AFRICAN DEVELOPMENT FUND

REPUBLIC OF NIGER

LOCAL HEALTH CARE SECTOR IMPROVEMENT PROJECT IN THE DEPARTMENTS OF MARADI AND DIFFA

LOAN No. F/NIG/REN-SAN/93/17
(2100150000760)

COMPLETION REPORT

HUMAN DEVELOPMENT DEPARTMENT | **OSHD**
January 2008

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CURRENCY EQUIVALENTS

Currency unit	=	CFA Franc (CFAF)
1 UA	=	CFA 399.675 at appraisal (June 1993)
1 UA	=	776.528 at completion report preparation (October 2004)

WEIGHTS AND MEASURES

Metric System

FISCAL YEAR

01 January – 31 December

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ACRONYMS AND ABBREVIATIONS

ADB	African Development Bank
ADF	African Development Fund
BD	Bidding Documents
DH	District Hospital
DHC	Departmental Hospital Centre
DHMT	District Health Management Team
DWS	Drinking Water Supply
EGD	Essential Generic Drugs
EPI	Expanded Programme on Immunization
HCRD	High Capacity Rural Dispensary
HDP	Health Development Plan
IHC	Integrated Health Centre
IMCI	Integrated Management of Childhood Illnesses
MAP/IDA	Multi-sectoral AIDS Programme/International Development Association
MC	Medical Centre
MCH	Maternal and Child Health
MCHC/FP	Mother and Child Health Care/Family Planning
MFE	Ministry of Finance and the Economy
MPH/EDC	Ministry of Public Health and Endemic Diseases Control
NHIS	National Health Information System
PIU	Project Implementation Unit
RD	Rural Dispensary
RDPH	Regional Directorate of Public Health
REW	Roads and External Works
SSB	Single Side Band
UA	Unit of Account

EXECUTIVE SUMMARY

1. The Local Health Care Sector Improvement Project in the Departments of Maradi and Diffa is the second Bank project in the health sector in Niger. The overall objective of the project was to improve the geographical and operational healthcare coverage in the Departments of Maradi and Diffa.

2. The loan became effective on 16 August 1995, i.e. 20 months after its approval. Implementation only really started in April 1997and continued until June 2004, i.e. 6 years after the estimated completion date. The amount disbursed from the ADF loan, as at October 2004, was UA 9,169,138.91, i.e. a disbursement rate of 99.34% with an undrawn balance of balance of UA 60 861.09. The Government's final contribution to the project financing, initially estimated at UA 1, 020, 000.00, amounts to UA 1, 682, 202.96, including UA 283, 507.02 not yet disbursed, at the time of the completion mission.

3. The objective of improving health facility coverage and strengthening the local healthcare sector has been partly achieved through the construction and rehabilitation of 20 integrated health centres (IHC), 6 Departmental Hospitals (DH), as well as their equipment with furniture and medicines. This has helped increase health coverage in the project areas. 45% of the population living within a 5 km radius of the IHC have benefited from these facilities. Furthermore, access to drinking water through the establishment of 19 water points and the training of local staff have improved living conditions and the quality of health care.

4. Nevertheless, some of the facilities visited were of average quality and lacked maintenance. In addition, the use of the related services by the population was not effective owing to (i) inadequate staffing and (ii) equipment delivered but not installed at the time of the completion mission. All these factors combined could lead to a rapid deterioration of the facilities and equipment.

5. Moreover, project implementation was affected by (i) the political and economic difficulties of the country; (ii) delays in releasing the tranches of the Government contribution; iii) lack of familiarization with Bank rules of procedure, especially the no-objection procedures for bids; iv) poor performance of the building contractors; and v) red tape – factors that accounted for the extension of the implementation period.

6. In view of the problems that characterized the project, the following measures are recommended to ensure the development and sustainability of the infrastructure and equipment and to improve the design and implementation of future operations.

6.1 To ensure project sustainability, it is recommended to

A The Bank to:

(i) see to it that, during future health sector missions to Niger, the Government has honoured its undertakings and taken the necessary steps to ensure that the infrastructure created under the project is operational (finishings, commissioning of the biomedical equipment, assignment of staff);

B The Government to:

(ii) make arrangements to assign the necessary personnel to the health facilities established under the project;

(iii) strengthen the measures taken to ensure sustainability of the outputs, in keeping with the new Health Development Plan for 2005-2009;

(iv) put in place a stock accounting system, i.e. undertake an identification (codification) of all the materials (furniture, equipment, etc.) provided;

(v) provide regular training of the health staff in equipment and infrastructure upkeep and maintenance and, if necessary, include the communities by involving them more in the maintenance of solar panels and water points; and

(vi) Sensitize the population on the proper utilization and maintenance of the infrastructure and equipment put at their disposal.

6.2 For future operations, the Bank shall:

(vii) Construct infrastructure only in the areas where electrification, water supply and access facilities already exist. Otherwise, envisage integrating these activities into the project;

(viii) For infrastructure-intensive projects, thoroughly study the geographical spread of the sites and their breakdown into lots. Consider the skills of the local enterprises and envisage international competitive bidding to ensure the quality of the works;

(ix) Ensure that the part of the project activities to be financed by the Government counterpart funds does not constitute a major obstacle to its completion; and

(x) Ensure the prompt processing of the various requests and correspondence relating to project implementation, submitted by Governments.

BASIC PROJECT DATA

1.	Loan number	:	2100150000760 (F/NIG/REN-SAN/93/17)
2.	Borrower	:	Government of Niger
3.	Beneficiary	:	Ministry of Public Health and Endemic Diseases Control (MPH/EDC)
4.	Executing Agency	:	Project Implementation Unit (MPH/EDC)

A. <u>LOAN</u>

	Estimate at appraisal	Actual
ADF:		
1.	UA 9.23 million	UA 9.17 million
2.	Repayment of the principal at the rate of % per annum from the 11th to the 20th year and 3% per annum thereafter.	
3.	Repayment period	40 years
4.	Grace period	10 years
5.	Negotiation date	Last quarter 1993

6.	Approval date	14 December 1993
7.	Signing date	15 December 1993
8.	Effectiveness date	16 August 1995

Government:

UA 1.02 million — UA 1.57 million

B. PROJECT INFORMATION SHEET

		Estimated Cost			Actual Cost		
		F.E.	L.C.	Total	F.E.	L.C.	Total
1.	Total cost (million UA)	8.30	1.95	10.25	6.57	4.28	10.85

2. Financing Plan (million UA)

ADF	9.23
Government	1.02
TOTAL	**10.25**

3.	Estimated first disbursement date	:	16/08/1995
4.	Effective first disbursement date	:	16/04/1997
5.	Estimated last disbursement deadline	:	31/12/1998
5	Revised last disbursement deadline	:	30/06/2004
7.	Start-up of project activities	:	April 1997
8.	Completion date of project activities	:	30/06/2004

C. PERFORMANCE INDICATORS

1.	Total disbursed	:	UA 9/17 million
	Unutilized balance	:	UA 0.06 million
2.	Time overrun/underrun		
▪	Slippage on effectiveness	:	20 months
▪	Slippage on completion date	:	72 months
▪	Slippage on last disbursement	:	66 months
▪	Number of extensions of the last disbursement deadline	:	3
3.	Project implementation status	:	completed (99%)

4. Verifiable indicators in relation to the allocation of expenditure categories:

A. Studies/supervision	:	100% implemented
B. Construction	:	99% implemented
C. Water works	:	99.5% implemented
D. Equipment/Furniture	:	99% delivered
E. Essential drugs	:	100% delivered
F. Technical assistance	:	100% implemented
G. Operation	:	100% implemented

5. Institutional Performance (Unsatisfactory/Average/Satisfactory/Highly Satisfactory)

Bank Group	:	Average
Government	:	Unsatisfactory

6. Performance of the Building Contractors : Unsatisfactory
Performance of the Consultants : Average

D. MISSIONS

Mission	No. of persons	Composition	Date
Identification	NA	NA	July 1988
Preparation	NA	WHO	November 1989
Appraisal	NA	ADB	17/02-03/03/1990
Re-appraisal	2	NARD.2/ NCPR.2	30/06 – 11/07/1993
Launching	NA	NA	August 1995
Supervision	NA	OCCW5	15-21/07/1997
	NA	OCCW5	20 /11-5/12/1998
	NA	OCCW5	01-16/07/1999
	NA	OCCW5	10-24/10/2000
	NA	OCCW5	23/06 - 15/07/2001
	NA	OCCW5	15-31/03/2002
	NA	OCCW5	06-27/12/2002
	1	OCSD.2	06-20/06/2003
	2	OCSD.2	16/11-02/12/2003
	1	OCSD.2	16/02-08/03/2004
	2	OCSD.2	16-24/07/2004
Internal audit	NA	AUDT	February 2001
Internal audit	NA	AUDT	April 2004
Completion	2	OCSD.2	11-22/10/2004

E. DISBURSEMENTS (In million UA)

ADF: Amount approved : UA 9.23 million
Undisbursed balance : UA 60, 861.09

Year	Estimate at appraisal	Actual	Percentage disbursed
1994	3.19		00.00
1995	3.95		00.00
1996	1.49		00.00
1997	1.62	1.05	11.37
1998		1.22	13.21
1999		0.76	08.23
2001		1.02	11.05
2002		1.67	18.09
2003		1.83	19.82
2004		1.63	17.66
Total		9.17	99.34

