# HEALTH DEVELOPMENT PLAN RESOURCE MAPPING

**REPUBLIC OF NIGER**
Fraternity - Work - Progress
**Ministry of Public Health**

December 2020

# CONTENTS


| | |
|---|---|
| **ACKNOWLEDGMENTS** | **4** |
| **EXECUTIVE SUMMARY** | **6** |
| **1. INTRODUCTION** | **8** |
| 1.1. Challenges and rationale | 8 |
| 1.2. Contextual elements specific to Niger | 9 |
| **2. METHODOLOGY** | **12** |
| 2.1. Preparatory phase | 12 |
| 2.2. Data collection process | 12 |
| 2.3. Data entry and processing method | 13 |
| 2.4. Data analysis and interpretation | 14 |
| 2.5. RPresentation of results | 14 |
| **3. RESOURCE MAPPING RESULTS** | **16** |
| 3.1. Health Development Plan funding analysis | 16 |
| 3.2. Covid-19 Response Plan funding analysis | 22 |
| 3.3. Health Development Plan funding gap analysis | 23 |
| 3.4. Covid-19 Response Plan funding gap analysis | 26 |
| **4. CONCLUSION AND RECOMMENDATIONS** | **28** |
| 4.1. Conclusion | 28 |
| 4.2. Recommendations | 29 |
| **APPENDICES** | **30** |
| Appendix 1: List of HDP priority interventions 2017-2021 | 30 |
| Appendix 2: Resource mapping timeline | 34 |
| Appendix 3: Description of the computerized collection tool | 36 |
| Appendix 4: Mapping results PowerPoint presentation | 48 |


# FIGURES


| | |
|---|---|
| **Figure 1 :** Les cinq étapes clés de la cartographie des ressources | 12 |
| **Figure 2 :** Évolution des dépenses de santé par habitant au Niger | 16 |
| **Figure 3 :** Répartition des ressources par source de financement du PDS | 17 |
| **Figure 4 :** Répartition des financements extérieurs par type de bailleur en 2020 | 17 |
| **Figure 5 :** Répartition des financements dans le budget de l'État en 2020 | 18 |
| **Figure 6 :** Répartition des financements par domaine prioritaire du PDS en 2020 | 18 |
| **Figure 7 :** Répartition des financements par programme et par source de financement en 2020 | 19 |
| **Figure 8 :** Répartition des financements par sous-programmes du programme 3 du PDS en 2020 | 20 |
| **Figure 9 :** Répartition des financements liés à la sécurité sanitaire et la gestion des épidémies | 20 |
| **Figure 10 :** Répartition des financements au niveau infranational en 2020 | 21 |
| **Figure 11 :** Comparaison du budget par région et par habitant en 2020 avec le niveau de mortalité infanto-juvénile | 21 |
| **Figure 12 :** Répartition des financements Covid-19 par source et modalité de financement en 2020 | 22 |
| **Figure 13 :** Répartition des financements Covid-19 par volet du Plan de Réponse en 2020 | 23 |
| **Figure 14 :** Estimation du déficit de financement du PDS en 2020 | 23 |
| **Figure 15 :** Estimation des besoins de financement du PDS 2017 & 2018 (en million XOF) | 24 |
| **Figure 16 :** Estimation du déficit de financement par programme du PDS en 2020 | 24 |
| **Figure 17 :** Estimation des déficits de financement au sein du Programme 2 du PDS en 2020 | 24 |
| **Figure 18 :** Estimation des déficits de financement au sein du Programme 3 du PDS en 2020 | 26 |
| **Figure 19** : Estimation du déficit de financement par pilier du Plan de Réponse à la Covid-19 en 2020 | 26 |


# ACRONYMS

**CS**: health accounts
**PCAC:** community-based growth monitoring
**PECADOM:** community-based malaria management
**PCIME COM:** Community-based Integrated Management of Childhood Illness
**DBC:** Community-based distribution (of contraceptives)
**PFE:** Essential Family Practices
**ATPC:** community-driven total sanitation
**DRSP:** Regional Public Health Directorate
**UEMOA:** West African Economic and Monetary Union
**DPPD:** Multi-year expenditure planning document
**ONPPC:** The National Office for Pharmaceutical and Chemical Products
**SONIPHAR:** Nigerien Pharmaceutical Industries Company
**EDSN-MICS:** Demographic Health Survey and Multiple Indicator Cluster Survey in Niger

# ACKNOWLEDGEMENTS

This study was entirely funded by the **Global Financing Facility in Support of Every Woman Every Child (GFF)** with technical support from the **GFF secretariat**, the GFF Liaison Officer for Niger **MR ABOUBACAR CHAIBOU BEGOU** and a national consultant, **MR ISSAKA KASSOUM**, health economist.

The authors sincerely thank **Dr Ranaou Abaché, Secretary General of the Ministry of Public Health (SS/MPH), the GFF government focal point in Niger** and **all the members of the GFF technical committee** for their facilitation and guidance in carrying out the study from start to finish.

Furthermore, we also thank the **Government, Technical and Financial Partners** and all the **organizations surveyed** for the valuable information provided, without which this study would not have been possible, and for their active role in validating this report.

# EXECUTIVE SUMMARY

**The Global Financing Facility (GFF) has been operating in Niger since July 2019, with reducing the funding gap for maternal and child health observed in most high-burden countries as its main objective.** As part of its mission, the GFF mobilized external technical assistance to map the resources available for funding the Health Development Plan (HDP) covering the period 2017-2021.

**This report details the implementation and results of the first resource mapping exercise conducted in Niger. This exercise had the following three objectives:**

1. To assess the alignment of internal and external resources with national priorities;
2. To estimate the funding gap (provide an overview of financial commitments with the estimated cost of national priorities);
3. To assess the level of equity in terms of subnational health funding.

Faced with the health crisis that arose during the exercise, the resource mapping was extended to include the new coronavirus preparedness and response plan developed for 2020.

At the operational level, the use of an electronic tool for data collection and the existence of a health budget consistent with the three HDP programs facilitated the mapping of resources. On the other hand, it also suffered from a number of limitations and uncertainties (eg: limited availability of stakeholders and data at the regional level, limited disaggregation of the information transmitted) reducing the accuracy of the analyses. That said, the results obtained on the financial commitments of the Ministry of Health and its main partners remain instructive. The resource mapping exercise was able to show:

- The importance of external resources to HDP funding and the new coronavirus response plan (67% of the resources committed for HDP funding in 2020 come from external funding and 91% for the Covid-19 response plan);
- The relatively large share of resources passing through the State budget (64%);
- The significant funding gap (83 billion XOF) suffered by HDP program 3 relating to the provision of health care and services. This is despite the fact that it alone receives over 45% of the total funding allocated to the HDP (almost exclusively from external partners);
- The preponderance of reproductive health, nutrition and epidemic management sub-programs among the 8 sub-programs identified in the HDP. It should be noted that more than 50% of the funds allocated to the health security and epidemic management sub-program are related to the fight against Covid-19,
- A lack of efficiency in resource allocation with overfunded sub-programs (capacity building, improving the availability of health products, nutrition) and largely underfunded programs (promotion of financial risk protection mechanisms, control of communicable diseases);
- Inequity in resource allocation at the regional level, which does not always correspond to needs (e.g: low level of resource allocation per capita in the Maradi region, which has one of the highest child mortality rates in the country);
- The scale of the new coronavirus response plan funding gap (approximately 143.2 billion XOF).

**Finally, concerning the recommendations made following the mapping exercise, they touch on the following points:**

1. Strengthen advocacy with relevant stakeholders (MF, MPH, TFP) on the importance of resource mapping (RM) to facilitate its replicability on an annual basis;
2. Ensure that the programmatic management for the new HDP is strengthened (eg: review and clarify the nomenclature of activities and results) in order to facilitate the insertion of donor interventions into this plan;
3. Ensure the integration of RM information needs into State budgeting tools;
4. Position a collection tool at partner level for regular completion each year at the beginning of the budget cycle in accordance with the requirements of the program budget reform (DPPD);
5. Establish an environment conducive to greater predictability of partners financial commitments.

# 1. INTRODUCTION

## 1.1 Challenges and rationale

### What is the GFF?

The Global Financing Facility in Support of Every Woman Every Child (GFF) is a multi-stakeholder[1] partnership that aims to close the funding gaps for maternal and child health observed in most high-burden countries. Granting a central role to governments[2] through the mobilization of domestic funding, the GFF also aims to guarantee the optimal use of existing financial resources by promoting their alignment with the priority actions identified in the areas of Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH-N).

These priorities are most often derived from the National Health Development Plans (NHDP) and are included in the GFF process in a document called the Investment Case (IC). The development of this IC is supposed to mark the first step for countries towards better management of their resources for health.

But this prioritization work must be accompanied by additional measures, in particular the establishment of a long-term sustainable funding strategy to support the programs and actions described in the IC. Thus, in order to inform the planning and budgeting process of the government and its partners regarding RMNCAH, the second step of the GFF process is to map the resources available for IC funding.

### The Resource Mapping exercise

For a given country, the RM aims to capture as well as possible all the financial commitments made by the government and its partners concerning the priority programs and actions in its IC.

**In doing so, this exercise has several objectives:**

- To assess the alignment of internal and external resources with national priorities;
- To estimate the funding gap (provide an overview of financial commitments with the estimated cost of national priorities);
- To assess the level of equity in terms of subnational health funding.

1 Launched at the Financing for Development conference in Addis Ababa in July 2015, the GFF is a partnership that includes civil society organizations, the private sector, UN agencies, GAVI, the Global Fund as well as recipient country governments.

2 More than 65 low and middle-income countries have signed a partnership agreement with the GFF.

## 1.2 Contextual elements specific to Niger

The Republic of Niger joined the GFF in July 2019. The Nigerien government welcomed this partnership as an opportunity to improve the cost-effectiveness and equity of health spending (both public and external) by aligning it with national priorities focused on RMNCAH and Nutrition.

### The reproductive health situation in Niger

Maternal and child health has been a public health priority in Niger for many years with one of the highest mortality rates in the West African region. Access to quality obstetrical care is still too limited, especially for the poorest women, and coverage of family planning (FP) needs remains low.

The child mortality rate estimated by the EDSN-MICS IV for 2006-2012 is 127 per 1,000 births and the maternal mortality rate is 535 deaths per 100,000 live births. During this same period, only 29.3% of births took place in a modern health facility with the support of qualified health personnel. This figure is largely indicative of a problem of access to care. According to the same survey, 60% of women cited the financial barrier as the main bottleneck limiting access to care. This proportion reaches 62% among women in rural areas. In terms of FP, only 11% of women of childbearing age use a modern contraceptive method. Here again, there are major disparities according to milieu and level of education.

Chronic malnutrition is evolving inconsistently at a very high level of more than 45% with a prevalence of 50% in 2006 against 45.7% in 2012.

Despite significant progress in recent years, reproductive health remains a key area of intervention where significant investment is still needed.

### The Health Development Plan 2017 - 2021

Le Plan de Développement Sanitaire (PDS) duquel ce DI doit découler couvre la période 2017 – 2021. Ce document prévoit six axes stratégiques relatifs aux différents piliers du système de santé et inscrit son action dans le cadre de trois programmes et 28 sous programmes[3].

**These three programs concern:**

1. Improving governance and leadership;
2. Access to health care and services;
3. Access to health care and services.

An evaluation of the costs of implementing these programs and a budget framing exercise were carried out during the preparation of the document. The estimated cost of the HDP is 1,469,225,692,243 FCFA. The cost per capita is estimated at 16,640 FCFA in 2017 and 17,647 FCFA in 2021, with a large share devoted to «the provision of health care and services» program. The most recent health accounts[4] (CS) show that approximately 40% of the projected budget is covered by the State and 56% by households5. Available funding was also estimated and revealed a funding gap of approximately 359 billion FCFA (24% of the overall cost of the HDP).

## Resource Mapping in Niger

In view of the time needed to develop the IC and since this was the very first RM exercise conducted in Niger, the choice was made to broaden the scope of the exercise to the entire HDP, with the IC map stemming from that of the HDP according to a nested approach. The two exercises (RM and IC development) should therefore be conducted in parallel.

It should also be noted that Niger was struck by the Covid-19 virus when the RM started. In order to face this health crisis, a «preparedness and response plan for the new coronavirus» was drawn up by the Ministry of Public Health (MPH) with the support of its Technical and Financial Partners (TFP) from March 2020. Taking into consideration the impact of Covid-19 on the financial commitments of partners and the Nigerien government, the decision was made to specifically include interventions related to this pandemic in the RM.

**As part of the Covid-19 preparedness and response plan, these interventions were structured around six components:**

1. Coordination;
2. Epidemiological surveillance;
3. Prevention and control of infection;
4. Risk communication and community engagement;
5. Health service capacity;
6. Isolation sites.

The Niger RM was entrusted to an international consultant who received technical support throughout the exercise from the GFF liaison officer posted at the MPH and a national consultant. These three people made up the «RM team”. Finally, in terms of governance, the anchoring of the GFF at the level of the MPH's Secretary General is intended to strengthen the government's leadership and the ownership of the approach by national stakeholders. Regarding RM, this anchoring should guarantee effective use of the results obtained from the ongoing work on Universal Health Coverage (UHC).

**Finally, the Niger RM, in addition to pursuing the general objectives mentioned above (see section 1.1), also aimed to achieve the following results:**

- **Guide the development of the next HDP.** The relatively short scope of the RM (2020-2021) limits the formulation of recommendations over this period but must provide key information (overfunded HDP programs and sub-programs, underfunded regions) which should guide the choices and the prioritization process during the development of the next HDP.
- **Raise awareness of the RM exercise among MPH executives and TFPs.** As this was the first RM exercise conducted in Niger, it was a learning process. The idea was to inform the MPH and TFPs about the objectives of the mapping exercise and its rationale, but also to identify success factors and bottlenecks that could impact the achievement of these objectives. This «learning by doing» work should make it possible to streamline and facilitate the organization of RM on an annual basis in Niger.

3 The Ministry of Public Health in Niger has been operating in program budget mode since 2018. The content of each program and sub-program in terms of priority actions is specified in Appendix 1.

4 Health Accounts (CS 2018).

5 Household contributions to HDP funding is exclusively focused on the «access to care» program.

# 2. MÉTHODOLOGIE

The RM was conducted from January to November 2020 following the five stages indicated below (see figure 1). The detailed work plan for the RM exercise is provided in Appendix 2.

