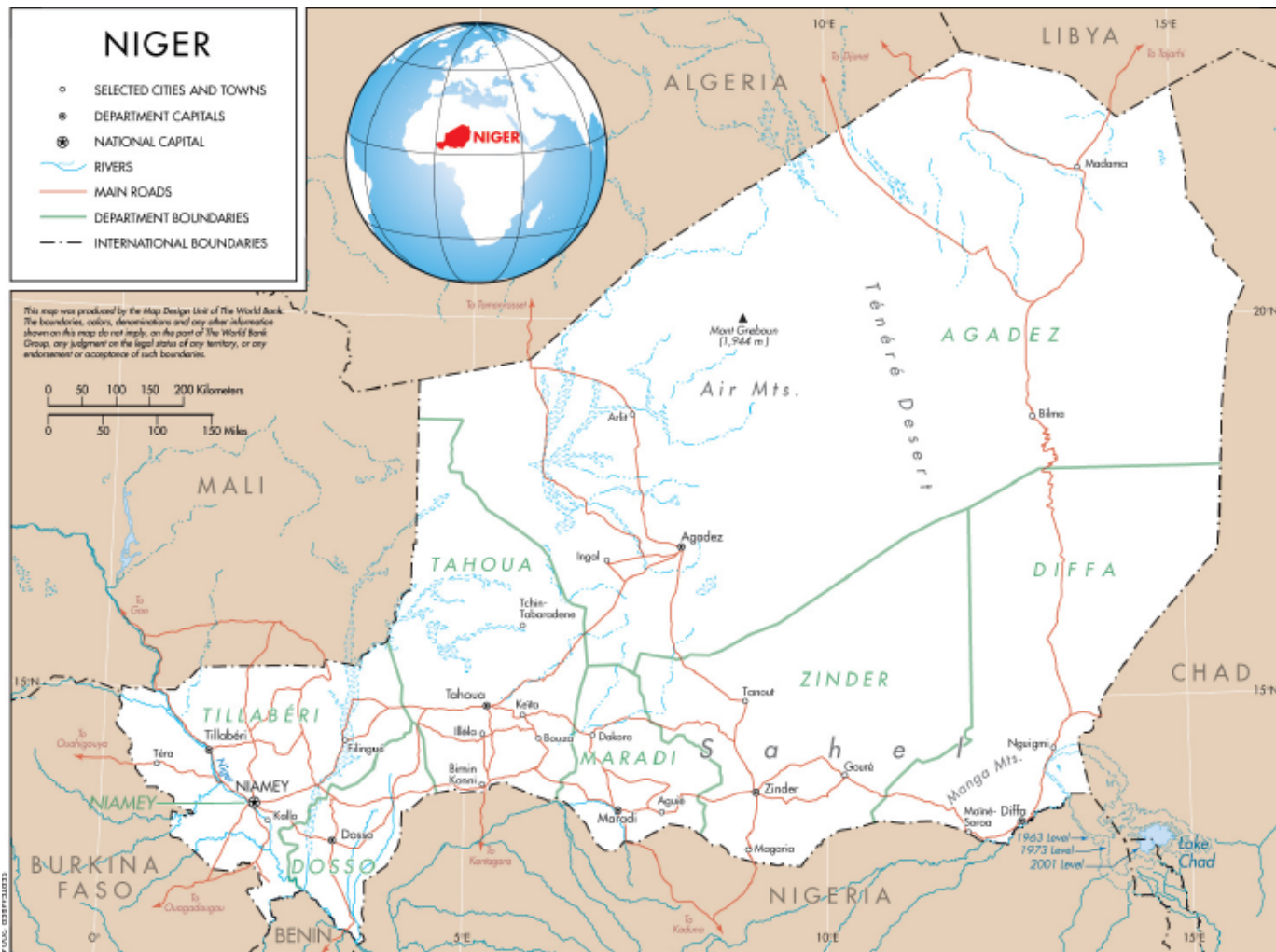


Evaluating and designing policy options for rural retention: some insights from Niger

