance	Satisfactory	Moderately Satisfactory	Moderately Satisfactory

[a] The Implementation Completion Report (ICR) is a self-evaluation by the responsible World Bank department. The ICR Review is an intermediate Independent Evaluation Group (IEG) product that seeks to independently verify the findings of the ICR.

Multi-Sector Demographic Project (P096198)

	ICR	ICR Review	PPAR
Outcome	Moderately Satisfactory	Moderately Unsatisfactory	Moderately Unsatisfactory
Risk to Development Outcome	Significant	Significant	Significant
Bank Performance	Moderately Satisfactory	Moderately Unsatisfactory	Moderately Unsatisfactory
Borrower Performance	Moderately Unsatisfactory	Moderately Unsatisfactory	Moderately Unsatisfactory

Key Staff Responsible

Institutional Strengthening and Health Sector Support Project

Project	Task Manager or Leader	Division Chief or Sector Director	Country Director
Appraisal	Djibrilla Karamoko	Alexandre V. Abrantes	Madani Tall
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Multi-Sector Demographic Project

Project	Task Manager/ or Leader	Division Chief/ or Sector Director	Country Director
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Independent Evaluation Group Mission: Improving World Bank Group development results through excellence in evaluation.

About this Report

The Independent Evaluation Group (IEG) assesses the programs and activities of the World Bank for two purposes: first, to ensure the integrity of the World Bank's self-evaluation process and to verify that the World Bank's work is producing the expected results, and second, to help develop improved directions, policies, and procedures through the dissemination of lessons drawn from experience. As part of this work, IEG annually assesses 20–25 percent of the World Bank's lending operations through fieldwork. In selecting operations for assessment, preference is given to those that are innovative, large, or complex; those that are relevant to upcoming studies or country evaluations; those for which Executive Directors or World Bank management have requested assessments; and those that are likely to generate important lessons.

To prepare a Project Performance Assessment Report (PPAR), IEG staff examine project files and other documents, visit the borrowing country to discuss the operation with the government, and other in-country stakeholders, and interview World Bank staff and other donor agency staff both at headquarters and in local offices as appropriate.

Each PPAR is subject to internal IEG peer review, Panel review, and management approval. Once cleared internally, the PPAR is commented on by the responsible World Bank department. The PPAR is also sent to the borrower for review. IEG incorporates both World Bank and borrower comments as appropriate, and the borrowers' comments are attached to the document that is sent to the World Bank's Board of Executive Directors. After an assessment report has been sent to the Board, it is disclosed to the public.

About the IEG Rating System for Public Sector Evaluations

IEG's use of multiple evaluation methods offers both rigor and a necessary level of flexibility to adapt to lending instrument, project design, or sectoral approach. IEG evaluators all apply the same basic method to arrive at their project ratings. Following is the definition and rating scale used for each evaluation criterion (additional information is available on the IEG website: ieg.worldbankgroup.org).

Outcome: The extent to which the operation's major relevant objectives were achieved, or are expected to be achieved, efficiently. The rating has three dimensions: relevance, efficacy, and efficiency. *Relevance* includes relevance of objectives and relevance of design. Relevance of objectives is the extent to which the project's objectives are consistent with the country's current development priorities and with current World Bank country and sectoral assistance strategies and corporate goals (expressed in Poverty Reduction Strategy Papers, Country Assistance Strategies, Sector Strategy Papers, and Operational Policies). Relevance of design is the extent to which the project's design is consistent with the stated objectives. *Efficacy* is the extent to which the project's objectives were achieved, or are expected to be achieved, taking into account their relative importance. *Efficiency* is the extent to which the project achieved, or is expected to achieve, a return higher than the opportunity cost of capital and benefits at least cost compared to alternatives. The efficiency dimension generally is not applied to adjustment operations. *Possible ratings for Outcome:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

Risk to Development Outcome: The risk, at the time of evaluation, that development outcomes (or expected outcomes) will not be maintained (or realized). *Possible ratings for Risk to Development Outcome:* High, Significant, Moderate, Negligible to Low, Not Evaluable.

World Bank Performance: The extent to which services provided by the Bank ensured quality at entry of the operation and supported effective implementation through appropriate supervision (including ensuring adequate transition arrangements for regular operation of supported activities after loan/credit closing, toward the achievement of development outcomes. The rating has two dimensions: quality at entry and quality of supervision. *Possible ratings for World Bank Performance:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

Borrower Performance: The extent to which the borrower (including the government and implementing agency or agencies) ensured quality of preparation and implementation, and complied with covenants and agreements, toward the achievement of development outcomes. The rating has two dimensions: government performance and implementing agency(ies) performance. *Possible ratings for Borrower Performance:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

Preface

This is the Project Performance Assessment Report (PPAR) for the Institutional Strengthening and Health Sector Support Project (ISHSSP) and the Multi-Sector Demographic (MSD) Project in Niger.

A credit for the ISHSSP was approved on January 5, 2006 in the amount of SDR 24.2 million (US$35 million equivalent). This credit was to support implementation of Niger's Health Sector Development Plan (2005–09) through a Sector-Wide Approach (SWAP). The total Program cost, estimated at 339.5 billion CFAF, was to be financed by Niger's public budget, cost recovery revenues, and various other development partners. The credit became effective on July 20, 2006 and closed, as planned, on June 30, 2011. The total Program cost at closing was estimated at 287.7 billion CFAF or 85 percent of the original estimate. The credit amount disbursed was SDR 23.9 million (99 percent of the credit); and SDR 0.3 million was cancelled.

A grant for the Multi-Sector Demographic Project in the amount of SDR 6.7 million (US$10 million equivalent) was approved by the World Bank on June 19, 2007 and became effective on January 8, 2008. It closed as scheduled on March 31, 2013 and was 99 percent disbursed (SDR 6.66 million disbursed; SDR 0.4 million cancelled). The United Nations Population Fund (UNFPA) also provided parallel support to Niger's population program, as planned, in the equivalent amount of some US$2.4 million.

This report is based on a review of project documents, aide-mémoires and supervision reports, data, and studies. Fieldwork was planned but ultimately not undertaken. The PPAR mission was rescheduled several times because of the security situation in Niger, so IEG decided to carry out these two project performance assessments as desk assessments. The team conducted phone interviews with project and government officials, as well as phone and in-person interviews with Bank staff and other knowledgeable persons. This PPAR provides an update of the data and analysis provided in the Implementation Completion and Results Report on the ISHSSP, which had been carried out prior to the availability of the 2012 Demographic and Health Survey (DHS) results. Analysis of trends between the DHS 2006 (which provided a reliable, updated baseline) and the DHS 2012 provided an opportunity for more rigorous trend analysis. Appendix B provides data and trends on which the evaluation is based and their sources. Appendix C provides a list of persons interviewed.

Following standard IEG procedures, a copy of the draft report was sent to the relevant government officials and agencies for their review and feedback. The Ministry of Health submitted comments on the ISHSS, which have been carefully considered by IEG and are enclosed in Appendix D. No feedback was provided on the Multi-Sector Demographic Project.

Summary

This report assesses the performance of two projects: the Institutional Strengthening and Health Sector Support Project (ISHSSP) (supported by an International Development Association (IDA) credit of SDR 24.2 million, approved on January 5, 2006); and the Multi-Sector Demographic Project (supported by an IDA grant of SDR 6.7 million, approved on June 19, 2007).

At the outset of these projects health indicators in Niger were among the worst in the world and highly inequitable. A National Health Development Plan (NHDP) 2005–09 sought to address key sector challenges: low, inequitable access to services; deficiencies in human resources; unreliable supply of essential medicines and supplies; chronic underfunding of the sector; suboptimal alignment of external resources with national priorities; and weak management capacity. High fertility and rapid population growth were recognized in Niger's policy and strategic documents as critical constraints on development prospects. A National Population Policy issued in 2007 attempted to address these constraints; and a Ministry of Population and Social Affairs (MoP) was created to coordinate implementation.

Institutional Strengthening and Health Sector Support Project (ISHSSP)

The project was designed as a Sector-Wide Approach (SWAP), supporting the implementation of Niger's NHDP 2005–09 (the Program). The project objective was to support the Program to improve efficiency and quality of care in the health system and contribute to the reduction of maternal and child mortality. Emphasis was placed on poor and vulnerable groups. Three project components covered the range of specific objectives (or areas of intervention) outlined in the Program: (1) Human Resource Development and Management; (2) Expansion of Services and Delivery of the Minimum Health Package aimed at reducing maternal and child mortality; and (3) strengthening Governance and Institutional Capacity.

The credit became effective on July 20, 2006 and was closed as planned on June 30, 2011. The objectives were not changed and there were no restructurings. Total Program cost was 287.7 billion CFAF (85 percent of the low-case financing scenario of 339.5 billion, estimated at appraisal). Data are lacking to compare planned and actual financing across components, both for the Program and for the project.

The project's outcome rating is Moderately Satisfactory. ***The project's objectives are substantially relevant*** to current country conditions, national strategy, and priorities for the sector and the Bank's country and sector strategies. But the Project Development Objective (PDO) statements were different in the legal and technical design documents. ***The design relevance is modest.*** Intermediate objectives supported by components are plausibly and logically linked to most elements of the objectives. But there are shortcomings, notably: weak results chains for the service quality and efficiency objectives; and a very ambitious program of capacity and institutional reforms and actions, whose coherence and prioritization were not fully spelled out.

The objective to improve efficiency and quality of care in the health system was modestly achieved. *There were no outcome indicators with which to measure improvements in the efficiency of the health system; and evidence on health systems efficiency is mixed at best.* The proportion of the health budget transferred to regions and districts increased from 20 percent in 2005 to 73 percent in 2010, surpassing the 60 percent target. But the efficiency with which funds were used is not well assessed and district plans were implemented at a rate of about 50–60 percent. There was no real follow-up on the establishment of a performance-based management system; and there were gaps in reporting between outputs and intermediate outcomes and full outcomes. The net effect of the SWAP on sector efficiency is both mixed and unclear. The SWAP may have contributed in part to improved sector coordination. But harmonization and alignment of assistance were limited; and sector stewardship does not appear to have been much enhanced.

Improvements to service quality were not systematically tracked and there is little evidence on trends in quality of care. The project did finance some inputs that are critical to service quality: improved availability of essential drugs; improvement of health infrastructure; provision of waste management equipment; and some improvements in the quantity and quality of health service staff. But these alone are insufficient. Quality of care involves the proactive, guided, and supported translation of these inputs into better patient care that adheres to established quality standards, better patient outcomes, and increased patient satisfaction with services. Neither activities, outputs, intermediate outcomes nor outcomes were sufficiently documented.

The objective to contribute to the reduction of maternal and child mortality was substantially achieved. There was substantial to high improvement in access, coverage, and utilization of most reproductive health services, with some improvement in equity. The proportion of women who received prenatal care from a qualified provider increased from 46 percent to 83 percent, exceeding the target, with greatest increases among the most disadvantaged groups. There was also an increase in use of prenatal services with greatest increases among rural women. Coverage of deliveries by qualified staff and postnatal care visits also increased, but gains were inequitable. The project target of a 15 percent modern contraceptive prevalence rate was not met. Child health services (vaccinations, treatment of diarrhea) also showed substantial gains overall in access, coverage, and utilization, with improved equity. Malaria program outcomes for mothers and children sleeping under bed nets fell short of targets, and inequities worsened. One-third of women were protected against malaria during pregnancy, but coverage was inequitable.

Between 2006 and 2012: the maternal mortality ratio decreased from 648 to 545 deaths per 100,000 live births; infant mortality declined from 81 to 51 deaths per 1000 live births; and under-five mortality declined from 198 to 127 deaths per 1000 live births.

Project efficiency is modest. The lack of project-specific cost data and the lack of specificity of Program cost and financing data make it impossible to assess how efficiently resources were used. Weaknesses in the results chain undermined certain aspects of technical efficiency. Implementation was modestly efficient because annual

action plans were slow to produce by the Ministry of Health (MoH) and slow again to review and approve by the Bank and other partners.

Risk to Development Outcome is rated Significant. Political and technical risks are moderate. Financial, institutional, and social risks are significant.

Overall Bank performance is Moderately Satisfactory. ***Quality at Entry is Moderately Unsatisfactory.*** The project design was grounded in Niger's NHDP, which had been developed on the basis of a participatory assessment of sector issues. But there were issues related to the differences in the statements of objectives and some weaknesses in the results chain. The SWAP design overestimated capacity for its implementation and lacked specific plans to strengthen capacity.

Quality of Supervision is Moderately Satisfactory. There was continuity in the task team leader, whose Niger base assured frequent and regular involvement; however, the focus on development impact might have been stronger. Combining supervision of this project with supervision of population and HIV/AIDS projects may have diluted focus on this complex project. There were delays in Bank approval of action plans.

Overall Borrower Performance is Moderately Satisfactory. ***Government performance is Moderately Satisfactory.*** The government was fully supportive of NHDP objectives and complied with all key covenants. But it did not increase the share of its budget for health from 6 percent to 15 percent. Underfinancing is a major constraint to the new policy of free services for the poor and vulnerable.

Performance of the Implementing Agency (MoH) is Moderately Satisfactory. Annual action plans were submitted regularly, albeit with delays. Biannual reviews were held, but were not sufficiently focused on policy and substance.

Monitoring and Evaluation (M&E) were Modest. Design did not fully support PDO monitoring, especially of quality and efficiency. Reviews were not sufficiently focused on results. There is no evidence that Program M&E contributed to decision-making.

Multi-Sector Demographic Project

The project objective was to strengthen Niger's capacity to address its demographic challenges through: (i) enabling the MoP to design and implement a nationwide Multi-Sector population program; and (ii) increasing general awareness on population and reproductive health issues. It supported four components: (1) Advocacy and Communication; (2) Women's Autonomy and Couples' Empowerment; (3) Harmonization and Coordination of Multi-Sector Interventions; (4) Capacity Building and Monitoring and Evaluation.

The IDA grant became effective on January 8, 2008. Objectives did not change, but a 2011 restructuring regrouped the original components, and added a new one (Strengthening the Supply of Reproductive Health Services). The grant closed as scheduled on March 31, 2013. Total project cost was US$10.1 million, close to the original estimate of $10 million.

The project's Outcome rating is Moderately Unsatisfactory. ***Relevance of objectives is substantial.*** Building country capacity is highly relevant to Niger's development challenges. But the strengthening of the MoP, a new, weak ministry with little capacity or authority to coordinate with other ministries, conflicted with the lessons from the first population project. A weak results chain caused ***design relevance to be modest,*** and was not resolved during restructuring.

The objective to enhance Niger's capacity to address its demographic challenges was modestly achieved. The MoP has not risen to the challenge of designing and implementing a nationwide multisector program, because of its limited capacity and its place in the governmental hierarchy. There is a paucity of data and trends on the general awareness of population and reproductive health issues. Although there are indications that knowledge has increased, attitudes and behaviors have changed very little. Modern contraceptive use has fallen short of targets; there has been no significant change in exclusive breastfeeding up to six months and in the median age at marriage.

Project efficiency was modest, because of the failure to devote resources to interventions that would have the greatest impact. The highly inefficient institutional setup was also a factor.

Risk to development outcome is Significant. All risks—financial, institutional, technical, political, and social—are considered to be significant.

Overall Bank performance is Moderately Unsatisfactory. ***Quality at Entry is Moderately Unsatisfactory.*** The design was modest, characterized by a weak results chain. The institutional arrangements seriously undermined the program's effectiveness and efficiency.

Quality of Supervision is Moderately Unsatisfactory. The Bank's focus on development objectives was insufficient, even during restructuring. The restructuring did, nevertheless, introduce more clarity as to roles and responsibilities for implementation. Combining supervision missions with ISHSSP and HIV/AIDS projects may have enhanced synergies on reproductive health services and dialogue, but the opportunity for more focus on cross-sectoral implementation and coordination may have been missed.

Monitoring and Evaluation were Modest. The choice of indicators was not fully aligned with the project objectives or results chain; and targets were ambitious. Baselines were collected and the M&E framework was implemented with reports disseminated quarterly. M&E implementation was challenged at the decentralized level where capacity was weak and data was lacking. Use of data for decision-making, especially during work planning meetings, is not documented.

Lessons

- The capacity-strengthening potential of SWAPs (including Program wide support) is not likely to be achieved in the absence of: clearly laid out capacity-strengthening objectives and viable institutional arrangements, intermediate objectives, a plausible results chain, relevant performance indicators; and proactive M&E.

- The evaluation of these two projects corroborates IEG's findings that the success (or failure) of a SWAP depends upon four critical factors: (1) the quality and relevance of strategies and annual work plans; (2) country capacity and systems for financial management, procurement, and strategic management; (3) the quality and functionality of partnerships with national and international actors and stakeholders; and (4) the predictability and flow of funds and the absorptive capacities of implementing agencies
    - Improved quality and relevance of strategies and plans for health and population might have contributed to the support of fewer, more relevant activities and a higher impact.
    - Had the strength of the Bank's fiduciary capacity building support been also applied to strategic management capacity building, including M&E, resources might have been allotted to interventions with the highest impact, and the results might have been stronger.
    - Stepped-up efforts to infuse biannual reviews with policy dialogue and to hold partners accountable for supporting national priorities may have improved both the quality of partnerships and their outcomes. Enhanced partnerships with national actors and stakeholders might have been instrumental in better understanding and addressing pockets of resistance to the project's population activities.
    - Inadequate predictability and flow of funds risks undermining absorptive capacity and efficient use of resources.
- Beneficiaries are unlikely to take full advantage of information and services offered by social sector programs if their situations, perspectives, needs and priorities are not documented and factored more systematically into program design, monitoring and evaluation. This involves (a) both quantitative and qualitative information and trends; and (b) a segmentation of information to capture inequities and vulnerable groups the projects were designed to address.

Nick York
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1. Background and Context

General Background[1]

1.1 Niger, with a population of 19 million people and an area of 1.3 million square kilometers, is located in an unstable subregion, surrounded by armed conflict and rebellions. Governance issues have also contributed to periods of political instability. The Libyan conflict led to the return of more than 100,000 migrants, an outflow of arms contributing to regional instability, and a drastic decline in remittances. The coup d'état and rebellion in Mali have precipitated an additional inflow of 64,000 refugees into Niger, compounding existing tensions in the north between Tuareg populations and the government in Niamey. Boko Haram attacks in Niger, Cameroon, and Nigeria contribute to regional instability. Historically unstable, Niger has experienced frequent political infighting and coups d'état.

1.2 Unfavorable climatic factors undermine agricultural production, which is the mainstay of the economy, including cereal production. with the present levels of rainfall, only 3 percent of the land area can be cultivated. Millet and sorghum are the only cereals that can be extensively cultivated and only 1 percent of the total land area can support maize. Frequent droughts and locusts further compromise the production of food and cash crops. The gap between national cereal production and needs is growing.

1.3 These harsh conditions notwithstanding, there has been some progress on economic growth and poverty reduction. But rapid population growth offsets the benefits. Annual economic growth was sustained at an average of 5.7 percent between 2008 and 2013 and rose to 6.5 percent in 2014. The rural sector has been the main engine of growth during the past decade, but this sector's performance is highly volatile given its dependence on rainfall, which fluctuates from year to year. Poverty declined from 64 percent in 2005 to 48 percent in 2011, affecting rural households and women, in particular. GDP per capita is still very low at US$360, compared to the average for Sub-Saharan Africa of US$1,647. Niger's recent economic growth is not contributing as much as it could to greater prosperity, towing to rapid population growth and a high dependency ratio. Impressive declines in child mortality, combined with very high fertility (7.6 children per woman) are precipitating rapid population growth (3.4 percent per year), a very young age structure (with 49 percent of the population below age 15) and a very high child dependency ratio of 1.05. The population is estimated to increase to 35 million by 2030 and 69 million by 2050.