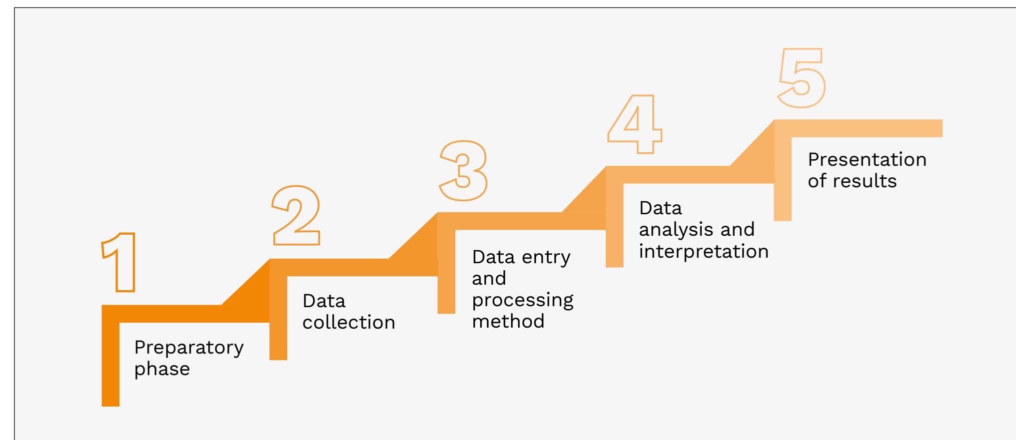



**Figure 1:** **The five main stages of the resource mapping**

Source: Niger Health Accounts

## 2.1 Preparatory Phase

The preparatory phase included (i) the process of recruiting the international consultant, (ii) the latter's configuration of the collection tool developed by the GFF6 and, (iii) the mapping of partners involved in the health sector in Niger.

This phase ended with the consultant organizing a first field mission to formalize contact with the health authorities and to raise partners' awareness of the nature and objectives of the RM. To this end, the effective and regular holding of the GFF technical committee coordinated by the SG was a facilitating factor.

## 2.2 Data Collection Process

The RM includes financial commitments related to national public finances and international donors in the health sector. It is therefore a forward-looking exercise centered on exclusively quantitative data.

Covering the last two years of the HDP (2020-2021), the RM relied primarily on secondary data collection from three information sources: the MF[7], the MPH[8], and the TFPs selected during the preparatory phase. Table 1 below presents a summary of the expected and actual number of partners interviewed by type of organization.

Based on the 2018 CS, the 24 partners targeted in the RM represented more than 80% of the health care expenditure made by organizations categorized as «rest of the world.» Of these 24 partners, 22 were included in the RM[9].

6 Drawing on experience gained in many countries in the subregion (Côte d'Ivoire, Senegal, etc.), the GFF team worked to develop a standard, user-friendly tool. It developed this tool taking into account the current reforms within UEMOA in the area of public finance and, in particular, the transition of countries to results-based management with the adoption of program budgets. A detailed description of the tool is provided in Appendix 3.

7 Finance Act and the MPH Annual Performance Project (PAP) 2020.

8 2020 Budgeted Annual Action Plans.

9 At the time of writing, UNICEF data was still pending and EU Covid-19 commitments could not be taken into account due to lack of detailed information on allocation programs.





| Categories | Targeted | Responses | Unusable responses | Missing responses | |
|---|---|---|---|---|---|
| Bilateral donors | 5 | 5 | - | - | 100% |
| Multilateral donors | 9 | 7 | 1 | 1 | 77% |
| Common Fund | 1 | 1 | - | - | 100% |
| NGO | 9 | 9 | - | - | 100% |
| **Total** | 24 | 22 | 1 | 1 | 91% |

**Table 1:** **Summary of targeted and interviewed partners**

Source: Niger Health Accounts

To facilitate data collection, a standard Excel spreadsheet file was developed. This file, configured according to Niger's demographic data and the structure of the health program budget, was sent to each information source along with a user guide. A review of the key mapping documents provided information on the estimated cost of the various programs.

## 2.3 Data entry and processing method

### Data entry and encoding

The data collection file was sent to all previously identified TFPs for completion. The data collection was therefore carried out by the partners themselves with the remote support of the RM team. The donors and executing agencies (NGOs) were thus able to link their activities to the programs, sub-programs and priority actions of the HDP by specifying for each activity the type of support (budgetary or extra-budgetary) as well as the sum of commitments planned for the two years covered. Regarding the State's budget commitments, this input and encoding work was done by the GFF liaison officer using data from the 2020 PAP.

The decision to extend the RM to the new coronavirus preparedness and response plan led to an adaptation of the collection file in order to facilitate the entry of more detailed information (higher level of data disaggregation than for the HDP) concerning activities relating to Covid-19. As well as the six components of the response plan presented above, these adaptations had to take into account the nature of the activities as well as their funding sources (funds originally allocated to Covid-19 or reprogrammed from another HDP program).

### Data consolidation

The data included in the collection files was consolidated in two analysis tools:

1. A standard HDP analysis file developed by the GFF and configured by the international consultant. This file includes two components relating to the "donor budget" and the "public budget" which are processed separately.

**What do we mean by "State Budget"?**

To collect information on domestic resources available for health, the RM team relied primarily on the PAP 2020. This included the State's own commitments (public treasury funds) and also the commitments of certain partners recorded in the form of loans or donations. For this RM, the choice was made to exclude all external funding from the «public budget» heading and to keep only the activities and interventions funded by the country's own resources. External funding sources, regardless of the funding method, were included in the «donor budget» component. This decision was made to:

- limit the risk of double counting partners' commitments
- ensure the visibility of State partners intervening through the public budget.

2. A Covid-19 analysis file, developed specifically by the international consultant to process information related to this pandemic separately.

The financial information shared by partners and national authorities (MF, MPH) having been provided in several currencies10, was converted into local currency and then into US dollars according to the exchange rate at the start of the data processing phase, i.e. on August 13, 2020[11].

## 2.4 Data analysis and interpretation

In line with the RM objectives, two main types of analysis were carried out.

First, an analysis of financial commitments broken down by funding source, health priority and region. This analysis aimed to answer the following policy questions:

- What resources are available to fund the HDP and the Covid-19 response plan? From what sources?
- To what extent are financial resources consistent with the country's health priorities?
- With what level of equity are these financial resources allocated by health region?

The second type of analysis involved locating and assessing the size of the HDP funding gap by program and sub-program. A similar analysis by component of the Covid-19 response plan was also carried out.

To facilitate the analysis and interpretation of results, a visualization tool based on several dynamic tables linked to the consolidated database was developed.

## 2.5 Presentation of results

The results were communicated through a PowerPoint presentation (Appendix 4) and two feedback workshops. A first workshop was held on October 13, 2020 for the GFF Secretariat and WHO Geneva and a second workshop was held on November 5, 2020 for the MPH and its TFPs. This report is also part of the dissemination of the RM results.

**10** Mainly in XOF, EURO or USD

**11** Exchange rate 1 USD = 554 XOF

# 3. RESOURCE MAPPING RESULTS

## 3.1 Health Development Plan funding analysis

### Analysis of HDP funding sources

Analysis of the 2018 Health Accounts clearly shows the three main sources of HDP funding to be direct household payments, the State budget (including budget support), and «rest of the world» funding. They contribute 48%, 34%, and 13%, respectively to the total resources spent on health in 2018. Figure 2 below shows the evolution of these three funding sources between 2015 and 2018.

According to the PAP, the budget allocated to the MPH for 2020 was 147.6 billion FCFA (i.e. 6,372 FCFA per capita), of which 82.7 billion FCFA was funded by Niger's own resources. According to the data collected from TFPs, the share of external funding in the form of budgetary and extra-budgetary support was 168.5 billion FCFA. In total, the resources available for HDP funding in 2020 amounted to 251.2 billion FCFA.

As mentioned above, the significant decrease in funding planned for 2021 can be explained in large part by the lack of visibility of the TFPs on their commitments.

A detailed analysis of external resources reveals that two-thirds come from multilateral donors, led by the World Bank, the Global Fund, the World Food Programme (WFP) and GAVI, The Vaccine Alliance. Then comes the Common Fund through which several partners (multilateral and bilateral) and bilateral donors (KfW, AFD, ENABEL, KfW, USAID, etc) intervene. Finally, foundations and other private organizations represent only 3% of the external resources committed to health in Niger in 2020.

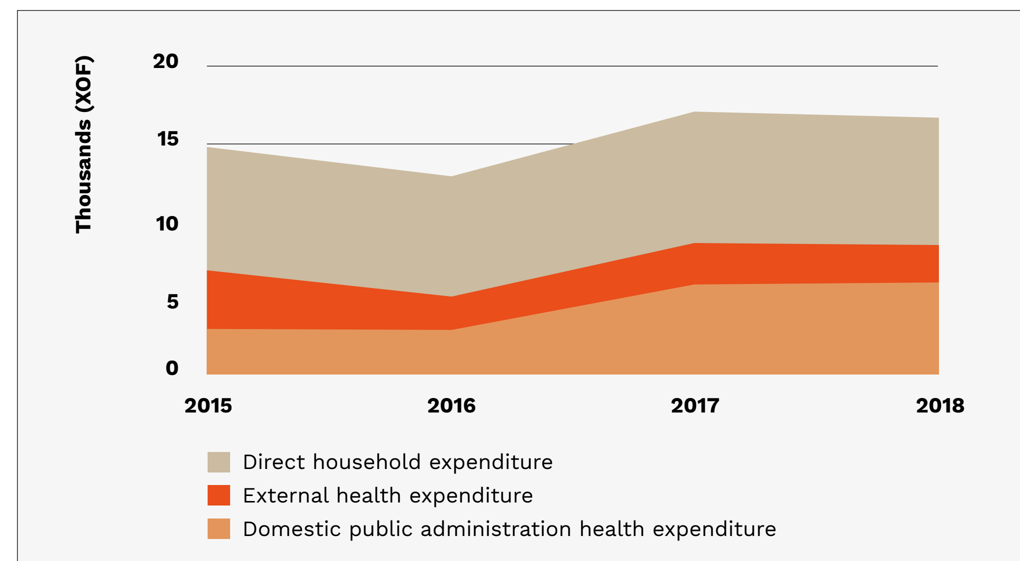



**Figure 2:** **Evolution of health expenditure per capita in Niger**

Source: Niger Health Accounts

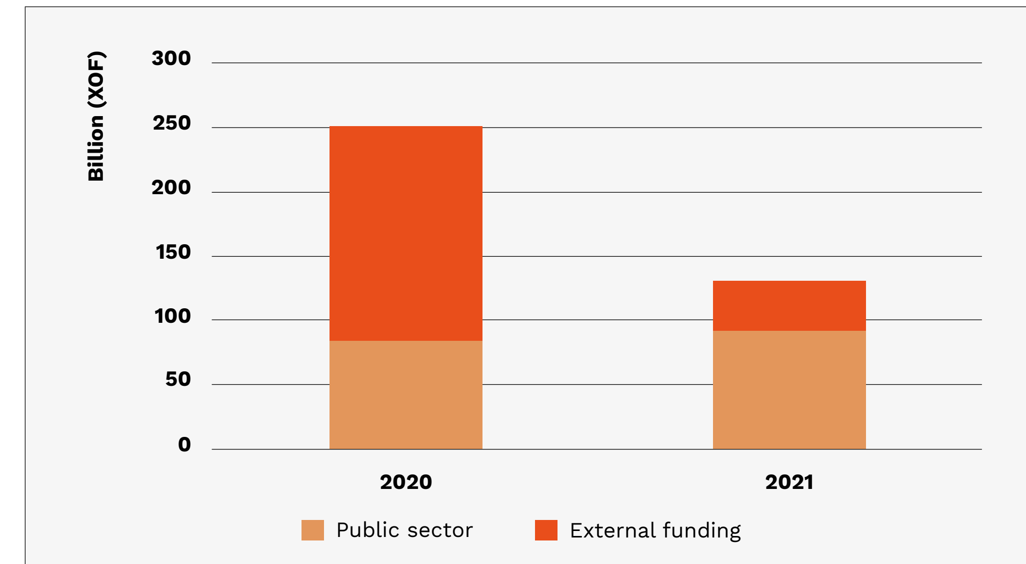



**Figure 3:** **Distribution of resources by HDP funding source**

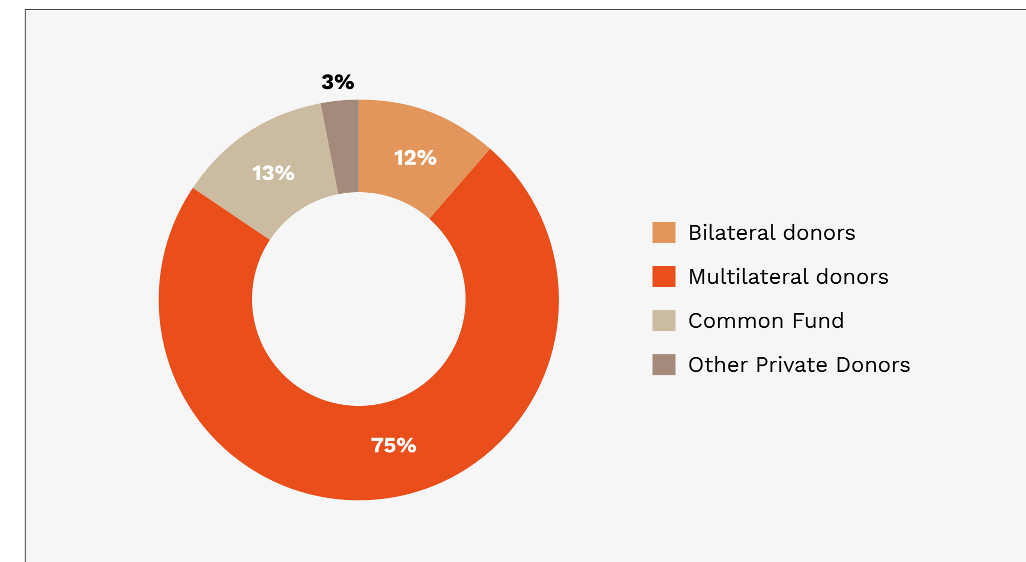



**Figure 4:** **Distribution of external funding by donor type in 2020**

### Analysis of HDP funding methods

According to RM data, 64% of the total available resources are presumed to be mobilized through the State budget. The resources of the main bilateral partners (AFD, ENABEL, KfW) are generally included in the finance act and integrated into the State budget, while the funds of most multilateral donors and private donors (e.g. foundations) are extra-budgetary.