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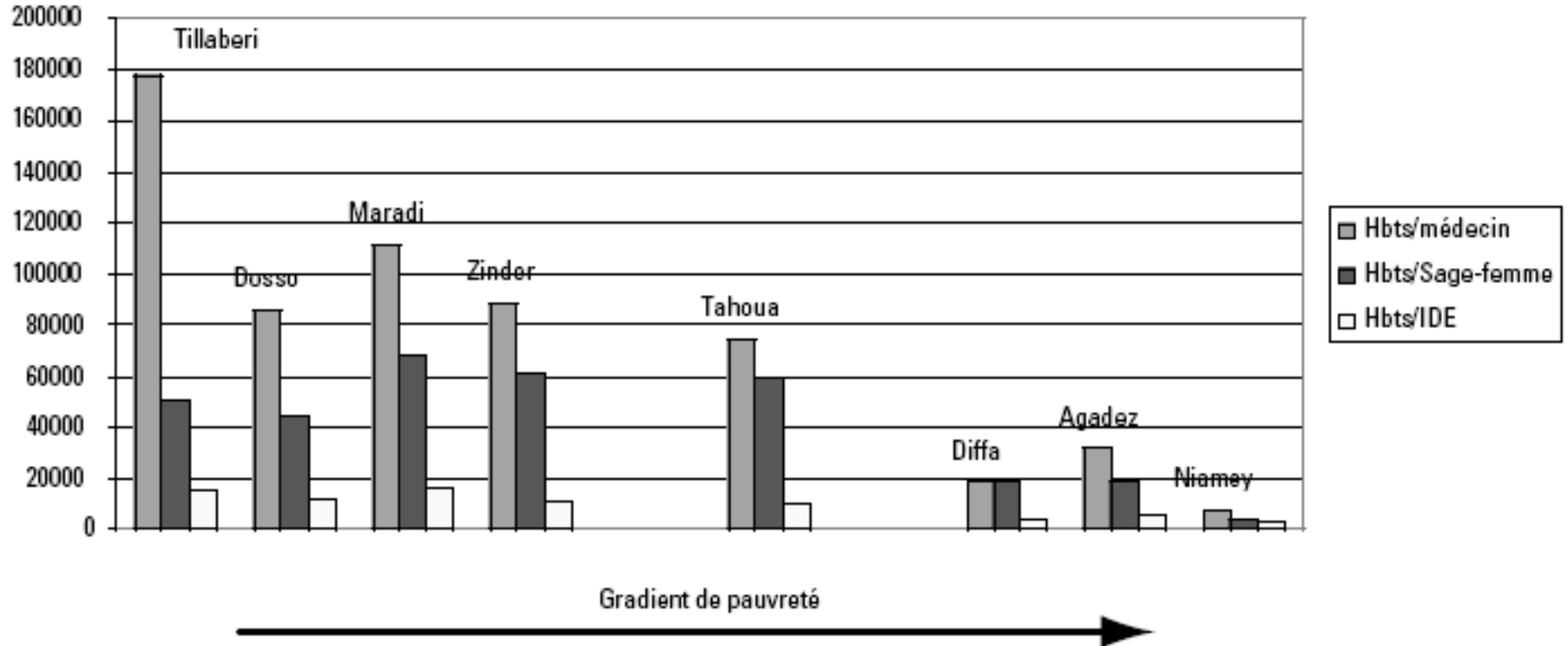
One of the poorest countries in the world



- 11 millions
- Child mortality: 136 (for 1,000 births)
- Maternal mortality: 1,800 (for 100,000 deliveries), the highest in the world

A highly skewed distribution of health workers

- Most of the HW are concentrated in the urban areas



Niger has implemented a financial incentive for doctors, without any significant results

- In 2005, a HW census found that 35% of doctors worked in Niamey, while only 20% of the population is there.
- In 2006, the MoH designed a financial incentive system
 - on average, \$162 per month (about 30% of base salary)
- In 2008, a new census was carried out and found that the distribution was unchanged: the same proportion of doctors are concentrated in the main urban area.

Explaining the policy failure

- Along with the 2008 census, a DCE was carried out among 100 doctors (out of the 292 in the country).
- We found that, to achieve a 60% probability that doctors will work in rural areas, the financial bonus should have been closer to \$275, a 70% difference with the actual bonus
- We also found that a 55% probability of getting a post-graduate education was valued as high as such a financial bonus.

Enriching policy dialogue

- These results (census + DCE) helped the WB and the MoH to explore different policy options:
 - A full financial bonuses may not be sustainable, especially if there is a spillover effect
 - Post-graduate training can be more cost-effective
 - Changing gender bias in nursing school may improve the nurses distribution
 - Rural pipeline is also explored (with a pilot study in 2 remote areas), at least for nurses:
 - preferential admission policy
 - local schools
 - improved curriculum
 - Same for “private wards”