1.4 ***Social indicators reveal high levels of poverty and inequity and compare unfavorably with other low-income countries.*** The following indicators, drawn from the Demographic and Health Survey (DHS) 2006, reveal the situation at the time of preparation of the two projects under review. Maternal mortality rate was 648 per 100,000 live births; infant mortality was 81 deaths per 1000 live births; and under-five mortality was 198 deaths per 1000 live births. While 93 percent of urban populations had access to clean water, only 31 percent of rural residents had such access. Access to sanitation (clean toilets) was also

[1] This section is drawn from two sources: the Project Appraisal Document (PAD) on the (ongoing) Population and Health Support Project (World Bank, May 2015) and the Country Partnership Strategy for Niger for the Period FY13–16 (World Bank, March 2013).

inequitable: 38 percent of the urban population had access, and 2 percent of the rural population had access. Only 43 percent of men and 30 percent of women completed primary school and 28 percent of men and 12 percent of women were literate. Eighty-four percent of children under five and 46 percent of women were anemic. Half of all children under five were stunted (weight for age).

1.5 Issued in 2007, Niger's Strategy for Accelerated Development and Poverty Reduction (2008–12) sought to boost its development prospects and alleviate poverty through a strategy comprising seven pillars: (1) a search for strong diversified, sustainable and job-creating growth; (2) equitable access to quality social services; (3) control of population growth; (4) reduction of inequities and strengthening of the social security of vulnerable groups; (5) infrastructure development; (6) promotion of good governance; and (7) effective implementation of the strategy.

B. Health

1.6 **Issues and Challenges.** At the time of preparation of the health project, the health sector's performance and outcomes were undermined by a number of issues. *First,* access to basic health services was both low and inequitable. Over and above geographic access—less than half of the population lives within 5 kilometers of a health facility—real access was even lower. Poverty, shortages of drugs and personnel, and perceptions of poor service quality have limited the use of services. *Second,* deficiencies in human resource quality, availability, distribution and management have plagued the health sector, resulting in suboptimal productivity and morale and diminished effectiveness in response to community health needs. *Third,* weak supply chain management has limited the availability of essential medicines, equipment and, related supplies. *Fourth,* chronic underfunding of the sector, precipitated both by the low public budget for health and the instability of external aid, has created a huge funding gap and rendered the system incapable of delivering basic services.

1.7 *Fifth,* external aid earmarked for primary health care has paid limited attention to systems strengthening and the restructuring of first-referral services, which are key for achieving better health outcomes. *Sixth,* donor support targeted to specific programs within primary health care has caused their "verticalization" and a lack of synergies and integration with other relevant programs and services, on the organizational, managerial, technical, and financial fronts. *Seventh,* weak overall sector coordination and management were characterized by the absence of technical and managerial skills for policy analysis, planning, and priority-setting for cost-effectiveness, intersectoral coordination, M&E, and aid coordination. High turnover among ministers and senior officials has eroded institutional memory. *Finally,* community participation has focused narrowly on cost recovery and drug management, and left untapped the potential for involving communities in decision making and in protecting and preserving their own health. Monitoring and evaluation of the effectiveness of community participation has not been routinely undertaken; nor have appropriate indicators been defined.

1.8 **Priorities.** In 2005 Niger issued a new National Policy and National Health Development Plan (NHDP) for 2005–09, which was designed to address sector issues and to elicit improved coordination of donor support to the sector (Box 1-1).

Box 1-1 Niger's National Policy and National Health Development Plan (NHDP) 2005–09

Goal:

Reduce maternal and child mortality through improvements in efficiency and quality of care in the health system.

Specific Objectives:

1. Increase the population's access to and utilization of quality health services;
2. Strengthen reproductive health activities;
3. Reinforce the decentralization process in health;
4. Promote greater community participation in health;
5. Improve management and institutional capacity within the MoH;
6. Overcome qualitative and quantitative deficits in health staffing;
7. Improve the effectiveness and efficiency of health infrastructure and inputs made available to health providers; and
8. Improve the availability of essential drugs and quality medical supplies in health facilities.

Funding Sources:

1. Government's investment and recurrent budgets;
2. Internally generated funds (cost recovery);
3. External donor funds; and
4. Other parallel-financed activities (local governments, hospital user fees, among others).

Source: Niger National Health Development Plan (NHDP) 2005–09.

C. Demographic, Population Growth and Development Issues

1.9 **Issues.** Niger's demographic indicators (high fertility, high but declining child mortality, rapid population growth, high maternal mortality, a high dependence ratio) impose a heavy burden on a resource- and capacity-constrained country struggling to achieve Millennium Development Goals (MDGs), development, and improved welfare. The following issues, which limit Niger's efforts to improve its demographic indicators, were identified as a part of the Bank's analytic work and policy dialogue, carried out in 2004.

1.10 *First,* high fertility rates are sustained by cultural values and belief as well as by the needs of subsistence agriculture. These factors promote and sustain early marriage and continuous childbearing. Girls' education through their late teenage years is not valued and often bypassed in favor of keeping them home to work in the household and on family economic tasks. *Second,* high child mortality drives most families to have a large number of children as replacement insurance. *Third,* women's social and economic status limits their ability to make choices on reproductive issues. Strong traditional and religious values as well as limited government policies to promote women's reproductive health rights and to

enhance their independence and involvement in economic activities are all factors. *Fourth,* demand for contraception and other reproductive health services is inhibited by a number of factors, including: rudimentary knowledge and appreciation of reproductive health services among spouses; high female illiteracy; and lukewarm commitment and support for such services among political and religious leaders.

1.11 *Fifth,* there are other barriers limiting women's ability to take advantage of reproductive health services, including contraception, to space or limit births. Among these are: problems of privacy for storage of commodities and limited access to service providers' advice and information; women depend on their spouses to visit and pay for such services. *Sixth,* national consensus on population and demographic problems remains very superficial. Major segments of Niger's population do not believe that state intervention to influence demographic variables, especially fertility, is necessary. *Finally,* the capacity of the newly created MoP was limited. Its organization and management skills were inadequate for implementing its responsibilities; and its ability to coordinate across ministries and to monitor and evaluate cross-sectoral program performance and progress against demographic targets was questionable.

Box 1-2 Declaration of National Population Policy, 2006

General objective:

To contribute to poverty reduction through major changes in attitudes and reproductive behaviors, which will lead to a significant increase in contraceptive prevalence and a reduction in early marriage, consequently leading to an eventual slowing of rapid population growth.

Intermediate objective:

To guarantee by 2015 access to reliable, effective, affordable, and quality reproductive health services so that modern contraceptive prevalence will increase by at least one percentage point per year, starting in 2007.

Four priority programs:

1. Advocacy and conscious-raising on population and development;
2. Information, education, and communication (IEC) and behavior change communication focused on reproductive health;
3. Promotion of reproductive health services access and utilization, in particular family planning;
4. Promotion of couples' responsibility for reproductive health and family size decisions and of women's economic autonomy.

Expected results by 2015:

- Between 15 percent and 20 percent of Nigerien couples use an effective method of contraception;
- A significant reduction in early marriage;
- Prolonged breastfeeding practices;
- A reduction in total fertility from an average of seven children per woman to five;
- A reduction in the rate of population growth from over 3 percent to 2.5 percent;
- Containment in the number of births per year to between 600,000 and 700,000 (versus an estimated 1.1 million in 2015 in the absence of policy implementation).

Source: Déclaration du Gouvernement en Matière de Politique de Population, Novembre 2006.

1.12 **Priorities.** Niger articulated a new Population Policy, which laid out a path for addressing the above-cited issues. This policy was originally slated for ratification by Parliament, but later was rendered effective by a March 20, 2007 letter from the Prime Minister's office authorizing its implementation.

D. World Bank and Other Support to Health and Population

1.13 **World Bank Support.** An itemization of Bank-financed population and health projects is provided in Annex B, Table B.1a. During the past 24 years Bank has supported three operations with specific population or demographic objectives (US$ amounts indicate Bank financing): an initial Population project in the amount of $17.6 million, approved in 1992; a Multi-Sector Demographic project in the amount of $10 million, approved in 2007, which is the subject of this review; and the currently ongoing Population and Health Support project, approved in 2015. There was almost a 10-year gap between the closing of the first Population project and the approval of the Multi-Sector Demographic Project.

1.14 The Bank's lending for health has spanned 30 years and is made up of six projects. *Four* of these projects supported health sector development: a first health project in the amount of $27.8 million, approved in 1986; a follow-on Health Sector Development Program in the amount of US$40 million, approved in 1996; a subsequent Institutional Strengthening and Health Sector Support Project in the amount of $35 million, approved in 2006, which is the subject of this review; and the currently ongoing Population and Health Support project, approved in 2015. *Two* of these projects focused exclusively on HIV/AIDS: the first Multi-Sector STI/HIV/AIDS Program in the amount of $25 million, approved in 2003; and the currently ongoing HIV/AIDS Support Project 2, approved in 2011. The Bank's support to health evolved over time from a focus on primary health care inputs to a more strategic support of the sector, grounded increasingly in national policy and priorities, gradually encompassing a systems approach, sector management capacity-building, and coordination with other donors.

1.15 **Other Main Actors.** Among other major external partners supporting Niger's population activities over the years, UNFPA has been the lead UN agency designing and implementing reproductive health projects. UNFPA has helped foster policy dialogue on population and reproductive health in Niger; additionally it has provided technical assistance on the preparation of a strategic framework and work plans underpinning the population policy; and it has provided financial support for the population censuses and DHS operations.

1.16 At the time of appraisal, partners' support during the period of the new health Program, in addition to the Bank, was expected from: Belgium, France, UNFPA, the World Health Organization (WHO), and the African Development Bank (AfDB) (Annex B, Table B.1b). The Bank, collaborating with WHO, has played a lead role among the donors.

2. Institutional Strengthening and Health Sector Support Project

Objectives, Design, and Their Relevance

PROJECT DEVELOPMENT OBJECTIVES (PDOS)

2.1 As stated in the Development Credit Agreement (DCA) of February 16, 2006, "The objective of the Project is to support the Borrower's Program to improve efficiency and quality of care in the health system and contribute to the reduction of maternal and child mortality." The PDO is stated differently in the Project Appraisal Document (PAD) of December 7, 2005 (World Bank 2005). [2] Although there is substantial overlap between the two statements, the DCA's quality of care objective is not captured in the PAD, nor is the PAD's sector management capacity building objective captured in the DCA. The PDO remained unchanged throughout the life of the project. In line with harmonized guidelines (World Bank 2006), this evaluation assesses performance against the PDO as stated in the DCA.[3] The evaluation will draw on details provided in the PAD's statement, as relevant.

RELEVANCE OF OBJECTIVES

2.2 The relevance of objectives is rated **Substantial.**

2.3 *First,* the PDO was responsive to country conditions. Although improving, the health status of Niger's population is poor compared to other Sub-Saharan African countries and low-income countries around the world. Mothers and children remain particularly vulnerable. System inefficiencies and poor service quality undermine the sector's potential to deliver services to the poorest and most vulnerable to improve their health. Inefficiencies include the inadequate level of financing and suboptimal use of sector resources; weak sector management and coordination capacity and results focus; underexploited potential for community-level involvement in health activities and health management; and sub-optimal coordination among donors and alignment of their support to Niger's priorities. Inadequate financing and inefficient spending also undermine physical and financial access to services. Service quality issues include inadequate and inequitably distributed sector inputs (well-trained, qualified health personnel, adequate supplies of drugs and other consumables, essential infrastructure and equipment), as well as weak quality assurance structures, mechanisms, standards, and guidelines to define, track, and improve service quality.

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[2] According to the PAD, "The overall PDO is to improve sector capacity, effectiveness, and efficiency in the provision of essential health care in Niger and contribute to the reduction of maternal and child mortality by providing a minimum package of essential health services targeted to the poor, women, and children. Specific objectives… support (Niger's) National Health Development Plan in (a) increasing access (geographical and financial) and utilization by the population to a minimum package of health essential services; (b) improving the effectiveness and efficiency of health services for women and children; (c) strengthening reproductive health services and malaria control; and (d) improving overall sector management and organizational capacity.

[3] The DCA PDO also matches the goal articulated in Niger's NHDP (2005–09) (see Box 1-1).

2.4 *Second,* the PDO was very relevant to Niger's strategic priorities. It embraced and directly supported NHDP's (2005–09) goal of "… reducing maternal and child mortality through improvements in efficiency and quality of care in the health system." The PDO was also relevant to Niger's subsequent five-year health development plan (PDS) (2011–15), whose eight strategic interventions[4] support its general objective to improve health through achievement of the health-related MDGs and its specific objective to offer quality services to the population, with a focus on vulnerable groups. Moreover, it is supportive of Niger's Economic and Social Development Plan (PDES) 2012–15, especially its strategic orientation toward promoting social development. Expressly aligned with the PDS, the health component of this strategic orientation aims to improve health status, especially of vulnerable groups, through its support to four programs: health care effectiveness; improved physical and financial access to quality services; protection of mothers and children; and health sector management and financing.

2.5 *Third,* the PDO is relevant to the Bank's current Country Partnership Strategy (FY13–16), which seeks to: (1) promote resilient growth; (2) reduce vulnerability; and (3) strengthen governance and capacity for public service delivery. The second objective includes support for improving access to health services; and the third includes support for improving budget execution, efficiency, pro-poor spending, and transparency. The PDO is also relevant to the Bank's health strategy, which aims to: (1) improve health outcomes, particularly for the poor and vulnerable; (2) prevent poverty due to illness; (3) improve financial sustainability; and (4) improve sector governance, accountability, and transparency.

2.6 A shortcoming in the PDO statement is the difference between the PDO statements, respectively, in the DCA and the PAD. The DCA statement specifies improved quality of care as an objective, while the PAD does not. On the other hand, the PAD specifies improved sector management and organizational capacity as an objective, while the DCA does not.

PROJECT DESIGN

2.7 The project was designed as a SWAP[5] to disburse against annual action plans (AAPs) emanating from the NHDP 2005–09 (Box 1-1), which were to be prepared by technical departments, programs, and service delivery facilities at all levels of the health system, providing details on specific activities, objectives, and resources needed. Project financing was to focus on select priorities, articulated around three project components, outlined in Box

[4] Strategic interventions: extension of coverage; improvement of reproductive health services; staffing of health facilities with quality personnel; permanent supply of drugs, vaccines, and other consumables; intensification of disease surveillance; strengthened sector governance and leadership at all levels; enhanced health financing mechanisms; and promotion of health research.

[5] The World Bank defines a SWAP as "...an approach to a locally-owned program for a coherent sector in a comprehensive and coordinated manner, moving toward the use of country systems. SWAPs represent a ...shift in the focus, relationship and behavior of donors and governments. They involve high levels of donor and country coordination for the achievement of program goals, and can be financed through parallel financing, pooled financing, general budget support, or a combination." Although the literature offers a wide array of SWAP definitions, attributes, and interpretations, it is consistent in highlighting an evolving partnership between governments and development partners (DPs), coalescing around their joint support of nationally-defined programs and focused on results.

2-1. The estimated International Development Association (IDA) allocations by component are shown in parentheses. The ICR did not report actual allocations across components.

Box 2-1 Institutional Strengthening and Health Sector Support Project Components

1. **Human Resource Development and Management (US$10.0 million):** This component aimed to improve the number, quality, and distribution of human resources in health, and to modernize human resources management. Activities included: priority staffing of existing health facilities, favoring the most disadvantaged areas and most understaffed facilities; revision of staffing norms; development of an incentive system to encourage deployment to remote areas; and development of training strategies.
2. **Expansion of Services and Delivery of the Minimum Health Package (MHP) (US$20 million):** This component aimed to increase access to a quality package of programs and services to reduce maternal and child mortality. Three subcomponents aimed at:
   a. Improving and sustaining a reliable supply of essential drugs and medical commodities in all public health facilities;
   b. Strengthening health programs and improving service to support gains in maternal and child health; and
   c. Improvement of health care demand and access to services through outreach strategies and revised cost-recovery policy exonerating charges for selected services for the poor.
3. **Strengthening Governance and Institutional Capacity (US$5.0 million)**
   a. Capacity Strengthening for good governance, equitable and transparent resource use, sector decentralization, performance-based management, and community participation;
   b. Programwide M&E.

Source: World Bank (2005a).

RELEVANCE OF DESIGN

2.8 The relevance of design is rated **Modest.**

2.9 Intermediate objectives supported by project components and subcomponents[6] are plausibly and logically linked to achievement of the outcomes articulated in the PDO (improved health system efficiency and improved quality of care) and to the impact also articulated in the PDO (contributing to reductions in maternal and child mortality). However, there are a number of shortcomings. *First,* although the goal of improved quality of care is supported by efforts to enhance the quantity and quality of inputs (staffing, essential drugs, materials, equipment, infrastructure, and the definition of a minimum package of services), this goal is not likely to be achieved in the absence of a quality assurance policy and strategy, which would define and enforce quality standards, translate them into clear guidelines and protocols which health centers would be accountable to implement, or in the absence of a

[6] Intermediate outcomes articulated in the PAD's results framework include: strengthened human resources quality and staffing; expanded availability and quality of a high-impact package of services for mothers and children; improved availability of drugs and other essential supplies; increased demand for services and enhanced geographical and financial access to services, culminating in increased utilization; and enhanced governance, strategic management, and institutional capacity and practices at every level of the system.

well-staffed and competent structure within MoH with a clear mandate to oversee and ensure tracking and proper adherence.

2.10 *Second,* the project components are stated in the PAD to be a subset of activities envisaged under the NHDP, reflecting those elements that are considered by the Bank to be of the highest priority.[7] However, a comparison of the *project* components (Box 2-1) and the strategic areas of intervention of the *program* (Box 1-1) reveals that the project components are not a subset of the program components. Rather, they capture the full range of components envisaged under the program.[8] The Bank's share of total program financing was estimated at 5 percent. *Third,* there was no sense of prioritization or strategic phasing of the wide range of activities envisaged in the project's capacity-building component. The main objective of a SWAP—to improve government leadership and sector stewardship—was discussed in the PAD, but this important objective was not explicit in the official PDO; nor were supportive intermediate objectives outlined in the design. Moreover, this component included a very ambitious range of major institutional and managerial reforms, whose coherence and ambition were not squarely addressed, especially in light of limited MoH capacity and the capacity lessons of previous projects. MoH's workload, responsibility and transaction costs associated with the management of a SWAP (at all levels of the system) appear to have been underestimated, especially for: the preparation, management, and follow-up of reviews of sector performance, the coordination of the technical and financial contributions of development partners, the leading of policy dialogue with the group of partners, and sectorwide M&E. Overlaying this major reform were other equally challenging reforms in MoH organization and management practices, with little guidance as to their links or sequencing: MoH restructuring, sector decentralization, performance-based management, community participation. In short, the results chain of such a large and challenging range of capacity-building activities contributing to improved health system efficiency is underdeveloped and does not convincingly address the efficiency objective.

2.11 **M&E Design.** The PDO, as articulated in the results framework (Annex 3 of the PAD), was different from what the PDO presented in the DCA (the one on which this evaluation is based).[9] In short, though it did capture the expected impact articulated in the DCA (reduction of maternal and child mortality), it did not include the other objectives of the DCA statement: improved health system efficiency and improved quality of care. This translated into a less-than stellar alignment of outcome indicators to the official PDO. Outcome indicators measuring infant, under-five and maternal mortality, were appropriate for measuring progress against the project impact. There were no outcome indicators for measuring health system efficiency. ("Trends in per capita allocation to the health sector" tracks levels of financing, not efficiency.) There was only one outcome indicator for measuring service quality, but it was vague and open to subjectivity: the proportion of health

[7] Priority-setting was noted as important in the PAD because (1) the estimated available financing for NHDP implementation was less than its estimated cost; and (2) health system capacity constraints dictated an effort to focus on the highest-impact activities and a proper phasing of activities.

[8] The only indication of prioritization is that the first two years of implementation will focus on existing services and on making existing health facilities operational before expanding geographical access. But this prioritization criterion was established at the program level (articulated in the MTEF), not at the project level.

[9] The PDO stated in the Results Framework (PAD, Annex 3) was to "…improve sector capacity to deliver (the) essential health package in Niger and contribute to the reduction of maternal and child mortality."

facilities with ability to effectively provide the minimum package of services. Three of the remaining four outcome indicators focused on coverage and physical access, and the fourth on services utilization. Among the intermediate outcome indicators: (a) there was no breakdown by income quintile of measures of physical and financial access, even though the project and program emphasize improved access for the poor; and (b) measures of governance and institutional capacity were weak.