Loan amount disbursed : UA 9.17 million
Undisbursed balance : UA 0.06 million

RETROSPECTIVE PROJECT MATRIX

HIERARCHY OF OBJECTIVES	GOAL AT APPRAISAL	RESULTS AT PROJECT COMPLETION	SOURCES UTILISED
A. SECTOR GOAL Improve the overall health status of the population	1.1 Significant reduction in mother and child mortality rate in the target area at the end of the project	1.1.1 Absence of basic indicators in the appraisal report; unavailability of the rate at the end of the project for the targeted regions.	
B. PROJECT OBJECTIVES 1. Strengthen health infrastructure in the Departments of Maradi and Diffa.	1.1 Increase attendance in the renewed health centres.	1.1.1 Absence of basic indicators in the appraisal report and unavailability of indicators at the end of the project for the targeted regions.	
	1.2 Thanks to IHC constructed, increase in health coverage within 0-5 km radius to 45% at the end of the project. .	1.2 .1 In 2004, health coverage within 0-5 km radius is 44.6% in Maradi and 42.4% in Diffa.	
	1.3 19 drinking water points made available to those living around the health facilities constructed under the project.	1.3.1 At the end of the project, 15 boreholes equipped with hand pumps and 2 mini DWS were put at the disposal of the population.	
2. Improve the efficiency and efficacy of the staff working in the health facilities of the local healthcare sector. .	2.1 Provide all the routine activities through the presence of 2 nurses for type 1 IHC; 2 nurses, 1 midwife and 1 lab assistant for type 2 IHC	2.1.1 Only one nurse was assigned to IHC instead of the two initially projected. All the type 2 IHC does not have midwives and lab assistants. They are being recruited by MPH.	
	2.2 Ensure the functioning of DH through the presence of one doctor and the entire technical staff.	2.2.1 Specialists are recruited through the South-South cooperation and United Nations volunteers. Recruitment of the technical staff is under way.	
3. Develop the programming, supervision, evaluation and training capacities of the Departmental Health Directorate of Maradi.	3.1 Presence of one DHMT (District Health Management Team) in each DH: 2 doctors, one administrator, one epidemiologist, one communicator.	3.1.1 Two doctors have been assigned per district. .	
C. OUTPUTS 1. Health infrastructure rehabilitated, renewed, built and equipped.	1.1 20 health centres built and/ or rehabilitated and equipped by 2004.	1.1.1 15 type I IHC and 5 type 2 IHC constructed.	1.1.1.1 Mission visited the facilities
	1.2 6 technical support centres in 6 DH, 1 DH laboratory and 1 biomedical workshop built and equipped.	1.2.1 6 DH with annexes constructed.	12.1.1 Idem
	1.3 Health facilities of 2 departments supplied with essential drugs.	1.3.1 Drugs supplied	1.3.1.1 Idem
	1.4 Boreholes in 19 health centres.	1.4.1 15 boreholes and 2 mini DWS constructed	1.4.1.1 Idem
2. Well-designed training and seminar programme.	2.1 Several middle-level and senior management staff will be trained through seminars.	2.1.1 201 staff trained	2.1.1.1 PIU and MPH/DHMT
3. Civil works will conform to existing standards.	3.1 Local enterprises selected.	3.1.1 Works executed by local enterprises.	3.1.1.1 Contracts signed
D. <u>Activities (by components)</u> **<u>Resources</u>** 1. Designation of the PIU/Office 2. Recruitment of technical assistance. 3. Identification of the training institutes 4. Launching and evaluation of bids for civil works. 5. Project implementation according to the schedule.	Planned implementation period: January 1994 to December 1998 ADF 9.23 Government 1.02 TOTAL 10,25 Project components: 1. Improvement of the local healthcare sector in the Department of Maradi. 2. Improvement of the local healthcare sector in the Department of Diffa. 3. Project Implementation Office	Implementation and management of all the activities.	PIU and MPH/DHMT Status reports Contracts entered in SAP and disbursements made.

1. INTRODUCTION

1.1 In the late 80s, in keeping with the objective of Health For All (HFA), Niger decided to expand its health coverage by the year 2000 to 60% of the population living within 5 km of a health facility. The Government therefore opted for (i) the opening of new health facilities in the landlocked and/or needy regions, (ii) the reconstruction and rehabilitation of the old health facilities. To that end, it prepared a local healthcare sector infrastructure development project and submitted a financing request to the African Development Bank.

1.2 Bank Group operations in Niger started in 1970 with a communications project. In the social sector, between 1975 and 1982, the Bank contributed to the construction of the School of Health Sciences (Ecole des Sciences de Santé) in Niamey (UA 10.10 million), which later became the Faculty of Medicine. It has been operational since 1987. The ADF Health Project I, 'Local Healthcare Sector Improvement in the Departments of Maradi and Diffa' was approved in December 1993. It corresponded to a second ADB health sector project in Niger (see map of the project intervention areas in annex 1). A third health project approved in 2001 is ongoing. It focuses on the improvement of healthcare quality in the regions of Tahoua and Tillabery.

1.3 Other development partners intervene in the health sector. The World Bank has supported, among others, the implementation of the 1994-2004 Health Development Plan and the rehabilitation/extension of the Diffa RHC. With its Health Project II, the World Bank participated in the financing of the local manufacture of pharmaceuticals. Its Health Project III supports the decentralized management of the health system and access to health care for the underprivileged. A specific HIV/AIDS (MAP/IDA) control programme for 2003-2006 has been set up. Many bilateral partners: (French Cooperation Agency, Belgium, Canada, Germany, Japan and Libya, etc), as well as the European Union and numerous NGOs, are involved in financing the development of the health system in Niger. The intervention areas are varied and include the supply of drugs, maternal health, malaria control, HIV/AIDS, cost recovery, immunization, family planning, etc.

1.4 The implementation of the ADF Health Project I experienced a delay of 6 years owing to the political and economic constraints that led to Niger coming under sanction with the suspension of ADB disbursements. Moreover, delays attributable to the PIO, such as: (i) the choice of audit firms, (ii) lack of familiarity with bidding procedures, (iii) team changes, and (iv) poor coordination in the planning of activities, delayed and hampered the smooth implementation of the project. As a result, project activities only started effectively in April 1997. During the implementation, three extensions of the last disbursement deadline were necessary.

1.5 The present completion report of the 'Local Healthcare Sector Improvement Project in the Departments of Maradi and Diffa' was based on the results of the Bank mission to Niger in October 2004. It was prepared on the basis of the data available at the archives of the Project Implementation Office (PIO) in Niamey and Bank documents on the project. Information was also gathered in Niger, during the working sessions with (i) members of the PIO, (ii) members of the technical committee in charge of preparing the project completion report for the Government, and (iii) the regional authorities of the Ministry of Public Health and Endemic Diseases Control in the Departments of Maradi and Diffa. Site visits (integrated health centres and district hospitals) also made it possible to meet with the beneficiaries and

find out their impressions of the project. The data collected was updated during the supervision missions of the Health Project II in Niger in December 2005 and April 2006. The list of documents utilized for preparing this report is attached as Annex 2.

2. PROJECT OBJECTIVES AND FORMULATION

2.1 Project Objectives and Components

2.1.1 The sector goal as defined in 1993, in the project matrix, was to improve the overall health status of the population, specifically that of mothers in the Departments of Maradi and Diffa. The overall project objective was to improve the geographical and operational healthcare coverage in the Departments of Maradi and Diffa. More specifically, it sought to: (i) strengthen health infrastructure in the Departments of Maradi and Diffa; (ii) enhance the efficiency and efficacy of staff working in the health facilities of the local healthcare sector and (iii) develop programming, supervision, evaluation and training capacities of the Maradi Departmental Directorate of Health.

2.1.2 The project had the following components: (i) improvement of the local healthcare sector in the Department of Maradi; (ii) improvement of the local healthcare sector in the Department of Diffa and (iii) the Project Implementation Unit. The retrospective project matrix (page vii) gives the quantified objectives and the main project outputs, as revised during its implementation.

2.2 Project Description

2.2.1 To improve the overall health status of the population of the Departments of Maradi and Diffa, the priority needs identified at appraisal focused on:

- quantitative and qualitative improvement of the health coverage;
- strengthening of the management process at the various levels of the health system; and
- preparation and establishment of healthcare cost recovery procedures.

2.2.2 The necessary measures to satisfy these needs were planned over 4 years and comprised:

For component I: Improvement of Local Healthcare Delivery in the Department of Maradi:

a – The conduct of studies and preparation of bidding documents (BD) for the works;

b – For the health infrastructure:

- The construction of 15 rural dispensaries (RD) and 2 high capacity rural dispensaries (HCRD);
- The construction of 5 surgical units, 5 analytical laboratories and 5 X-ray units in the 5 district headquarters of Maradi;
- The extension of the departmental health directorate of Maradi;
- The construction of one MCHC/FP (Maternal and Child Health Care/Family Planning) centre and the extension of Tessaoua maternity;

c – The establishment of 17 water points;

d – The supply of equipment and furniture for the health facilities built and/or rehabilitated, the supply of communication and lighting equipment, as well as vehicle supply;

e – The gradual supply of essential drugs to all the health facilities of the Department, starting with the 17 Programme facilities;

f – The training abroad of national staff, the financing of seminars and local training;

For component II: Improvement of local healthcare in the department of Diffa. As in the department of Maradi the project was to:

a – Conduct studies and prepare BD;
b – Construct one RD and one HCRD;
c – Establish 2 water points;
d – Provide the health institutions with equipment and furniture;
e – Provide the essential drugs;
f – Train national staff;
g – Strengthen the supervision services.

For component III: Project Implementation Unit (PIU). A PIU was established at the Ministry of Health in Niamey with an office in Maradi. It was provided with the necessary resources for its operation (premises, equipment, furniture, supplies and operating expenses). The PIU and its Maradi office were also strengthened with technical assistance in order to ensure rapid and smooth implementation for the project.

2.3 Project Origin and Formulation

2.3.1 The purpose of the financing request addressed to ADF in 1988 by the Niger Government was to speed up access of the population to primary healthcare in the health districts. Health coverage in Niger corresponds to the ratio of the population within a radius of 5km to the total population served by one IHC. The aim was to expand health coverage to 45% and specifically in the departments of Maradi and Diffa. To date, the department of Mardi is still the most densely populated region in the country (20% of the population). In 1993, with an average density of 36 inhabitants/km^2 health coverage was around 10%, i.e. 1 health facility for 24,358 inhabitants. The department of Diffa, which covers 11% of the territory, had in 1993 a population density of 1.4 inhabitants/km^2 and health coverage of 30%, representing 1 health facility for 12,367 inhabitants. Nonetheless, in view of the low population density in this region and the area of the Department (140.000 km^2) these figures reflect a less favourable reality. The project identified was, therefore, in keeping with the objectives of the Niger Government.

2.4 Identification, Preparation and Appraisal

2.4.1 In response to the request of the Niger Government, ADB fielded an identification mission in July 1988. In November 1989, WHO carried out a 6-week preparation mission, the findings of which were used as a basis for the Bank appraisal mission in February 1990. The economic and political problems in Niger led the Bank to carry out a re-appraisal mission in June 1993.

2.5 Negotiation and Approval

2.5.1 The negotiations took place at the Bank headquarters in Abidjan during the last quarter of 1993 and the Niger party accepted all the terms and conditions of the loan agreement. Following these negotiations, the project was submitted to the Board of Directors of the Bank, which approved it at its meeting of 14 December 1993. The loan agreement was signed on 15 December 1993.

3. PROJECT IMPLEMENTATION

3.1 Effectiveness and Start-up

The loan agreement only became effective on 16 August 1995, i.e. 20 months after its approval, because the Government was late in fulfilling the 5 conditions precedent. The Borrower fulfilled the other 6 conditions (listed below) with the exception of the one relating to the assignment of the necessary staff to the health facilities, as and when the conditions were fulfilled and prior to project completion.