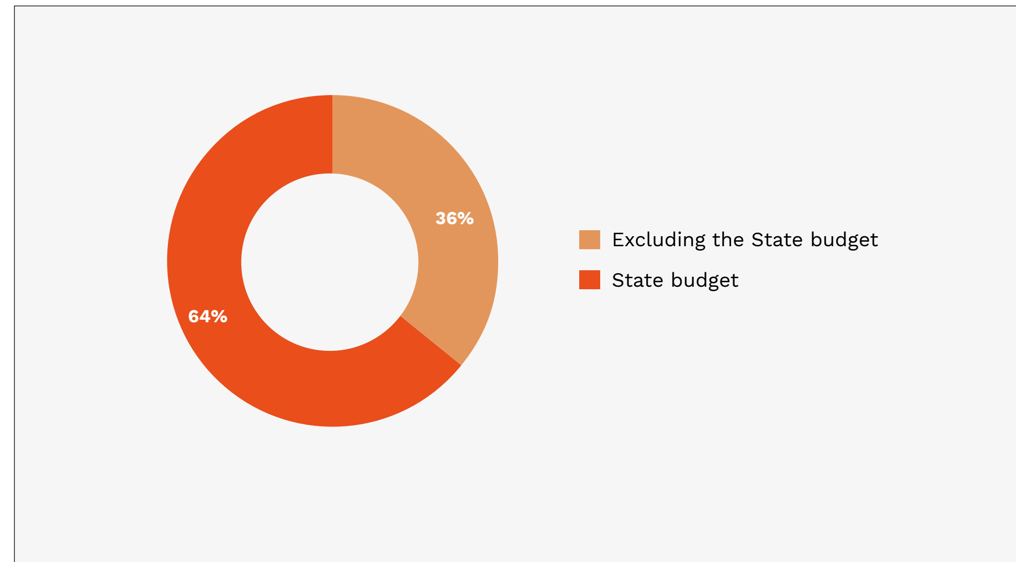



**Figure 5:**
**Distribution of funding in the State budget in 2020**

Source: Niger Health Accounts

## Funding analysis by priority area

Of the three priority programs identified in the HDP, program 3 on health service provision is presumed to take the largest share of resources allocated to health (45%). It is followed by the second program, «access to care», and the «governance and leadership» program, which account for 28% and 27% of total budget commitments respectively.

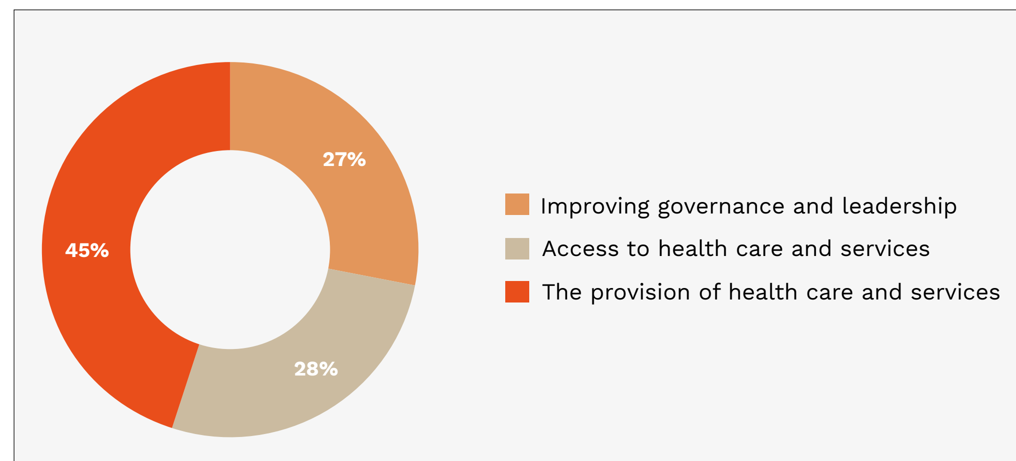



**Figure 6:**
**Funding distribution by HDP priority area in 2020**

RM data (see Figure 6) shows that a limited number of donors fund the «leadership and governance» program outside the Common Fund. This finding seems logical insofar as the activities included in this program largely come under the regulatory functions of the Ministry of Health (steering, sectoral dialogue, tracking and inspection, etc.).

Conversely, the State budget program allocates very few resources to program 3 «provision of health care and services». This program is largely funded by partners through their interventions in the fight against neglected tropical diseases, those aimed at improving reproductive health and their activities in the field of nutrition.

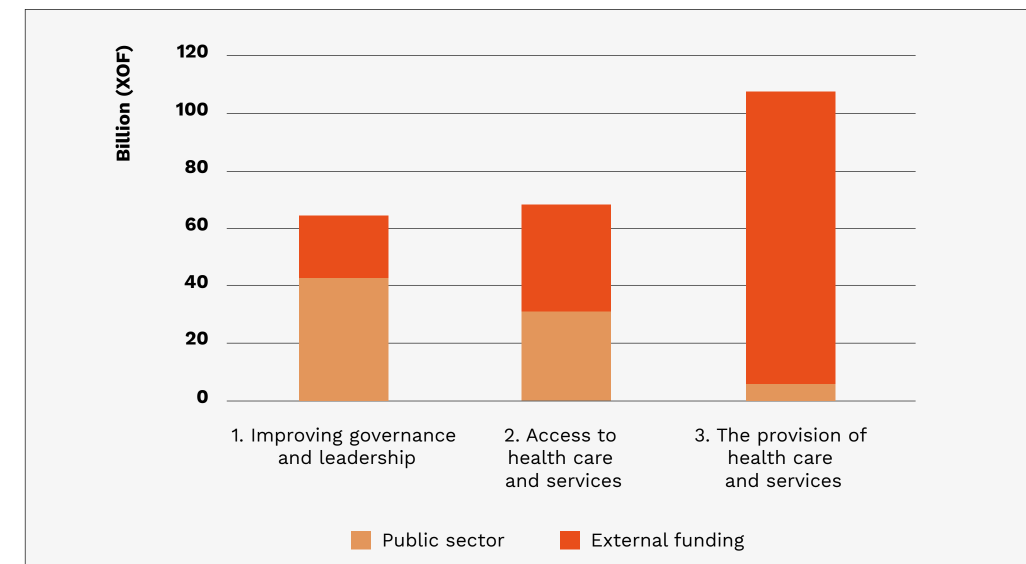



**Figure 7:**
**Funding distribution by program and funding source in 2020**

## Funding analysis by health program

4 of the 8 sub-programs identified in program 3 of the HDP mobilize almost all (93%) of the resources committed by partners and the State. Reproductive health alone monopolizes more than 30% of funds, or around 34 billion FCFA. The bulk of these funds are dedicated to strengthening maternal and newborn health services (88%) and family planning activities (11%). Note that no funding has been recorded to combat non-communicable diseases. Finally, it should be noted that the "health security, epidemic, emergency and disaster management" sub-program includes part of the funds initially linked to the fight against Covid-19[12]. These funds represent half of the resources mobilized in this sub-program, which explains its relative size (see figure 8).

12 Une analyse détaillée des interventions liées à la Covid-19 est fournie en section 2.

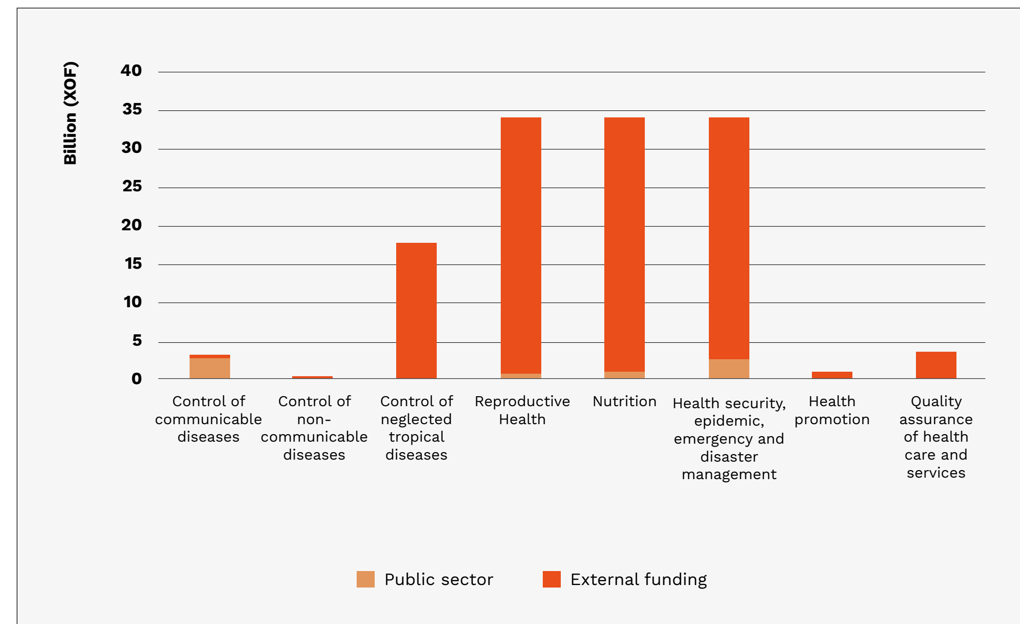



**Figure 8:** **Funding distribution by HDP program 3 sub-program in 2020**

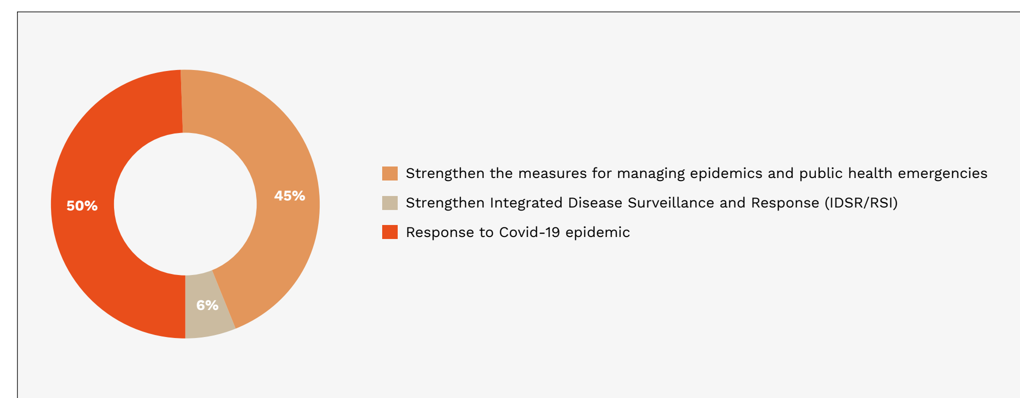



**Figure 9:** **Funding distribution linked to health security and epidemic management**



## Funding analysis at the subnational level

Of the 251.2 billion FCFA recorded in the RM, 14% can be distributed at the subnational level, the rest being allocated at the national level. The regions of Tillabéry de Tahoua, Dosso and Zinder represent the largest share of resources allocated at the subnational level. However, the adjusted per capita allocation indicates that the areas of Tillabéry, Agadez and Diffa receive the most funds per capita, while the areas of Maradi, Tahoua and Zinder receive the least.

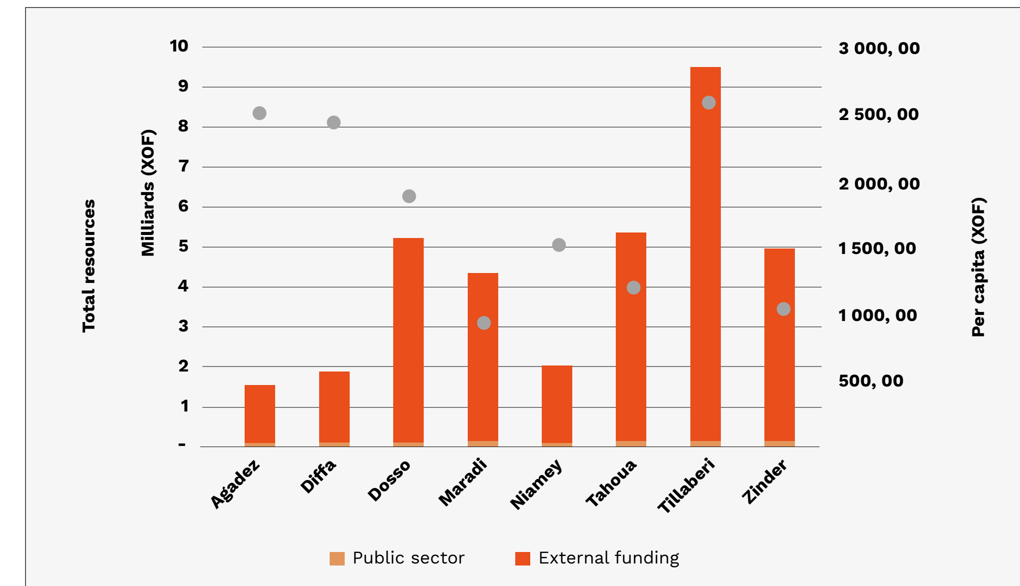



**Figure 10:** **Funding distribution at subnational level in 2020**

Significant disparities therefore seem to exist between regions. While the Maradi region receives a little less than 1,000 FCFA per capita, the Tillabéry region (which benefits from the support of several bilateral partners) receives more than 2,500 FCFA. In addition, the comparison of funding per capita and health outcomes by region shows that funding is not always in line with needs (see Figure 10).

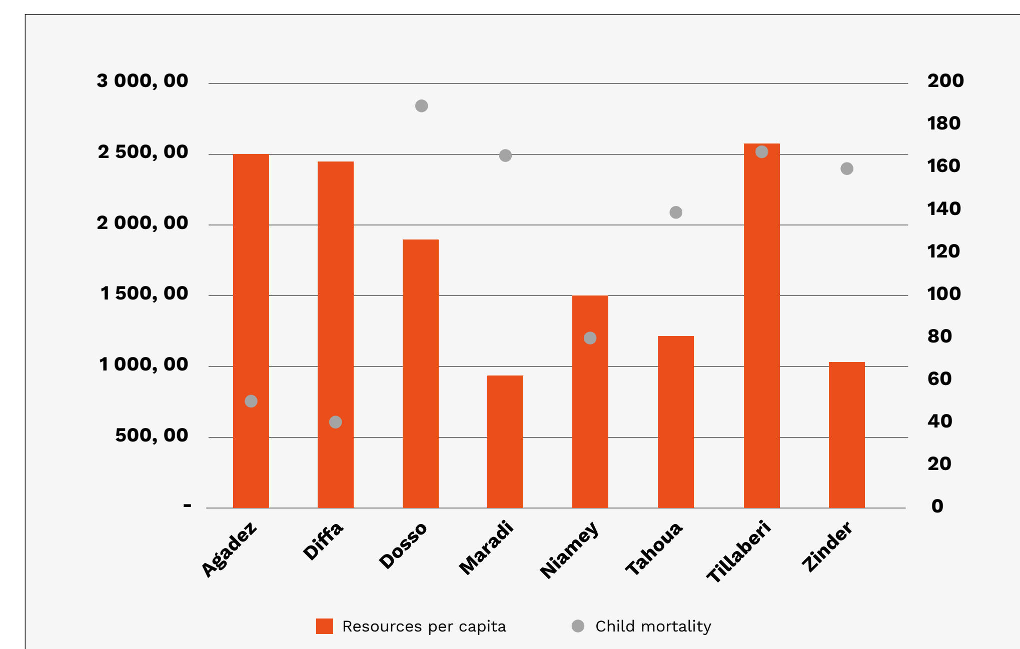



**Figure 11:** **Comparison of the budget per region and per capita in 2020 with the child mortality rate**

Source: EDSN-MICS IV 2012

## 3.2 Covid-19 response plan funding analysis

### Analysis of funding sources and methods

The total amount of commitments captured by the RM and dedicated to the fight against Covid-19 for 2020 amounts to 16.5 billion FCFA, of which 15.1 is registered by TFPs. This amount includes the commitments initially planned for the fight against this epidemic (up to 10.4 billion FCFA) and also the reprogramming carried out from the State budget and other health programs (approximately 6.1 billion FCFA). A very large part of the funds initially allocated to Covid-19 come from the Covid-19 emergency response project supported by the World Bank (an estimated budget of 7.9 billion FCFA).