2.12 Indicators were drawn directly from the NHDP, which specified methods for their calculation and analysis and also established structures and responsibilities for M&E. Evaluative assessments and surveys (particularly to clarify baseline data) were planned. However, the PAD's emphasis on key sector reform implementation and the SWAP design was not matched with clear indicators and outcomes to measure capacity built. Over and above routine data collection and analysis, each year selected themes were to be studied to enhance performance and outcomes. M&E plans included surveys and studies to complement routine data to assess outputs, outcomes, service utilization, and the extent to which the project reached the poor. M&E implementation arrangements are summarized in paragraph 2.12.

2.13 **Implementation Arrangements.** In keeping with a SWAP design, no project unit was established. Instead, MoH structures were to be developed and strengthened to take on sectorwide implementation arrangements, within which the project would be managed. Analytic work, undertaken during preparation, identified three areas for such strengthening: (a) adapting MoH structures at each level to its mandate and functions in the context of the NHDP; (b) developing a human resources management system; and (c) improving the management of sector public finances and expenditures. Overall coordination and oversight were the responsibility of the Secretary-General. *On the technical front*, preparation of AAPs by various MoH units, programs, and services at every level of the system were to be prepared and approved, on which basis performance contracts would be signed and disbursements would flow. Mechanisms for performance-based contracting were to be detailed in a Project Implementation Manual. *On the fiduciary front,* MoH's limited fiduciary capacity was to be backstopped by externally recruited technical assistance with the mandate to transfer knowledge and capacity by the midterm.

2.14 *On the M&E front*, a system was to be established that would monitor progress, identify and resolve problems in a timely fashion, and enable tracking and linking of the NHDP plan and the medium-term expenditure framework (MTEF). To this end the following M&E committees would review M&E data and reports, assess the progress and impact of the program, and use information to inform strategic decision-making: (a) the Health National Technical Committee, chaired by the Secretary-General; (b) the Health Regional Technical Committee, including civil society and traditional leaders; (c) the Regional and Communal Technical, including national deputies and advisors; (d) the District Health Committee; and (e) the Integrated Health Center Health Committee. Development partners were to meet twice annually with government and other stakeholders to (a) review progress accomplished under the NHDP during the previous year; and (b) agree on the plan and budget for the following year, aligned with NHDP priorities. *Project disbursements* were to be made on the basis of approved AAPs, and, within these, the specification of which activities would be supported under the Common Fund.

Implementation

2.15 **Key Dates.** Approved by the Board of Directors on January 5, 2006, the IDA credit became effective on July 20, 2006. There was no midterm review (at least not noted in the ICR Basic Data Sheet), nor were there any restructuring exercises. The project closed on June 30, 2011, as planned.

2.16 **Planned versus Actual Costs by Program or Project Component and Financing.** The ICR does not present or analyze estimated and actual costs by component for either the Sectorwide Program/NHDP (including all activities planned/implemented during the program period and all financing sources) or for the Project (showing estimated and actual IDA financing by component). The PAD does provide two scenarios of projected costs of the Program with NHDP as articulated in the MTEF for 2005–09: (1) including most or all activities envisaged (cost: 372.6 billion CFAF); and (2) a subset of prioritized activities in anticipation of inadequate financing (cost: 339.5 billion CFAF). A financing gap of 82,638 million (24 percent of the lower-cost NHDP) was identified, on the basis of a low-growth financing scenario. The actual financing by source presented in the ICR is not easily analyzed against PAD projects because they summarize different categories and years. But it is significant to note that (1) actual out-of-pocket expenditures are (for the most part) a small fraction of planned levels, with erratic patterns over time; and (2) actual external financing makes up about two-thirds of all financing and is higher than PAD projections. Compared with the projected cost of 339.5 billion CFAF for the lower-cost scenario, the ICR reports actual expenditures of 287.7 billion CFAF, or 85 percent of costs.

2.17 The ICR does present a table showing actual financing (as of June 30, 2011) and expenditures of the Common Fund into which both IDA and the French Development Agency (AFD) were to channel their funds. Against planned contributions noted in the PAD of US$35 million for IDA and US$18 million for AFD, actual financing of the Common Fund amounted to US$51.7 million equivalent, of which $30.7 million (IDA), $15.6 million (AFD) and the balance financed by the Spanish Agency for International Development Cooperation (AECID), the Global Alliance for Vaccines and Immunization (GAVI), UNICEF and UNFPA.[10] The IDA credit of SDR 24.2 million was 99 percent disbursed (SDR 23.9 million disbursed; SDR 0.3 million cancelled).

2.18 **Factors Affecting Implementation** that were *outside of the control of MoH* encompassed the overall political stability of the country as well as key ongoing national reforms. The project was developed during a period of political stability, but the implementation period was complicated by some periods of instability.[11] Some national reforms affected MoH's organization, mandate, and responsibilities, especially: the

[10] These amounts are reported as of the Project's closing date (June 30, 2011) and do not represent all IDA disbursements, because some were made during the four-month grace period after project closing.

[11] Among which: union strikes (2005); drought and locust infestations causing severe malnutrition (2005); the Tuareg rebellion (2007); a controversial referendum approving a new constitution allowing the sitting President to seek a third term and assume broader powers (2009); a coup d'état replacing the President with a transitional military government (2010); kidnappings of foreign nationals (2010 and 2011); return to civilian rule with the election of President Issoufou (2011); an influx of Malian refugees into Niger escaping the conflicts (2012); suicide bomber attacks on a military barracks and a French-run uranium mining site in the north (2013).

introduction of autonomous governance at the local level and key reforms in public financial management and public procurement. Moreover, the President's Special Program (established and financed with heavily-indebted poor country (HIPC) funds) introduced the concept of free health services for specific groups. In addition, rapid turnover of Ministers and of other high-level staff undermined the already weak management and implementation capacity in the sector. Program implementation was also undermined by the failure of the government to meet its obligations under the Abuja declaration (and under this project) to allocate at least 15 percent of its entire budget to the health sector.

2.19 *Other factors (somewhat) within the control of MoH* also affected implementation. The NHDP was overly ambitious, in terms of: (a) its cost (vis-à-vis available financing); (b) limited health system implementation capacity, especially in light of the demands of a SWAP; and (c) the wide-reaching reform agenda. A longer implementation period coupled with a better-designed, more specific capacity-building program, and a phasing of reforms and reform measures might have mitigated implementation challenges and delays.

2.20 **M&E Implementation.** Committees were established to strengthen the M&E system at the central, regional, district and health center levels. But there is little information about the effectiveness of these committees and it is not clear whether they possessed requisite M&E expertise to function properly. Joint reviews for the sector program were conducted twice annually, as planned. However, the ICR indicates that these reviews were focused more on implementation and less on tracking progress against intermediate outcomes and development objectives or on discussion of underlying policies that was necessary to accelerate implementation and enhance prospects for stronger outcomes. Most midterm and final assessments were conducted, though the DHS was postponed because of conflict with the population census. Other donors, such as UNICEF, continued to provide small annual evaluations, using the DHS modules to obtain data. There was discussion within the Bank of restructuring the project, mostly to address program-level targets, which were considered to be too ambitious. The Bank ultimately decided not to restructure because (a) it considered it important to support national program targets and (b) revised baselines indicated that the targets were achievable. This decision prevented the opportunity to add relevant program targets, especially those related to the PDO (service quality, health system efficiency) and those related to key intermediate outcome indicators that were emphasized in the project's design (capacity building, key sector reform implementation).

2.21 **Safeguards Compliance.** This Category "B" project triggered OP/BP/GP 4.01 on Environmental Assessment to address medical waste issues. In consultation with relevant central- and regional-level technical services, a medical waste management plan was prepared based on the National Medical Waste Management Plan (2003). The project included institutional support to MoH for plan implementation. According to the ICR, a 2007 implementation review noted shortcomings due primarily to delays in developing specifications for procuring incinerators and chlorine production materials. Safeguard compliance was rated Moderately Satisfactory following the midterm review because the equipment procured under the project was not yet fully functional and activities were not yet fully implemented. Although the proportion of health facilities with available resources to manage health care waste did increase, it fell significantly short of the target. The ICR does not indicate whether these issues were resolved, though the project team confirmed that

safeguard compliance was satisfactory overall. Niger has since adopted a new medical waste management plan in the context of the follow-up Health Development Project.

2.22 **Fiduciary Compliance.** Preparation for adequate *financial management* included a capacity assessment of MoH's Directorate of Finance and Administration, and measures to address weak elements of that capacity, particularly: supplemental, contractual staff, technical assistance to strengthen regional accounting capacities, and a detailed action plan for strengthening sectorwide financial management. There were disbursement difficulties because of initial inexperience in using the Financial Management Reports, and frequent delays in the joint review of reports by the Bank. There also were recurring difficulties with allowable expenditures, owing to misunderstandings about the eligibility of certain expenses and delays in justifying expenditures incurred at regional and district levels. Several annual audits were qualified because of these issues, which the ICR reports were mostly resolved. According to the project team, Niger complied with the Bank's fiduciary policies. Nevertheless, data on planned versus actual program costs and financing by component are not available.

2.23 *Procurement performance* was rated Satisfactory or Moderately Satisfactory, except for just after the mid-term review, when it was rated Moderately Unsatisfactory owing to the deteriorating quality and speed of procurement. After the procurement specialist staff was replaced, an Independent Procurement Review determined that performance had improved. Difficulties generally arose from: weak procurement capacity; difficulties in defining needs, technical specifications and terms of reference; procedural delays attributable to multiple review procedures of the Common Fund partners; and poor contract and record keeping.

Achievement of Objectives

2.24 This section assesses the achievement of program objectives (which are also the project objectives) and links between the project's support and outcomes. It is important to note that, especially in the context of a SWAP design: (1) the Bank was one among several development partners working in support of Niger's programwide objectives; (2) the project's share of total financing is estimated at 5 percent; and (3) the project's components encompassed the full range of specific objectives (areas of intervention) laid out in Niger's NHDP. Thus, outcomes assessed in this section cannot be solely attributed to the Bank's support. Nevertheless, this section will attempt to highlight, where feasible, the Bank's contribution.

OBJECTIVE 1. IMPROVE EFFICIENCY AND QUALITY OF CARE IN THE HEALTH SYSTEM

2.25 The achievement of objective 1 is rated **Modest**.

2.26 ***1. a. Improve health system efficiency***

2.27 **Outputs/Intermediate Outcomes.** Support for capacity building provided under the program included technical assistance culminating in an analysis of human resource management information channels, an update of file management, a study on the impact of financial incentives given to doctors, pharmacists, and dentists, development of a software package for human resource management, and a plan for human resource development. Two national directorates were created within MoH, one for human resources development and

one for nutrition. Committees were established to strengthen M&E at the central, regional, district and health center levels. An evaluation of the cost recovery system was undertaken. Although the budget almost doubled between 2005 and 2010 in absolute terms, the increase in the proportion of the government's budget allocated to the health sector over this period rose from 5.96 percent to 7.85 percent, falling far short of the 15 percent target. The proportion of functioning health management committees per district increased from 78 percent to 86 percent between 2005 and 2010, surpassing the target of 80 percent. However, the criteria, methodology, and responsibility for defining, assessing, and reporting functionality are not provided; nor are program inputs and activities specified.

2.28 **Outcomes**

2.29 There were no outcome indicators that allowed adequate measurement of this PDO; and evidence on the efficiency of health systems is mixed at best. The ICR reports that the proportion of the health budget allocated and transferred to regions and health districts increased from 20 percent in 2005 to 73 percent in 2010, surpassing the target of 60 percent. But the efficiency with which these funds were used is not well assessed. The ICR reports that regional and district action plans were only implemented at a rate of about 50–60 percent. The proportion of health centers operating under a performance-based management system was unknown, because of the varying use of numerators and denominators across the different regions; the ICR reports that there was no real follow-up on performance.

2.30 ***There are also some gaps in reporting between outputs, intermediate outcomes and full outcomes.*** Notwithstanding the establishment of a human resources directorate and improved human resource planning, the ICR reports a lack of effective policies for human resources deployment and motivation at the end of the project. Likewise, the functionality and effectiveness of the new nutrition directorate are not clear, with unclear results on nutrition services and outcomes during the project. The outcome of functional health management committees is not assessed in terms of their contribution to health system efficiency. Although a health financing policy was developed to reduce the cost burden to the poor, health facilities are not routinely reimbursed for the provision of free services to eligible populations. This undermines the sustainability of this important policy. Likewise, although the availability of six essential drugs in health facilities did improve, the ICR reports a lack of sustainable means to strengthen supply-chain management for drugs.

2.31 ***The net effect of the SWAP on sector efficiency is both mixed and unclear***.[12] *First,* the SWAP may have contributed in some part to *improved sector coordination.* The five-year NHDP (2005–09) provided a medium-term vision for sector development. An MTEF projected resource availability and expenditure plans. Structures and processes for negotiating issues, allocating resources, and reviewing sector performance were laid out in design documents and in a Memorandum of Understanding between the government and its partners.

[12] Because there were no indicators for tracking MoH capacity building, this analysis draws, as relevant, on the analytic framework for SWAPs in IEG's Working Paper 2009/4 *Do Health Sector-Wide Approaches Achieve Results? Emerging Evidence and Lessons from Six Countries.*

2.32 *Second, improvements to the harmonization and alignment of development assistance* were limited. The SWAP did support the organization of biannual meetings of government and national and international partners to review progress in plan implementation and to plan and allocate resources for the following year. However, the extent to which resource allocation was grounded in sound criteria (needs, priorities, and performance or review findings) rather than donor- or supply-driven priorities is not adequately analyzed. This process involved heavy transaction costs, imposed a heavy burden on an already capacity-constrained ministry, and incurred significant delays in the review and approval of action plans at all levels (health center, district, regional, and central), on which basis disbursements under the Common Fund were made. The extent to which these meetings affected the allocation of other donor resources (usually linked to particular diseases or programs) is unclear. The ICR does not analyze the benefits and transaction costs before and after the SWAP. It is also interesting to note that, prior to the SWAP under the previous project, MoH planning and budgeting were already based on action planning and approvals at each level of the system. Plan quality and timely disbursements were thus already issues, but do not seem to have been resolved. *Third,* sector stewardship does not seem to have been enhanced. There is no evidence to document improved efficiency in the use of sector resources. Moreover, neither the focus on results nor the ability to define and track accountabilities for results was improved. Indeed, the new (ongoing) project was expressly designed to enhance results and accountabilities.

1.b. Improve quality of care in the health system

2.33 **Outputs/Intermediate Outcomes.** The program addressed a number of critical inputs to service quality. It contributed to improvements in the availability of the six most ***essential drugs*** in health facilities. Niger's Statistical Directory shows that between 2006 and 2010 the stock-out rate for these drugs declined from 5.1 percent to 1.6 percent, short of the target of 0 percent. It enhanced health ***infrastructure***, including: construction/rehabilitation of 50 rural dispensaries, 14 district hospitals and four regional health centers; biomedical equipment and emergency obstetric equipment and supplies; and equipment, drugs, supplies, and 250,000 impregnated bed nets[13] for the malaria control program. The Program financed ***waste management*** equipment to support adherence to waste management standards. The proportion of health centers and hospitals with available resources to manage health care waste increased from 28 percent in 2006 to 59 percent in 2010, falling significantly short of the target of 100 percent.

2.34 The program also supported improvements to the quantity and quality of ***health facility staff***, but intermediate outcomes were modest between 2006 and 2010, according to Niger's Statistical Directory. From a baseline of 58 percent, only 59 percent of health centers were fully staffed, falling short of the 95 percent target. Likewise, staffing of regional hospitals (at 86 percent) did not change from the baseline value of 85 percent, falling short of the 100 percent target. On the other hand, district hospital staffing did improve, from 20 percent to 70 percent, but still fell short of the 100 percent target. Between 2006 and 2010, 4,323 staff (including both contractual staff and civil servants) were recruited, or 53 percent of the 8,065 staff requested. The program trained 328 paramedical staff and 219 medical staff (versus

[13] These nets complemented the 2.8 million bed nets provided by the Global Fund.

Program targets of 425 paramedical and 340 medical staff) of which 10 percent were financed by the project. An intermediate outcome of investment at the health district level is the increased proportion of health districts offering Basic Emergency Obstetric Care, from 27 percent to 81 percent between 2006 and 2010.

2.35 **Outcomes**

2.36 ***Improvements to service quality were not systematically tracked and there is little evidence on any trends in the quality of care.*** Although the above-cited outputs and intermediate outcomes are critical components of service quality, they are insufficient conditions for ensuring quality. Quality of care involves the proactive, guided, and supported translation of these inputs into better patient outcomes and increased patient satisfaction with the services. There is no tracking of quality assurance criteria, neither from the supply side (for example, adherence to service protocols) nor from the client side (for example, wait time, demeanor of provider, time with provider). The Program's (and project's) indicators focus on enhancing geographical and financial access to MCH services and on stimulating demand for these services through outreach activities, all of which are assessed as a part of PDO#2 (below). The PAD did include a quality-related intermediate outcome indicator (percent of patients satisfied with service quality), but no baseline was provided, nor was this assessed during the project.

OBJECTIVE 2. CONTRIBUTE TO THE REDUCTION OF MATERNAL AND CHILD MORTALITY

2.37 The achievement of objective 2 is rated **Substantial**.

2.38 **Outputs/Intermediate Outcomes.** Outputs itemized under PDO#1 (improved availability of essential drugs, recruitment and training of service providers, investments in health infrastructure, equipment, supplies and materials, and the establishment of a minimum package of services for maternal and child health) all contributed, as well, to a number of intermediate outcomes related to this PDO, including: improved access, coverage, and utilization of services, especially by those considered the most vulnerable: the poorest income quintiles and those living in rural areas. Appendix B, Table B.1c provides an update of data and trends reported in the ICR, which adds value on a number of fronts: (a) it uses the same source of information to establish the baseline and trends;[14] (b) it updates ICR 2010 data with data from the 2012 DHS, which became available after the ICR was issued; and (c) it shows pre project trends (drawn from the 1992 and 1998 DHS) to add perspective on trends achieved during the project period.

2.39 ***For the most part there was substantial to high improvement in the achievement of targets associated with access, coverage, and utilization of reproductive health services, with some improvement in equity.*** (All of the following trends happened between 2006 and 2012, as documented in the DHS.) The proportion of women who received prenatal care

[14] PAD baselines were established before DHS 2006 data were available and turned out to portray a more negative picture than DHS 2006 data ultimately documented. Targets were set on the basis of the PAD baselines and turned out to be, for the most part, less ambitious than ultimately set. Appendix B shows PAD baselines and targets for the record, but measures real progress against the corrected baselines (as reflected in the 2006 DHS) and the actual achievements (as reflected in the 2012 DHS).

from a qualified provider (doctor, nurse, or midwife) increased from 46 percent to 83 percent, a greater increase (at 178 percent) than the 167 percent increase intended at appraisal. Increases were much more significant both for rural and lowest-income-quintile women than for their urban and highest-income counterparts. Moreover, there was an increase in overall use of prenatal services: the proportion of women who made four or more prenatal visits[15] increased from 15 percent to 33 percent; and the proportion of women who made two to three prenatal visits also increased from 27 percent to 47 percent. And there was a major decline in the proportion of women making no prenatal visits from 53 percent to 14 percent. All of these gains benefited rural women disproportionately. The only qualifier to this impressive performance is that the median stage of pregnancy at the first prenatal care visit has not changed substantially (4.9 months vs. 5.0 months), whereas an early stage or first trimester visit is highly recommended for a healthy pregnancy and safe delivery.