Conditions precedent to first disbursement:

i. Evidence of the establishment of a project implementation unit (PIU) at the Ministry of Health and a branch office at the Departmental Health Directorate of Maradi;
ii. Evidence that the PIU in Niamey has been provided with suitable premises;
iii. Evidence of the appointment of a National PIU Manager, a public health doctor and a water engineer, head of the Maradi office, whose curriculum vitae will have been approved beforehand by the Fund;
iv. Evidence of the assignment to PIU of the national professional staff comprising: one (1) accountant; two (2) senior construction technicians; two (2) senior nursing technicians; and
v. An undertaking to adopt and apply a health personnel redeployment programme for the regions concerned by the project.

Other conditions:

vi. Provide the project with the national support staff needed for the project implementation;
vii. Submit to the Fund for approval, 12 months after identification of the personnel concerned within the Ministry of Public Health and Endemic Diseases Control (MPH/EDC), a training programme with the names, qualifications, positions and experience of the proposed candidates, as well as the training locations for the staff concerned within the MPH/EDC;
viii. As soon as possible submit to the Fund for approval, the undertakings signed by the candidates selected for long-term training, to serve in the MPH/EDC for at least five (5) years after their training;
ix. Submit to the Fund for approval, a comprehensive work plan for the PIU and its Maradi office, six (6) months after the appointment of the PIU Manager;

x. Submit to the Fund for approval 12 months after effectiveness of the loan agreement, a comprehensive staff redeployment programme for the health facilities to be rehabilitated; and

xi. In keeping with the redeployment, assign the necessary staff to the health facilities, as they are completed and prior to project completion.

3.2 Modifications

3.2.1 The designations of the health facilities were changed; thus the rural dispensaries (RD) were changed to Type 1 Integrated Health Centres (IHC), the High Capacity Rural Dispensaries (HCRD) to Type 2 IHC and, the medical centres (MC) to District Hospitals (DH).

3.2.2 Changes were made in the programming of the activities to be implemented under the project, following the new Health Development Plan adopted by the Niger Government in 1994 (1994-2000 HDP). These changes concerned rehabilitation and construction work and training in project components 1 and 2. They are summarized in Annexes 4.1 and 4.2, which compare the activities planned during appraisal and the actual project outputs.

3.2.3 With regard to the construction and rehabilitation work, owing to the delay in implementing the project, certain structures envisaged under the project were financed or implemented by other donors, or even by private individuals. As a result, new buildings were put up on sites not identified in the appraisal report. These supplementary outputs helped: (i) increase health coverage in the target region; (ii) improve staff working conditions and (iii) facilitated care of patients and their families. Unfortunately, the expected benefits have not yet been realized, especially in the case of the DH, as there is a shortage of medical and paramedical staff and the equipment procured is not operational due to a lack of electrical installation capacity.

3.2.4 Overall, the changes to the content of the training courses have been beneficial to the participants: they were able to acquire skills relevant to the needs of each Department. Therefore, when the health staff is present, these health facilities operate to the users' satisfaction. On the other hand, the equipment maintenance and management courses, which did not take place (1 person trained out of an estimated 93), had a negative impact considering that the storage of medicines and the maintenance of the equipment provided under the project are poorly managed (see chapter 4.1). The outcome of the community development courses was positive as they have enabled the population to assume ownership of the management of the IHC.

3.2.5 In the case of the DH, the gap between the end of training and the commissioning of the facilities resulted in the redeployment of the trained staff to other regions or facilities. The commissioning of these DH which correspond to the referral level in the health district is thus victim of an additional problem.

3.2.6 With regard to the procurement of goods and services, the planned procedure for the acquisition of medical equipment and laboratory supplies through the UNIPAC, the United Nations Packing and Assembly Centre was modified. In effect, UNIPAC was unable to meet the specifications required by the project. An international competitive bidding procedure was therefore utilized. Likewise, for the water works, the negotiated contract with the Ground Water Authority (OFEDES) was not complied with owing to the financial

difficulties encountered by the Authority. The project had to proceed with national competitive bidding. The local contractors proved competent in the execution of hydraulic works.

3.3 Implementation Schedule

3.3.1 It was planned that the project would be implemented over a 4-year period as from December 1993. The table below shows the differences between the estimated schedule at appraisal and the actual implementation schedule.

Table 3.1
Comparison between the Estimated and Actual Project Implementation Schedules

Activities	Estimated Schedule	Actual Schedule
Loan approval	December 1993	December 1993
Establishment of the PIU/Maradi Office	January 1994	February 1994
PIU premises in Niamey	January 1994	October 1994
Selection of the national staff	January 1994	Dec. 94 / Jan. 95
Recruitment of the consulting firm for the Designs	March 1994	February 1998
Recruitment of PIU technical assistants	December 1993	October 1997
Engineering designs and BD for construction work	Oct.- Dec. 94	February 98/Sept 2002
Implementation of the construction/hydraulic works	June 95/July 96	Sept. 98/ Oct. 04
Bid Analysis, contract award (equip/furniture/supplies)	Jan.- March 96	Dec. 97 / Nov. 2003
Delivery and installation	April 96 / Sept 97	2002 / 2004
Training	Dec.94 / March 96	Sept. 97/Sept. 2004

3.3.2 The estimated implementation schedule was therefore not adhered to. The first disbursement was effected only in August 1995 because of the time it took the Niger party to fulfill the conditions precedent.

3.3.3 The activities scheduled for January 1994 only started in April 1997. Then, the project was again delayed by the suspension of ADB disbursements between August 1999 and February 2001 for non-payment of arrears. Political and economic problems further hampered the satisfactory implementation of the project activities. In November 2001, there was a change in the management of PIU. In spite of the preparation of an emergency plan for the implementation of the remaining activities, 3 extensions (31/12/2001, 31/12/2003 and finally 30/06/2004) were required. The project therefore ended on 30 June 2004 whereas the initial first disbursement date was 31 December 1998.

3.3.4 The principal outcome of all these delays was the disruption of the schedule for the construction/rehabilitation activities of the district hospitals and the delivery of the biomedical equipment. After acceptance, the equipment had to be stored pending its installation. As the storage conditions are still not suitable, they are likely to affect the smooth functioning of the equipment when it is eventually installed in the operational premises. In fact, the electrification work scheduled by the Niger authorities in the district headquarters has not yet been finalized which has serious consequences for the commissioning of the DH built in them.

3.4 Reporting

3.4.1 In total 19 quarterly status reports, in keeping with the ADB format, were prepared and submitted between 1998 and 2004. On the basis of the recommendations and observations made by the various Bank supervision missions, the quality of these reports has improved. The Borrower also prepared and submitted the required completion report to Bank in December 2004. This report gives a general status of the project, but reveals shortcomings in the analysis of its implementation.

3.4.2 Eight (8) audits of the project accounts were performed and submitted to the Bank. The audits of the 1997-2001 accounts was non-conforming. In 2002, the Bank noted the absence of an accounting system which was essential for project management and SAARI/SAGE software was installed but a parametering defect delayed its application. Once corrected, this software helped improve the audits of the subsequent fiscal years. The audits of the project accounts in respect of 2002-2004 have been performed and transmitted to the Bank. However, not all the recommendations of the external auditors were not implemented.

3.5 Procurement of Goods and Services

3.5.1 Unlike the negotiated contracts with UNIPAC and OFEDES, the procurement of goods and services complied with the methods defined in the appraisal report, in particular the breakdown into bid packages in the local and international competitive bidding for the construction works, equipment and drugs.

- Competition on the basis of a short list for the supplementary engineering designs, work supervision and technical assistance services;
- National competitive bidding for construction/rehabilitation work and non-medical equipment;
- International competitive bidding for the procurement of medical equipment; and
- Local shopping for the procurement of equipment (furniture, office equipment etc.) of the PIU, including vehicles.

3.5.2 The process, from the launching of bids to bid analysis and contract awards, was often long. Lack of familiarity with Bank procedures for the procurement of goods and services often led to the rejection of documents submitted to the Bank for no-objection, approval or disbursement. This extended the project implementation period. Consequently, the Bank had to reject the bid analysis documents three times for non-conformity.

3.6 Sources of Finance and Disbursements

3.6.1 The total project cost, net of taxes, was estimated at UA10.25 million: UA 8.30 million in foreign exchange and UA 1.95 million in local currency, as indicated in the table below. At completion, the project cost net of duties and taxes was UA 10.95 million.

Table 3.2
Estimated Project Cost by Expenditure Category and Source of Finance

Expenditure Categories	ADF	GVT	**TOTAL**
GOODS	3.11	0.18	**3.29**
WORKS	3.85	0.84	**4.69**
SERVICES	1.69	0.00	**1.69**
Operation	0.58	0.00	**0.58**
TOTAL	**9.23**	**1.02**	**10.25**

3.6.2 The amount disbursed by ADF was UA 9.17 million, representing 99.34% of the entire loan and 84.50% of the total project cost. All the extensions granted by the Bank were necessary for the achievement of the project goals. They did not however facilitate the finalization of all the activities owing to delays in the disbursement of the national counterpart.

3.6.3 In respect of the national counterpart, a total amount of UA 1.399 million was disbursed, i.e. 137.15% of the initial amount of the Government contribution and 13.64% of the entire project cost. The payments of the counterparts were irregular during the project implementation.

3.6.4 The estimated and actual financing plans for ADF and the Government are summarized in the following table:

Table 3.3
Estimated and Actual Financing Plan (ADF)

Initial amount approved : UA 9.23 million

Year	Estimate at appraisal	Actual	Total percentage disbursed /year	
1994	3.19		00.00	
1995	3.95		00.00	
1996	1.49		00.00	
1997	1.62	1.05	11.37	11.37
1998		1.22	13.21	24.59
1999		0.76	08.23	36.07
2000		0.00	00.00	36.07
2001		1.02	11.05	47.12
2002		1.67	18.09	65.22
2003		1.82	19.82	85.04
2004		1.62	17.66	99.34
Total		9.17	99.34	

Loan amount disbursed : UA 9.17 million
Undisbursed balance : UA 0.06 million

Table 3.4
Estimated and Actual Financing Plan (Government)

Year	Estimate at Appraisal	Actual	Total percentage disbursed / year	
1994	0.31	0.00	0.00	
1995	0.51	0.00	0.00	
1996	0.20	0.00	0.00	
1997	0.00	0.00	0.00	
1998		0.103	10.09	10.09
1999		0.114	11.17	21.26
2000		0.000	00.00	21.26
2001		0.488	47.84	69.10
2002		0.058	05.68	74.73
2003		0.253	24.80	99.53
2004		0.383	37.55	137.08
Total		1.399	137.08	

Initial counterpart amount: UA 1. 02 million
Final amount disbursed: UA 1. 399 million

4. PROJECT PERFORMANCE

4.1 Operational Performance

4.1.1 In terms of the initial objectives, which were to improve health facility coverage in the Departments of Maradi and Diffa, the outputs envisaged under the project were achieved: (i) Construction/rehabilitation of the health facilities, (ii) establishment of water points, and (iii) Support to the training of health and community personnel. Thus a total of 15 type 1 IHC, 5 type 2 IHC, 6 district hospitals with their technical platforms and their annexes, 19 wells or boreholes, training courses and support to PIU were implemented. The operational performance of the project by component is summarized below:

Component I: Improvement of Local Healthcare in the Department of Maradi

4.1.2 Thirteen (13) type 1 IHC (Ajekoria, Gadabeji, Maiyra, Dargue, Tiadi, Tchizon Kouregue, Gourage, Dan Koulou, Dan Kori, Oura, Guidan Dawey, Garare and Dan Aï) and 5 type 2 IHC (Guindawa, Tchadoua, Ourafane, Dakoro and Mayahi) were built under the project. The planned construction/rehabilitation work and additional works have been completed for the type 1 IHC and the health centres are operational. For the type 2 IHC, 3 out of the 5 have been commissioned and are operational.