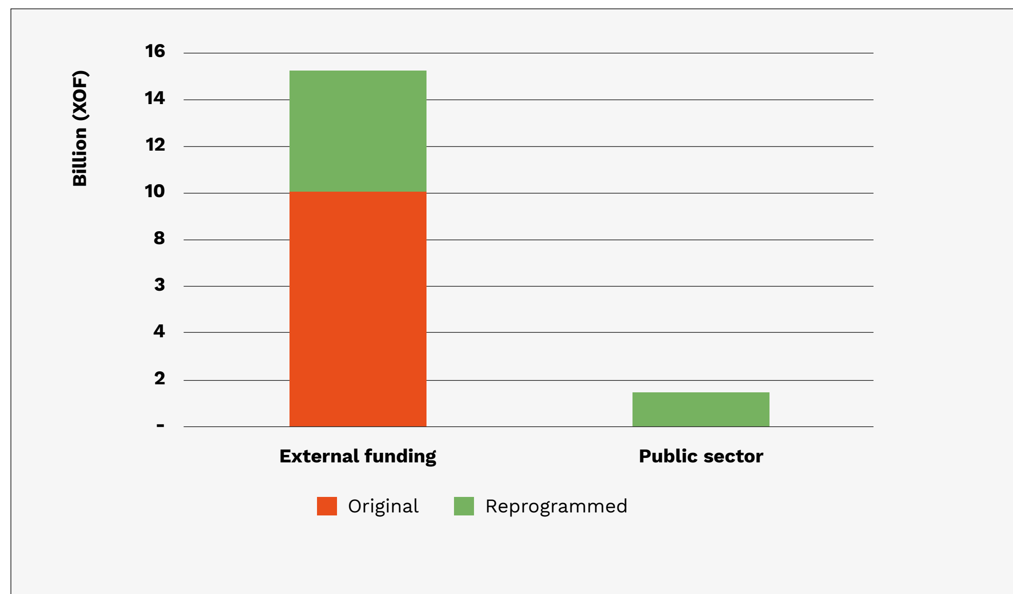



**Figure 12:** **Covid-19 funding distribution by source and funding method in 2020**

Of the 6 components of the new coronavirus preparedness and response plan13, the pillar aimed at strengthening health service capacity (supply of medicines, protective equipment and treatment, recruitment of health workers and volunteers, etc.) mobilizes half of the funding allocated to Covid-19. Epidemiological surveillance comes second (23%), followed by pillars related to infection prevention/control (10%) and communication (10%).

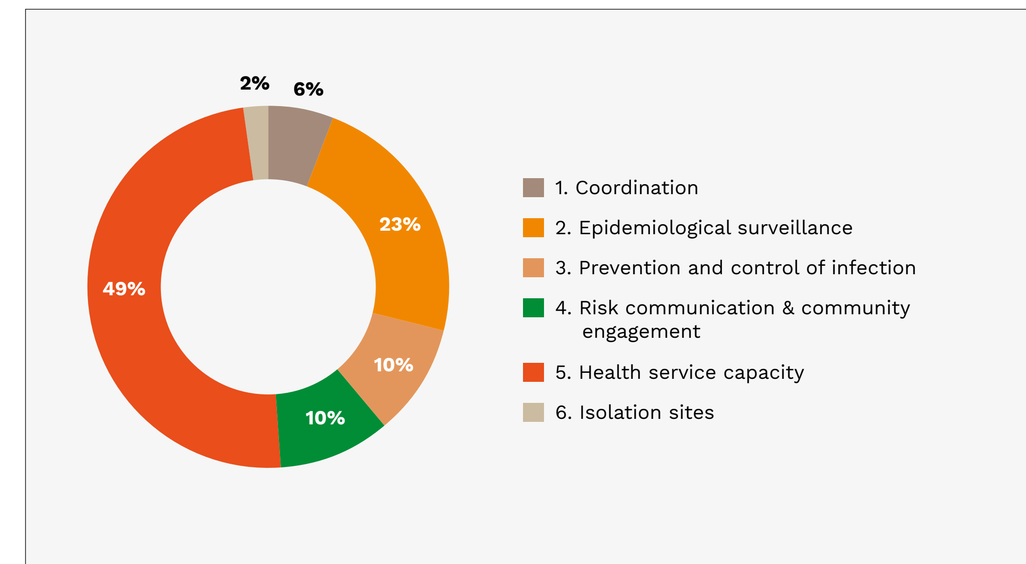



**Figure 13:** **Covid-19 funding distribution by Response Plan component in 2020**

## 3.3 Health Development Plan funding gap analysis

### Analysis of the overall HDP deficit

The cost of the HDP in 2020 was estimated at 309.9 billion FCFA. As seen above, the total commitments recorded by the RM for that same year amounted to 251.3 billion FCFA. The HDP funding gap for 2020 would therefore be 58.6 billion FCFA (see figure 13). For 2021 and on the basis of forecasts made in the State budget, the funding gap amounts to 140.6 billion FCFA.

13 Le volet coordination ne comprend que les financements extérieur. Aucune information financière (coût ou engagement de l'État) n'est fournie par le plan de réponse sur le volet 1.

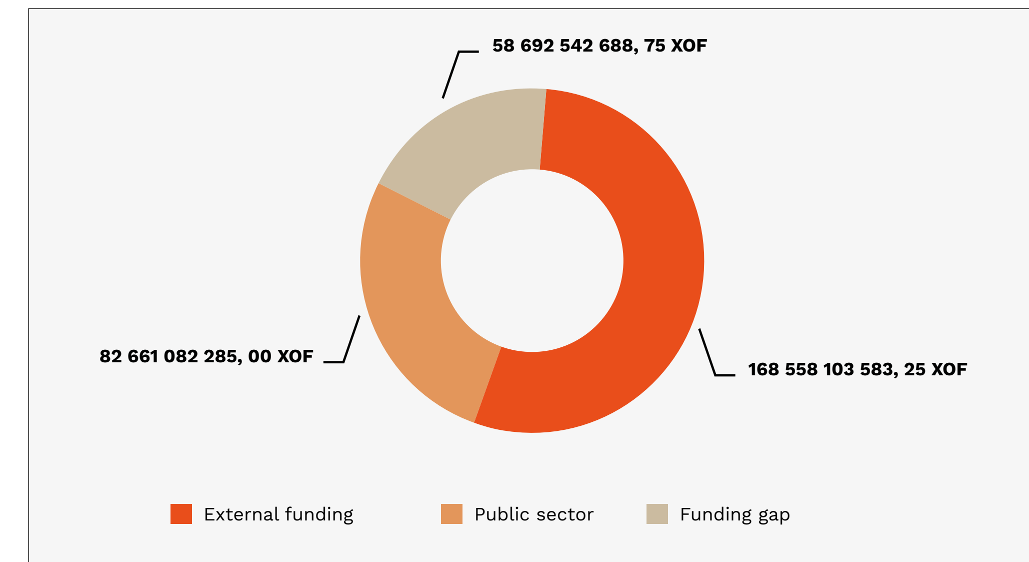



**Figure 14:** **Estimated HDP funding gap in 2020**

## Analysis of funding gap by HDP priority area in 2020

A quick retrospective analysis of the National Health Accounts 2017 and 2018 gives a fairly clear picture concerning the location and size of the main funding gaps14. Thus, of the three HDP programs, only the “leadership and governance” program does not have a funding gap.

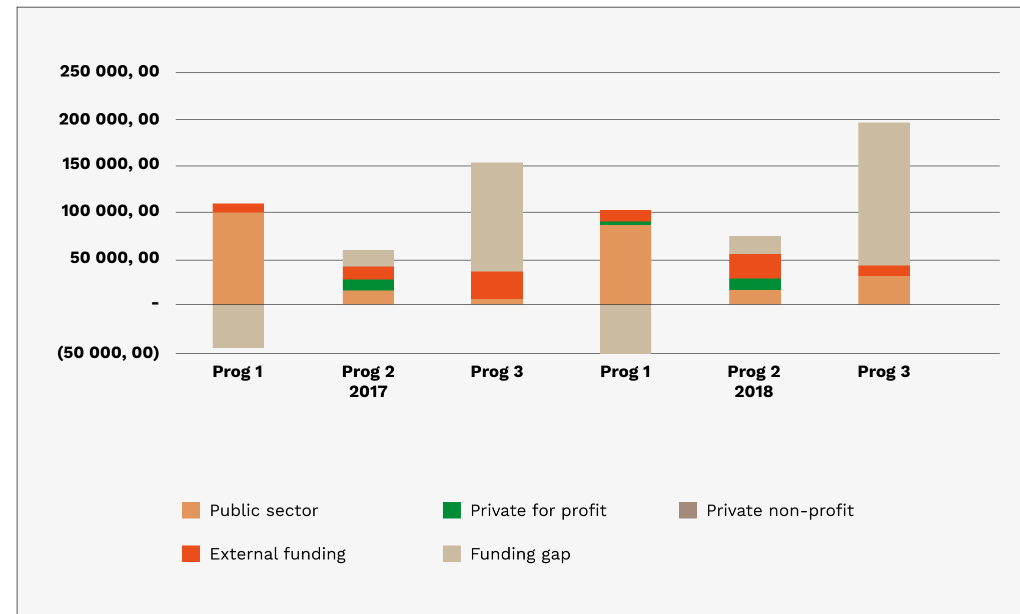



**Figure 15:**
**Estimated HDP funding requirements 2017 & 2018 (million XOF)**

The largest deficit was in program 3 «provision of health care and services» with a gap passing from 112 to 152 billion FCFA between 2017 and 2018.

RM data for 2020 confirms the size of the funding gap for program 3 of the HDP. This deficit is estimated at 83 billion for a total cost of 194 billion FCFA. Although on a smaller scale, program 1 relating to leadership and governance has a funding surplus.

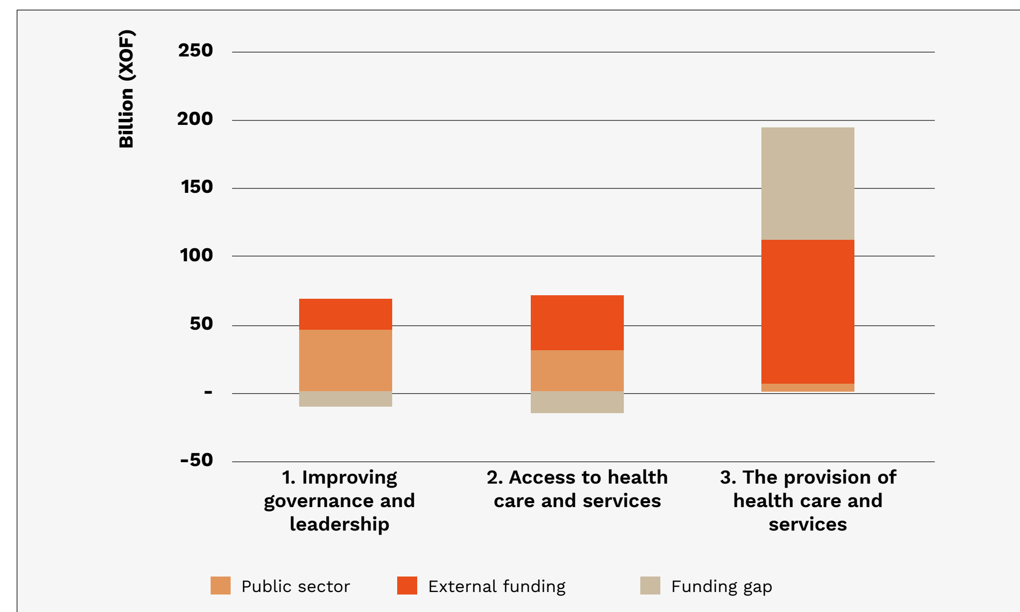



**Figure 16:**
**Estimated funding gap by HDP program 2020**





This element denotes the pattern identified in the National Health Accounts, and the funding surplus recorded for program 2 (surplus estimated at 14 billion FCFA). This result, positive at first glance, hides significant disparities between sub-programs. Thus, sub-programs 2.1 and 2.6 related respectively to capacity building and the availability of health products have significant funding surpluses (17 and 7 billion FCFA). At the same time, sub-programs 2.2 and 2.3 relating to health infrastructure and financial risk protection mechanisms15 show significant funding gaps (5 and 13 billion FCFA).