2.40 ***DHS show improvements in the coverage of deliveries and postnatal care for all groups, but gains were inequitable.*** The proportion of deliveries assisted by a qualified health provider (doctor, nurse, or midwife) increased from 18 percent to 29 percent, exceeding the PAD target of a 56 percent increase, but between urban and rural groups gaps persisted and widened between the highest and lowest incomes. The proportion of live births delivered in a health facility also increased from 17 percent to 30 percent, but inequities did not change between urban and rural populations and got worse between the highest and the lowest income quintiles. The proportion of mothers receiving at least two anti-tetanus injections during pregnancy also rose substantially, from 23 percent to 50 percent, with improved equity. Postnatal care uptake was also substantial (from 12 percent to 37 percent of women), but inequities between urban and rural women worsened.

2.41 Only one, albeit critical, reproductive health intermediate outcome fell far short of the target. From its estimated baseline of 4 percent, the PAD set an end-of project target of a modern contraceptive prevalence rate of 15 percent (reflecting the Program target), or a 275 percent increase. Actual achievement was 8.3 percent,[16] up from the corrected baseline of 5 percent, or a 66 percent increase.

2.42 Only a slightly smaller proportion of women report ability to pay as an impediment to their access to services: 60 percent in 2006 versus 65 percent in 2006. On the positive side, these slight gains accrued to rural and lowest income women, and not to their urban and highest income counterparts.

2.43 ***Child health services also showed substantial gains overall in access, coverage and utilization, with improved equity across urban/rural and highest/lowest income populations.*** There was a substantial increase in the proportion of children 12–23 months who are fully vaccinated: from 29 percent to 52 percent, with gains for rural children slightly greater than for urban children, but with an increased gap between lowest and highest income children. Measles vaccination target was highly achieved, increasing from 47 percent to 69 percent (or by 46 percent, compared to a 17 percent increase projected at appraisal). There was a decline in

[15] WHO recommends four prenatal visits.

[16] Both 2006 baseline and 2012 actual data are net of breastfeeding, which was classified as a traditional method in 2006 and as a modern method in 2012.

the proportion of children under five who had diarrhea during the preceding two weeks, from 21 percent to 14 percent, with improvements in urban to rural and highest to lowest income quintile equity. A much greater proportion of children with diarrhea were brought to a health facility (from 17 percent to 51 percent); and more were treated with packaged or home oral rehydration solution (from 26.2 percent to 47 percent). A smaller proportion of children with diarrhea received no treatment (from 27 percent to 19 percent); and a greater proportion of women knew about ORS packets and prepackaged liquids (from 78 percent to 92 percent). All of the diarrhea-related improvements were achieved with improved equity across urban and rural and across the highest and lowest income populations. These gains are likely attributable to enhanced outreach activities undertaken with Program support to improve awareness and encourage child protection and increased consultation of health facilities.

2.44 ***However, malaria program outcomes for mothers and children sleeping under bed nets fell far short of targets, and inequities worsened***. The proportion of children under five who slept under simple or impregnated bed nets increased only modestly from 15 percent to 24 percent, falling far short of the 90 percent target set by the Program; the proportion of children under five who slept under an insecticide-treated bed net increased from 7 percent to 20 percent. Likewise, the proportion of pregnant women who slept under an insecticide-treated bed net increased from 7 percent to 20 percent, falling far short of the 90 percent target set by the Program. The modest gains in bed net use accrued largely to privileged groups (urban and highest-income populations), causing a worsening of inequity. It is important to note that the Program contributed a small portion of all bed nets provided during the period under review (250,000 versus more than 2 million from the Global Fund).

2.45 ***One-third (35 percent) of women 15–49 years old received at least two doses of SP and Fansidar to protect them against malaria during pregnancy; at least one of these was received during a prenatal visit*** (DHS 2012)**.** This protection is not equitably distributed. Thirty-four percent of rural women received this intermittent preventive treatment versus 42 percent of urban women. Lowest-income women were covered at 30 percent, compared with 44 percent of their highest-income counterparts. The 2006 DHS did not measure this particular indicator, so no trends can be assessed. Trends in coverage of pregnant women receiving at least some (but not necessarily full) protection appear to show improvements both in overall coverage (from 47 percent in 2006 to 59 percent in 2012) and in equitable coverage. But slight differences in the definition of indicators need to be taken into account (Appendix B, Table B.1c, Footnote).

2.46 The ICR shows an increase in the treatment of malnutrition cases from 27 percent in 2005 to 121 percent in 2010, but neither the indicator nor the data are clear.

2.47 **Outcome.** ***The maternal mortality rate (MMR) decreased from 648 deaths per 100,000 live births in 2006 to 535 in 2012.[17] This represents a substantial drop*** even though it falls short of the PAD's target of 500 set from a higher baseline of 700 (17 percent actual reduction versus 29 percent reduction set in the PAD). Moreover, this drop is significant when compared with negligible decline in MMR during the previous 15 years. The drop in

[17] The MMR of 648 reported in the 2006 DHS is based on data covering the period 1997-2006; and the rate of 535 reported in the 2012 DHS is based on data covering the period 2006-2012.

MMR is likely attributable in significant part to the above-cited gains in reproductive health services access, coverage and utilization.

2.48 ***Declines in infant and under-five mortality rates exceeded targets set under the Program and reflected in the PAD.*** Infant mortality declined by 37 percent between 2006 and 2012 from 81 deaths of infants under one per 1000 live births to 51. This compares favorably to the PAD's targeted reduction of 16 percent (from its estimated baseline of 156 to 131). Likewise, under-five mortality declined by 36 percent from 198 deaths per 1000 live births in 2006 to 127 in 2012, comparing favorably with the PAD's targeted reduction of 23 percent (from its estimated baseline of 265 to 205). Infant and under-five mortality are affected by health services access, coverage and utilization; and they are also affected by factors outside of the health sector's mandate, particularly levels of poverty. It is plausible to assume that Program achievements in improved access, coverage and utilization did contribute to declines in infant and child mortality. It is also plausible that declines in poverty during the Program period were also an important factor.

Efficiency

2.49 Efficiency is rated **Modest**.

2.50 There is a lack of sufficient information for adequately assessing efficiency. The project's design documents stated their intention to support Niger's five-year health development plan and, within this plan, to prioritize the use of project resources for the health of women and children through a minimum package of services that are known to be cost-effective (prenatal care, bed nets and childhood immunizations among others). However, an analysis of Program and project areas of intervention reveals that the project components (which were presented as the prioritized elements of the Program) encompassed all areas of intervention of the Program. The project was also meant to focus on rural areas where health status was particularly poor and to favor the improvement of existing services (for the initial two years) before supporting the expansion of services. The lack of project-specific cost data and the lack of specificity of Program cost and financing data (planned versus actual, and by component and regions) make it impossible to assess the extent to which project and Program resources were used efficiently. Technical efficiency was largely sound, but weaknesses in the results chain did undermine certain aspects of technical efficiency: e.g., absence of quality assurance measures and the full range of critical interventions to achieve quality objective.

2.51 Implementation efficiency was modest. Even though the project closed as originally scheduled, the SWAP proved to carry high transaction costs and precipitated delays and inefficiencies. Annual action plans were significantly delayed first by the late and incomplete submission by MoH and second by the delayed approval by Common Fund partners, causing implementation to be delayed from the first of the year to February, March and even later. As a consequence, preparation and execution of the procurement plan also suffered delays. This, combined with the closing of district-level accounts at the end of November, reduced the annual implementation period to 8 or 9 months. Notwithstanding the principle to prioritize, annual action plans included several hundred activities, with an implementation rate of

between 50-60 percent. It is not clear whether what was implemented was actually of highest priority.

Ratings

PROJECT'S OUTCOME

2.52 The project's Outcome rating is **Moderately Satisfactory.** The project's objectives are very relevant to current country conditions, national strategy and priorities for the sector and the Bank's current CPS, as well as its Health, Nutrition and Population Strategy. But the PDO statements were different in the DCA and PAD and not fully overlapping. The design relevance is modest overall. Intermediate objectives supported by components are plausibly and logically linked to achievement of most service performance and health status outcomes articulated in the official (DCA) PDO. But there are shortcomings, notably: a weak results chain for the improved service quality objective; a weak results chain for the health system efficiency objective; and a very ambitious program of reforms and actions whose coherence and prioritization were not entirely spelled out. The objectives to improve efficiency and quality of care in the health system were modestly achieved. The objective to contribute to the reduction of maternal and child mortality was substantially achieved. Project efficiency is modest because of the absence of Program and project costs and financing data for the proper assessment of efficient use of available financing. Implementation under a SWAP proved to have high transaction costs for a capacity-stretched MoH and precipitated important delays and shortcomings in the preparation and implementation of annual action plans.

RISK TO DEVELOPMENT OUTCOME

2.53 The risk to development outcome is rated **Significant.**

2.54 ***Political risk is moderate.*** The sector reform program and priority activities have been incorporated into the current National Health Development Plan for 2011-2015, and thus are likely to be continued. There is concern about the adequacy of vision and leadership within MoH and among other partners for health sector reform.

2.55 ***Financial risk is significant.*** The sector continues to suffer from chronic underfunding from domestic resources (falling far short of the Abuja target of 15 percent of government budget allocated to health). Moreover, the government has fallen behind in providing health facilities with funds lost through the elimination of user fees for the poor. The adequacy of financial support from external donors was also questioned at the end of the project.

2.56 ***Institutional risk is significant.*** The SWAP design appears to have overestimated MoH capacity for sector stewardship and coordination and underestimated the transaction costs of the approach (para. 2.25). Excessive turnover of qualified staff and appointment of unqualified staff contribute to this risk. The project design envisaged a new organizational structure for MoH and a clarification of roles and responsibilities. But it appears that roles and responsibilities might be better clarified.

2.57 ***Technical risk is moderate.*** The development and prioritization of a minimum package of services targeted to the health and well-being of women of reproductive age and

children was a technically sound investment, and this prioritization is likely to continue receiving strong acknowledgement and support. However, there are underlying reforms that could benefit from more technical rigor (in their design and in their implementation) and investment, including, but not limited to: capacity building, human resource management and motivation, health financing and cost recovery, and sustainable management of drug supplies in health facilities.

2.58 ***Social risk is significant.*** Improved supply of services, coupled with demand-side interventions (especially selective free services for vulnerable populations) have culminated in greater access, coverage, and use of priority services for women and children. MoH's failure to reimburse health facilities for free services to these populations may inhibit facilities' ability to continue to provide free services. The credibility of the health system in the eyes of the population would then be placed at serious risk.

BANK PERFORMANCE

2.59 ***Quality at Entry is rated moderately unsatisfactory.*** The project design was grounded in Niger's Health Development Plan, which had been developed on the basis of a participatory assessment of sector issues. Project preparation involved most major development partners already supporting Niger's health sector (UNFPA, UNICEF, France, WHO, and others). A Japanese Policy Human Resources Development (PHRD) Grant (financing studies on human resources development, service quality, and institutional assessment) and a Project Preparation Facility (financing the preparation of the first year's AAPs) made critical technical and financial assistance available to the preparation process. The choice of priorities was sound (favoring highest-impact programs and services aimed at the health and well-being of women of reproductive age and children under five).

2.60 However, there were significant issues surrounding the different statements of PDOs (in the DCA and PAD) and some weaknesses in the results chain supporting the objectives of improved service quality and health system efficiency. Although the PAD delves into lessons learned under previous health operations on the importance of understanding and squarely addressing sector capacity issues, these lessons were not fully exploited. The principle of bypassing a Project (or Program) unit in favor of making MoH and its various units directly responsible for management and implementation is laudable; but the SWAP design overestimated MoH's capacity for sector stewardship and coordination and did not clearly articulate capacity-building objectives and intermediate outcomes (or benchmarks). Moreover, capacity-building interventions (supporting sector reform, decentralization, performance-based management and SWAP principles and processes) were not entirely coherent or explicit. The design also overestimated the ability of MoH and partners to coordinate in the preparation, approval, and financing of decentralized action plans at the start of each year. Overall the program design was highly ambitious. M&E design, especially the choice of indicators, was weak.

2.61 ***Risk assessment and mitigation were somewhat vague.*** Essentially issues of institutional capacity and regional and district capacity were raised but not sufficiently specific, and mitigation measures were likewise nonspecific, touching upon: technical assistance, institutional strengthening support, exploitation of annual review mechanisms, strengthening of management skills, support for institutional reforms, among others.

2.62 ***Quality of Supervision is rated moderately satisfactory.*** There was continuity in the task team leader, whose Niger base assured frequent and regular communication and collaboration with the government and its partners. However, the focus on development impact might have been stronger. According to the ICR, annual program implementation reports were "somewhat incomplete" and internal supervision reporting was "generally informative but not particularly useful for monitoring the (key performance indicators)." Supervision of fiduciary aspects appears to have been adequate, overall. However, data on planned versus actual program costs and financing by component are not available. It is not clear how closely safeguard aspects were supervised. No safeguard experts appear to have joined supervision missions. There were two supervision missions per year in 2006, 2007, and 2009, and three supervision missions in 2008. However, a quick review of aide-mémoires produced under this project reveals two potential issues that may have affected the adequacy and depth of supervision inputs and processes for such a demanding and complex project. *First,* more than half of the missions covered three or more projects (ISHSSP, Population Project, HIV/AIDS, and RSRC-2), possibly stretching the mission team's capacity to focus in depth on the health program. *Second,* available aide-mémoires indicate only one mission in 2010 and one in 2011, the latter mission focused exclusively on the malaria program. Supervision reporting and interviews together reveal that performance-based contracting was not properly supervised.

2.63 Differing views of the documents required for disbursement, particularly those related to eligibility for financing of selected activities itemized in AAPs, undermined partner coordination. Moreover, differences of opinion caused delays in the Bank's provision of its non-objections for AAPs and for procurements. The Bank considered revising the project objective and key performance indicators after effectiveness, at midterm, and in the final year of the project so as to make them less ambitious. However, no revisions were made, because the government preferred to maintain the project objectives, which were consistent with the NHDP and DHS survey results (available after effectiveness), which suggested that a number of indicators could be achieved.

2.64 Overall Bank Performance is rated **Moderately Satisfactory**.

BORROWER PERFORMANCE

2.65 ***Government performance is rated Moderately Satisfactory.*** The government articulated a framework of national development priorities that was fully supportive and reflective of the NHDP objectives and priorities. Moreover, it complied with all key covenants, and the Ministry of Finance and other key elements of the national government participated regularly in biannual sectorwide reviews. However, the government did not increase the share of its budget for health from 6 percent to 15 percent (as envisaged under this project, and in line with the Abuja Declaration). It did approve a slight increase, nevertheless, to 8 percent. One important repercussion of sector underfinancing is that health facilities are not properly reimbursed for providing free services to exempted populations under the new cost recovery policy. The sustainability of these free services and the credibility of the system vis-à-vis the population are thus put at risk.

2.66 ***Performance of MoH as Implementing Agency is rated moderately satisfactory.*** MoH was successful in preparing AAPs emanating from various levels of the health system:

central, regional, district and health center. These were submitted regularly, albeit with delays. MoH did also succeed in disbursing the bulk of health financing to deconcentrated levels of the system. AAPs were implemented at about 50–60 percent, culminating in numerous project outputs that did indeed contribute to improved access, coverage, and utilization of priority reproductive and child health services. MoH organized biannual reviews of sector performance, as was envisaged under the SWAP, attended by national and international partners. However, these reviews focused more on implementation and processes than on outcomes and relevant policy discussions. Disbursements were initially delayed due to inadequate fiduciary capacity. But performance improved over time thanks to improved staffing and training. Issues raised in qualified audit were resolved over time. Some procurement difficulties arose because of weak capacity, resulting in implementation delays and inadequate contract management.

2.67 MoH chose not to follow the Bank's advice to improve its M&E framework, which included: updating its baseline estimates in light of the 2006 DHS, revising its targets in light of revised baselines and actual progress, and scaling back the overall ambitious nature of the Program.

2.68 Overall Borrower Performance is rated **Moderately Satisfactory.**

MONITORING AND EVALUATION

2.69 **M&E Design** did not fully provide for the monitoring of PDOs. There were no viable outcome indicators for tracking improvements in service quality or in health system efficiency. There was no provision for breaking down data by urban/rural residence or by income quintile, even though the project (and Program) was focused on targeting the poorest and most vulnerable (para. 2.1 and footnote 2; and PAD PDO p. 10 and Annex 3). PAD baselines, set before DHS 2006 data became available, documented for the most part a much worse starting point for health status and for service delivery statistics than the real baseline, when it became available the following year.

2.70 **M&E Implementation.** Original Program (and project) targets became much less ambitious in light of the more realistic baseline as documented in the DHS 2006.[18] Targets were not revised during implementation. Biannual reviews took place largely as planned, but are reported to have focused more on processes and progress in implementation and much less on results and substantive policy dialogue than originally envisaged. The role of the M&E committees established at each level of the health system at the Program's outset is not discussed in the ICR.

2.71 **M&E Utilization.** There is no evidence that Program M&E contributed to decision-making. The ICR reports that action planning was not sufficiently prioritized; much energy of government and Common Fund partners was more focused on reviewing plans in terms of their eligibility than for their results or in light of the the previous year's performance.

2.72 M&E is rated **Modest**.

[18] For most indicators, original baseline data presented in the PAD for 2005 indicated a much worse situation than the (more reliable) DHS 2006 ultimately documented. The targets, set against the PAD's baseline, were thus much more likely to be achieved than was initially thought.

3. Multi-sector Demographic Project

Objectives and Design, and Their Relevance

PROJECT DEVELOPMENT OBJECTIVE (PDO)

3.1 As stated in the Financial Agreement of June 29, 2007, "The objective of the Project is to strengthen the Recipient's capacity to address its demographic challenges through: (i) enabling the Ministry of Population (MoP) to design and implement a nationwide multisector population program; and (ii) increasing general awareness on population and reproductive health issues. The PDO stated in the PAD is substantially the same as in the DCA. Although the PDO was not revised, the April 2011 project restructuring did modify outcome and intermediate outcome indicators to simplify the results framework and align activities with expected results. Because no target values were raised or lowered, a split methodology is not necessary.

RELEVANCE OF OBJECTIVES

3.2 The relevance of objectives is rated **Substantial**.

3.3 The overarching objective to strengthen Niger's capacity to address its demographic challenges is highly relevant to: Niger's country conditions; its National Population Policy; and the Bank's Country Partnership Strategy (CPS) for Niger for the period FY13–16 (World Bank 2013a). Niger's Population Policy, its Poverty Reduction Strategy Paper. and the Bank Group's CPS all emphasize that Niger's rapid population growth seriously undermines its progress toward its development goals and prospects, including: poverty alleviation; employment rates; the fight against malnutrition and food insecurity; successful coverage and outcomes of key social services, including health and education; agricultural productivity and arable lands; and mitigating the degradation of harsh environmental conditions. The Population Policy seeks to change attitudes and reproductive behaviors which would lead to a significant increase in contraceptive prevalence and a reduction in early marriage, culminating in an eventual slowing of rapid population growth. The PDO addresses one of the three pillars of the CPS: to reduce vulnerability (through increased access to population services and support to population programs and diagnostic work with a view to achieving higher national awareness and action on demographic issues and on gender).

3.4 However, the relevance of the subobjective of enabling MoP to design and implement a nationwide multisector population program is modest. The ministry was created in 2004 as an add-on to the mandate of an already existing, but weak, Women's Affairs Ministry. The subobjective to strengthen this Ministry was in direct conflict with the lesson learned from the first Population project, which clearly demonstrated that any Ministry (and especially a weaker one) is not capable of cross-sectoral program coordination and that program implementation is best undertaken by the Ministry with the appropriate technical mandate and comparative advantage. Cross-sectoral coordination is the clear mandate of the prime minister's office. Moreover, according to the Bank's analytic and advisory activities (AAA) work, a 2004 governmental decree placed a National Population Commission under the prime minister and included in its mandate the coordination of population and reproductive

health activities of various ministries. Capacity building for coordination would thus have been better aligned with the function and mandate of the prime minister's office. In addition, the design and implementation of different ministries' various contributions to Niger's population policy implementation would best be left to these technical ministries, and not to a population ministry. It would make sense for this ministry (and/or the prime minister's office) to coordinate both the design and implementation of these various components and to ensure and exploit their synergies and potential impact. The relevance of the subobjective to increase general awareness on population and reproductive health issues is substantial.