4.1.3 For the 6 district hospitals of Dakoro, Aguié, Tessaoua, Mayahi, Guidan Roumdji and Madarounfa, over 95% of the construction work (including annexes) has been completed and the equipment for the technical platforms has been delivered. At the Maradi RCH, the extension of the Departmental Health Directorate, the cold room, the laboratory unit/pharmacy and the biomedical maintenance workshop have also been commissioned.

4.1.4 There were many defects in the execution of the works owing to poor programming of the operations of the different trades (for example, several holes were cut in the walls for the electrical wiring after the finishing works). In many cases, acceptance was only

provisional to enable the contractor to correct the defects. Nonetheless, even with this procedure, there are significant differences in the quality of the finishings, depending on the contractors selected for the different bid packages. For future Bank operations, the selection of the contractors during bid analysis should not be limited only to the lowest bidder financially, but should include technical skills and references in the field concerned.

4.1.5 All the furniture and biomedical equipment intended for the IHC have been delivered and installed. Their quality and the quantities delivered comply with the orders. The solar panels have been delivered and are operational. Thus, electricity supply in the areas not connected to the national grid improves the quality of service delivery of these health facilities. Out of the 29 health facilities that were to benefit from the installation of SSB radios to facilitate communication between the peripheral structures and the central structures, 3 radios are still to be installed due to the supplier's fault. The 8 ambulances have all been purchased and are operating in their respective regions, to facilitate evacuations to the referral centres. The other vehicles have also been commissioned. Similarly, six generators have been purchased and installed in the 6 DH to ensure the functioning of their technical platforms.

4.1.6 The biomedical equipment intended for the DH technical platforms and laboratories has been delivered and accepted. Unfortunately, due to a lack of operational premises, it has not been installed and put into service. A contract has however been signed with MARVEL to operationalize the technical platforms when the conditions are met. Besides, the mission noted that this equipment is stored in conditions that seriously jeopardize its commissioning. In effect, it is not protected from the dust or debris from ongoing work sites. The attention of the Departmental health authorities have been made aware of these points. Some work, essential for its start-up, such as the connection of the buildings to the national grid, is still being carried out. All the generators programmed have been delivered and installed, but their commissioning was still not effective during the April 2006 supervision mission.

4.1.7 100% of the drugs have been delivered, but only to the health facilities built under the project. In the operational IHCs, the cost recovery system introduced by the communities ensures an uninterrupted supply, to the satisfaction of the populations. On the non-operational sites like the DH, drugs and laboratory reagents are stored and, in the absence of a rational allocation before the expiry dates, there is risk of loss. The Departmental Health Directorates having been informed, steps have been taken to re-allocate these stocks, as envisaged during appraisal, to all the Departmental health facilities.

4.1.8 The hydraulic works, 17 water points corresponding to 15 boreholes equipped with hand pumps and 2 mini DWS, have been handed over and are operational. They have improved access to drinking water for people living around the health facilities established under the project. Water management committees have also been set up.

Component II: Improvement of Local Healthcare in the Department of Diffa

4.1.9 The facilities in Diffa Department, 2 type 1 IHC and 2 wells in Kojimeri and Bilahardey, have been completed. The equipment, furniture and solar panels have been delivered and installed. The Bilahardey well has not been equipped with a water extracting system. The medicines supplied have been allocated to the beneficiary structures. An ambulance has been delivered to N'Guigmi hospital to facilitate the evacuation of patients from the remote regions of the Department.

<u>Component III</u>: Support to the Project Implementation Unit (PIO) and its Maradi office

4.1.10 The project has permitted expansion of the PIU offices in Niamey, the supply of equipment and vehicles, the functioning of the Niamey headquarters and the Maradi branch office. In addition to staff recruitment, the project has given project management training to the Manager.

4.1.11 The various training course programmed by the project were satisfactorily organized and skills have been acquired. However, the people trained did not resume work in the project areas or in the public health sector. They turned to the private sector (NGOs) in spite of the five-year undertaking signed with the Ministry, because the latter did not envisage any coercive measures for non-compliance with the undertakings. Out of the 4 national staff trained abroad in project management (2 persons), public health (1 person) and biomedical equipment maintenance (1 person), only one has returned to work in the MS/EDC, namely the training officer under the Health Project II, financed by the Bank in Niger.

4.1.12 With regard to local training, 7 general practitioners trained in essential surgery have never been able to practice surgery in the Maradi and Diffa district headquarters. The main reason is that the facilities were not operational upon completion of their training. Furthermore, as such training was not really recognized, most of the beneficiaries later moved on to academically valid specialties. It would therefore be necessary in the future to rethink the curricula of the courses planned to ensure they meet the expectations of the young doctors and the real medical staff requirements of the health facilities. Moreover, the assistant anaesthetists, assistant surgeons and radiology manipulators trained at the School of Health Sciences (Ecole des Sciences de la Santé) under the project could not be assigned to the project areas because the health facilities were non-operational.

4.1.13 On the other hand, community-oriented training courses were satisfactory, as they really enabled the beneficiaries to assume ownership of the management of the IHC. On this model, it would perhaps be interesting to include in the district management teams in the DH members of the communities for a greater involvement of the population in the improvement of their health care.

4.1.14 Providing qualified staff for the operation of Niger's health structures is a general problem. The 2005-2009 HDP therefore plans to remove the recruitment conditionalities (freeze on the employment of civil servants) and postpone the early retirement measures in the health sector. This should limit the consequences of a protracted shortage of skilled personnel on the quality of service delivery. Immediate measures were taken by the Ministry to address this staff shortage. Thus, in December 2004, 729 contract workers had to be hired at national level. In its completion report, the Niger party stated that these new recruits would help meet staffing requirements in the Departments of Maradi and Diffa. However, even with these recruitments, it will not be possible to assign a second nurse to the type 1 IHC to improve the health care of the population.

4.2 Institutional Performance

4.2.1 In keeping with the appraisal report, a project implementation unit (PIU), under the supervision of the Ministry of Public Health and Endemic Diseases Control, was established and put in charge of project implementation. Since the PIU headquarters was in Niamey a branch office was set up in Maradi. The personnel comprised qualified national staff supervised by the international experts of a consulting firm. This organization of the PIU was intended to ensure smooth and rapid implementation of the activities. The putting of Niger under sanction between 1999 and 2001 for non-payment of arrears, considerably disrupted the work of the international consulting firm Louis Berger/CREDES, recruited in 1998. In 2001, the PIU management was renewed. An MPH/DHMT official trained in France in 'project management' under the project- financed training programme was appointed to head the PIU.

4.2.4 The PIU has not always taken the necessary steps to ensure the timely conduct of annual audits in conformity with Bank procedures. The audit of the project accounts in the first three years, by the same firm, did not conform to the standards and failed to note the weaknesses in the project management and the absence of accounting software. Moreover, the structures could have been of better quality if the PIU had more satisfactorily controlled the activities of the consultants in charge of works supervision. Similarly, the deliveries of biomedical equipment and drugs did not always comply with standards. In more than one case, the supplier delivered goods to ongoing sites with no arrangements for storage. Furthermore, for the procurements, the Bank three times rejected the medical equipment procurement documents. The recommendations made by experts during Bank supervision missions were not adequately followed by the PIU. In conclusion, the performance of the PIU is considered just average.

4.3 Performance of the Consultants and Suppliers

Performance of the Consultants

4.3.1 The international consulting firm, Louis Berger/CREDES, which between 1998 and 2001 formed the first team of consultants for the project, initiated all the studies for the civil works and launching of bids for the planned project activities – construction, supply of furniture, equipment and drugs etc. Its performance is difficult to evaluate because it worked when Niger was under ADB sanction (August 1999 to February 2001). However, for the preparation, acceptance and installation of the biomedical equipment and drugs ordered, the Louis Berger biomedical engineer's contract was extended to December 2002. However, he only received part of the equipment. From the second quarter of 2001 three local assistants were hired (1 architect, 1 civil engineer and 1 administrative manager). They modified the implementation schedule of the project activities, which they supervised up to the completion in 2004. Supervisions were regular. Nevertheless, the quality of the structures built was deemed average. The performance of these technical assistants is considered satisfactory.

4.3.2 The firms in charge of the studies and monitoring of the health facilities construction and rehabilitation works conducted the studies, but did not carry out the entire supervision of the sites owing to the suspension of financing. Their performance is unsatisfactory.

4.3.3 The services of the various firms hired to audit the project accounts did not always give satisfaction. Adbou SIDIBE's 1997, 1998 and 1999 audit reports did not conform to the Bank format. The performance of this firm is unsatisfactory. PANAUDIT– Niger, which was responsible for the 2000 and 2001 audits did not meet the recommended international standards and failed to comply with the deadlines for the submission of reports. The performance of the firm is also deemed unsatisfactory. Only the performance of the last firm (CGIC), for the 2002, 2003 and 2004 audits was considered satisfactory.

Performance of the Contractors

4.3.4 In total, 27 national enterprises participated in the health facility construction/rehabilitation works of the project. In 2001 during the resumption of works following the suspension of ADB disbursements, some contractors refused to resume works without an amendment relating to cost adjustments. The sites were therefore abandoned and new bidding procedures initiated for them. Overall, all the works commissioned were executed, albeit with significant delays in the delivery of the buildings and a lot of defects. In fact, 4 sites at the finishing stage were abandoned by the contractors for default of payment of 20% of the Niger Government's counterpart. Other contractors had therefore to be hired to finalize these works. Besides, as the construction contracts were awarded by lots, differences could be noted on the same site in the quality of the work. The performance of the contractors is deemed unsatisfactory.