15 Sous-programmes les plus coûteux du programme 2 « accès aux soins et services de santé » du PDS.

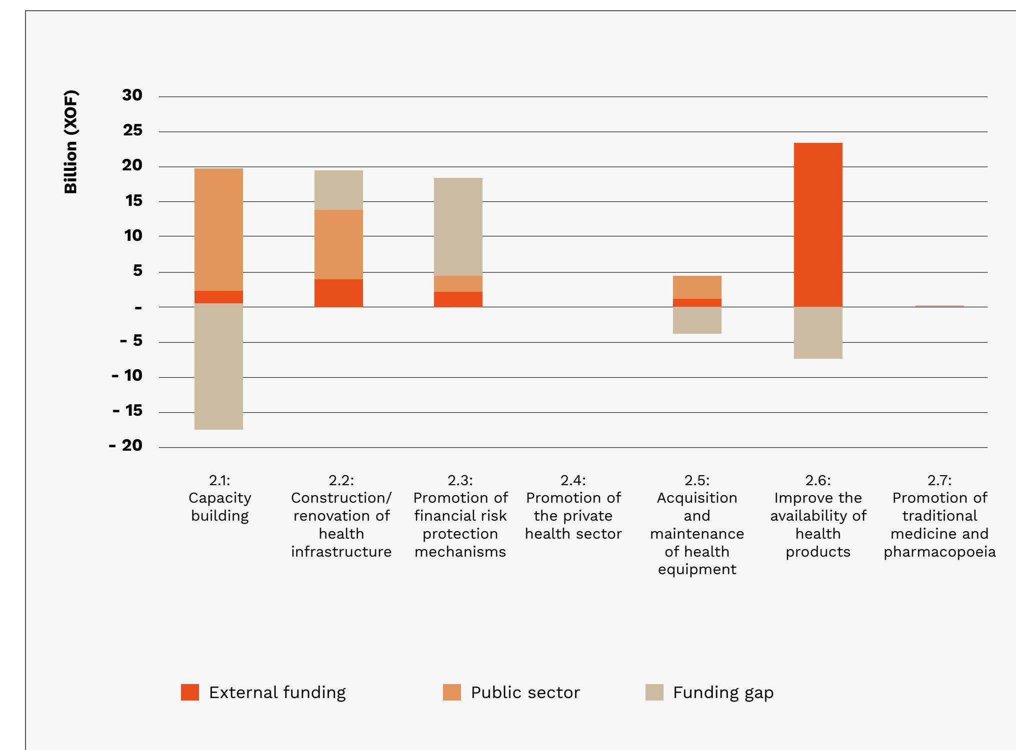



**Figure 17:**
**Estimated funding gaps within HDP Program 2 in 2020**

These disparities are also found in the «provision of health care and services» program where significant inequalities appear to exist between sub-programs. Programs 3.1 and 3.4 relating respectively to the fight against communicable diseases and reproductive health register major deficits of around 84 and 42 billion FCFA. The funding surplus for program 3.8 is mainly explained by the massive commitments related to the fight against Covid-19.

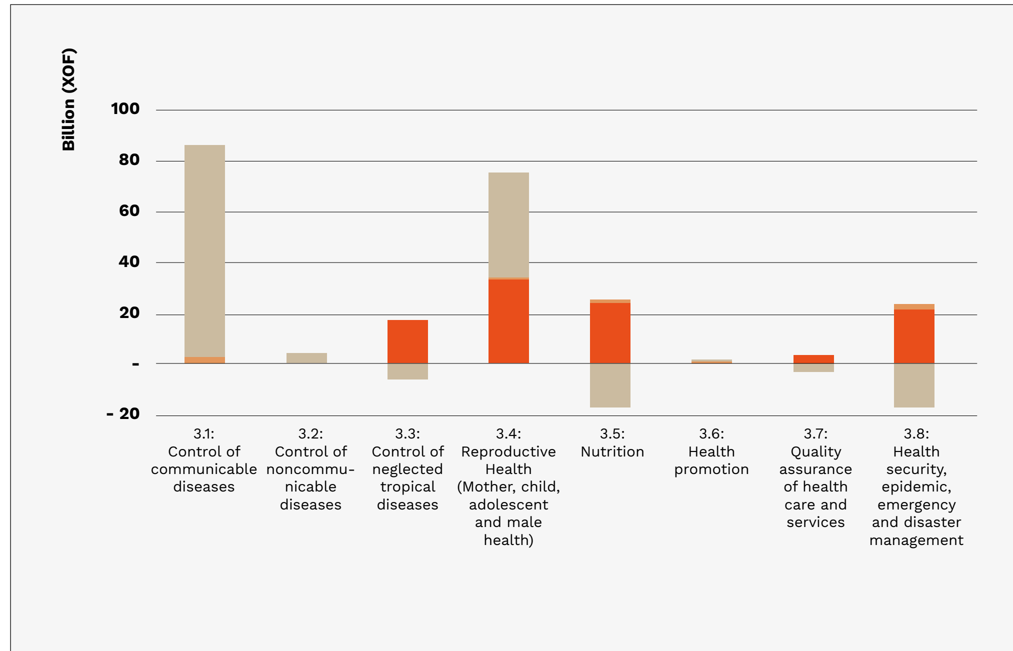



**Figure 18:**
**Estimated funding gaps within HDP Program 3 in 2020**

## 3.4 Covid-19 response plan funding gap analysis

The total cost of the new coronavirus preparedness and response plan is 159.7 billion FCFA16. As a reminder, the total amount of financial commitments relating to Covid-19 for 2020 is 16.5 billion FCFA, resulting in a funding gap of approximately 143.2 billion FCFA. This deficit registers in three components of the plan, namely isolation sites (deficit of 52 billion FCFA), prevention and control of infection (44 billion FCFA), and finally health service capacity (33 billion FCFA).

16 Selon la version du plan de préparation et de réponse disponible lors de l'étude.

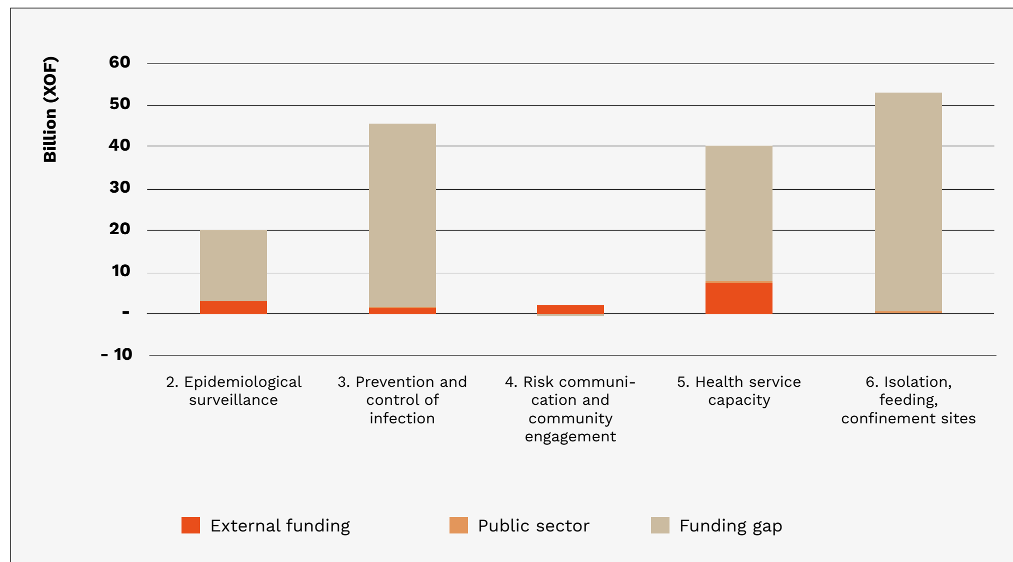



**Figure 19:**
**Estimated funding gap per pillar of the Covid-19 response plan in 2020**

# 4 CONCLUSION AND RECOMMENDATIONS

## 4.1 Conclusion

The purpose of this RM exercise was to capture all the financial commitments of the State and its partners in the health sector in Niger. This new approach was made possible by the use of an electronic tool, which makes it possible to easily collect financial data from stakeholders and link this information to the country's health priorities. It also benefited from a health budget consistent with the three HDP programs, obtained as part of Niger's move to program budget mode in 2018.

### RM limitations

**It is important to stress that the Niger RM suffered from a number of limitations and uncertainties, the main components of which are listed below:**

- It was not always possible for TFPs to indicate the amount of their financial commitments beyond 2020. Their financial commitments recorded for 2021 are therefore largely underestimated. This lack of predictability is the main limitation of the RM exercise.
- UNICEF contributions were not taken into account due to the absence of information sent by the donor over the period covered by the RM. However, the TFP response rate (> 90%) seems high enough to guarantee the reliability of the picture transmitted on HDP funding for 2020.
- Certain financial data was provided by partners in a format that did not allow them to be classified by sub-program and priority action. The estimated cost of the sub-programs (variable for their respective importance within the PDS) was used to distribute the amounts allocated to each sub-program.
- Certain interventions, due to their nature, could be linked to several programs or sub-programs (e.g. the Purchasing Fund component of the KfW project was initially encoded in sub-program 3.4 «reproductive health» then in the sub-program 2.3 "promotion of financial risk protection mechanisms"). There is therefore an element of subjectivity in the classification of interventions.
- Several partners were unable to provide data by region. When specific targeting of intervention regions was possible, a breakdown of the data according to the demographic weight of the regions was carried out. The RM results at subnational level were therefore interpreted with great caution.
- The RM relied on the version of the Covid-19 response plan available at the start of the exercise (March 25, 2020) and on the data shared by the TFPs between June and September 2020. Taking into account the sudden nature of this epidemic, it is quite possible that the structure of the plan and the information relating to the cost and commitments allocated to the various components have changed marginally over the last months of the RM exercise.
- Finally, in the absence of information on the State budget for 2021, an extrapolation from an average annual growth rate calculated between 2015 and 2020 was carried out.

**In view of these reservations, the values of the financial commitments presented in this report should be considered as orders of magnitude (all the more so for the data presented at the subnational level).**

### Use of RM results

The RM gives a probably correct view of the volume and distribution of stakeholder financial commitments in the health sector. It can therefore constitute an important asset in the process of drawing up the IC but especially the new HDP, insofar as it allows a breakdown by sub-program and by geographical area..

Knowing that the achievement of Universal Health Coverage (UHC) implies a more efficient management of available resources, better knowledge of the financial volumes committed to the health sector and of the programs presenting funding gaps is notable progress which should feed sectoral dialogue.

By way of example, looking at Figure 17 it can immediately be deduced that the «financial risk protection mechanism» sub-program contributes significantly to the «access to care» program funding gap. At the same time, the "capacity building" sub-program appears to be largely over-funded.

**In conclusion, knowledge of the main stakeholders' financial commitments to the health sector acquired in the RM, even if imperfect, can and should be regarded as a key guidance document to strengthen the budgeting and planning process of the MPH and its partners.**

## 4.2 Recommendations

The analyzes of the funding gap carried out based on RM data lead to the formulation of logical recommendations on medium-term re-allocation possibilities. Here, the recommendations will focus more specifically on the institutionalization of mapping within the MPH which deserves to be strengthened.

**The recommendations are:**

1. Strengthen advocacy with relevant stakeholders (MF, MPH, TPF) on the importance of RM
2. Ensure the strengthening of programmatic management for the new HDP (e.g: review and clarify the classification of activities and results) in order to facilitate the inclusion of donor interventions in this plan
3. Ensure the integration of RM information needs into State budgeting tools
4. Position a collection tool at partner level for regular completion each year at the start of the budget cycle in accordance with the requirements of the budget program reform (DPPD)
5. Establish an environment conducive to greater predictability of partners' financial commitments.

# APPENDICES

Appendix 1

## List of HDP priority interventions 2017-2021

### 1. 1. IMPROVING GOVERNANCE AND LEADERSHIP

**1.1: Steering, dialogue and coordination of MPH actions and partners**

1.1.1 : Promote multisectoral policy dialogue in favor of the health sector

1.1.2 : Strengthen the coordination of actions and partners

1.1.3 : Strengthen the implementation of results-based management

**1.2 : Sectoral reforms including decentralization**

1.2.1 : Develop a roadmap to track reform implementation

1.2.2 : Accelerate the implementation of decentralization in the health sector

1.2.3 : Strengthen coordination between sector planning and Communal Development Plans (PDC)

**1.3 : Contrôles, audits et Inspection Générale des Services**

1.3.1 : Strengthen the General Health Inspectorate (IGS)

1.3.2 : Strengthen internal and external audit activities

**1.4 : Participation communautaire**

1.4.1 : Strengthen the effective involvement of communities in the management of health services

1.4.2 : Adopt the texts on Community participation in context

1.4.3 : Strengthen the implementation of the care strategy at community level (PCAC, PECADOM, PCIME COM, DBC, PFE, ATPC, etc.)

1.4.4 : Promote community PBF (Performance Based Funding)

**1.5 : Planning, tracking and evaluation:**

1.5.1 : Strengthen the results-based planning process

1.5.2 : Generalize the use of multi-year priority action plans at all levels

1.5.3 : Track the implementation of action plans through the organization of joint reviews and periodic missions

1.5.4 : Organize integrated supervision at all levels

1.5.5 : Organize mid-term and final evaluations of the HDP

1.5.6 : Popularize the mechanisms for implementing the health card that can be used by all

**1.6 : Regulation and standardization**

1.6.1 : Revise the legal corpus of the Ministry of Public Health for the proper functioning of the health system

**1.7 : Communication (internal and external), documentation and archiving**





1.7.1 : Implement a sectoral communication plan

1.7.2 : Establish documentation-archive units at the DRSP and district levels

1.7.3 : Computerize documentation-archiving at all levels

1.7.4 : Update the «documentation-archives» database at the DRSP and district levels

1.7.5 : Make the “documentation-archives” collected at all levels accessible on the MSP website and intranet

**1.8 : Health sector funding (growth and management)**

1.8.1 : Strengthen mechanisms for mobilizing internal financial resources

1.8.2 : Initiate innovative funding mechanisms for health

1.8.3 : Strengthen the pooling of funds

1.8.4 : Strengthen the absorption capacity of the credits granted

1.8.5 : Rational management of existing resources

**1.9 : Management of material resources**

1.9.1 : Computerize the management of material resources

**1.10 : Human resource management**

1.10.1 : Implement the organic reform of the MPH for the proper functioning of the health system

1.10.2 : Effectively manage human resources for health

1.10.3 : Operationalize the staff evaluation and promotion system

**1.11 : Construction/renovation and equipment of administrative and educational infrastructure**

1.11.1 : Decentralize health schools

1.11.2 : Operationalize technical and administrative structures

**1.12 : Health information**

1.12.1 : Develop a national information strategy integrating the needs of services at all levels of the system and those of the sector’s partners in terms of tracking the impact of actions carried out, and knowledge of the human, material and financial resources available in the sector

1.12.2 : Update data collection tools to reduce the fragmentation and multiplicity of tools currently observed in the field, including those of the sector

1.12.3 : Strengthen feedback to feed the indicators at all levels

1.12.4 : Generalize networks for data collection

**1.13 Promotion of research**

1.13.1 : Establish mechanisms for the development of health research

## 2. 2. ACCESS TO HEALTH CARE AND SERVICES

**2.1 : Capacity building**

2.1.1 : Pursue continuing education

2.1.2 : Produce quality HR

2.1.3 : Increase the number of health personnel

**2.2: Construction/renovation of health infrastructure**

2.2.1: Transformation of health infrastructure

2.2.2 : Upgrade existing infrastructure

2.2.3 : Renovation of existing infrastructure

2.2.4 : Construction of new infrastructure

2.2.5 : Strengthening of innovative strategies for geographic access to health care and services