Box 3-1 Multi-sector Demographic Project – Original Components, Estimated Costs

1. **Advocacy and Communication (US$3.1 million):** This component aimed at keeping population and reproductive health issues high on the national development agenda and building a strong national consensus around them. Target groups were to include: populations, traditional and religious leaders and NGOs working in rural areas, and decision makers and stakeholders at the national level.
   a. **Population and Development Subcomponent:** aimed at establishing an advocacy and communications strategy, encompassing all aspects of population and development relationships to be implemented at the central and decentralized levels.
   b. **Development and Implementation of Information, Education, and Communications (IEC) and Behavior Change Communication** in reproductive health, family planning, and breastfeeding.
2. **Women's Autonomy and Couples' Empowerment (US$1.3 million):** This component aimed to strengthen women's autonomy and thereby foster higher demand for birth spacing, family planning, and reproductive health services. Specifically it aimed to:
   a. **Reinforce efforts to improve girls' school enrollment and performance** through community outreach and sensitization, focusing on areas where the gender gap was greatest (supplementing successful outreach under a Bank-financed education project;
   b. **Strengthen women's economic opportunities,** including better economic and statistical analysis on obstacles to women's economic empowerment; community-level training for women on income-generating activities; and provision of equipment and materials to alleviate domestic task burdens; and
   c. **Help trigger legal reforms,** including measures to increase minimum marriage age; study of customs and practices relating to marriage, divorce, and other family issues; conduct of outreach and sensitization on gender and legal issues.
3. **Harmonization and Coordination of Multi-sector Interventions (US$1.1 million):** This component was to help MoP coordinate, monitor, and evaluate all population-related activities, aligning annual work plans with population policy and supporting cross-sectoral annual reviews.
4. **Capacity Building and Monitoring and Evaluation (US$2.8 million):**
   a. **Collection, analysis, dissemination, and utilization of data for project M&E**
   b. **Institutional strengthening and capacity building of MoP**
   c. **Strengthening of subnational public institutions affecting population and reproductive health**, as part of the process of decentralization.
5. **PPF (US$0.95 million)**
6. **Operating Costs (US$0.75 million)**
7. **Unallocated (US$1.0 million)**

Source: Project Appraisal Document, May 17, 2007.

PROJECT DESIGN

3.5 The project was originally designed around four components (with estimated costs) shown in Box 3-1.[19]

3.6 The project was restructured in May 2011, following the 2010 midterm review, in light of: (a) slow progress on project implementation, notably subnational-level advocacy; (b) design imbalance between the generation of demand for reproductive health services and the supply of those services to meet that demand; and (c) overcentralization of project management. This restructuring essentially: combined the first three components under the original design into one "Advocacy, Communication, and Coordination" component; added a brand new component to strengthen the supply of reproductive health services; and retained the "Capacity Building and M&E" component, adding support for NGO activities and oversight and for enhanced fiduciary management of the project. Box 3-2 summarizes components and presents estimated costs at restructuring and actual costs at closing.

Box 3-2 Multi-Sector Demographic Project – Restructured Components and Costs[20]

1. **Advocacy, Communication and Coordination (estimated at restructuring: US$4.5 million; actual: US$4.4 million):** This component regrouped the first three components in the original design, with more clarity on roles and responsibilities in implementation: work at the community level (NGOs contracted by MoP); multisectoral advocacy and communication (MoP); strengthening of women's economic opportunities (MoP); promotion of girls' schooling (Ministry of Education); and preparation of legal documents for women and children's protection (Ministry of Justice contracted by MoP). Alignment of project activities with those of other IDA-funded projects was also envisaged.
2. **Strengthening the Supply of Reproductive Health Services (estimated at restructuring: US$1.8 million; actual: US$0.9 million):** This new component was to complement the ongoing health project to address supply-side constraints, especially: training of nurses and midwives to replace retiring staff, and training of community health workers to complement facility-based family planning promotion; and the financing of contraceptives to meet an expected increase in demand.
3. **Capacity Building and Monitoring and Evaluation (estimated at restructuring: US$3.7 million; actual: US$4.8 million):** This component included the same activities as the original component 4, plus training of NGOs in project and financial management and the supervision of projects implemented by NGOs. The component supported project fiduciary management by MoP.

Source: World Bank (2013b).

[19] Estimated costs are taken from the PAD, Annex 7, and reflect IDA financing because no government counterpart was programmed. There is an inconsistency between this estimated cost data (adding up to US$11.0 million equivalent) and the covering page of the PAD, which showed that the SDR 7 million loan was equivalent to US$10 million.

[20] Estimated costs at restructuring are taken from the Project Restructuring Paper of April 26, 2001 (pages 3–4). Actual costs are taken from the ICR of September 19, 2013 (p. 36).

RELEVANCE OF DESIGN

3.7 The relevance of design is rated **Modest**.

3.8 The results chain that supported the overarching objective of strengthening Niger's capacity to address its demographic challenges was weak, both before and after the restructuring of components. The first subobjective (design and implementation of a nationwide multisector population program) is plausibly linked to the capacity-building objective, and two original components (harmonization and coordination of multisectoral interventions with capacity building and M&E) provided support to this end. However, all support was directed to MoP, which had little authority to effectively undertake cross-sectoral coordination, oversight, or resource allocation. The project design does not address the cross-sectoral coordination mandate of the prime minister's office, in general, or of the National Population Commission, specifically, which was created around the time of project preparation and housed in the prime minister's office. Furthermore, these two components do not provide sufficient detail on what elements of capacity needed strengthening and how they would be strengthened. Nor was it clear how the Annual Work Plan (AWP) process would be undertaken, whether planning would be initiated by the technical ministries and coordinated by MoP. Language in the PAD indicates, rather, a top-down approach of AWPs "…assigning specific tasks and goals to stakeholders and partners."

3.9 The second sub-objective, to increase the general awareness of population and reproductive health, is more an outcome of Niger's strengthened capacity than a support to it. This sub-objective was supported by two original components: Advocacy and Communication; and Women's Autonomy and Couples' Empowerment. But, indeed, these components aimed to do more than just raise general awareness. They sought to effect: behavior change (exclusive breastfeeding of infants up to six months; increased use of modern contraception; increased age at first marriage among women); and other outcomes related to women's autonomy and development, including: girls school enrollment; enhanced income-generating activities; and legal reforms, including increasing the minimum marriage age). The Advocacy and Communication component was not well developed, lacking specific strategies, sequencing, and expected outcomes for the range of very different target groups (such as political and administrative actors and decision-makers, traditional leaders, men, and religious leaders).

3.10 These same results chain issues persisted after the restructuring of components, which, nevertheless, did provide more specificity on roles and responsibilities within this broad cross-sectoral agenda. The addition of a new component to strengthen the supply of reproductive health services did support the overarching capacity-strengthening objective of the project, but it did cause a reallocation of almost US$1 million away from the Advocacy, Communication, and Coordination component. Moreover, it is unclear why this would not have been supported under the ongoing ISHSSP, which focused on the supply of reproductive health services.

3.11 **M&E Design.** The choice of indicators reflects the weakness of the project results chain, both in terms of the sequencing of inputs, outputs, outcomes, and impacts, and in terms of proper measures of project performance and outcomes. *Prior to restructuring*, one of five outcome indicators measured progress against the first sub-objective (design and

implementation of a nationwide multisector population program).[21] The four remaining outcome indicators addressed the second sub-objective, but most were much more ambitious than the objective of raising general awareness. Of these one was actually an output indicator, which did not segment the various target groups;[22] one measured enhanced understanding and consequent changes in attitude;[23] and the remaining two measured behavior change.[24] Two other original[25] outcome indicators were also overly ambitious vis-à-vis the PDO and project results chain: an increase in the median age at marriage among women 25–29 years old from 15.5 to 16.5; and an increase in the share of women aged 20–24 in union using modern contraception from 4.4 percent to 7 percent. Baselines were provided, drawn, where possible, from the 2006 DHS.

3.12 Changes to indicators introduced under the 2011 restructuring (itemized in Appendix B) were made to clarify and simplify the results framework; they did not raise or lower target values that would change the original PDO. Although a few modifications may have clarified measures or simplified the results framework, these changes did not fundamentally address the issues associated with the misalignment of indicators with objectives and the overly ambitious nature of indicators and targets.

3.13 **Implementation Arrangements.** The new Ministry of Population and Social Action (MoP) was responsible for project implementation, which involved the coordination of other line ministries supporting the population agenda. These included: Women's Promotion and Child Protection, Health, Education, Justice, Interior and Decentralization, and Territory Administration and Community Development. It was also assigned responsibility to coordinate the interventions of other actors and stakeholders active in population matters and reproductive health. To guide this newly established ministry, a Steering Committee, made up of members from the public and private sectors and civil society and open to donor participation, was established to provide strategic guidance and monitoring support. The project did not establish a project management unit as activities were to be carried out within the existing structure of MoP. Considerable technical assistance and the contracting out of activities were envisaged to this end. The main tool for program coordination was the program approach, which, as of Year 2, would involve the preparation of annual work plans (AWPs) with performance indicators, which would be reviewed annually by a Round Table.

Implementation

3.14 **Key Dates.** The project was approved by the Board on June 19, 2007 and became effective on January 8, 2008. A midterm review, planned for March 19, 2020, actually took

[21] At the end of the project, a program approach to population will be in place. (Annual work plans (AWPs) are designed (including M&E indicators), adopted through annual reviews with stakeholders and donors, and implemented under monthly supervision of the MoP.)

[22] Eighty-five percent of the population will have been sensitized on population and reproductive health issues.

[23] The share of women who want to postpone their next pregnancy will have increased from 49 percent to 55 percent;

[24] The share of children 0–5 months exclusively breastfed will have increased from 14 percent to 20 percent; and women's fertility levels at young ages (15–19) will have decreased from 199 to 180 per thousand.

[25] These were not in the PAD, but were listed in the Project Restructuring Paper of April 26, 2011 as original indicators. The ICR on this project of September 19, 2013 also lists these two among the original indicators.

place on June 14, 2010. This review led to a restructuring on May 12, 2011, which: (a) preserved the PDO; (b) regrouped existing components and added an additional one to support the supply of reproductive health services; and (c) modified indicators in an attempt to simplify the results framework. A second restructuring in March 2012 reallocated grant proceeds to ensure that important activities, especially IEC and BCC, received enough funding to enable the achievement of the PDO.

3.15 **Planned versus Actual Costs and Financing.** The total project cost was US$10.1 million, almost exactly the appraisal estimate of US$10.0 million.[26] But the allocation of expenditures across project components changed somewhat between original estimates, revised estimates at restructuring, and end-of-project costs, as indicated in Table 3-1. Actual expenditure on Advocacy, Communication, and Coordination was US$1.1 million less than originally planned, but almost the same as the estimate at restructuring. Expenditure on the Supply of Reproductive Health Services was just half of the estimate at restructuring, when this component was added. The US$4.8 million spent on Capacity Building and M&E was probably close to the same as estimated at appraisal (net of the US$1.0 million unallocated amount), and US$1.1 million more than the revised costs estimated at restructuring. The IDA Grant was 99 percent disbursed (SDR 6.66 million disbursed against a total grant amount of SDR 6.7 million). The ICR does not specify the extent to which the UNFPA parallel financing of the program, estimated at US$2.4 million equivalent at appraisal, was actually used.

Table 3-1 Planned versus Actual Costs by Project Component[27] (US$ million)

Component	Original Estimate	Revised at Restructuring	Actual Costs
1. **Advocacy, Communication and Coordination**	5.5 *(50%)*	4.5 *(45%)*	4.4 *(44%)*
• Advocacy and Communication *(Original Component 1)*	*3.1*		
• Women's Autonomy *(Original Component 2)*	*1.3*		
• Harmonization and Coordination of Multi-Sector Interventions *(Original Component 3)*	*1.1*		
2. **Strengthening the Supply of Reproductive Health Services** *(Added during restructuring)*	-	1.8 *(18%)*	0.9 *(9%)*
3. **Capacity Building and Monitoring & Evaluation**	5.5 *(50%)*	3.7 *(37%)*	4.8 *(47%)*
• Capacity Building, M&E *(Original Component 4)*	*2.8*		
• PPF *(itemized separately)*	*0.95*		
• Operating Costs *(itemized separately)*	*0.75*		
• Unallocated *(itemized separately)*	*1.0*		
Total	11.0 *(100%)*	10.0 *(100%)*	10.1 *(100%)*

Sources: PAD of May 17, 2007, Restructuring Paper of April 26, 2011, and ICR of September 19, 2013.

3.16 **Factors Affecting Implementation.** *Outside of the government's control* a number of factors slowed implementation, including: regional and national conflicts, a coup d'état,

[26] Although the cost table in the PAD adds up to US$11.0 million, the IDA grant amount (which was to finance 100 percent of project costs) was US$10 million equivalent. It is thus suspected that a mistake was made in the cost table, which should have added up to US$10 million. No cofinancing or counterpart financing was envisaged.

[27] Components are shown as they were restructured in April 2011. Original components are itemized and reflected within these new components for clarity and for the purposes of analyzing cost trends.

floods, and droughts. These factors also caused a number of Bank missions to be delayed or cancelled.

3.17 *Within the government's control* two factors adversely affected implementation. *First,* the government's decision to assign the coordination and oversight of a multisector population program to a new ministry with limited institutional capacity was unfortunate. This mandate was more appropriate to the prime minister's office, which coordinates all ministries in support of national development programs. The MoP lacked stature and coordinating authority among participating ministries, its capacities were overestimated at appraisal, and measures to strengthen it were slow to implement and inadequate. A restructuring and renaming of MoP during implementation only added to the challenges. *Second,* frequent turnover of Population Ministers and other ministry officials curtailed both institutional memory and capacity.

3.18 **M&E Implementation.** Baseline data were collected and the national M&E framework was implemented with information collected and disseminated on a quarterly basis. These data underpinned the annual work programs, which included indicators. The ICR reports that a national multisector M&E system was developed and that this system was made operational, albeit with some delays. The exact nature of this system and its use are not detailed in the ICR and would require a mission to assess adequately. In the meantime, the weak results framework and choice of indicators (both original and restructured) raise questions about the quality and effectiveness of this system for tracking progress on this complex, multisector program. At the decentralized level, implementation of M&E was challenged by the weak capacity of decentralized coordination bodies and a lack of reliable data. The MoP chaired periodic coordination meetings with other related ministries and coordinated some outreach activities. The ICR does not indicate the use of data for decision making, especially during annual work planning meetings.

3.19 **Safeguards Compliance.** The project fell under Category C. Therefore, no safeguards were triggered.

3.20 **Fiduciary Compliance.** The MoP's Directorate of Administration and Finance had overall responsibility for project financial management and was strengthened so that it could meet the Bank's requirements for financial management. Specifically, an accountant was recruited; and all fiduciary staff were trained in Bank financial management and disbursement procedures. No major issues arose in financial management during implementation. Project audits were performed on time and were unqualified.

3.21 Initial years of project implementation were challenged by issues associated with the setting up of sound procurement capacity and the launch of procurement activities responsive to implementation schedules. The two procurement specialists on the team resigned: one because of conflicts with the MoP and the other because of a conflict of interest (he was working for another project). There was an extended delay in hiring a UNFPA-funded communications specialist, who was ultimately hired rather late in the project (2010). As a consequence, the MoP had periods where needed technical assistance was not in place. Minor irregularities were found in the purchase of office supplies and cleaning goods,

prompting the Bank to send a letter to the authorities in June 2009 requesting full compliance with procurement. No further procurement issues arose, as a consequence.

Achievement of Objectives

3.22 There was one overarching objective for this project: to strengthen Niger's capacity to address its demographic challenges. This objective was to be supported through two types of interventions, expected to culminate in intermediate outcomes, which the project components were designed to support: (a) enabling the MoP to design and implement a nationwide multisector population program; and (b) increasing general awareness on population and reproductive health issues. This assessment of efficacy is organized around the analysis of outputs and intermediate outcomes of these two clusters of support, the assessment of the achievement of the overarching project objective, and the attribution of the project to these outcomes.

OBJECTIVE. STRENGTHEN THE RECIPIENT'S CAPACITY TO ADDRESS ITS DEMOGRAPHIC CHALLENGES

3.23 The achievement of the objective is rated **Modest.**

1a. Program Management and Coordination Capacity Building

3.24 **Outputs.** MoP benefited from the recruitment of new staff, including an accountant, an administrative assistant, and specialists in procurement, financial management, and M&E. As part of the project arrangements to guide and support MoP in assuming its new responsibilities, a project Steering Committee, made up of representatives from the public and private sectors and civil society, was created and rendered functional. However, it could not compensate for the poor placement of population program coordination and management within the government hierarchy. The project equipped MoP with vehicles, motorcycles, office equipment, and supplies. Subnational coordination units to address population and reproductive health issues were established. However, they were not functional and their activities overlapped significantly with regional health directorates. Thirty-six departmental coordination cells were also established, but they are not fully functional.

3.25 A system of regular coordination meetings was established to review project progress and activities: monthly departmental meetings, quarterly regional meetings, and biannual central-level meetings. A system of regular supervision missions was established, including quarterly supervision missions by regional personnel to the departmental level and biannual supervision missions by central-level personnel to the regional level. However, the ICR reports that these systems did not function. The project coordination and development partners undertook one joint field visit annually, with a second supervision mission undertaken by the Bank. The target was two joint field visits annually. Project annual reviews were carried out regularly. These outputs are said to have contributed to improving M&E and planning capacity. However, they did not culminate in the desired intermediate outcomes.

3.26 **Intermediate Outcomes**. The capacity of MoP to design and implement a multisector program was improved with the project, but still remained very weak; at the

project's end it was far short of the project's intention. Its coordination capacities were insufficient, both because of capacity constraints and because of its placement in the government's hierarchy (equal in hierarchy to other ministries which it was intended to coordinate but also much newer and weaker in capacity than other seasoned, well-established ministries, such as Health, Education, and Justice). The MoP's ability to effectively influence population-related activities and programs of other relevant ministries was limited. The ICR reports that the project scaled back its capacity-building objective from a programwide to a project-specific focus during the 2011 restructuring. However, this change did not involve an amendment of the PDO statement, which specified a multi-sector program. The ICR reports that five annual work programs were prepared. But it does not provide any indication of the quality and relevance of these programs, what process was used for their adoption, and the extent to which they were financed and implemented.

1.b Increase in General Awareness of Population and Reproductive Health Issues

3.27 The project invested in activities to: increase the general awareness ofpopulation and reproductive health issues; prompt changes in attitudes and behavior about reproductive health; and address some of the determinants of fertility preferences and contraceptive use.

3.28 **Outputs.** *In support of increasing general awareness and changes in attitudes and behaviors,* MoP was supported by a UNFPA-funded international population communication expert for 10 months, who helped implement the communication strategy and subsequent plans.[28] By 2013, 95 percent of the population over the age of 15 was sensitized about population and reproductive health issues through IEC and BCC campaigns facilitated by NGOs. These campaigns were provided to the general population and to target groups, including: politicians, the media, religious leaders, women's groups and youth organizations at the central, regional, and local levels. Against a target of 1000, 682 health personnel and 270 community health workers received training in family planning and reproductive health. Two televised debates were organized each year on population and reproductive health. Four youth sensitization campaigns on population, development, and reproductive health were organized between 2007 and 2012. All of the reported coverage of activities centered on the general population and special groups within the population. But there is no indication of the types, number, and coverage of activities targeted at other critical groups noted in the project design, especially politicians and local authorities.

3.29 *In support of activities to address some of the determinants of fertility and contraceptive use,* two legal texts and measures to increase the minimum age of marriage were prepared, but they were not passed by Parliament. A national gender policy was adopted and is under implementation. Six hundred women's groups received training in business management. The project also provided equipment for women's groups to alleviate the heavy burden of domestic tasks. Fifteen sensitization campaigns on women's rights and birth spacing were implemented (three per year). A memorandum of understanding with Ministry of Education was signed to finance NGO support to school management committees in carrying out community outreach and sensitization on the importance of female schooling, but activities and outcomes are not detailed. The supply of reproductive health services was

[28] Unfortunately weaknesses in procurement capacity delayed the recruitment of this critical expertise until 2010.

strengthened through: development of guidelines and material; provision of training material and equipment; training of health providers and community health workers; and provision of contraceptive products (along with MoH and other partners, including KfW and UNFPA).