4.3.5 The performance of the contractors which implemented the hydraulic works is considered satisfactory, but that of CONCI, which won the Boulahardey well contract, is unsatisfactory.

Performance of the Suppliers

4.3.6 In total, 13 local and international suppliers contributed to the achievement of the project objectives. The performance of the suppliers of the furniture and vehicles for the PIU and the health facilities is satisfactory.

4.3.7 Manutention Africaine Niger; which supplied and installed the solar panels, gave satisfaction. Its performance is satisfactory.

4.3.8 Concerning the supply of the biomedical equipment by 3 international suppliers (Sociétés MARVEL, FSE and UNILAND International), the quality of the material delivered complies with the specifications. Equipment for the surgical and radiology units was installed and commissioned by the company MARVEL after the completion of works. The performance of these suppliers is deemed satisfactory.

4.3.9 The installation of SSB radios has been completed, but considerably behind schedule. BETP, the supplier, did not comply with the contractual commitments for the installation of radios in sites not easily accessible. The performance of this supplier is considered unsatisfactory.

5. SOCIAL AND ENVIRONMENTAL IMPACT

5.1 Social Impact

5.1.1 At project completion, a positive impact was noted - better health coverage within 0-5 km radius of the health facilities in two departments. In 2004, coverage reached 44.6 and 42.4% for Maradi and Diffa respectively, which is close to the national average of 49.78%. This national average is 60% if the health huts are included in addition to the IHCs among the health facilities. There are, however, marked disparities in the project area. In 2003, health coverage based on the IHC is 16% for Dakoro and 23% for Guidanroumdji compared to 95% for Maradi-Commune (source the 2005-2009 HDP). Hopefully, the assignment of an additional nurse to the IHCs will improve medical care for the population and possibly result in a higher rural health coverage rate. The second nurse will therefore be able to visit the more remote areas once a week thereby increasing the physical access to healthcare. Higher attendance at these centres is a positive indicator of the needs covered by the project. In the IHC visited, the number of curative consultations varies between 20 and 50 patients per jour depending on the population living in the health area and the economic activity (market day for instance). As the structures are not yet fully operational, it is not possible to assess the improvement of all the socio-health indicators in relation to the outputs in the project area. Their improvement will depend to a large extent on the operationalisation of the DHs, which represent the referral centres.

5.1.2 The monitoring of pregnancies in antenatal consultations and the presence of volunteer traditional midwives in the IHC have improved the health care of pregnant women. Niger has one of the highest maternal mortality rates in the world with 700 deaths for 100 000 live births. The 2005–2009 HDP plans to halve maternal mortality by the year 2009 (350‰). The project infrastructure is already contributing to this reduction, even if the coverage rate of assisted deliveries remains low (18%) in the whole country. In Diffa Department, antenatal coverage rose from 20% in 1999 to 53% in 2003. The Kojimeri IHC, commissioned in November 2003, will participate in this improvement. Furthermore, these health facilities will help to promote family planning programmes. This activity is important, as the contraceptive prevalence rate is low in Niger (4%) with one of the highest total fertility indexes in the world (7.5 children per woman).
(Sources 2005-2009 HDP).

5.1.3 The provision of curative and preventive care has improved child health care and the treatment of recurrent diseases, namely malaria, acute respiratory diseases and diarrhoea. This helps to reduce infant and child mortality, which, between 1992 and 1998, dropped at the national level by 16% (from 323 to 280‰). Counselling by the health personnel also helps to reduce malnutrition among very young children. The IHCs are moreover involved in the national vaccination days (NVD), which complement the routine activities of the EPI (vaccination of mothers, newborns and children). In Maradi Department, for example, the coverage rate for VAT2 (second anitetanus vaccination) rose from 41% in 1999 to 51% in 2003 (source SNIS/HDP). Certain IHCs in the project area, which started their activities in 2002, are already contributing to increased vaccination coverage.

5.1.4 With the expansion of the HIV/AIDS epidemic in Niger, as everywhere in Africa, these health facilities are also information centres on the means of HIV/AIDS prevention. They will, therefore, help maintain an HIV/AIDS seroprevalence rate below 0.87%, as envisaged by the 2005-2009 HDP with the promotion of risk-free behaviour.

5.1.5 Once in place, the qualified health personnel who have been trained will improve the diagnostic and therapeutic coverage of the pathologies included in the training. The working conditions of the management teams of two districts in Maradi (Tessaoua and Mayahi), nurses and midwives, have been improved by the construction of new offices, accommodation and by the supply of equipment.

5.1.6 The establishment of management and health committees during the community sensitization activities has enabled the population to take charge of health activities. The funds generated through cost recovery are utilized in priority to replenish the essential generic drugs – EGD - (70 to 80%). Then the committees' spending is on management tools and IHC operating expenses. Instead of being saved, the profits generated could be utilized to service the equipment (solar panels, maintenance of the buildings) or, for example, to provide free family planning, information and education in areas such as reproductive health and the prevention of malaria and HIV/AIDS.

5.1.7 The water points established with the health structures have helped improve access to drinking water in the rural areas of the Departments, which was 38% in 2000 for Maradi Department (MCRS 2000). They are useful to the population, especially to women and girls, by reducing the household chore of providing drinking water. The management of these water points by the population has helped generate funds for the maintenance of the wells. In some big villages (like Madarounfa), there is a plan to finance the installation of a mini DWS. Access to drinking water also reduces the incidence of infectious (diarrhoea) and parasitic (schistosomiasis) water-borne diseases among the inhabitants of the project area. Furthermore, given that essential generic drugs (EGD) are available in all the health centres, the project has a positive impact on poverty reduction by lowering spending on health. It improves the well-being of the population in general and of mothers and children in particular, who are the most vulnerable groups.

5.2 Environmental Impact

The project was approved in 1993, prior to the adoption of environmental categorization and environmental impact assessments. We are of the opinion, however, that the project impact on the environment is very limited. In effect, technical measures were taken to avoid environmental degradation. The project construction and rehabilitation work was carried out in keeping with the required hygienic and sanitation measures, taking into consideration the physical characteristics of the sites. Work has resumed on the abandoned sites. The health facilities are equipped with toilet blocks and incinerators for biomedical waste. Shrubs and flowers have been planted. These measures facilitate medium and long-term environmental protection.

6. SUSTAINABILITY

6.1 The increase in health infrastructure in the Departments of Maradi and Diffa was not accompanied by the provision of qualified personnel to achieve the project objectives. Consequently, the equipped structures will not contribute to the improvement of healthcare if the staff is not available. The high mobility of health workers in Niger and their shortage represent a major constraint that could in the short-term compromise the project achievements. Dialogue between the Bank and the Government should be established to make up for the shortage of qualified medical and paramedical personnel.

6.2 Lack of maintenance of the health facilities and their equipment, attributed to the shortage of support staff, will have a negative impact on the sustainability of the project achievements. Most of the centres visited suffered from lack of maintenance (no daily cleaning of the working areas, the floor, etc.); inadequate protection of the equipment (heavy and light equipment) from dust; stocks of equipment, consumables and unused drugs not always updated. Sensitization on good hygienic practices, as well as on the preventive and curative maintenance of equipment, should be envisaged for the health staff. A biomedical maintenance workshop built under the project in the Maradi DH could serve as a referral centre. A possible solution is to involve the communities, which would be responsible for providing and paying the maintenance staff from the profits made from the recovery of the costs of medicines.

7. PERFORMANCE OF THE BANK AND THE BORROWER

7.1 Performance of the Bank

7.1.1 The performance of the Bank in the implementation of this project is satisfactory. Between 1997 and 2004 the total number of supervision missions (including the completion mission) is 11, i.e. an average of 1.57 over 7 years. It should be underscored that between 2000 and 2004, periods corresponding to the actual project implementation phase, the average number of supervisions was 2.25 per annum. In general, the missions helped process pending matters and release the counterpart funds, but the major problem lay in the failure to follow the recommendations made by Bank experts. There were, however, some delays in the processing of payment requests, which hampered the implementation of the project.

7.1.2 Two internal financial audit missions to the Bank were organized in 2001 and 2004. They introduced corrective measures such as the establishment of an accounting system. They also helped in the selection of competent audit firms (see paragraph 3.4.2).

7.2 Performance of the Borrower

In addition to the significant initial slippage due to delays in fulfilling the conditions precedent to effectiveness of first disbursement, project implementation was disrupted by several factors connected with the borrower, in particular: (i) the suspension of ADB disbursements for non-payment of arrears, arising from the political and economic problems; (ii) non-compliance with the Bank rules of procedure for the bid analysis process, which in several cases led to the rejection of the results and the relaunching of the bidding process; (iii) inadequate number of qualified health staff assigned to the health facilities; (iv) difficulties in providing the total national contribution; and (v) coordination gaps in the planning of activities. All these factors delayed and hampered the smooth implementation of the project. The performance of the borrower was deemed unsatisfactory.

8. OVERALL PROJECT PERFORMANCE

The initial activities planned at appraisal were implemented. The modifications, with the additional structures, sought to improve the health care coverage of the population and the working conditions of the personnel. The quality of the works is acceptable, but that of the equipment and furniture is fairly satisfactory. The project implementation performance presented in Annex 7 is unsatisfactory, but the project impact on development (poverty reduction) set out in Annex 6 is satisfactory.

9. CONCLUSIONS, LESSONS AND RECOMMENDATIONS

9.1 Conclusions

In the light of the foregoing analysis, it can be concluded that the project only partially achieved its objectives. Only health coverage in the Departments of Maradi and Diffa was extended to 45% of the population living within 0-5 km radius of an IHC. The two regions benefited from: (i) health infrastructure; (ii) the provision of drugs and equipment, and (iii) specialized training in the Departments where healthcare demand remains high. However, healthcare improvement is not fully effective, as adjustments are necessary to make the referral facilities operational. Thus, in the short term, the expectations of the populations and the objective of strengthening the referral level in the local healthcare sector remain to be met. Health infrastructure coverage alone cannot improve the utilization of the services by the target population. For a real impact on the lives of the population, provision should be made for a series of activities to operationally these structures.

9.2 Lessons

Several lessons have been learnt from the implementation of this project: (i) envisage structures in the regions where electrification, water supply and means of access already exist, or mainstream these activities in the project; (ii) envisage international competitive bidding if the national enterprises are not efficient, so as to ensure the quality of the construction and rehabilitation works; (iii) ensure that the activities to be financed by the counterpart funds do not constitute an obstacle to project completion; (iv) need to have, at the national level, a health sector training plan to sustainably support the actions of improving the health infrastructure and equipment through the availability of sufficient qualified staff; (vi) envisage activities to maintain and service the infrastructure and equipment provided under the project; and (vii) need to issue calls for applications for the recruitment of high-level skills for the implementation unit to coordinate the preparation, implementation and monitoring of the activities. In view of these lessons, the following measures are recommended to contribute to the sustainability of the project and improve the design and implementation of future operations.