**2.3 : Promotion of financial risk protection mechanisms**

2.3.1 : Support the implementation of the UHC roadmap

2.3.2 : Capitalize on experiences in the field of Health Risk Coverage (CRM)

2.3.3 : Strengthen the capacity of territorial collectivities in the management of free health care

**2.4 Promotion of the private health sector**

2.4.1 : Facilitate intersectoral collaboration on private health training schools

2.4.2 : Facilitate the establishment of private health structures in accordance with the health map

2.4.3 : Implement the quality system concerning private health schools

2.4.4 : Organize private health promoters into an alliance

2.4.5 : Create an environment conducive to public-private collaboration in the health sector

**2.5 : Acquisition and maintenance of health equipment**

2.5.1 : Acquisition of health equipment

2.5.2 : Maintenance of health equipment

**2.6 : Improving the availability of health products**

2.6.1 : Recapitalize the ONPPC

2.6.2 : Strengthen the storage capacity of the ONPPC and in the regions

2.6.3 : Strengthen medicine distribution capacity

2.6.4 : Improve the internal management of the ONPPC and its distribution channel

2.6.5 : Strengthen local medicine production

2.6.6 : Strengthen the institutional framework of the Directorate of Pharmacy and Traditional Medicine

2.6.7 : Increase SONIPHAR production capacity

2.6.8 : Establish a drugs agency

2.6.9 : Strengthen drug quality control

2.6.10 : Intensify the fight against the illicit sale of medicines and counterfeit medicines

2.6.11 : Make medicine, consumables, reagents, blood and derivatives and ARVs available

2.6.12 : Set up an efficient drug safety system

**2.7 : Promotion of traditional medicine and pharmacopeia**

2.7.1 : Regulate traditional medicine and pharmacopeia

2.7.2 : Integrate traditional medicine and pharmacopeia into the healthcare system

## 3. 3. PROVISION OF HEALTH CARE AND SERVICES

**3.1 : Control of communicable diseases**

3.1.1 : Intensify the fight against communicable diseases (Malaria, Tuberculosis, STI/HIV/AIDS, Viral hepatitis)

3.2 : Control of noncommunicable diseases

3.2.1 : Intensify the fight against non-communicable diseases (diabetes, cardiovascular diseases, cancer and chronic respiratory diseases (CRD) and sickle cell anaemia)

**3.3 : Control of neglected tropical diseases**

3.3.1 : Intensify the fight against neglected tropical diseases (bilharzia, lymphatic filariasis, intestinal worms, leprosy, trachoma, human trypanosomiasis, guinea worm, Onchocerciasis, leishmaniasis and rabies)

**3.4 : Reproductive Health (Maternal, Child, Adolescent and Male Health)**

3.4.1 : Strengthen maternal and newborn health services

3.4.2 : Establish a multisectoral coordination framework for RH

3.4.3 : Strengthen family planning services

3.4.4 : Strengthen the provision of child health services

3.4.5 : Strengthen the provision of male health services

3.4.6 : Strengthen the provision of youth and adolescent health services

**3.5 : Nutrition**

3.5.1 : Strengthen the capacity of malnutrition management services

3.5.2 : Intensify actions to prevent malnutrition

3.5.3 : Develop the fight against obesity

**3.6 : Health promotion**

3.6.1 : Reorient health services to the needs of the population

3.6.2 : Strengthen the conditions for a healthy living and working environment

3.6.3 : Create favorable conditions for sector Ministries to adopt public health promotion policies

3.6.4 : Strengthen the skills and capacities of individuals in health promotion activities

3.6.5 : Establish a multisectoral health promotion coordination framework at national, regional and departmental level and ensure its operation

3.6.6 : Strengthen the effective participation of individuals and communities in the definition of priorities, decision-making and achievement of health actions

**3.7 : Quality assurance of health care and services**

3.7.1 : Improve the quality of health care

**3.8 : Health security, management of epidemics, emergencies and disasters**

3.8.1 : Strengthen the system for managing epidemics and public health emergencies

3.8.2 : Strengthen Integrated Disease Surveillance and Response (IDSR)

Appendix 2

# Resource Mapping Timeline

| N° | Activités | Feb-20 | | | | Mar-20 | | | | | Apr-20 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | WK1 | WK2 | WK3 | WK4 | WK1 | WK2 | WK3 | WK4 | | WK1 | WK2 | WK3 | WK4 |
| 1 | Phase 1. Preparation | | | | | | | | | | | | | |
| 1.1 | Project preparation (initial briefing, document review and logistics) | | | | | | | | | | | | | |
| 1.2 | Analysis of the Ministry of Planning's collection tool | | | | | | | | | | | | | |
| 1.3 | Calibration of collection and analysis tools | | | | | | | | | | | | | |
| 1.4 | GFF focal point and Ministry of Health briefing | | | | | | | | | | | | | |
| 1.5 | Individual meetings with the TFPs | | | | | | | | | | | | | |
| 1.6 | Workshop to design the collection tool | | | | | | | | | | | | | |
| 1.7 | Completion of the collection tool | | | | | | | | | | | | | |
| 1.8 | Workshop or meeting for validation and distribution of tools | | | | | | | | | | | | | |
| L 1 | Deliverable 1: Data collection tool validated | | | | D1 | | | | | | | | | |
| L 2 | Adapted data analysis and visualization tool | | | | D2 | | | | | | | | | |
| 2 | Phase 2. Data collection and analysis | | | | | | | | | | | | | |
| 2.1 | Tracking data collection and entry | | | | | | | | | | | | | |
| 2.2 | Adaptation of the collection tool to map COVID interventions | | | | | | | | | | | | | |
| 2.3 | Data collection process relaunched to include COVID | | | | | | | | | | | | | |
| 2.4 | Data analysis (in collaboration with the Ministry of Public Health) | | | | | | | | | | | | | |
| 2.5 | Collection of additional data related to COVID interventions | | | | | | | | | | | | | |
| 2.6 | Draft report written | | | | | | | | | | | | | |
| L 3 | Completed data analysis and visualisation tool | | | | | | | | | | | | | |
| L 4 | Draft report | | | | | | | | | | | | | |
| 3 | Phase 3. Finalisation and validation of results | | | | | | | | | | | | | |
| 3.1 | Follow-up and receipt of partners' comments on the draft report | | | | | | | | | | | | | |
| 3.2 | Finalization of the analysis and the mapping report | | | | | | | | | | | | | |
| 3.3 | Dissemination and feedback workshop in the field | | | | | | | | | | | | | |
| L 5 | Complete mapping database | | | | | | | | | | | | | |
| L 6 | Final HDP and IC mapping report | | | | | | | | | | | | | |

| N° | Activités | May-20 | | | | Jun-20 | | | | Jul-20 | | | | Aug-20 | | | | Sep-20 | | | | Oct-20 | | | | Nov-20 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | WK1 | WK2 | WK3 | WK4 | WK1 | WK2 | WK3 | WK4 | WK1 | WK2 | WK3 | WK4 | | | | | | | | | | | | | S1 | S2 | S3 | S4 |
| 1 | Phase 1. Preparation | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.1 | Project preparation (initial briefing, document review and logistics) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.2 | Analysis of the Ministry of Planning's collection tool | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.3 | Calibration of collection and analysis tools | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.4 | GFF focal point and Ministry of Health briefing | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.5 | Individual meetings with the TFPs | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.6 | Workshop to design the collection tool | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.7 | Completion of the collection tool | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1.8 | Workshop or meeting for validation and distribution of tools | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| L 1 | Deliverable 1: Data collection tool validated | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| L 2 | Adapted data analysis and visualization tool | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2 | Phase 2. Data collection and analysis | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2.1 | Tracking data collection and entry | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2.2 | Adaptation of the collection tool to map COVID interventions | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2.3 | Data collection process relaunched to include COVID | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2.4 | Data analysis (in collaboration with the Ministry of Public Health) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2.5 | Collection of additional data related to COVID interventions | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2.6 | Draft report written | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| L 3 | Completed data analysis and visualisation tool | | | | | | | | | | | | | | | | | | | | | | | | | D3 | | | |
| L 4 | Draft report | | | | | | | | | | | | | | | | | | | | | | | | | D4 | | | |
| 3 | Phase 3. Finalisation and validation of results | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3.1 | Follow-up and receipt of partners' comments on the draft report | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3.2 | Finalization of the analysis and the mapping report | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3.3 | Dissemination and feedback workshop in the field | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| L 5 | Complete mapping database | | | | | | | | | | | | | | | | | | | | | | | | | | | | D5 |
| L 6 | Final HDP and IC mapping report | | | | | | | | | | | | | | | | | | | | | | | | | | | | D6 |

Fieldwork

Work at headquarters

Appendix 3

# Description of the collection tool user guide

## HDP Resource Maping

Collection tool user guide

## About the GFF

The Republic of Niger joined the Global Financing Facility (GFF) in July 2019. The GFF aims to increase financial resources for maternal, newborn and child health and nutrition in high-burden countries with an increasing emphasis on domestic funding. At the same time, with a view to efficiency, the GFF helps national authorities channel these additional funds to high-impact actions and better define their intervention priorities with the aim of achieving Universal Health Coverage by 2030.

The Ministry of Public Health (MPH) therefore welcomed the GFF as an opportunity to mobilize and better align external and national contributions around an Investment Case.

To achieve this objective, the first step is to map the resources available to fund the priorities listed in the 2017-2021 Health Development Plan (HDP). This will help the Nigerien government and its partners to identify the funding gap that needs to be filled through better alignment of external aid and increased mobilization of domestic funding.

**You have been identified as a major stakeholder in the health sector**: this is why we wish to collect, from your departments, the data necessary for this mapping exercise conducted under the leadership of the MPH. In order to help you with this, we will provide you with a standard data collection tool.

## Overview of the tool

### Presentation of the tool

This is a computerized collection tool running in an Excel spreadsheet, the aim of which is to capture all the financial resources available for funding the 2017-2021 HDP in Niger.

Drawing on experience gained in several countries in the sub-region, the GFF team worked to develop an easy-to-use standard tool. It developed this tool taking into account the current results-based health sector reforms, including the transition to the program budget.

Based on the financial data collected, the tool aims to answer the following questions:

1) What financial resources are available and from what sources?
2) How does actual expenditure align with the HDP programs?
3) What is the level of equity in the allocation of available resources by region?

### Tool layout

- The Excel file has three tabs:

-Lists
- HDP programs
- HDP sub-programs
- HDP priority actions

-Subnational Analysis
- Names of Nigerien health regions

-Donor Budget
- Program descriptions
- Budget specifications
- Categories for detailed budget analysis
- Budget distribution by year
- Budget distribution by region

**IMPORTANT :**

The grey “Lists” and “ Subnational Analysis” tabs are pre-populated and allow automatic entry (using a drop-down menu) of HDP priority interventions and health regions in the “Donor Budget” tab. You must only fill in this last green tab

# Using the tool

The "Donor Budget" tab is made up of five tables to be completed as described below.

**Grille 1 : Description des interventions**

The table has the title of the project or the expected result on which you are providing information in column C. The next two columns (D and E) allow you to provide more detailed information on the intervention by specifying the component of the project (if relevant) and the activities to which it refers. This information must be entered manually, specifying, if possible/necessary, the executing agency of the project in column G.

**PLEASE NOTE :**

By executing agency we mean the principal recipient who implements the project (eg: an activity funded by USAID would typically have an international NGO as the primary executor).

It is possible that one project has several components linked to different HDP programs, sub-programs or priority actions. Whenever possible, use a separate line for each component so that it can be linked more easily to the HDP intervention categories (Table 3).

**Columns H and I** are used to assess the progress of the input for each project. **Do not fill in these two columns.**





**Table 2: Budget Specifications**

The purpose of this table is to avoid double counting donor funds during analysis.

Using the drop-down menu in column K, specify whether the corresponding activity is financed with your own funds or not. If you choose "additional funds", this indicates that the activity was initially financed by another donor. If so, indicate the original donor in column L.

*Example: if the Gates Foundation funds GAVI for a specific activity, these funds should not be counted for each of the two donors. To avoid this, it is important that GAVI specify in Grid 2 that the activity was initially funded by the Gates Foundation.*

Similarly, specify in column M whether the project is financed through the State budget or outside the State budget. This information will avoid double counting the cost of the project from data collected from the Ministry of Health or Finance.

**Table 3: Categories for detailed budget analysis**

From the pre-populated drop-down menus, link each activity to the HDP priority intervention to which it belongs. Column O indicates the HDP program. Depending on the program selected, specify in column P the sub-program and then in column Q the priority action to which the project is primarily linked.

**PLEASE NOTE :**

It is possible that an activity may not be related in its entirety to an HDP priority action or sub-program. If a breakdown of the activity (and the related budget) can be done, this

option should be chosen. Otherwise, link the activity to the priority intervention that is most relevant to you.

| 3. Catégories pour l'analyse granulaire du budget | | | 4.1 Dépense |
|---|---|---|---|
| Programme | Sous Programme | Action | 201 |
| 2. Accès aux soins et services de santé | 2.4 Promotion du secteur sanitaire privé | 2.4.3 : Mettre en place le dispositif qualité au niveau des écoles de santé privées | |

**Tables 4.1 and 4.2 Expenditure and budget distribution by year**

In Table 4.1 enter for each activity, component or project (depending on the level of detail available) the expenditure executed since 2017 (if possible).

In Table 4.2 enter the budget available for 2020 and 2021. This is the very heart of the mapping exercise. Remember that only the **available budget** should be counted. If no budget is set for 2021 yet, leave this column blank.

| 4.1 Dépenses exécutées par année | | | | 4.2 Budget disponible par année | | |
|---|---|---|---|---|---|---|
| 2017 | 2018 | 2019 | TOTAL | 2020 | 2021 | TOTAL |

**IMPORTANT :**

It is important not to count the same amount twice. For example, if UNICEF has a child survival activity or component that affects multiple HDP programs, the activity or component line should be copied several times (Table 1), changing only the program or sub-program for each line in Table 3. But at the end, the sum of each line (expenditure or budget) must be equivalent to the total amount of the activity or component planned by the project.

**Table 5: Geographical budget distribution**

If possible, enter the available budget by region

**PLEASE NOTE :**

The AF column also includes the budget for the central level.