3.30 **Intermediate Outcomes.** According to DHS data, between 2006 and 2012 both men and women had greater exposure to family planning messages delivered by radio, television, and newspaper, but increases were modest and coverage is still low**.** The share of women who reported no exposure to such messages through the media declined from 64 percent to 53 percent, a modest improvement: more than half of the women have still not had any exposure. Likewise, the share of men who reported no exposure to such messages through the media declined from 49 percent to 38 percent, with just slightly over one-third with no exposure. Improvements were inequitable, showing virtually no change for men and women in the lowest income quintile. Unmet need for family planning services[29] actually increased slightly from 14 percent in 2006 to 16 percent in 2012. This trend, too, was inequitable, with unmet need declining among urban and high-income populations, while increasing for the less privileged (rural and low-income).

3.31 ***Knowledge of modern contraceptives improved but the desire to space pregnancies or limit family size did not.*** Among women in unions, knowledge of any method of contraception increased from 72 percent to 91 percent; and knowledge of any modern method increased from 68 percent to 89 percent. There was no significant change in the share of women who wanted to postpone their next pregnancy: 49 percent in 2006 and 51 percent in 2012 (versus a target of 55 percent) (Source: DHS). Among women 15–49 years in a union, the ideal number of children per woman increased from 9.1 to 9.5 children. Among all women 15–49 years, whether in a union or not, the ideal number of children also went up from 8.8 to 9.2 children. Although this number increased for all groups, rural and low-income populations' ideal size was about two children more than that of their urban and high-income counterparts.

3.32 **Outcomes.** These outcomes draw on outcome indicators and other relevant DHS data to assess how project outputs and intermediate outcomes translated into the achievement of project objectives.

3.33 ***Early marriage and early onset of procreation have not changed.*** The share of adolescents 15–19 years who have already started their procreative life[30] did not change substantially: 39.3 percent in 2006 versus 40.4 in 2012. However, the rate substantially increased for the lowest quintile: 40 percent in 2006 versus 49 percent in 2012. The median age at first union among women 25–49 years hardly changed from 15.5 years in 2006 to 15.7 years in 2012, not meeting the target of 16.5.

3.34 Modern contraceptive prevalence rate rose by three percentage points. It is still extremely low, and highly inequitable across urban and rural populations and income quintiles. Among women in union 8.3 percent were currently using modern contraception

[29] Defined as the share of women in union whose needs (whether for spacing or limiting births) are not met.

[30] Defined as already having a child or pregnant with their first child.

methods in 2012, up from 5.0 percent in 2006. The target for this indicator is not entirely clear.[31] Gains were disproportionately greater among urban populations and for the highest income quintile. There was only a slight increase for rural populations and virtually no change for lower income quintiles, whose baselines were already substantially lower at the project's outset, thus exacerbating inequities. Total fertility actually increased from 7.1 in 2006 to 7.6 in 2012, after a period of decline (from 7.5 in 1998 to 7.1 in 2006); and rates became more inequitable during the project period: fertility rose among rural populations and lowest income quintile, and declined among urban populations and the highest income quintile.

Efficiency

3.35 Efficiency is rated **Modest**.

3.36 ***The economic analysis undertaken in the PAD was focused largely on the consequences of rapid population growth and high fertility—scarcity of arable land, poor maternal and child health, poverty and inequitable wealth distribution, food scarcity, growing demand for and cost of expanding social services, among others—and the benefits of slowing population growth related to each of these consequences.*** The ICR's assessment of efficiency discussed these same consequences, and attempted to outline health benefits and nonhealth benefits (both micro- and macro-level), with the caveat that these are difficult to quantify. The ICR also assessed allocative and technical efficiency, limited largely to family planning supply and demand, and productive (or implementation) efficiency.

3.37 This PPAR bases its efficiency rating in large part on the extent to which project funds were used to support the most high-impact and cost-effective interventions for supporting the PDO. The main determinants of high fertility are numerous and complex (Box 3-3) and are likely to be influenced by country context. Evidence is not convincing that the project resources were efficiently used to address critical determinants of high fertility and, as a part of this work, to undertake a learning-by-doing (or operations research) approach to ensure that interventions were most appropriate to Niger's context. Health and Education sectors clearly have much to contribute to addressing some of the critical determinants of high fertility (child health services and reproductive health services, including family planning information and services; and girls' and women's education and literacy). It is not clear why or how relevant sector activities, which clearly fall under the respective mandates of these Ministries, were included in the multisector population programs and slated for project financing. The supply of reproductive health and family planning services provides an illustration: Under the original design, there was no provision for these services because MoH was assumed to be providing them. Under the restructured design, a component was

[31] The Restructuring Paper shows an original indicator of "Percentage of modern contraceptive use among women in union aged 20–24 has increased from 4.4 percent to 7 percent." Then it shows a change to this indicator for the purposes of clarification, "Contraceptive prevalence rate (modern methods for women aged 15 to 49)." However, this revised indicator is measuring something different and does not reflect the correct baseline, which was available at the time. Therefore, no target appears to have been set for this new indicator.

added to directly support the provision of these services, because demand was expected to outpace supply. At the end of the project, only half of this component allocation was used.

3.38 It appears that relatively little effort and few resources were devoted to the preparation of legal documents to raise the age at first union, which ultimately did not happen. Sociocultural and political obstacles also discouraged the use of contraception. Although the project made provision for addressing these, the design of activities did not appear to take into account the analysis of underlying opinions across and within target groups and across different ethnic groups so as to tailor and deliver messages effectively. Not much headway appears to have been made in support of women's development, including provisions to lighten their household tasks and enhance their economic and educational opportunities. Discussion of women's autonomy and empowerment risk are not well received by some traditional elements in Nigerien society; better tailored messaging might have been couched in terms that would be perceived as less threatening and more in keeping with "win-win" investments in family wellbeing. In short, a more efficient and politically and socially acceptable way of prioritizing and targeting messages would have been grounded in operational research for a learning-by-doing approach. The Prime Minister's March 2007 directive to MoP to begin implementing the Population Policy may have accelerated the launch of the multisector program, but bypassing a process to achieve a national consensus on the Population Policy may have made the program more costly in the end. There are still strong pockets of resistance among social, political, administrative, and traditional factions.

Box 3-3 Main Determinants of High Fertility

High demand for children: The demand for children is high in most of the remaining high-fertility countries (especially in Central and West Africa). This demand is precipitated by poverty and lack of economic opportunity, under which people demand children for their social security, support to labor-intensive tasks in the household, and for earning income for the household.

Unmet need for family planning: Many high-fertility countries have moderate to high levels of unmet need for family planning.

Age at first union: Age at first union is relatively young in most high-fertility societies. Several years' delay would contribute to fertility decline, and it would have other health and socioeconomic benefits.

Mortality: Improved child survival is perhaps the most powerful stimulant of fertility decline. In contrast, increased mortality due to the HIV pandemic is having minimal overall impact on rates of fertility and population growth.

Education: Formal schooling is second only to mortality as a determinant of fertility.

Income: By contrast, income is a relatively weak predictor of fertility decline, and of mortality and education. Poor economic performance is not in itself an obstacle to fertility decline.

Obstacles to contraception: Non-access obstacles (cultural, social, psychic) appear to be robust in some settings but are not well quantified.

Family planning services: The evidence on access obstacles is less ambiguous. In diverse settings expanded provision of family planning services has had an impact on fertility, typically a 10–25 percent net reduction in fertility.

Source: Casterline (2010).

Institutional and implementation inefficiencies also contributed to the modest rating. The placement of program oversight responsibility in a new, weak ministry that had no convening, coordinating or technical authority over other, long-established technical ministries undermined efficiency and accountabilities. New institutional structures set up at regional and departmental levels were also inefficient because their mandates overlapped significantly with regional and departmental health directorates.

Ratings

PROJECT'S OUTCOME

3.39 The project's Outcome rating is **Moderately Unsatisfactory.** The project's overarching objective is highly relevant to current country conditions and challenges, national strategy, and priorities for the sector, and to the Bank's strategies for the country and the sector. But the sub-objectives were not appropriately articulated or fully supportive of the overarching objective, culminating in a substantial rating of the relevance of objectives. A weak results chain caused design relevance to be modest, and it remained modest even after restructuring of components. The project objective was modestly achieved. Niger's capacity to effectively address its demographic challenges was only modestly achieved. The MoP has not risen to the challenge of designing and implementing a nationwide multisector program because of shortcomings in technical and managerial capacities, and because its placement in the governmental hierarchy gives it insufficient coordinating and convening power. There is a paucity of data and trends on the general awareness in the country of population and reproductive health issues, especially among key target groups identified in the project design. Although there are indications of some enhanced knowledge, attitudes and behaviors have not changed, falling short of targets set for the project. Efficiency was modest because of the failure to allocate project resources to interventions that would have the highest impact, and because of the highly inefficient institutional setup, despite very clear lessons from a past population project.

RISK TO DEVELOPMENT OUTCOME

3.40 ***Financial risk is significant.*** Despite the recognition of population issues in Niger's development policy papers, public financing of population activities after the project's closing is fragile at best. Although reproductive health and family planning receive financial support from the public budget and development partners, the sustainability of crosssectoral IEC/BCC activities is very much in question.

3.41 ***Institutional risk is significant.*** The persistently weak capacity of the MoP and its location and stature in government limit its potential to fulfill its very ambitious and politically sensitive mandate. Significant overlaps between its eight regional and 36 departmental branches and the regional and departmental health directorates are inefficient and not likely to continue to enjoy financial, peer, and social support. Its placement in the government hierarchy also undermines accountabilities of the other ministries for delivering on their part of multisectoral population agenda.

3.42 ***Technical risk is significant.*** The weak capacity of the MoP, its poor placement in the hierarchy to carry out its coordination functions, and the overlap of its mandate (at the central, regional, and departmental levels) with technical ministries, especially health, work together to threaten the technical quality and cohesiveness of various sectors' interventions.

3.43 ***Political and social risks are significant.*** Senior political leadership is not as forceful in expressing its commitment to the population agenda to national actors, stakeholders, and the general public as it is to development partners. There are still strong pockets of resistance to many components of a population program, including: reduction in family size, especially with government intervention; legally mandating a minimum age for marriage; investment in girls and women to enhance their development, autonomy, and economic prosperity.

3.44 The risk to development outcome is rated **Significant**.

BANK PERFORMANCE

3.45 ***Quality at entry is rated moderately unsatisfactory*** for two reasons. *First*, the design was modest, characterized by a weak results chain, of which the underlying logic and sequencing were not well developed. M&E design was also weak. *Second*, the institutional home of the project seriously undermined the effectiveness and efficiency of Niger's national population program. Not only was MoP new and lacking essential capacity, it was also ill-placed in the government's hierarchy to exert the authority required to coordinate, oversee, and render accountable the various sectoral ministries and other actors and contributors to the population program. Consequently, the links were weak between this very critical, cross-cutting program and macroeconomic dialogue and policy, which should have taken place at higher levels—at the prime minister level on the government's side, and at the country director, and even vice-presidential level, on the Bank's side. It is interesting to note that the AAA work undertaken in 2004–05, which prompted the preparation of this project, did not squarely address intersectoral issues. It mentioned the (then) recent creation of a National Population Commission in the prime minister's office. It also mentioned the importance of placing the coordination function at a sufficiently high level. But it was not sufficiently specific where it could have been. The previous Bank-financed population project in Niger failed largely because of the same institutional set-up that this present project adopted.

3.46 The preparation process identified several risks to achieving program goals, but mitigating measures were inadequate, depending heavily on buy-in of stakeholders, which proved to be more challenging than anticipated. There was no clear, structured vision of how MoP capacity was to be strengthened was inadequate and not structured. The articulation of responsibilities between MoP and other ministries was unclear. The Bank placed only superficial importance on increased general and technical education and productive employment; especially for the youth, these opportunities are most likely to increase modern contraceptive use.

3.47 ***Quality of Supervision is rated moderately unsatisfactory***. The Bank's focus on the project (and program) development objectives during supervision was less than strong. This is especially evident in the restructuring exercise, which did not: clarify the PDO, strengthen a weak results chain, or choose outcome and intermediate outcome indicators that were better

aligned to the PDO and reasonably attributable to the project's support. Insufficient emphasis was placed on the critical obstacles to the completion of Niger's demographic transition (already declining mortality being complemented by lower fertility): low female employment and economic opportunity; strong pronatalist sentiments; and a strong male-dominated culture undermining women's status, among others. The restructuring did, nevertheless: introduce more clarity on roles and responsibilities for implementation of various activities within the project, including the contracting of NGOs for community outreach. Detailed review of financial management was carried out during supervision. The appointment of a field-based staff as task team leaders in July 2009 served to improve the Bank's presence on this project.

3.48 Two Bank supervision missions were planned for each year. However, sometimes these missions had to be postponed or cancelled because of the challenging environment in Niger: political conflict, droughts and locusts, and governance issues. Moreover, for the most part, these population missions were combined with supervision missions for other projects (ISHSSP, HIV/AIDS, and social sector policy lending). Although there were certainly opportunities for synergy across these projects (especially with regard to reproductive health and HIV/AIDS), the combined missions, which included only one population specialist, precluded the opportunity for an in-depth focus on this complex, politically sensitive, cross-sectoral operation. There is no evidence of the strong engagement of Bank senior management in addressing population issues and in working to alleviate resistance among politicians and administrators.

3.49 Overall Bank Performance is rated **Moderately Unsatisfactory.**

BORROWER PERFORMANCE

3.50 ***Government Performance is moderately unsatisfactory.*** The Government of Niger's commitment to addressing population and demographic issues was high, as reflected in its overall development policy and poverty reduction strategies and goals. These were complemented by the issuance of a National Population Policy, which sought to address population and demographic challenges to Niger's development. However, government leadership did not appear to be as forceful as it might have been to ensure the successful implementation of this policy. This is especially true of the prime minister's office, which had: the mandate for cross-sectoral coordination, the authority for holding various ministries accountable for delivering on their mandate, and a National Population Commission established in 2004, whose membership was representative of key actors and stakeholders. Failure to clarify MoP's role as coordinator of population initiatives undermined this already weak ministry's management of the program. The Project Steering Committee and eventual definition of roles and responsibilities of some ministries helped somewhat. Lagging implementation performance of investments in women's initiatives might have been avoided with stronger Borrower commitment. Pockets of resistance to these activities and others (such as promotion and use of family planning) might have been more rigorously—and sensitively—addressed.

3.51 ***The Implementing Agency's Performance was moderately unsatisfactory.*** MoP, as the main implementing agency, was not very effective in carrying out its functions. Part of

the reason might have been beyond its ability to manage: it was a new ministry with weak capacity and little authority over the other ministries it was meant to coordinate. But MoP's own way of doing business also impeded smooth implementation: It insisted upon managing the project centrally, with little delegation of responsibilities to technical ministries, when these ministries clearly had the comparative advantage in their relevant fields. Moreover, MoP initially was reluctant to contract with NGOs, which were critical for reaching out to communities. These issues caused delays in project implementation and were addressed—but not fully—during the two restructurings: the first to clarify roles and responsibilities; the second to allocate remaining resources to the most critical activities. A national multisectoral M&E framework was developed and put into use.

3.52 The project was designed and managed as a multisector program, adopting some elements of a SWAP with participating donors contributing most of the funds. MoP performance was constrained by varying schedules of individual donors' financial modalities and disbursements. Internal political differences and rapid turnover of ministers and senior management adversely affected startup activities, complicated decision making and intersectoral coordination, and slowed procurement during the initial years.

3.53 Overall Borrower Performance is rated **Moderately Unsatisfactory.**

MONITORING AND EVALUATION

3.54 **M&E Design.** The choice of indicators was not fully aligned with the project objectives or results chain. And they were ambitious. The situation was not much improved through restructuring (para 3.9 and para 3.10)

3.55 **M&E Implementation.** Baseline data were collected and the national M&E framework was implemented with information collected and disseminated on a quarterly basis. This information was reported to underpin the annual work plans (AWPs), which included indicators. At the decentralized level, M&E implementation was challenged by weak capacity and lack of reliable data.

3.56 **M&E Utilization.** The ICR does not indicate the use of data for decision making, especially during annual work planning meetings. Reviews of documents and interviews indicate that the AWP process and annual reviews were much more focused on activity planning and much less so on review of performance or outcomes. Moreover, there is no evidence that MoP was staffed with M&E expertise. A field trip would have been necessary to analyze this in more depth.

3.57 M&E is rated **Modest.**

4. Lessons

4.1 Looking across these two very complex projects, three lessons emerge that are relevant to both.

Box 4-1. Basic Attributes of the Sectorwide Approach (SWAP) in Health

A sectorwide approach to health development is:

A ***sustained partnership,*** led by national authorities, involving different representatives of government, groups in civil society, and one or more donor agencies;

With the ***goal of achieving improvements in people's health*** and contributing to national human development objectives;

In the context of a ***coherent sector***, defined by an appropriate institutional structure and national financing program;

Through a ***collaborative program of work*** (PoW) focusing on:

The development of ***sectoral policies and strategies,*** which define the roles of the public and private sectors in relation to the financing and provision of services, and provide a ***basis for prioritizing*** public expenditures;

The preparation of ***medium-term projections of resource availability and sector financing and spending plans,*** consistent with a ***sound public expenditure framework;***

The establishment of ***management systems*** by national government and donor agencies, which will facilitate the introduction of ***common arrangements*** for the disbursement and accounting of funds, procurement of goods and services, and monitoring of sector performance, and

Institutional reform and capacity building in line with sectoral policy and the need for systems development;

With established ***structures and processes for negotiating strategic and management issues, and reviewing sectoral performance*** against jointly agreed milestones and targets.

Source: Cassels 1997.

4.2 ***The potential of SWAPs (and Program-wide support) to strengthen capacity is not likely to be achieved in the absence of: clearly laid out capacity-strengthening objectives, intermediate objectives, a plausible results chain, relevant performance indicators, and proactive M&E.*** ISHSSP did support a capacity building component, but it did not articulate capacity-building objectives as part of its PDO; nor did it include indicators to track progress, and its capacity building results chain was both complex and weak. The overarching objective of the Multi-Sector Demographic project focused squarely on strengthening Niger's capacity to address its demographic challenges. Although it did include an intermediate objective (to enable MoP to design and implement a nationwide multisector population program) and indicators (AWPs adopted and implemented; and M&E system in place and in use), it fell short of developing a coherent results chain and of capturing and measuring the extremely ambitious goals: of establishing a new, multisector population program for which there was less than total buy-in in the country and of ensuring its coordination, financing, monitoring, and evaluation by a new, weak ministry, which had no real authority over other more senior and well-established ministries. The anticipated capacity benefits of the SWAP

(or Programwide approach), suggested in an IEG study of health SWAPs (improved sector coordination; greater harmonization and alignment of development assistance; and enhanced sector stewardship) and related indicators (itemized in that report) may provide guidance for better definition and measurement. These objectives and indicators were derived from the original definition of a Health SWAP, which is still relevant today and helpful in sorting out both capacity needed and themes for capacity strengthening (Box 4-1).