9.3 Recommendations

9.3.1 To ensure project sustainability it is recommended to

A. The Bank to:

(i) see to it that, during future health sector missions to Niger, the Government has honoured its undertakings and taken the necessary steps to ensure that the infrastructure created under the project is operational (finishings, commissioning of the biomedical equipment, assignment of staff);

B. The Government to:

(ii) make arrangements to assign the necessary personnel to the health facilities established under the project;

(iii) strengthen the measures taken to ensure sustainability of the outputs, in keeping with the new Health Development Plan for 2005-2009;

(iv) put in place a stock accounting system, i.e. undertake an identification (codification) of all the materials (furniture, equipment, etc.) provided;

(v) provide regular training of the health staff in equipment and infrastructure upkeep and maintenance and, if necessary, include the communities by involving them more in the maintenance of solar panels and water points; and

(vi) Sensitize the population on the proper utilization and maintenance of the infrastructure and equipment put at their disposal.

9.3.2 For future operations the Bank shall:

(vii) construct infrastructure only in the areas where electrification, water supply and access facilities already exist. Otherwise, envisage integrating these activities into the project;

(viii) for infrastructure-intensive projects, thoroughly study the geographical spread of the sites and their breakdown into lots. Consider the skills of the local enterprises and envisage international competitive bidding to ensure the quality of the works;

(ix) ensure that the part of the project activities to be financed by the Government counterpart funds does not constitute a major obstacle to its completion; and

(x) ensure prompt processing the various requests and correspondence relating to project implementation, submitted by Governments.

Annex 1

REPUBLIC OF NIGER

LOCAL HEALTH CARE SECTOR IMPROVEMENT PROJECT IN THE DEPARTMENTS OF MARADI AND DIFFA

ADMINISTRATIVE MAP OF NIGER AND THE PROJECT AREAS

This map is intended exclusively for the use of readers of the report to which it is attached. The names used and the borders shown do not imply on the part of the Bank and its members any judgment concerning the legal status of a territory nor any approval or acceptance of these borders

Annex 2

REPUBLIC OF NIGER

LOCAL HEALTHCARE SECTOR IMPROVEMENT PROJECT IN THE DEPARTMENTS OF MARADI AND DIFFA

SOURCES OF INFORMATION

Project Appraisal Report
ADF Loan Agreement
Quarterly PIU Reports
Audit Reports
Supervision Reports
Niger, 2005-2009 Health Development Plan
Borrower's Completion Report
Disbursement Tables and Ledger
Outcome of the Discussions with the Project Implementation Staff

REPUBLIC OF NIGER – HEALTH PROJECT I

LOCAL HEALTHCARE SECTOR IMPROVEMENT PROJECT IN THE DEPARTMENTS OF MARADI AND DIFFA

LIST OF CONTRACTS

A. CONSTRUCTION AND REHABILITATION WORKS (ADF Share: 80%)

Contract	Name	Nature	Signing date	Amount
No. 02/08/GC/Y Lot 1.	HAMADI MOHAMED	Construction of the Technical Platform of the Dakoro District Hospital	01/10/2002	196 776 126 CFAF
No. 02/07/GC/Y Lot 3	ALPHA OUMAROU	Construction of Annexes + REW of the Dakoro District Hospital	01/10/2002	61 126 918 CFAF
No.02/03/GC/Y Lot 2	HAMIDOU SOULEYMANE	Construction of the Administrative Block + Referral Consultation + Inpatient wards + Dakoro district hospital accommodation	08/07/2002	112 946 881 CFAF
No.02/04/GC/Z Lot 2	EYA	Construction of the Administrative block + Referral Consultation + in patient wards + Mayahi District hospital accommodation	08/07/2002	122 522 077 CFAF
No. 02/05/GC/Z Lot 3	MOUTARI IDI	Construction of Offices + REW of Mayahi District hospital	08/07/2002	94 549 100 CFAF
No. 02/003/GC/Z Lot 1	E.G.B.T.P	Construction of the Technical Platform of Mayahi District hospital	08/07/2002	171 632 200 CFAF
No. 02/02/GC/W	SADDI KEMIL	Extension and rehabilitation of Ourafane IHC 2	10/04/2002	63 360 610 CFAF
No. 02/01/GC/N Bis	ECBTP	Construction of Offices + REW of Tessaoua District Hospital	10/04/2002	90 034 602 CFAF
No. 01/07/GC/X	ECBTP	Extension and rehabilitation of Tchadoua IHC 2	23/11/2001	51 955 684 CFAF
No. 01/06/GC/ G Bis	SOTRAP NIGER	Construction of Offices + REW of Madarounfa District Hospital	23/11/2003	108 088 713 CFAF
No.01/ 05/GC/BO	TECHNIBAT	Extension and rehabilitation of the Surgical Unit of the Maradi Regional Hospital Centre	23/11/2001	91 494 884 CFAF
No.01/04/GC/E Bis	TECHNIBAT	Construction of offices + REW of Guidan Roumdji District Hospital	23/11/2001	99 969 085 CFAF
No. 01/ 03/GC/AB	EGBTP	Biomedical workshop at the Maradi Regional Health Directorate	23/11/2001	17 565 831 CFAF
No. 02/02/GC/A bis	EGBTP	Construction of the Administrative Block + Referral Consultation + In patient wards + Accommodation + Offices + USD of Aguié District Hospital	23/11/2001	128 334 002 CFAF
No.01/01/GC/V	EPRITA	Construction of Bilahardey IHC 1	18/04/2001	109 875 453 CFAF
No.99/18/GC/U	KACHE ET FILS	Construction of GOURAGE IHC 1	03/07/2000	45 468 055 CFAF
No. 99/17/GC/T	KACHE ET FILS	Construction of OURA IHC 1	03/07/2000	43 478 320 CFAF
No. 00/01/GC/S	BINAY	Construction of DAN AÏ IHC 1	03/07/2000	49 970 768 CFAF
No. 99/16/GC/R	KACHE ET FILS	Construction of MAYARA IHC 1	03/07/2000	45 190 065 CFAF
No. 99/15/GC/Q	SANI S. DAN GARA	Construction of ADJEKORIA IHC 1	03/07/2000	51 019 945 CFAF
No. 99/14/GC/P	EPRITA	Construction of KOGIMERI IHC 1	30/04/1999	53 354 744 CFAF
No. 99/13/GC/0	ABATI	Construction of Maradi RHC Laboratory-Pharmacy Block	30/04/1999	58 847 752 CFAF
No. 99/06/GC/N	SONIMAP	Construction of Tessaoua Laboratory-Radio Block	19/02/1999	30 197 590 CFAF
No. 99/06/GC/M	SONIMAP	Construction of Gararé IHC 1	19/02/1999	44 109 628 CFAF
No. 99/06/GC/L	SONIMAP	Construction of Guindawa IHC 2	19/02/1999	68 182 976 CFAF

Contract	Name	Nature	Signing date	Amount
No. 99/05/GC/K	SOBAFOR	Construction of Dan Kori IHC 1	19/02/1999	50 110 498 CFAF
No. 99/04/GC/J	KACHE ET FILS	Construction of Dan Koulou IHC 1	19/02/1999	50 467 790 CFAF
No. 99/03/GC/I	BABTI	Construction of Mayahi IHC 2	19/02/1999	70 105 079 CFAF
No. 99/12/GC/H	SABO OUMAROU	Construction of TCHIZON KOUREGUE IHC 1	30/04/1999	45 112 214 CFAF
No. 99/11/GC/G.	BEN YACINE MOHAMED	Construction of the Technical Platform of Maradounfa District Hospital	30/04/1999	112 210 657 CFAF
No. 99/02/GC/F	MAMAN ISSA	Construction of Dargue IHC 1	19/02/1999	53 554 938 F CFA
No. 99/01/GC/E	BEN YACINE MOHAMED	Construction of the Technical Platform of Guidan Roumdji District Hospital	19/02/1999	120 172 258 CFAF
No. 99/10/GC/D	SADDI KEMIL	Construction of GADABEDJI IHC 1	30/04/1999	50 277 990 CFAF
No. 99/09/GC/C	BABTI	Construction of DAKORO IHC 2	30/04/1999	71 512 858 CFAF
No. 99/08/GC/B	BABTI	Construction of Guidan Dawèye IHC 1	30/04/1999	45 314 204 CFAF
No. 99/07/GC/A	MAMAN ISSA	Construction of the Technical Platform of Aguié District Hospital	30/04/1999	110 159 122 CFAF
No. 341 /R3	SANI SOULEY DAN GARA	Extension of Maradi RDPH	11/09/1998	36 985 774 CFAF
No.349 /R3	SOBAFOR	Extension of Niamey PIU	17/09/1998	26 947 182 CFAF

B: **HYDRAULIC WORKS** (ADF Share: 100%)

Contract	Name	Nature	Signing date	Amount
No. 001/2001/BEP/H	ESAFOR	Construction of eight (8) boreholes in Maradi department	21/08/1998	99 228 000 CFAF
No. 001/2001/BEP/H	ENBAFOR	Construction of eight (8) boreholes in Maradi department	31/05/2002	98 899 300 CFAF
No. 003/2002/HYD/BEP/MSP/LCE	CONCI	Construction of the Boulahardey wells	20/05/2002	34 718 900 CFAF
No. 002/ 2002/HYD/BEP/MSP/LCE	TOUTHYDO	Installation of two mini DWS in Maradi Region	20/05/2002	77 044 975 CFAF
No. 001/ 2002/HYD/BEP/MSP/LCE	TOUTHYDO	Installation of 14 hand pumps in Maradi Region	20/05/2002	49 325 080 CFAF

C: **SERVICES** (ADF Share: 100%)

Contract	Name	Nature	Signing date	Amount
No. 341 / R3	Cabinet LOUTOU	Supervision of the Mayahi and Dakoro DH infrastructure construction/rehabilitation phase 2	11/09/1998	15 680 000 CFAF
No. 341 /R3	Groupement AAI/BETAS	Supervision of health infrastructure construction/rehabilitation phase 2: Offices, 4 DH, 2 IHC, Extension of BO/RHC and RDPH biomedical workshop.	11/09/1998	27 520 000 CFAF
No. 99/01/TP	Cabinet INGENIGER	Health infrastructure topographical studies phase 2	05/08/1999	9 900 000 CFAF
No. 98/01/TP	Cabinet INGENIGER	Health infrastructure topographical studies phase 1	30/01/1998	18 679 450 CFAF
	Cabinet ETAG	IHC topographical studies, phase 1, TIADI.	29/08/1998	700 000 CFAF
No. 191 R 3/8	Groupe LOUTOU/ADOBE	Supervision of health infrastructure 1, Lots 1,2,4,7 and 8	04/08/1998	39 835 000 CFAF
No. 191 R 3/8	Groupement AAI/BETAS	Supervision of health infrastructure 1, Lot 3	21/05/1998	10 400 000 CFAF
No. 198 R ¾	CINCAT INTERNATIONAL	Supervision of health infrastructure 1, Lots 5 and 6	21/05/1998	22 611 215 CFAF