**REMINDERS**

- If you have any questions about the tool, please contact Matthieu Antony (manthony@oeconomia-expertise.com) or Aboubacar CHAIBOU BEGOU (gff.niger@gmail.com)
- Please return the contact form as soon as possible so that we can actively support you in this exercise
- The deadline for sending the collection file is May 31, 2020



## Appendix 1 : List of HDP 2017-2021 Priority Interventions

**1. IMPROVING GOVERNANCE AND LEADERSHIP**

**1.1: Steering, dialogue and coordination of MPH actions and partners**

1.1.1: Promote multisectoral policy dialogue in favor of the health sector

1.1.2: Strengthen the coordination of actions and partners

1.1.3: Strengthen the implementation of results-based management

**1.2: Sectoral reforms including decentralization**

1.2.1: Develop a roadmap to track reform implementation

1.2.2: Accelerate the implementation of decentralization in the health sector

1.2.3: Strengthen coordination between sector planning and Communal Development Plans (PDC)

**1.3: Checks, audits and General Inspection of Services**

1.3.1: Strengthen the General Health Inspectorate (IGS)

1.3.2: Strengthen internal and external audit activities

**1.4: Community participation**

1.4.1: Strengthen the effective involvement of communities in the management of health services

1.4.2: Adopt the texts on Community participation in context

1.4.3: Strengthen the implementation of the care strategy at community level (PCAC, PECADOM, PCIME COM, DBC, PFE, ATPC, etc.)

1.4.4: Promote community PBF (Performance Based Funding)

**1.5: Planning, tracking and evaluation:**

1.5.1: Strengthen the results-based planning process

1.5.2: Generalize the use of multi-year priority action plans at all levels

## Appendix 1 : List of HDP 2017-2021 Priority Interventions

**1. IMPROVING GOVERNANCE AND LEADERSHIP**

**1.1: Steering, dialogue and coordination of MPH actions and partners**

1.1.1: Promote multisectoral policy dialogue in favor of the health sector

1.1.2: Strengthen the coordination of actions and partners

1.1.3: Strengthen the implementation of results-based management

**1.2: Sectoral reforms including decentralization**

1.2.1: Develop a roadmap to track reform implementation

1.2.2: Accelerate the implementation of decentralization in the health sector

1.2.3: Strengthen coordination between sector planning and Communal Development Plans (PDC)

**1.3: Checks, audits and General Inspection of Services**

1.3.1: Strengthen the General Health Inspectorate (IGS)

1.3.2: Strengthen internal and external audit activities

**1.4: Community participation**

1.4.1: Strengthen the effective involvement of communities in the management of health services

1.4.2: Adopt the texts on Community participation in context

1.4.3: Strengthen the implementation of the care strategy at community level (PCAC, PECADOM, PCIME COM, DBC, PFE, ATPC, etc.)

1.4.4: Promote community PBF (Performance Based Funding)

**1.5: Planning, tracking and evaluation:**

1.5.1: Strengthen the results-based planning process

1.5.2: Generalize the use of multi-year priority action plans at all levels

1.10.1: Implement the organic reform of the MPH for the proper functioning of the health system

1.10.2: Effectively manage human resources for health

1.10.3: Operationalize the staff evaluation and promotion system

**1.11: Construction/renovation and equipment of administrative and educational infrastructure**

1.11.1: Decentralize health schools

1.11.2: Operationalize technical and administrative structures

**1.12 Health information**

1.12.1: Develop a national information strategy integrating the needs of services at all levels of the system and those of the sector's partners in terms of tracking the impact of actions carried out, and knowledge of the human, material and financial resources available in the sector

1.12.2: Update data collection tools to reduce the fragmentation and multiplicity of tools currently observed in the field, including those of the sector

1.12.3: Strengthen feedback to feed the indicators at all levels

1.12.4: Generalize networks for data collection

**1.13 Promotion of research**

1.13.1: Establish mechanisms for the development of health research

**2. ACCESS TO HEALTH CARE AND SERVICES**

**2.1: Capacity building**

2.1.1: Pursue continuing education

2.1.2: Produce quality HR

2.1.3: Increase the number of health personnel

**2.2: Construction/renovation of health infrastructure**

2.2.1: Transformation of health infrastructure

2.2.2: Upgrade existing infrastructure

2.2.3: Renovation of existing infrastructure

2.2.4: Construction of new infrastructure

2.2.5: Strengthening of innovative strategies for geographic access to health care and services

**2.3: Promotion of financial risk protection mechanisms**

2.3.1: Support the implementation of the UHC roadmap

2.3.2: Capitalize on experiences in the field of Health Risk Coverage (CRM)

2.3.3: Strengthen the capacity of territorial collectivities in the management of free health care

**2.4: Promotion of the private health sector**

2.4.1: Facilitate intersectoral collaboration on private health training schools

2.4.2: Facilitate the establishment of private health structures in accordance with the health map

2.4.3: Implement the quality system concerning private health schools

2.4.4: Organize private health promoters into an alliance

2.4.5: Create an environment conducive to public-private collaboration in the health sector

**2.5: Acquisition and maintenance of health equipmen**t

2.5.1: Acquisition of health equipment

2.5.2: Maintenance of health equipment

**2.6: Improving the availability of health products**

2.6.1: Recapitalize the ONPPC

2.6.2: Strengthen the storage capacity of the ONPPC and in the regions

2.6.3: Strengthen medicine distribution capacity





2.6.4: Improve the internal management of the ONPPC and its distribution channel

2.6.5: Strengthen local medicine production

2.6.6: Strengthen the institutional framework of the Directorate of Pharmacy and Traditional Medicine

2.6.7: Increase SONIPHAR production capacity

2.6.8: Establish a drugs agency

2.6.9: Strengthen drug quality control

2.6.10: Intensify the fight against the illicit sale of medicines and counterfeit medicines

2.6.11: Make medicine, consumables, reagents, blood and derivatives and ARVs available

2.6.12: Set up an efficient drug safety system

**2.7: Promotion of traditional medicine and pharmacopeia**

2.7.1: Regulate traditional medicine and pharmacopeia

2.7.2: Integrate traditional medicine and pharmacopeia into the healthcare system

**3. PROVISION OF HEALTH CARE AND SERVICES**

3.1: Control of communicable diseases

3.1.1: Intensify the fight against communicable diseases (Malaria, Tuberculosis, STI/HIV/AIDS, Viral hepatitis)

3.2: Control of noncommunicable diseases

3.2.1: Intensify the fight against non-communicable diseases (diabetes, cardiovascular diseases, cancer and chronic respiratory diseases (CRD) and sickle cell anaemia)

3.3: Control of neglected tropical diseases

Annexe 4

# Presentation PowerPoint mapping results

## BACKGROUND

- The Republic of Niger joined the GFF in 2019
- "Program budget" management since 2018
- National Health Accounts (CNS) available until 2018
- IC being produced
- Covid-19 epidemic

## WHY DO THE RESOURCE MAPPING?

To inform government and donor planning and budgeting processes

- Assess the alignment of domestic and external resources with national priorities
- Estimate the funding gap (put into perspective with the estimated cost of national priorities)
- Assess the level of equity in terms of subnational health funding
- Guide the establishment of IC priorities and assess allocative efficiency

## METHODOLOGY

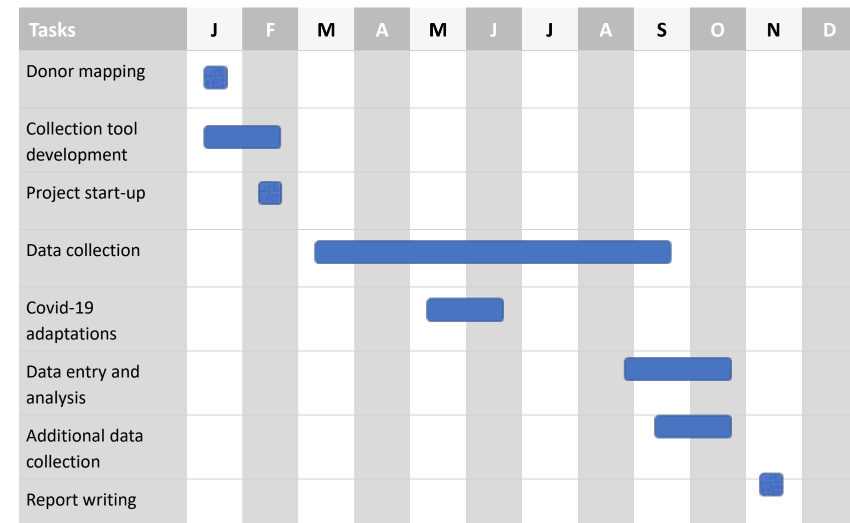
- **Approche**
  - Prospective study
  - Focused on budget commitments for 2020 and 2021
- **Design**
  - See work plan
- **Data collection methods**
  - Use of a standard collection and analysis tool in Excel
  - Configuration based on strategic documents and the most recent demographic data
  - Use of secondary data (CNS) for triangulation of results

## METHODOLOGY

### Contacted partners

| Categories | Targeted | Responses | Partially usable responses | Missing partners | % |
|---|---|---|---|---|---|
| Public | 1 | 1 | - | - | 100% |
| Bilateral donors | 5 | 5 | - | - | 100% |
| Multilateral donors | 9 | 7 | 2<br>(EU ; UNICEF) | - | 77% |
| Common Fund | 1 | 1 | - | - | 100% |
| NGO | 9 | 9 | - | - | 100% |
| Total | 25 | 23 | 2 | 0 | 92% |

## WORK PLAN



## CHALLENGES AND LIMITATIONS

### CHALLENGES

- Achieve the best response rate
- Avoid double counting (implies clarifying what is meant by budget support)
- Collect Covid-19 financial data

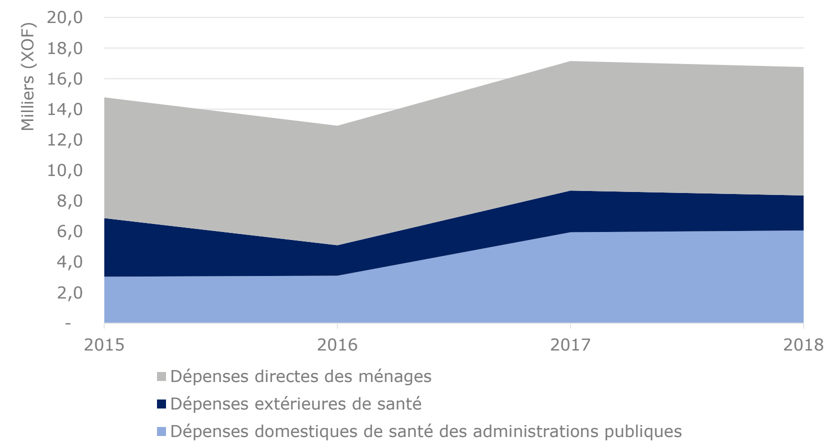
### LIMITATIONS

- Inability to assign each activity to a specific HDP program/sub-program
- Distribution of information by region

> which can lead to the development of general allocation formulae

## RESOURCES MAPPING

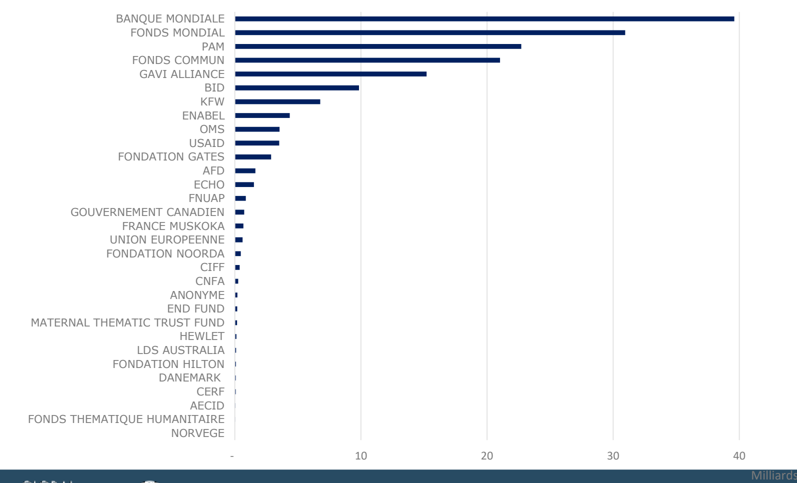
### Health expenditure per capita (source CNS)




GLOBAL FINANCING FACILITY | WORLD BANK GROUP | OECONOMIA

## RESOURCE MAPPING

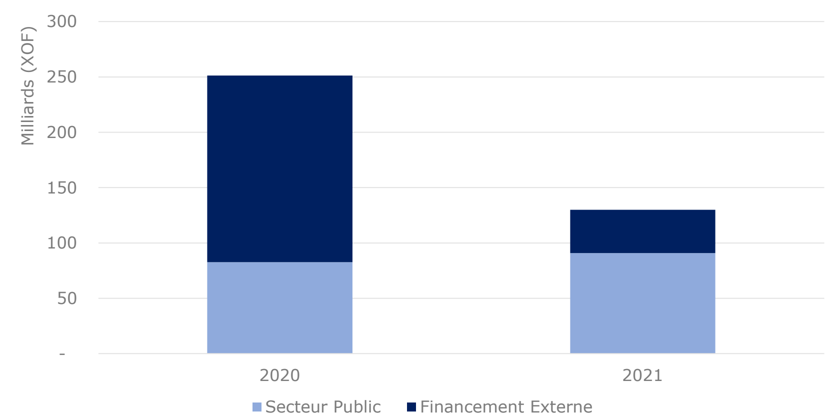
### Donor mapping in 2020 (billion XOF)