4.3 ***The evaluation of these two projects corroborates IEG's findings that the success (or failure) of a SWAP (or Program wide approach) depends upon four critical factors: (1) the quality and relevance of strategies and AWPs; (2) country capacity and systems for financial management, procurement, and strategic management; (3) the quality and functionality of partnerships with national and international actors and stakeholders; and (4) the predictability and flow of funds and absorptive capacities of implementing agencies***

- ***Improved quality and relevance of strategies and plans for health and population might have contributed to the support of fewer, more relevant activities and a higher impact.*** For health both the five-year plan and AWPs exceeded the available capacity and financing to implement them. Annual plans were only implemented at an average rate of 50–60 percent and it is not clear whether, or to what extent, they were sufficiently prioritized to address program objectives, including quality. Likewise, it is not clear to what extent the multisector population AWPs were sufficiently strategic and prioritized to address the highest-impact interventions or aligned with available capacity and resources. The results orientation of these plans was mixed.
- ***Had the strength of the Bank's fiduciary capacity-building support been also applied to building the capacity for strategic management, including M&E, the allocation of resources might have been better aligned with the highest-impact interventions and the results focus might have been stronger***. The Bank was largely effective in assessing and addressing country capacities and systems to respond to fiduciary policies and standards for the two projects. Both design and supervision of fiduciary capacities and systems were thorough and well-resourced, with frequent visits and oversight of Bank technical expertise and guidelines. In contrast, Bank expertise, technical supervision, and guidelines for strategic sector management (including the whole cycle of policy formulation and policy dialogue, planning, programming, budgeting, and—especially—M&E design, implementation, and use) is weak. This weakness undermines the ability for overall management—linking resources to results—and for establishing and enforcing accountabilities for results.
- ***Stepped-up efforts to infuse biannual reviews with policy dialogue and to hold partners accountable for supporting national priorities may have improved both the quality of partnerships and their outcomes***. ***Enhanced partnerships with national actors and stakeholders might have been instrumental in better understanding and addressing pockets of resistance to population activities***. For health, partnerships with donors might have been improved through the biannual review meetings. But the support of many development partners is still driven by their HQ and global initiatives, and designed as parallel projects, with multiple reporting requirements and management procedures, which put a strain on limited capacity and on national

efforts to allocate all resources available to the sector in line with national priorities. Joint review meetings are reported to focus more on plan implementation and review with, inadequate time devoted to substantive and policy dialogue and the assessment of results. For population, partnership among national actors and stakeholders has been undermined by: the inadequate convening authority of the MoP; and persistently significant pockets of resistance. The failure to ratify the National Population Policy was a missed opportunity for needed national-level dialogue and leadership. The ICR reports that MoP was resistant to contracting NGOs to undertake critical outreach work.

- ***Inadequate predictability and flow of funds risks undermining absorptive capacity and efficient use of resources.*** A long and tedious process by the Bank and AFD for reviewing annual health action plans (to assess their eligibility for financing and ultimately to approve them for disbursement under the Common Fund) caused these plans to be financed several months after the start of the year. This compression of the implementation period precipitated a low (50–60 percent) implementation rate and intensive end-of-year spending that is unlikely to have been efficient.

4.4 ***Beneficiaries are unlikely to take full advantage of information and services offered by social sector programs if their situations, perspectives, needs, and priorities are not documented and factored more systematically into program design, monitoring, and evaluation. This involves (a) both quantitative and qualitative information and trends; and (b) a segmentation of information to capture inequities and vulnerable groups the projects were designed to address.*** Qualitative information that might have provided value added includes: baseline, midterm and end-of-project surveys on service quality and affordability (for health services); and baseline, midterm and end-of-project surveys on knowledge, attitudes, and behaviors of various groups on population issues, fertility regulation, and various underlying determinants for tailoring and fine-tuning messages and other interventions. For projects aimed at poor and vulnerable populations, the breakdown of trends by urban or rural residence and by income quintile is critical for fine-tuning interventions during implementation and for end-of-project efficacy assessment.

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Appendix A. Basic Data Sheet

INSTITUTIONAL STRENGTHENING & HEALTH PROJECT (LOAN 4141-NIR)

Key Project Data (amounts in US$ million)

	Appraisal estimate	Actual or current estimate	Actual as % of appraisal estimate
Total project costs	n/a	n/a	n/a
Loan amount	35.0	35.0	100%

Source: Implementation Completion & Results Report.

Cumulative Estimated and Actual Disbursements

	FY07	***FY08***	***FY09***	***FY10***	***FY11***	***FY12***
Appraisal estimate (US$M)	3.29	8.35	15.07	20.83	34.15	35.00
Actual (US$M)	3.37	8.79	16.07	22.45	36.31	37.21
Actual as % of appraisal	102%	105%	107%	108%	106%	106%
Date of final disbursement: **October 31, 2011**						

Source: Project portal.

Project Dates

	Original	Actual
Concept Review	05/06/04	05/06/04
Negotiations	11/04/05	11/04/05
Board approval	01/05/06	01/05/06
Signing	02/16/06	02/16/06
Effectiveness	07/20/06	07/20/06
Closing date	06/30/11	06/30/11

Source: Project portal.

Staff Inputs (staff weeks)

Stage of Project Cycle	*Staff Time and Cost (Bank Budget Only)*	
	No. of staff weeks	*US$ Thousands (including travel and consultants costs)*
Lending		
FY05		202.79
FY06		94.18
TOTAL		**296.97**
Supervision/Implementation completion and Results report		
FY06		28.95
FY07		44.05
FY08		79.77
FY09		63.40
FY10		73.46
FY11		47.65
FY12		23.60
TOTAL:		**360.88**

Task Team members

Names	*Title*	*Unit*
LENDING		
Djibrilla Karamoko	Sr. Health Specialist	
Abdoul-Wahab Seyni	Sr. Social Development Spec	AFTCS
Johanne Angers	Sr. Operations Officer	ECSH1
Edeltraut Gilgan-Hunt	Former Staff	
Stephane Henri Legros	Former Staff	
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Laura McDonald	Consultant	MNSHD
Andrew Osei Asibey	Sr. Monitoring and Evaluation Specialist	AFTDE
Khama Odera Rogo	Lead Health Specialist	CICHE
Franco Russo	Operations Analyst	AFTED
Anne Marie Bodo	Consultant	AFTHE
SUPERVISION/IMPLEMENTATION COMPLETION AND RESULTS REPORT		
Tshiya A. Subayi	Operations Officer	AFTHE
Yao Wottor	Sr. Procurement Specialist	LCSPT
Karima Laouali Ladjo	Program Assistant	AFMNE
Helene Bertaud	Sr. Counsel	LEGAF
Moussoukoro Soukoule	Program Assistant	EACVQ
Boubou Cisse	Human Development Economist	AFTED
Daniele A-G. P. Jaekel	Operations Analyst	AFTHE
Menno Mulder-Sibanda	Sr. Nutrition Specialist	AFTHE

Malonga Miatudila	Consultant	AFTHE
Christophe Lemière	Sr. Health Specialist	AFTEN
Ibrah Sanoussi	Sr. Procurement Specialist	AFTPC
John F. May	Sr. Population Specialist	AFTHE
Jean-Jacques de St. Antoine	Lead Operations Officer	AFTHE
Dominic Haazen	Lead Health Policy Specialist	AFTHE
Peter Bachrach	Consultant	AFTHE

Other Project Data

Borrower/Executing Agency:

Follow-on Operations

Operation	*Credit/Loan /Grant no.*	*Amount (US$ million)*	*Board date*
Multi-Sector Demographic Project	H 3090	35.00	06/19/2007

MULTI-SECTOR DEMOGRAPHIC PROJECT (GRANT H 3090)

Key Project Data (amounts in US$ million)

	Appraisal estimate	*Actual or current estimate*	*Actual as % of appraisal estimate*
Total project costs	10.17	10.14	100 %
Loan amount	10.00	10.00	100 %
Cancellation			

Source: Implementation Completion & Results Report.

Cumulative Estimated and Actual Disbursements

	FY08	*FY09*	*FY10*	*FY11*	*FY12*	*FY13*	*FY14*
Appraisal estimate (US$M)	1.4	2.33	3.58	5.73	8.11	10.00	10.00
Actual (US$M)	1.11	2.43	3.68	5.83	8.55	10.28	10.36
Actual as % of appraisal	107%	104%	103%	102%	105%	103%	104%
Date of final disbursement: July 31, 2013							

Source: Project portal

Project Dates

	Original	*Actual*
Concept Review	01/17/2006	01/17/2006
Negotiations	04/10/2007	04/10/2007
Board approval	06/19/2007	06/19/2007
Signing	06/29/2007	06/29/2007
Effectiveness	01/08/2008	01/08/2008
Closing date	03/31/2013	03/31/2013

Source: Project portal

Staff Inputs (staff weeks)

Stage of Project Cycle	*Staff Time and Cost (Bank Budget Only)*	
	No. of staff weeks	*US$ Thousands (including travel and consultants costs)*
LENDING		
FY06	27.48	114.39
TOTAL:	**27.48**	**358.76**

SUPERVISION/ICR		
FY07	48.97	244.37
FY08	39.00	177.02
FY09	47.35	235.7
FY10	32.33	178.55
FY11	32.81	182.41
FY12	29.15	126.19
FY13	23.59	62.6
FY14	1.45	7.6
TOTAL	**254.65**	**1,214.44**

Mission Data

Names	*Title*	*Unit*
LENDING		
C. Mark Blackden	Consultant	AFCC2
Jean-Pierre Guengant	Consultant	AFTH2
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Rama Lakshminarayanan	Sr Health Spec.	HDNHE
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John F. May	Lead Population Specialist	AFTHE
Anne M. Pierre-Louis	Lead Health Specialist	AFTHE
Khama Odera Rogo	Lead Health Specialist	CICHE
Abdoul-Wahab Seyni	Senior Social Development Spec	AFTCS
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SUPERVISION/IMPLEMENTATION COMPLETION AND RESULTS REPORT		
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Mohamed I. Diaw	Operations Assistant	CFPPM
Ibrahim Cheik Diop	Communications Officer	AFRSC
Rachidatou Idrissa Madougou	Temporary	AFMNE
Djibrilla Karamoko	Sr Health Spec.	AFTHE
Karima Laouali Ladjo	Program Assistant	AFMNE
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Ibrah Rahamane Sanoussi	Procurement Specialist	AFTPC
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Mamadou Yaro	Sr Financial Management Specialist	AFTFM

Appendix B. Statistical Annexes on Health

Table B.1a: Relevant Bank Lending

World Bank Lending to Republic of Niger: Population, Health and Nutrition. related Social Sectors				
Project Title	**Project ID**	**Amount (US $ million)**	**Status**	**Approval Date**
1. Population and Health Support	P147638	103.0	Active	May 22, 2015
2. HIV/AIDS Support Project 2	P116167	20.0	Active	April 26, 2011
3. Multi-Sector Demographic	P096198	10.0	Closed	June 19, 2007
4. Institutional Strengthening and Health Sector Support Project	P083350	35.0	Closed	January 05, 2006
5. Multisector STI/HIV/AIDS Program	P071612	25.0	Closed	April 4,2003
6. Health Sector Development Program	P001999	40	Closed	September 05, 1996
7. Health Project	P001966	27.8	Closed	March 20, 1986
8. Population Project	P001976	17.6	Closed	April 30, 1992
Bank Lending to Republic of Niger for Related Social Sectors				
1. Urban Water and Sanitation	P117365	90.0	Active	April 26, 2011
2. Second Emergency Food Security	P123567	15.0	Closed	January 25, 2011
3. EFA-FTI Basic Education	P115436	8.0	Closed	July 09, 2009
4. Emergency Food Security Support	P113222	7.0	Closed	August 26, 2008
5. Rural and Social Policy DPL II	P098963	50.0	Closed	June 19, 2007
6. Safety Net	P123399	70.0	Active	May 19 2011
Source: World Bank Lending database.				

Table B.1b Expected Resources from Health Sector Donors Estimated during Appraisal

Donors	***2005***	***2006***	***2007***	***2008***	***2009***	***2010***	***Total***
European Union		1,400,000	127,200				1,527,200
Belgium		3,000,000	3,600,000	3,600,000			10,200,000
France		3,600,000	3,600,000	3,600,000	3,600,000	3,600,000	18,000,000
Luxembourg	978,000						978,000
Helen Keller International	775,928	854,044					1,629,972
Global 2000	618,474	772,824					1,391,298
International Trachoma Initiative (ITI)	7,252,139						7,252,139
UNICEF		7,051,600					7,051,600
UNFPA		1,451,849	3,037,380		9,112,125		13,601,354
WHO	8,642,881	8,642,881	3,741,000				21,026,762
IDA		6,300,000	9,800,000	7,700,000	4,900,000	6,300,000	35,000,000
French Development Agency		3,240,000	5,040,000	3,960,000	2,520,000	3,240,000	18,000,000
African Development Bank (AIDB)		10,672,000					10,672,000
Global Funds (Malaria)	5,887,000	11,258,000					17,145,000
Global Funds (HIV/AIDS)	4,237,649	4,237,649					8,475,298
TOTAL	28,392,071	62,480,847	28,945,580	18,860,000	20,132,125	13,140,000	171,950,623

Table B.1c: Achievement of PDO#2: Contribute to the reduction of maternal and child mortality

Indicators	***1992 DHS***	***1998 DHS***	***PAD Baseline***	***PAD Target***	***2006 DHS (Real Baseline)***	***2012 DHS (Actual)***	***Achievement of Target (and net changes)***
Maternal mortality rate	652 *(1979-1992)*	n/a	700	500 *(29% reduction)*	648 *(1997-2006)*	535 *(2006-2012)* *(17% reduction)*	*Substantial* drop, but short of PAD target set from higher baseline
Contraceptive prevalence: % of women currently in union using modern method (sterilization, pill, IUD, injectable, male condom)[32]			4.0%	15.0% *(275% increase)*	5.0%	8.3% *(66% increase)*	+3.3 percentage points *Modest* achievement, worsening inequities
Rural					2.7		+3.1
Urban					18.2	5.8	+5.0
Lowest quintile					2.3	23.2	+0.1
Highest quintile					15.8	2.4	+4.7
						20.5	
% women who received *prenatal care* from a qualified trained provider (doctor, nurse or mid-wife)	30.1%	39.3%	42	70 *(167% increase)*	46.4%	82.8% *(178% increase)*	+36.4 percentage points *High* achievement
Rural	19.9	29.9			38.9%	80.4%	+41.5
Urban	85.7	89.6			87.7	96.9%	+9.2
Lowest quintile	n/a	n/a			36.0	71.2	+35.2
Highest quintile	n/a	n/a			83.3	96.0	12.7
Median stage of pregnancy at first *prenatal care* visit (months)	4.6	4.6			4.9	5.0	+0.1 month *Negligible* achievement
Rural					5.1	5.2	
Urban					4.3	4.1	
% women 15-49 yrs who:							*High* gains, improved equity
Made *4 or more prenatal visits*:	8.4%	11.4%			14.9%	32.8%	+17.9 percentage points
Rural					11.1%	30.5%	+19.4
Urban					35.3%	46.3%	+11.0
Made *2-3 prenatal visits*:	18.9%	23.3%			26.6%	46.5%	+19.9 percentage points
Rural					23.3%	46.6%	+23.3

[32] Excluding breastfeeding: categorized as traditional method in 2006 DHS, categorized as a modern method in 2012, but CPR is also presented net of breastfeeding.

Indicators	***1992 DHS***	***1998 DHS***	***PAD Baseline***	***PAD Target***	***2006 DHS (Real Baseline)***	***2012 DHS (Actual)***	***Achievement of Target (and net changes)***
Urban					44.2%	45.9%	+1.7
Made *1 prenatal visit*:	2.8%	4.7%			5.5%	5.9%	+0.5 percentage points
Rural					4.9%	6.2%	+1.3
Urban					9.0%	4.3%	-4.7
Made *no prenatal visits*:	69.4%	60.0%			52.9%	14.4%	-38.5 percentage points
Rural					60.5%	16.4%	-44.1
Urban					11.2%	2.6%	-8.6
% *deliveries assisted* by a qualified health provider (doctor, nurse or midwife):	14.9%	17.6%	16%	25% *(56% increase)*	17.7%	29.3% *(66% increase)*	+11.6 percentage points *High* achievement but persistent/ worsening income inequities
Rural	4.9%	8.1%			8.3%	21.2%	+12.9
Urban	69.9%	68.7%			70.5%	83.0%	+12.5
Lowest quintile	n/a	n/a			5.0%	12.8%	+7.8
Highest quintile	n/a	n/a			57.0%	71.0%	+14.0
% live births *delivered in a health facility*:	15.5%	18.0%			17.2%	29.8%	+ 12.6 percentage points *Substantial*, but inequitable gains
Rural	5.0%	8.1%			7.9%	21.8%	+13.9
Urban	73.0%	70.1%			69.4%	82.6%	+13.1
Lowest quintile	n/a	n/a			4.9%	11.8%	+6.9
Highest quintile	n/a	n/a			57.8%	71.0%	+13.2
% mothers received at least 2 *anti-tetanos injections* during pregnancy:	14.0%	18.6%			23.0%	49.5%	+26.5 percentage points *Substantial* gains, greater equity
Rural	7.5%	14.4%			21.0%	50.4%	+29.4
Urban	49.9%	40.8%			33.9%	44.8%	+10.9
Lowest quintile	n/a	n/a			18.1%	44.3	+26.2
Highest quintile	n/a	n/a			35.7%	51.4%	+15.7
% women who received *postnatal care* during the first two days after delivery:					12.3%	36.9%	+ 24.6 percentage points *Substantial* increase, but inequity
Rural					11.9%	32.1%	+20.2
Urban					18.9%	67.2%	+48.3
Lowest quintile					n/a	23.9%	-
Highest quintile					n/a	63.1%	-
% women 15-49 years reporting that lack of money inhibits access to services:					64.9%	59.8%	-5.1 percentage points *Modest* reduction, equity gains
					69.3%	62.4%	-6.9

Indicators	***1992 DHS***	***1998 DHS***	***PAD Baseline***	***PAD Target***	***2006 DHS (Real Baseline)***	***2012 DHS (Actual)***	***Achievement of Target (and net changes)***
Rural Urban Lowest quintile Highest quintile					47.0% 75.0% 44.8%	48.7% 69.9% 49.2%	+1.7 -5.1 +4.4
Infant Mortality Rate	123	123	156	131 *(16% reduction)*	81	51 *(37% reduction)*	*High* achievement, partially attributable to health sector
U-5 Mortality Rate Rural Niamey Other towns	318	274	265	205 *(23% reduction)*	198 231 132 144	127 *(36% reduction)* 163 80 84	*High* achievement, partially attributable to health sector
% children 12-23 months *fully vaccinated* (BCG, DTCoq3, Polio3, Measles) Rural Urban Lowest quintile Highest quintile	17.4% 9.6% 53.7% n/a n/a	18.4% 10.5% 54.2% n/a n/a			29.0% 25.1% 48.4% 20.1% 48.4%	52.0% 49.1% 68.6% 34.9% 66.8%	+23 percentage points *Substantial* gain, mixed trends on equity +24.0 +20.2 +14.8 +18.4
Measles vaccination coverage: Rural Urban Lowest quintile Highest quintile	27.8% 20.2% 63.5% n/a n/a	34.9% 27.8% 67.1% n/a n/a	60	70 *(17% increase)*	47.0% 42.0% 72.1% 32.2% 73.6%	68.7% *(46% increase)* 67.1% 77.9% 61.4% 75.1%	+21.7 percentage points *High* achievement, improved equity +25.1 +5.8 +29.2 +1.5
% children under five years who had *diarrhea* during the preceding 2 weeks: Rural Urban Lowest quintile Highest quintile		37.8% 39.0% 31.6% n/a n/a ** < 3 yrs*			20.8% 21.5% 17.5% 22.0% 17.5% ** < 5 years*	14.1% 13.9% 15.9% 13.2% 14.7% **< 5 years*	-6.7 percentage points *Substantial* gain with improved equity -7.6 -1.6 -8.8 -2.8