No. 62 /R3	S.C.P. Agence ARCHI PLUS	Supervision of the Extension/Rehabilitation of the Maradi DDS office and Niamey PIU	12/02/1998	5 383 889 CFAF
No. 002/BEP	Direction Départementale de l'Équipement de MARADI	Supervision of the health infrastructure of IHC 1, TIADI	09/09/1998	2 682 660 CFAF
	Cabinet SIDIBE	Audit of the 1998 and 1999 accounts	21/09/1998	51 320 000 CFAF
	Cabinet PAUDIT NIGER	Audit of the 2000 and 2001 accounts	05/02/2002	21 043 200 CFAF
	Cabinet CGIC –Afrique	Audit of the 2002 and 2003 accounts	04/02/2004	18 432 000 CFAF
	Cabinet CGIC –Afrique	Audit of 2004 accounts	16/07/2004	7 000, 000 CFAF
No. 00175/ BEP/PRSSSL/MI/DA	SYRIS Informatique	Introduction of the accounting system	02 /09/1998	9 400 000 CFAF

D : <u>GOODS AND EQUIPMENT</u>

Contract	Name	Nature	Signing date	Amount
No. 03/01/GC/CF	ELYFROS	Installation and Equipment of the cold room of Maradi Regional Hospital		CFAF
No.003/2001/EQ/solaires/BEP	MANUTENTION AFRICAINE NIGER S.A	Solar equipment of 19 IHC	22/06/2001	54 470 000 CFAF
No. 002/2001/EQ/Groupe/BEP	TALIMEX	Supply and installation of 6 generators	22/06/2001	64 266 360 CFAF
No. 01/99/EQ	BETP	Supply and installation of 34 SSB Radios	19/12/1999	87 837 450 CFAF
No. 001/2001 /Eq/VEH/BEP	CFAO-Niger	Supply of nine (9) SW 4X4 Ambulances	22/06/2001	314 590 863 CFAF
No. 003/2001/Mob/BEP	BUROPA SARL	Supply of the Furniture of the Health Facilities	28/09/2001	103 502 000 CFAF
No. 004/2001/Mob/BEP	BUROPA SARL	Supply of the Furniture of the Health Facilities	28/09/2001	15 628 000 CFAF
No. 001/2001/MOBBEP	Hamdalaye Meuble	Supply of the Furniture of the Health Facilities	28/09/2001	138 847 000 CFAF
No. 002/2001/Mob /BEP	Boubacar SIDI	Supply of the Furniture of the Health Facilities	28/09/2001	18 895 000 CFAF
No.5000016342	Société IMRES BV	Supply of Essential Generic Drugs	08/07/2003	362 452,68 EUROS
No.5000016342	Société Pharmaceutique du Centre	Supply of medico-surgical consumables	08/07/2003	189 246,42 EUROS
No.5000016343	Société Pharmaceutique du Centre	Supply of lab reagents	08/07/2003	82 852,54 EUROS
No. 003-R3	CFAO-Niger	Supply of 4 SW 4X 4 vehicles, one station wagon, one saloon, two motor bikes 125, one motor bike 50	02/01/1998	124 835 000 CFAF
No.L1/001/2003/EQ/BIO	Société MARVEL	Equipment of five radiology units of Diffa DH	07/07/2003	404 734,40 EUROS
No.L3/0031/2003/EQ/BIO	Société MARVEL	Equipment of five radiology units of the DH and Maradi DHC	07/07/2003	656 465,40 EUROS
No.L2/002/2003/EQ/BIO	Société FSE	Equipment of six laboratory units of the DH and Maradi DHC	30/07/2003	493 772,90 EUROS
No.L5/005/2003/EQ/BIO	Société UNILAND	Equipment of 15 type 1 IHC of Maradi and Diffa	07/07/2003	144 654 EUROS
No.L5/005/2003/EQ/BIO	Société UNILAND	Equipment of five type 2 IHC of Maradi and Diffa	07/07/2003	61 731,95 EUROS

Annex 4.1

REPUBLIC OF NIGER

LOCAL HEALTHCARE SECTOR IMPROVEMENT PROJECT IN THE DEPARTMENTS OF MARADI AND DIFFA

MODIFICATIONS TO THE CONSTRUCTION/REHABILITATION WORKS

Type of construction	Estimates at appraisal	Outputs	Benefits / Observations*
Type 1 IHC	15 type 1 IHC (Guidan Dawey, Gadabedji, Dan Goulbi, Ajekoria, Korahane, Dargué, Tiadi, Tchizon Kourégué, Dan Koulou, Tchakaï, Garare, Gourage, Oura, Maï Jirgui, Kojiméri)	Locations modified for 4 type 1 IHC (Dan Goulbi, Korahane,, Guidan Amoumoun and Tchakaï) which have become Mayara, Dakoro, Dan Aï, Mayahi and Dan Kori)	Improvement of health coverage for Maradi region. In the end, 15 type 1 IHC are made available to population following these modifications.
Type 2 IHC	3 type 2 IHC to be constructed (Kossotori), reconstructed (Tchadoua) or for extension (Ourafane)	- 5 type 2 IHC constructed or rehabilitated: Guindawa, Tchadoua, Ourafane, Dakoro, Mayahi - 5 houses for midwives built	- Improvement of health coverage in 2 departments. For Diffa department one additional IHC (that of Bilahardey built in place of that of Kossotori) in a remote region . - Creation of attractive living conditions for the midwives.
Tessaoua DH	Extension of the MCC and construction of the maternity	- Rehabilitation of the referral consultation block - Construction of a Pharmacy/laboratory block - Construction of the radiology unit - Offices of the district health management team	- Improvement of the health coverage of the region and better medical cover of the population with the provision of services that did not exist in this hospital. -Improvement of the working conditions of the district health management team.
Mayahi DH	Technical platform (surgical unit, medical laboratory analysis, radiology unit)	- Pharmacy/consultation block - Offices of the district health management team - 1 technical platformt - 3 inpatient wards - 1 house for the surgeon	- Provision of additional services -Improvement of the living conditions of the district health management team.
Aguie, Dakoro, Tessaoua, Madarounfa and Guidan Roumdji DH	Technical platforms (surgical unit, medical analysis laboratory, radiology unit)	- Annexes = kitchen, incinerator, wash house, sheds for the waiting room, bathrooms, mortuary - 4 technical platforms - Offices of the district health care management teams - 4 referral consultations Rehabilitation of 4 pharmacies - 12 inpatient wards in medicine and surgery	- Improvement of the conditions of receiving patients and their families
Maradi RDPH	Extension of the RDPH (training and meeting rooms, service rooms, offices)	- In addition to the projections at appraisal, construction of a biomedical maintenance workshop.	- Lack of trained staff to operate the biomedical workshop.
Maradi RHC	Medical analysis laboratory/ Pharmacy	Extension of the surgical unit (4 additional rooms)	

* The full impact of the benefits will be realized when all the services are operational in the DH in terms of infrastructure and the provision of staff.

REPUBLIC OF NIGER
LOCAL HEALTHCARE SECTOR IMPROVEMENT PROJECT IN THE DEPARTMENTS OF MARADI AND DIFFA
COMPARISON BETWEEN PLANNED AND ACTUAL TRAINING PROGAMMES

A			B				
Topics planned at appraisal	**Programme duration/ number of cycles**	**Number and quality of the planned beneficiaries**	**Topics or activities effectively implemented**	**Number of workers trained for Maradi and Diffa**		**Period**	
Management	10 d / 1	20 senior doctors and nurses					
			Project management ([n France)	2		Sept 97 / August 98	
Work Organization	5 d / 3	90 nurses for RD, HCRD and MC					
			Health services management (short term local training)	2		2002	
			Management modules (District Health Management Teams)	28		Oct- Nov 1997	
			Programming and Health Information (short term)	1		2002	
			Health planning	1		2003	
Training of supervisors	10 d / 1	20 doctors and nurse administrators					
Public Health	12 months	1 scholarship	Public Health (short term scholarship in Benin)	1		Oct 98 / Sept 99	
			Keeping of the National Health Information System Supports	36	8	Oct 98	March 98
			District Surgery	7		2001 / 2002	
Epidemiology	3 months	1 scholarship	Management of epidemics		10	April 1999	
Community Outreach Activities	10 d / 3	90 nurses for RD, HCRD and MC					
			Information and Sensitization of the	89284		November	

			Communities on Participation in Health Activities			2001	
			Establishment of Health Committees	130		December 2001	
			Establishment of Management Committees	18	2	Dec 2001	Oct 2003
			Training of members of the management committees in revenue and drug management tools	90	10	2001 2002	2003
Diagnosis/ treatment of major diseases	5 d / 3	90 nurses for RD, HCRD and MC					
			Risk management in MIH and partogram	15	13	June 98	March 98
			Complaints and treatment strategy	36	12	Oct. 98	May 99
			ICID (integrated coverage of infant diseases)			2003	
			Early identification of epidemics		10	Oct 2003	
Radiology	30 d / 1	20 senior doctors and nurses					
			Support to the Faculty of Health Sciences for the training of assistant surgeons, assistant anaesthetists and radiographers	18		2000 – 2001	
Equipment and drug management	5 d / 3	90 nurses for RD, HCRD and MC					
Maintenance of medical equipment	12 months	3 scholarships	Training in biomedical equipment maintenance (in France)	1		2002- 2003	
Medical biology training.	6 months	1 scholarship					
Laboratory technology	10 d / 2	20 technicians					
Village health	10 d / 2	20 nurses					

NB: Part A on the left side of the table corresponds to the topics of the trainings programmed at appraisal with their duration, frequency and the categories of the beneficiary staff. Part B on the right lists the trainings actually provided with the number of beneficiaries and the training periods.