GLOBAL FINANCING FACILITY | WORLD BANK GROUP | OECONOMIA

## RESOURCE MAPPING

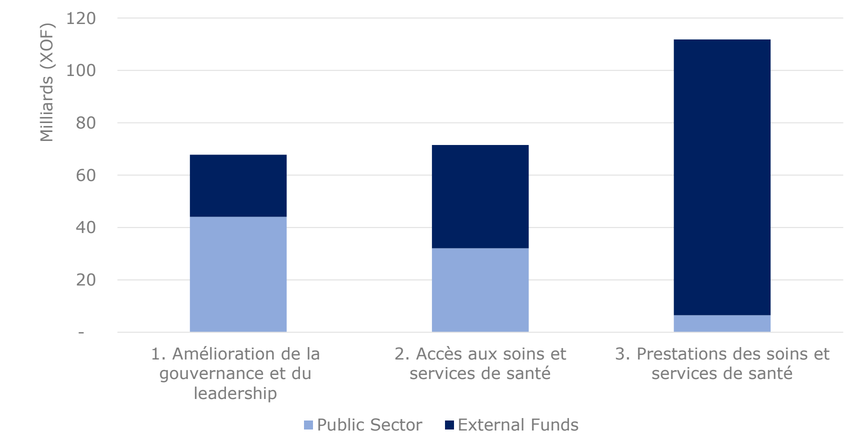
### Budget commitments




GLOBAL FINANCING FACILITY | WORLD BANK GROUP | OECONOMIA

## RESOURCE MAPPING

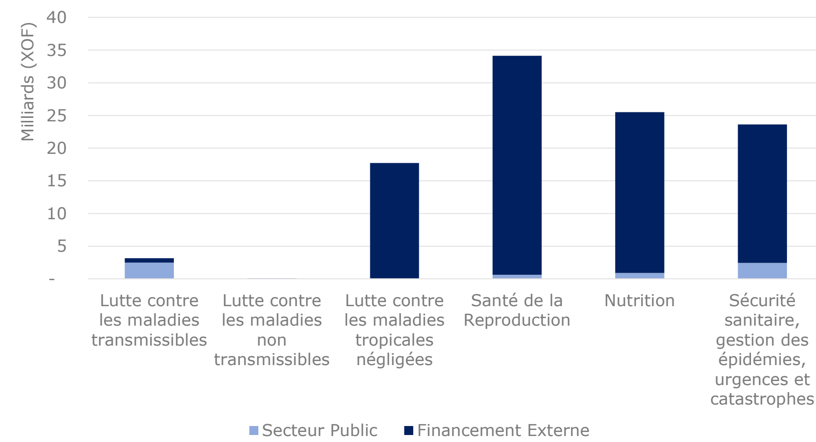
### Funding by priority area in 2020




GLOBAL FINANCING FACILITY | WORLD BANK GROUP | OECONOMIA

## RESOURCE MAPPING

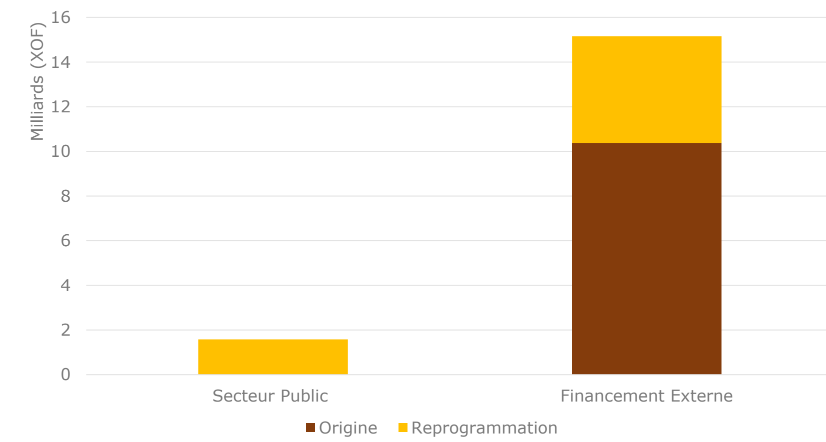
### Funding by priority program in 2020




GLOBAL FINANCING FACILITY | WORLD BANK GROUP | OECONOMIA

## RESOURCE MAPPING

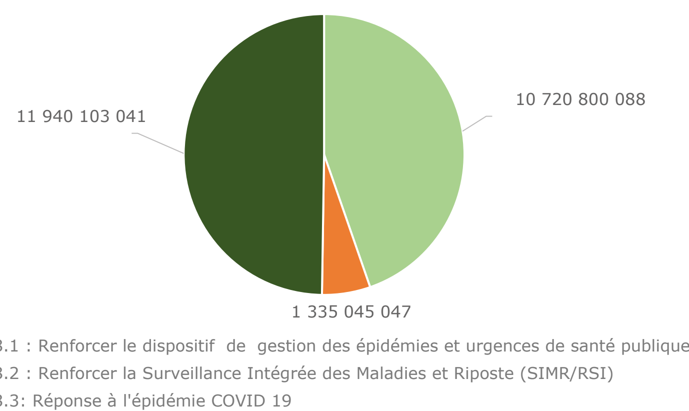
### Covid-19 Response Plan funding in 2020




GLOBAL FINANCING FACILITY | WORLD BANK GROUP | OECONOMIA

## RESOURCE MAPPING

### Sub-program: health security and epidemic management funding in 2020 (XOF)

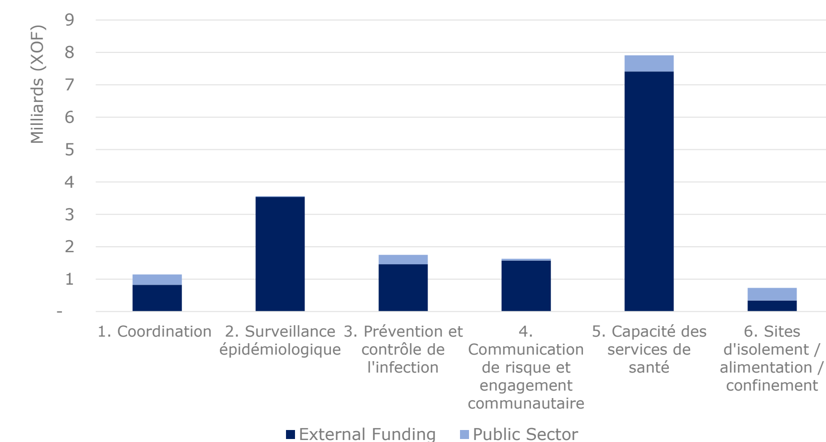



- 3.8.1 : Renforcer le dispositif de gestion des épidémies et urgences de santé publique
- 3.8.2 : Renforcer la Surveillance Intégrée des Maladies et Riposte (SIMR/RSI)
- 3.8.3: Réponse à l'épidémie COVID 19

GLOBAL FINANCING FACILITY | WORLD BANK GROUP | OECONOMIA

## RESOURCE MAPPING

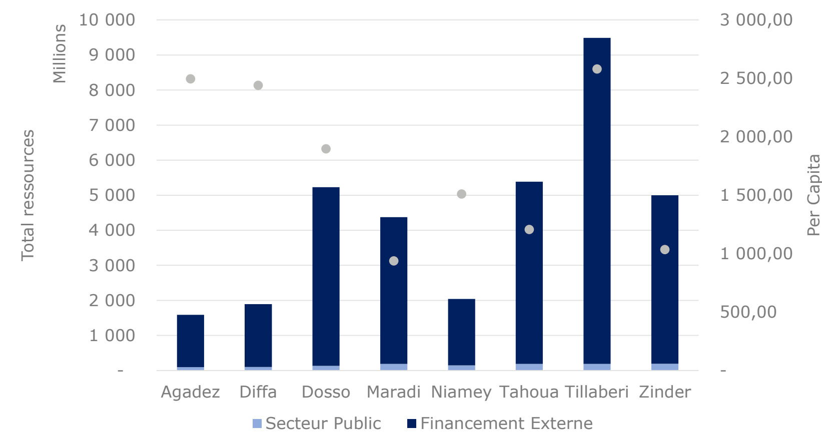
### Covid-19 Response Plan funding by priority area in 2020




GLOBAL FINANCING FACILITY | WORLD BANK GROUP | OECONOMIA

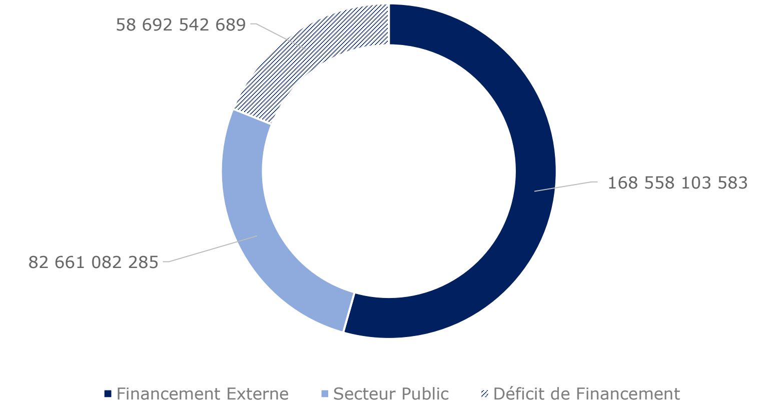
## RESOURCE MAPPING

### Subnational funding in 2020



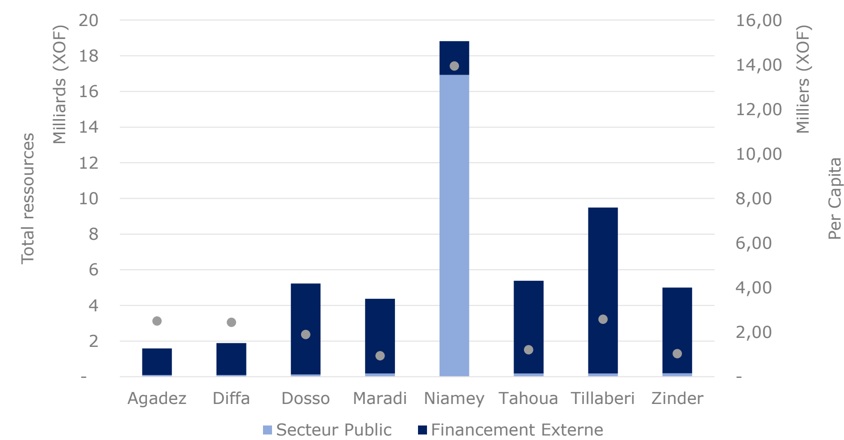
## FUNDING GAP ANALYSIS

### Funding gap in 2020 (XOF)



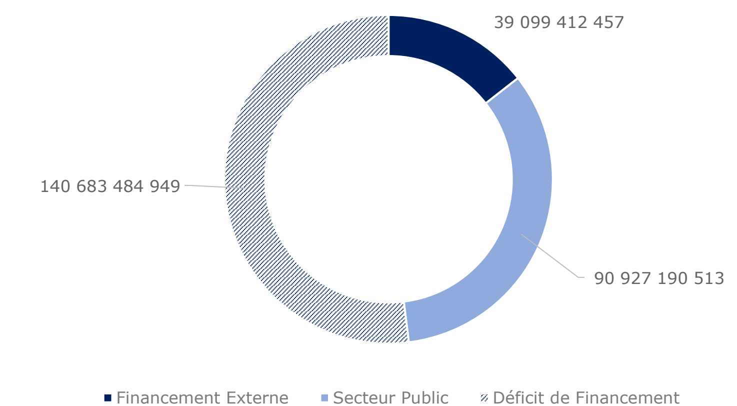
## RESOURCE MAPPING

### Subnational funding in 2020



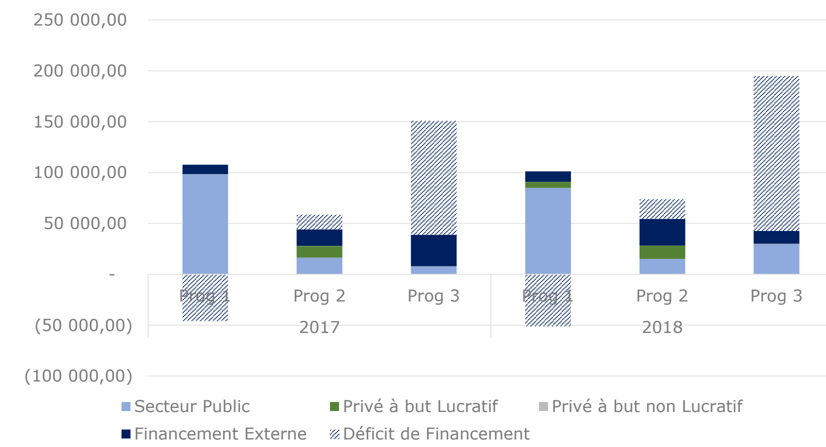
## FUNDING GAP ANALYSIS

### Funding gap in 2021 (XOF)



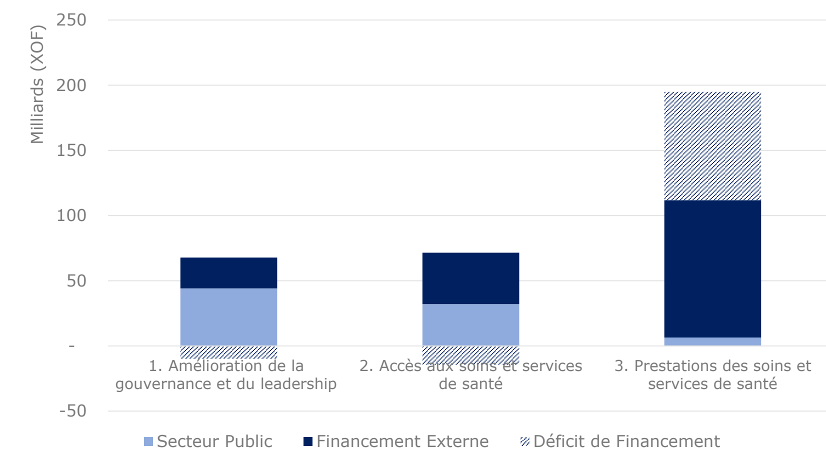
## FUNDING GAP ANALYSIS

### Funding gap by priority area based on CNS 2017 & 2018 (million XOF)



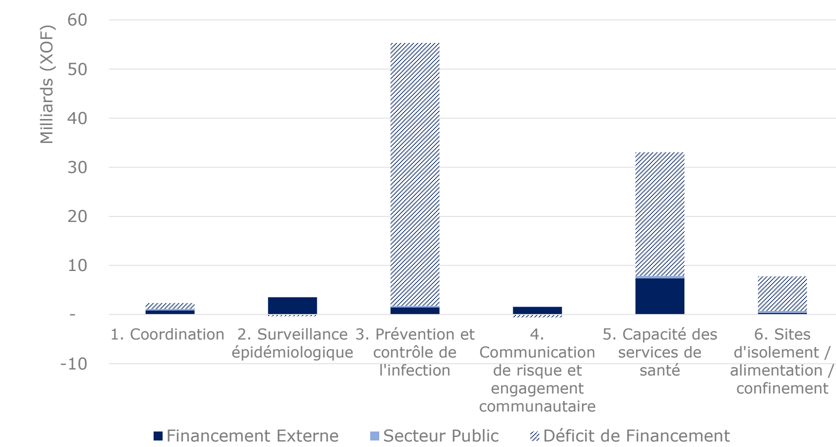
## FUNDING GAP ANALYSIS

### Funding gap by priority area in 2020



## FUNDING GAP ANALYSIS

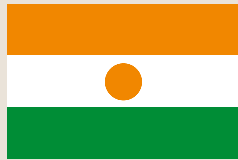
### Covid-19 Response Plan funding gap in 2020



## THANK YOU

For more informations :

mantony@oeconomia-expertise.com



# Health Development Plan Resource Mapping

**REPUBLIC OF NIGER**
Fraternity - Work - Progress
**Ministry of Public Health**

2021 © The World Bank Group. Design: www.pi-marketing-communication.com