Indicators	*1992 DHS*	*1998 DHS*	*PAD Baseline*	*PAD Target*	*2006 DHS (Real Baseline)*	*2012 DHS (Actual)*	*Achievement of Target (and net changes)*
% under-five children with *diarrhea* who were brought to a health facility:					17.2%	50.9%	+33.7 percentage points *Substantial* gain with improved equity
Rural					15.1%	51.1%	+36.0
Urban					30.9%	49.9%	+19.0
Lowest quintile					13.0%	41.1%	+28.1
Highest quintile					32.0%	52.6%	+20.6
Outpatient visits per capita							ICR shows an increase from 0.23 in 2005 to 0.57 in 2010
% children < 5 with *diarrhea* treated with packaged or home ORS:		21.3%			26.2%	47.4%	+21.2 percentage points *Substantial* gain with improved equity
Rural		17.4%			24.1%	47.0%	+22.9
Urban		45.5%			39.9%	49.8%	+9.9
Lowest quintile		n/a			22.3%	36.1%	+13.9
Highest quintile		n/a			40.5%	50.7%	+10.2
% children <5 with *diarrhea* who received no treatment:		35.6%			27.3%	18.6%	-8.7 percentage points *Modest* improvement, enhanced
Rural		37.6%			28.5%	18.7%	equity
Urban		22.7%			19.6%	18.0%	-9.8
Lowest quintile		n/a			34.1%	30.2%	-1.6
Highest quintile		n/a			16.2%	17.4%	-3.9
							+ 1.2
% women who *know about ORS* packets and pre-packaged liquids:		72.1%			77.9%	92.4%	+15.9 percentage points *Substantial* improvement, with equity
Rural		67.9%			75.8%	91.7%	+15.9
Urban		94.1%			89.6%	96.6%	+7.0
Lowest quintile		n/a			73.0%	83.5%	+10.5
Highest quintile		n/a			90.0%	97.1%	+7.1
% *children* <5 who *slept under simple or impregnated bed nets*			17	90	15.2	24.3	+ 9.1 percentage points *Modest* achievement, worsening
Rural					12.1	21.3	inequity
Urban					32.1	43.7	+9.2
Lowest quintile					10.7	13.7	+11.6
Highest quintile					27.6	40.9	+3.0
							+13.3
% *children* <5 who *slept under an ITN* (MII) the previous night:					7.4	20.1	+12.7 percentage points *Modest* coverage, worsening inequity

Indicators	***1992 DHS***	***1998 DHS***	***PAD Baseline***	***PAD Target***	***2006 DHS (Real Baseline)***	***2012 DHS (Actual)***	***Achievement of Target (and net changes)***
Rural					6.1	17.5	+11.4
Urban					14.9	37.1	+22.2
Lowest quintile					5.2	11.0	+5.8
Highest quintile					13.6	34.1	+20.5
% *pregnant women* 15-49 who *slept under an ITN* (MII) the previous night:			61%	90%	6.7% 5.4%	19.9% 17.9%	+13.2 percentage points *Modest* coverage, worsening inequity +12.5
Rural					14.8%	33.2%	+18.4
Urban					3.5%	13.3%	+9.8
Lowest quintile					13.2%	29.7%	+16.5
Highest quintile							
% women receiving intermittent treatment for malaria during pregnancy[33]			TBD	n/a	47.3 41.4	59.4 57.8	+12.1 percentage points +16.4
Rural					79.9	69.3	-10.6
Urban					38.2	49.1	+10.9
Lowest quintile					76.9	70.6	-6.3
Highest quintile							
Anemia among children <5:					83.9	73.4	-10.5 percentage points *Modest* progress, mixed equity trends
Rural					85.0	73.9	-11.6
Urban					77.7	69.8	-7.9
Lowest quintile					85.3	76.3	-9.0
Highest quintile					79.7	69.1	-10.6
Anemia among women 15-49 years:					45.6	45.8	+0.2 percentage points
Rural					47.2	46.5	*Negligible* progress
Urban					38.8	42.4	
Lowest quintile					50.6	52.4	
Highest quintile					36.7	40.1	
Stunting in children <5(height/age):		41.1			50.0	43.9	-6.1 percentage points *Modest* gains with improved equity

[33] Assessment of this trend must be qualified, given the two different indicator definitions used in 2006 and 2012, respectively. The 2006 definition is: percentage of women 15-49 years old who had a live birth over the five years preceding the survey who took anti-malaria medication for preventive purposes during her last pregnancy. The 2012 definition is: percentage of women 15-49 years old who had a live birth over the two years preceding the survey who received SP/Fansidar during a prenatal visit/utilization of intermittent preventive treatment.

Indicators	*1992 DHS*	*1998 DHS*	*PAD Baseline*	*PAD Target*	*2006 DHS (Real Baseline)*	*2012 DHS (Actual)*	*Achievement of Target (and net changes)*
Rural		43.0			53.3	45.9	-7.4
Urban		31.2			31.3	29.6	-1.7
Lowest quintile		n/a			53.7	46.9	-6.8
Highest quintile		n/a			37.2	34.5	-2.7
Emaciation in children <5 (weight/height):		20.7			10.3	18.0	+7.7 percentage points *Negative trend*, increased inequities
		22.1			10.6	18.6	+8.0
Rural		13.3			8.4	14.2	+5.8
Urban		n/a			11.7	22.2	+ 10.5
Lowest quintile		n/a			8.3.	13.1	+4.8
Highest quintile							
Underweight in children <5 (weight/age):		49.6			44.4	36.4	-8.0 percentage points *Substantial* progress, improved equity
		52.4			47.3	38.3	-9.0
Rural		35.3			27.3	22.8	-4.5
Urban		n/a			48.0	40.7	-7.3
Lowest quintile		n/a			30.2	25.7	-4.5
Highest quintile							
Under five treatment of malnutrition							ICR shows increase from 27% in 2005 to 121% in 2010 but neither the indicator nor the data are clear

B.2 Multi-Sector Demographic Project Assessment of Efficacy

Total Fertility Rate: Median number of children born to a woman by the time she reaches menopause			
	2006	**2012**	**Comments**
	7.1	7.6	TFR remained stable between 1992 and 1998 (at 7.4 and 7.5 respectively), then decreased to 7.1 in 2006. However, it actually increased during the project period slightly exceeding rates of 25 years ago.
Rural	7.4	8.1	10% increase 2006/2012
Urban	6.0	5.6	6.7% decrease 2006/2012
Lowest Quintile	8.0	8.2	2.5% increase 2006/2012
Highest Quintile	6.2	6.1	1.6% decrease
Age at first birth reported by women by age group			
20-24	17	18.1	Only a 6.5% change
25-29	18	18.1	No significant change at first birth for these different cohorts.
30-34	18.1	18.3	
35-39	18.1	18.9	
40-44	18.0	19.3	
45-49	19.4	19.4	
Percentage adolescent females already procreating (have had a child or was pregnant at time of survey)			
All Niger	39.3	40.4	Shows rise in fertility during life of PRODEM Only Urban category shows a 3.1 point drop in percentage.
Rural	45.4	47.1	
Urban	20.3	17.2	
Lowest Quintile	39.1	49.2	
Highest Quintile	24.1	24.3	
Knowledge of Contraceptive Methods by Men in Union			
Any method	93.5	91.6	This shows a consistently high level of knowledge throughout the project period, albeit with a slight decline from the baseline.
Knowledge of Contraceptive Methods by women in Union			
Any method	72.2	90.7	Data show that the problem is not lack of knowledge on contraception for women in union but no desire to adopt CP.
Any modern method	68.3	89.3	
Percent of women in union currently using modern contraceptives			
All Niger	5.0	8.3	Rates increased modestly, and inequitably, with greater gains among most privileged groups. * Both sets of data are presented in this table net of breastfeeding as a contraceptive method (Breastfeeding is reported separately from modern methods in 2006 DHS, but included among modern methods in 2012 DHS).
Rural	2.7	5.8	
Urban	18.2	23.2	
Lowest Quintile	2.3	2.4	
Highest Quintile	15.8	20.5	
Women Not using contraceptives by reason of non-use			
Opposition to use	n/a	32.2	About one in five women report non-use because of lack of knowledge. One in three report non-use of contraception due to their opposition to their use.
Lack of knowledge	n/a	18.6	
Percent women 15-49 not exposed to any media for family planning message by radio, TV or newspaper			
All Niger	63.6	53.1	Exposure improved by about 10 percentage points during the project period. Still, more than one half of all Nigeriens report no exposure to family planning messages through the media. Inequities between lowest and highest income quintiles worsened, with no change for lowest quintile and significant improvement for highest quintile.
Rural	69.6	58.7	
Urban	39.2	28.9	
Lowest Quintile	61.4	61.1	
Highest Quintile	41.6	27.5	
Proportion of women reporting first union before reaching age of 15 years by age group			
15-19	28.9	23.7	A decline of five percentage points among the 15-19 year age group reveals improvement.
20-24	16.1	28.0	

25-29	34.7	29..9	
30-34	40.3	29.6	
35-39	38.1	28.6	
40-44	42.9	31.4	
45-49	33.4	33.6	
Median age at first Union for women 25-49 years old			
All Niger	15.5	15.7	No significant change, overall. Improvements mostly accrued among the more privileged groups (urban and highest income).
Rural	15.4	15.6	
Urban	16.7	17.9	
Lowest Quintile	15.4	15.5	
Highest Quintile	16.3	17.4	
Fertility preference: share of all women who do not want more children			
All Niger		8.7	
Percent of women in union who do not want more children			
All Niger		8.9	These figures reflect persistent high demand for children. Even among the highest Quintile only 14.2 % do not want more children.
Rural		7.7	
Urban		15.8	
Lowest Quintile		7.6	
Highest Quintile		14.2	
Percent of women with unmet demand for family planning			
All Niger	14.0	16.0	Unmet demand for family planning increased slightly, overall. Inequities are evident in the declining unmet demand among urban and highest income quintile groups, while unmet demand actually increased for rural and lowest income groups.
Rural women in union	14.4	15.8	
Urban women in union	23.7	17.7	
Lowest Quintile	15.7	17.7	
Highest	20.6	15.7	
Attitudes to family size –Ideal number of children desired by women un union aged 15-49 years old			
Women 15-49	8.8	9.2	Total desired family size is on the rise for all even among higher income people.
Women in union 15-49	9.1	9.5	
Rural	9.2	9.6	
Urban	7.1	7.4	
Lowest Quintile	9.4	9.7	
Highest Quintile	7.4	7.9	
Desired family size (a function of current number of children)			
All Niger (Actual)	6.9	7.6	Desired family size as expressed by women increased by 0.7 children, all of this increase attributable to rural women. It actually declined for rural women.
Rural	7.2	7.9	
Urban	5.6	5.4	
Lowest Quintile	7.8	7.9	
Highest Quintile	5.9	5.9	
Median duration (in months) of exclusive breastfeeding			
All Niger	0.5	0.5	There has been very little change in the very short duration of exclusive breastfeeding, falling far short of the recommendation of practicing exclusive breastfeeding for all infants up to 6 months of age. Exclusive breastfeeding is not promoted by health facility professionals.
Rural	0.5	0.5	
Urban	0.4	0.5	
Lowest Quintile	0.5	0.6	
Highest Quintile	0.4	0.6	

Comment: Because of issues with M&E (discussed in the report), this Annex drew on relevant trends in the Demographic and Health Surveys for 2006 and 2012, which shed light on the efficacy with which the PDO was achieved. Specifically it assesses trends on indicators of knowledge and attitudes (a direct link with the PDO sub-objective to raise general awareness of population and reproductive health issues) and of actual changes in behaviors (linked with the objective of improving Niger's capacity to effectively address demographic issues, and with the outcome indicators of the Project). Other project outcome indicators (e.g., AWP production, approval…) are also addressed, in the efficacy section.

Appendix C. List of Persons Interviewed

1.	Ousmane Diagana	WB/VP (former Country Director)
2.	Trina Haque	Practice Manager
3.	Djibrilla Karamoko	Task Team Leader
4.	Paul Noumba Um	Country Director Niger
5.	Siaka Bakayoko	Country Manager Niger
6.	Sadia Afroze Chowdhury	Senior Health Specialist
7.	Ernest E. Massiah	Practice Manager
8.	Ibrahim Magazi	Senior Health Specialist
9.	Dr. Maina Boucar	Independent Consultant
10.	Issa Abdou Razaou	Demographer
11.	Peter Bachrach	Consultant
12.	Jenny R. Gold	Senior Health Specialist
13.	Jean Pierre Guengant	Consultant

Appendix D. Borrower Comments

REPUBLIQUE DU NIGER
Fraternité-Travail-Progrès

MINISTERE DE LA SANTE PUBLIQUE
SECRÉTARIAT GENERAL

Niamey, le 23 JUIN 2016

N°-0214/MSP/SG

Le Ministre

à

Monsieur le Ministre des Finances
Niamey

Objet : Rapport d'Evaluation Rétrospective du Projet de Renforcement Institutionnel et d'Appui au Secteur de la Santé et du Projet Démographique Multisectoriel

J'ai l'honneur de vous demander de bien vouloir transmettre aux Autorités de la Banque mondiale les commentaires ci-joints sur le rapport d'évaluation rétrospective du Projet de Renforcement Institutionnel et d'Appui au Secteur de la Santé et du Projet Démographique Multisectoriel.

P.J : Commentaires

REPUBLIQUE DU NIGER
LE MINISTRE
MINISTERE DE LA SANTE PUBLIQUE

KALLA MOUTARI

Ampliations :

SG
Chrono
BM

COMMENTAIRES SUR LE RAPPORT D'EVALUATION DES RESULTATS DU PROJET DE RENFORCEMENT INSTITUTIONNEL ET D'APPUI AU SECTEUR SANTE (PRIASS)

« Les résultats des projets sont jugés moyennement satisfaisants »

Cette appréciation ne nous semble pas être fondée pour les raisons suivantes :

Nous avions eu trois (3) évaluations dont deux ont jugé les résultats satisfaisants et une (1) très satisfaisants. IL s'agit des évaluations faites par le Gouvernement (à travers un consultant indépendant) ; ensuite celle de l'évaluateur indépendant recruté par la Banque mondiale (pour le rapport d'achèvement du projet) et enfin l'Agence Française de Développement (AFD) dont voici quelques extraits :

- 1) « Le degré de la pertinence des objectifs, par rapport à la conformité du projet aux politiques et stratégies de santé au Niger et aux priorités techniques retenues par la Banque Mondiale en matière d'orientation des aides en général et d'appui au secteur de la santé en particulier, **la mission estime que la pertinence des objectifs du PRIASS serait probablement Haute (« High »)**. »(**Rapport de l'évaluateur Indépendant Peter Bachrach)** contrairement au présent rapport qui stipule que « **le degré de pertinence de la conception est modeste ».**

- **2) Quant aux évaluateurs de l'AFD dont deux projets** ayant appuyé la mise en œuvre du Plan de développement Sanitaire (PDS) à travers le Fonds Commun (FC) de 2006-2010 et 2011- 2014 avec une première subvention qui couvre la même période d'intervention du PRIASS, ils ont mentionné dans leur Rapport, que « la performance des deux projets évalués est sur le plan de : :
  - **La pertinence et la cohérence des contributions au FC Sante sont très satisfaisantes (A) ;**
  - **L'efficacité (interne et externe) des contributions au FCS est désormais satisfaisante (B) ;**
  - **L'efficience des contributions au FCS est satisfaisante (B) :**
  - **La viabilité des contributions au FCS est très satisfaisante (A) :**
  - **Les contributions de l'AFD au FCS ont eu une valeur ajoutée très satisfaisante (A). »**

- 3) **« Tous les vingt-quatre (24) indicateurs du PRIASS (cf. annexe 2) ont connu une évolution dont quinze (15) ont dépassé la cible fixée soit 63% ; Les autres indicateurs ont tous dépassé 50% de l'objectif fixé.**

Toutes les réalisations faites ont contribué à faire baisser de manière sensible les indicateurs de mortalité suivants:

- ❑ le taux de mortalité infanto juvénile passe de 265 pour mille en 2005 à 130,5 pour mille en 2010 (pour un objectif attendu de 205 pour mille) ;

- le taux de mortalité infantile qui passe de 156 pour mille en 2005 à 65,5 pour mille en 2010 (pour un objectif attendu de 131 pour mille) ;
- le taux de mortalité maternelle intra hospitalière qui passe de 53,2% en 2005 à 0,2% en 2010 (pour un objectif attendu de <1%) ;
- le taux de mortalité périnatale intra hospitalière qui passe de 0,6% en 2005 à 0,9% en 2010 (pour un objectif attendu de 4%).

La contribution du Fonds Commun, associée à celle des autres Partenaires Techniques et Financiers du secteur de la santé qui ne sont pas dans le fonds commun, a permis d'améliorer sensiblement les indicateurs clés du secteur.

En effet, le niveau atteint par ces indicateurs, reflètent les performances enregistrées au cours de la période 2006 – 2010, dont l'appui du fonds a impulsé une nouvelle dynamique des bailleurs des fonds du secteur de la santé.

- Cette performance a attiré d'autres bailleurs de fonds qui commencent à s'intéresser au financement du secteur de la santé dans le cadre du fonds commun qui à l'origine était l'initiative de la Banque Mondiale et de l'Agence Française de Développement ;

- Le projet a atteint ses objectifs de façon satisfaisante. Car grâce à l'intervention de l'IDA et des autres bailleurs du secteur de la santé, beaucoup d'indicateurs de performance ont dépassé les 100% de juillet 2006 à décembre 2010 ;

- l'amélioration remarquable du processus d'élaboration et approbation des PAA par les structures concernées a été observée d'une année à l'autre ;

- L'amélioration de la maîtrise des outils de gestion du fonds par l'ensemble des intervenants a permis de rationnaliser l'utilisation des ressources à tous les niveaux ;

- L'information financière et comptable produite par les services financiers et comptable dans le cadre de la mise en œuvre du FC/PDS est sincère et fiable ; ***(CF : les rapports d'audit financiers annuels) ;***

- Les états financiers ont été préparés suivant les procédures administratives, financières et comptables du FC et améliorés pour répondre aux exigences des partenaires financiers; ***(CF : les rapports d'audit financiers annuels) ;***

La Banque mondiale a facilité le dialogue entre le Gouvernement et les autres Partenaires Techniques et Financiers du secteur en général et en particulier a joué un rôle primordial dans les résultats obtenus à travers le financement du Fonds Commun ;

Elle a aussi joué le rôle de chef de file des PTF du FC en matière de passation de marchés publics et de gestion financière avec ses conseils, ses appuis pour le

renforcement de capacités des acteurs dans les domaines fiduciaires. Capacité qui existe actuellement et qui continue à être utiliser pour la mise en œuvre du programme sectoriel malgré le retrait de la Banque mondiale en 2011 (à la clôture du projet).

L'IDA a contribué au financement des 8 programmes des activités du PDS à hauteur des 60% et à 100% le volet paludisme soit un financement de 3 768 843 681 francs FCFA de Juillet 2006 et juin 2011. L'impact significatif de cette contribution a fait évoluer de façon sensible les indicateurs de lutte contre le paludisme ». **(Rapport élaboré par la partie gouvernementale)**.

Ces quelques extraits illustrent bien l'atteinte des résultats du PRIASS. Ce qui a d'ailleurs à conduit d'autres Partenaires Techniques et Financiers à intégrer le Fonds Commun. C'est le cas de l'Agence Espagnole de Coopération Internationale au Développement (AECID) et GAVI Alliance en 2011, l'UNICEF en 2012, l'UNFPA en 2014.

Le PRIASS est donc un exemple de projet réussi et ayant reçu tout le long de son exécution l'accompagnement des autorités politiques, administratives et de la Banque mondiale à travers l'appui technique de qualité et des supervisions régulières.

Nous invitons l'équipe d'évaluation rétrospective à effectuer le déplacement au Niger pour une meilleure appréciation des résultats du PRIASS et surtout tirer les leçons qui peuvent servir d'exemple aux programmes à venir.

Une revue documentaire à distance et aussi sans interviews préalables des principaux acteurs qui ont mis en œuvre le projet, ou qui ont bénéficié du projet, ou qui ont évolué dans l'environnement du projet, ne peut servir à notre avis d'évaluation rétrospective complète permettant de tirer les leçons et surtout l'impact de la réalisation cinq (5) ans après.

Nous n'avons pas trouvé dans le rapport de nouvelles recommandations ou leçons apprises formulées par l'évaluateur. Nouvelles leçons qui nous permettront d'orienter la mise en œuvre du programme sectoriel en cours de finalisation par le gouvernement (Plan de Développement Sanitaire 2016-2020).