REPUBLIC OF NIGER

LOCAL HEALTHCARE SECTOR IMPROVEMENT PROJECT IN THE DEPARTMENTS OF MARADI AND DIFFA

PROJECT IMPLEMENTATION PERFORMANCE

Evaluation Criteria	Rating	Observation
1. Adherence to the implementation schedule	1	The project was to be implemented in 4 years. There was a gap of 6 years between the initial completion date and the effective completion date (1998/2004). As a result, the rating is 1: the gap between the initial completion date and the effective completion date exceeds 50% of the initial implementation time as scheduled at appraisal.
2. Adherence to the cost schedule	2	The balance of UA 0.06 million is negligible and has no impact on the implementation of the project activities. The rating is therefore 2: the price variance is within the limit of +/- 50% of the cost estimated at appraisal.
3. Compliance with the conditions/covenants	1	There was a slippage of 20 months on the entry into force. The clause on staff allocation was not respected. The mark is therefore 1: compliance with the clauses is of minimum importance and negligible
4. Relevance of the supervision	2	The technical supervision rate was 1.25 supervisions per annum on average during the project duration, but the recommendations of the Bank experts were not adequately followed. Quarterly status reports were prepared and sent to the Bank, but they were very descriptive and never raised the problems encountered in the implementation. The rating is therefore 2: the efficacy of the monitoring, evaluation and the reports was negligible.
5. Satisfactory operations	N.A*	According to the Operations Manual, the rating of this criterion will be made on the basis of the specific sector performance indicators and will be defined by the retrospective evaluation mission; their utility will be justified.
Total	6	Overall, project implementation was average. It helped increase health infrastructure coverage in the two Departments, but they are not all operational for lack of staff.
Overall implementation evaluation	1.60	Unsatisfactory. The project achievements (construction of health facilities) will improve local healthcare in the Maradi and Diffa Departments of Niger only if the DH and the related services become operational.

N.A* : Not applicable

Annex 6

REPUBLIC OF NIGER

LOCAL HEALTHCARE SECTOR IMPROVEMENT PROJECT IN THE DEPARTMENTS OF MARADI AND DIFFA

PERFORMANCE OF THE BANK DURING THE PROJECT CYCLE

Indicators and Components	Rating	Observations
1. At identification	3	The Bank organized one identification mission in response to the request of the Niger Government.
2. At preparation	3	One 6-week WHO mission obtained the information used for the project preparation.
3. At appraisal	2	The Bank appraisal mission was based on the report of the WHO mission in addition to the Bank's own observations. A re-appraisal mission in 1993 made it possible to update the data.
4. At supervision	2	From 1997 to 2004, supervisions averaged 1.5 per annum, but the recommendations of the Bank's experts were not adequately followed. Delays in the processing of documents and disbursement applications were long and there was no mid-term review.
Total	10	
Overall performance evaluation of the Bank	2.50	Satisfactory: The project design process followed all the required stages. Supervision was regular, but Bank recommendations were not adequately followed.

Annex 7

REPUBLIC OF NIGER

LOCAL HEALTHCARE SECTOR IMPROVEMENT PROJECT IN THE DEPARTMENTS OF MARADI AND DIFFA

PROJECT IMPACT ON DEVELOPMENT

No.	Indicators and components	Mark	Observations
1	**Relevance and achievement of the objectives**	**2.16**	The project contributed to: - the increase in health infrastructure coverage in the Departments of Maradi and Diffa (20 type 1 IHC constructed, which increased health coverage to 42 and 44% for Diffa and Maradi respectively) - Sensitization of the communities and their healthcare coverage. - Training of the health personnel.
(i)	Macro-economic policy	2	
(ii)	Sector policy	2	
(iii)	Physical implementations	3	
(iv)	Financial policy	2	
(v)	Poverty reduction (social, gender)	2	
(vi)	Environment	2	
(vii)	Private sector promotion	SO	
(viii)	Others (specify)	SO	
2	**Institution building**	**1.25**	Support to the Departmental Health Directorate of Maradi and the provision of equipment, infrastructure and drugs, significantly built up the capacities of MPH/EDC in the Departments of Maradi and Diffa.
(i)	Institutional framework, including restructuring	2	
(ii)	Financial and management information systems (including audit systems)	1	
(iii)	Transfer of technology	1	
(iv)	Human resources (including turnover rate, training and counterpart staff)	1	
3	**Sustainability**	**1.00**	The infrastructure (houses, health training premises) and equipment installed have improved the environment and the work environment of the nursing staff. They are built with reliable and durable materials. However, their sustainability depends on the ability to ensure high quality preventive and curative upkeep and maintenance.
(i)	Borrower's continuing commitment	1	
(ii)	Environmental policy	1	
(iii)	Institutional framework	1	
(iv)	Technical viability and staff guidance	1	
(v)	Financial viability and cost recovery mechanisms	SO	
(vi)	Economic viability	1	
(vii)	Environmental viability	1	
(viii)	Operation and maintenance (availability of funds to cover recurrent costs)	1	
4	**Rate of return**	**NA**	
	Total	25	
	Overall impact on development.	**1.47**	Unsatisfactory

REPUBLIC OF NIGER

LOCAL HEALTHCARE SECTOR IMPROVEMENT PROJECT IN THE DEPARTMENTS OF MARADI AND DIFFA

MATRIX OF RECOMMENDATIONS AND FOLLOW-UP MEASURES

Key observations/Conclusions	Recommendations	Follow-up Measures	Responsibility
Formulation/Justification The project design meets the needs determined by the Niger Government at the time of its request. The additional outputs are in line with the improvement of the health care coverage of the population, but as the related costs were not included in the basic contracts of the contractors, the start-up of the infrastructure was delayed.	It is necessary to monitor the evolution of health programming plans, but it should be ensured that the national counterpart funds can finance, in the short term, the modifications envisaged.	Include in the supervision missions of the ADF Health Project II in Niger a component on the collection of information relating to the utilization of the structures put up by Health Project I.	Government and Bank
Project implementation Project implementation experienced a time overrun of 6 years on the initial estimate. The programming of coordination between the provision of the infrastructure and the installation of the equipment was disrupted, with the result that many facilities have not yet been put into service.	In case of necessity (equipment delivery not coordinated with the works) store the equipment under conditions that guarantee its functionality at the time of installation.	Communicate to the Bank the arrangements made to put the premises and the equipment into service.	Government
	Put in place stock accounting for the equipment delivered. Train the users in preventive and curative maintenance. Establish a maintenance service.	Inform the Bank of the steps taken to restructure the existing technical services, put the Maradi biomedical maintenance workshop into service and develop a maintenance culture at all the levels.	Government
This delay led to a redeployment of the trained staff to other sites.	Provide qualified staff to operate the health facilities.	Communicate to the Bank the steps taken to redeploy the trained staff to the project sites.	Government
Compliance with the loan agreement conditions The conditions have been fulfilled except for the one relating to personnel. The national counterpart funds are still to be released to	Ensure recruitment of the necessary staff and its assignment to the project facilities.	Inform the Bank of the recruitments in respect of the facilities built and rehabilitated under the project.	Government

operationalize certain project structures functional.	Suspend ADF disbursements on other projects in the event of outstanding balance owed by the counterparty.	Inform the Bank of the disbursement schedule of the counterpart funds for other Bank Group projects in Niger.	Government
Performance evaluation The achievement of the project objectives improved health coverage qualitatively. All the planned activities have been implemented, but they are not all functional.	Ensure that all the DH technical platforms are put into service to qualitatively improve the health of the population of the two Departments.	Communicate to the Bank the timetable for commissioning the equipment and the buildings.	Government
Sustainability Project impact and sustainability could be jeopardized if the equipment is not put into service and the qualified staff is not available.	In future Bank interventions, insist on the servicing and maintenance of the equipment and infrastructure provided, as well as on human resource development. Pursue the health staff recruitment policy.	Propose projects with a training component for senior health personnel and the development of a maintenance culture in Niger. Achieve the targets of the Health Development Plan (HDP) 2005-2009 on health staff recruitment.	Bank Government

Annex 9

REPUBLIC OF NIGER

LOCAL HEALTHCARE SECTOR IMPROVEMENT PROJECT IN THE DEPARTMENTS OF MARADI AND DIFFA

EXTRACT FROM THE BORROWER'S COM PLETION REPORT

The Borrower's completion report was prepared in December 2004. It is a 35-page report with nine annexes. Its format conforms to that recommended by the Bank. It is a descriptive report of the project activities with analysis of the causes of the delays and the poor performance of the project. In the conclusions of the report, the following should be noted:

The expected project results, including the general objective of improving the geographical and operational coverage of the local healthcare sector in the departments of Maradi and Diffa, are fully achieved, as attested by the various outputs, some of which greatly exceeded projections (health infrastructure). The support of the African Development Bank and the Niger Government was decisive in the implementation of the project to the satisfaction of the beneficiaries.

The extension of health coverage, improvement of the technical platform, the enhancement of the workers' skills, the availability of drugs and reagents, etc, all represent concrete actions that improve the health conditions of the population, in keeping with the objectives. These interventions will thus help reduce poverty.

However, while the beneficiaries of the project are highly satisfied, the fact remains that a lot still needs to be done considering the pressing demand of the segment of the population that continues to cover long distances to access health care.

That is why the support of the technical and financial partners, particularly the African Development Bank, is necessary for the implementation of the new Health Development Plan 2005 – 2009, in order to sustain the achievements and envisage the expansion of health coverage.

The recommendations made to the Ministry of Public Health and Endemic Diseases Control are: i) take the necessary steps to complete the remaining works (Dakoro, Madarounfa, Guidan Roumdji DHs and Maradi RHC), installation of SSB radios, operating of generators and installation of biomedical equipment); ii) take all the necessary steps to make the DH operational by equipping them with health staff in quantity and quality; iii) build the electrical capacities of the DH and iv) examine with the Ministry of Economy and Finance the provision of the financial resources needed to ensure the smooth functioning of the infrastructure.

Annex 10

REPUBLIC OF NIGER

LOCAL HEALTH CARE SECTOR IMPROVEMENT PROJECT IN THE DEPARTMENTS OF MARADI AND DIFFA

BORROWER'S OBSERVATIONS ON BANK PCR

The observations of the Borrower on the Bank's PCR submitted to the Bank in August 2006 are summarized as follows:

- Overall, the report highlights the implementation status of the local healthcare improvement project in the Departments of Maradi and Diffa. The shortcomings and difficulties underlined in the report are relevant and will serve as lessons to be taken into consideration for the satisfactory implementation of future projects. Most of the recommendations were based on the objectives of the 2005-2010 HDP.;

- The construction of Aguie, Dakoro, Madarounfa, Mayahi and Tessaoua district hospitals, constitutes an achievement for Niger. Once operational, the DH will help very significantly enhance the level and quality of health care. MPH/EDC has taken certain measures to operationalize them:

    - Increase in electrical capacities and installation of generators in the district hospitals;
    - Assignment of a second doctor to each district;
    - Training in district surgery;
    - Recruitment of specialists through South-South cooperation and United Nations Volunteers (UNV);
    - Recruitment of 714 health workers (lab assistants, nurses, doctors, midwives, assistant anaesthetists, radiographers and surgical assistants).