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User fees abolition policy in Niger: Comparing the under five years exemption implementation in two districts

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ABSTRACT

Objective: Analysis of the implementation process for a national user fees abolition policy aimed at children under age five organized in Niger since October 2006.
Methods: This was a study of contrasted cases. Two districts were selected, Keita and Abalak; Keita is supported by an international NGO. In 2009, we carried out socio-anthropological surveys in all the health facilities of both districts and qualitative interviews with 211 individuals.
Results: Keita district launched the policy before Abalak did, and its implementation was more effective. The populations and the health workers of both districts were relatively well aware of the user fees abolition. Both districts experienced significant delays in the reimbursement of treatments provided free of charge in the health centres (9 months in Keita, 24 months in Abalak). The presence of the NGO compensated for the State's shortcomings, particularly with respect to maintaining the drug supply, which became difficult because of payment delays. In Abalak, district officials reinstated user fees.
Conclusions: The technical relevance of user fees abolition is undermined by the State's lack of preparation for its funding and organizational management.

1. Introduction

According to evaluation experts and global health scientists [1], implementation processes merit particular attention because "*if implementation fails, everything fails*" [2]. Experts in health services funding and user fees abolition offer the same advice on implementation [3]. Today, it is widely recognized that abolishing user fees promotes health services utilization [4]. Thus, UN Agencies, the European Commission's Humanitarian Aid Office (ECHO), the World Bank and DFID all recommend this policy instrument to African States for achieving universal access to healthcare [5]. However, how they undertake such abolition and stakeholders' reactions to this decision have, to date, been little studied [6,7]. This is particularly true in West Africa, where the experiences are much more recent than in southern or eastern regions of Africa. Thus, we have very little evidence, for example, on reimbursement modalities for treatments provided free of charge by health centres, or on the distribution of inputs (e.g. medicines) [8–10]. Healthcare workers are also demanding more involvement in organizational decisions, and populations want to be better informed [9,11,12].

2. Background

In April 2006, Niger's government decided to abolish user fees for children under the age of five years. This was

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a political decision by the president in power at that time, and it surprised many people. It appears to have been taken during negotiations with the international financial institutions and without prior discussion with technical experts [13,14]. In this context where the financial barrier, while not the only one, presented a serious obstacle to healthcare access [15], the government mobilized both its own and external resources to fund this policy. Further justification for this policy, which figured among the objectives of the 2005–2010 Health Development Plan (PDS) [16] was provided by the persistence of severe malnutrition exacerbated by the 2005 food crisis [17]. As is well known, access to health services is a determinant of malnutrition [18].

Niger's pyramidally structured healthcare system is based on Bamako Initiative (BI) principles. Each district, managed by a district management team (DMT), has a district hospital with a physician and a midwife. The second level consists of integrated health centres (IHC) managed by a nurse, of which there are two types. Type 1 IHCs carry out curative and preventive activities, while Type 2 IHCs offer maternity and laboratory services. Finally, there are also health posts, recently expanded under a presidential program (the Heavily Indebted Poor Countries Initiative), where community health workers (CHW), trained in six months (of which three are IHC internships), provide first aid services for payment. Each health facility collects payments for services; these funds are retained and managed locally by a management committee (COGES) whose members are from the community. A "free services cell" coordinates the policy at the central level. Healthcare facilities are reimbursed for services provided for free, based on fixed rates according to the type of care and of facility. Fixed rates vary between 500 F CFA (0.75 €) for children's curative visits in an IHC to 12,000 F CFA (18.3 €) if a child is hospitalized in a district hospital. These funds allow the facilities to stock supplies of medicines in the community pharmacies, which are satellites of the central purchasing office (ONPCC). In the first months of implementation, UNICEF distributed essential medicines for children in all districts of the country so the system could begin functioning while the reimbursement system was being organized. Most IHCs also had financial reserves from the cost-recovery system.

In 2009, two years after the launch of the national policy, a study was carried out to document the implementation process in two health districts.

3. Materials and methods

The methodological approach was one of multiple case studies with several embedded levels of analysis [19]. The case was the health district. For heuristic and comparative purposes, we selected two contrasted cases because "*multiple cases* [are] *often considered more compelling* [and] *robust*" [19]. The first contrast is that one district was supported by an international NGO, which we felt would benefit the policy's implementation. Then, the second contrast is that they have different contextual characteristics (Table 1). Thus, only Keita District was supported by Doctors of the World (Médecins du Monde – MDM), since 2006. This support was not limited to organization of the abolition policy. The NGO also intervened in management, quality of care, patient evacuation, staff training, renovation of health centres, etc. For financial and logistical reasons, we decided to select the comparison district from among those near Keita, and Abalak was the district that provided the strongest contextual contrast.

The study used qualitative data collected between January and March 2009. Analysis of documents and socio-anthropological field surveys [20] were carried out in *all* the health facilities of both districts ($n = 23$) including district hospitals. With a view toward data triangulation, we carried out in-depth individual interviews and focus groups with the key players, organized into three categories: (i) the implementers (healthcare workers, NGO members, COGES members, etc.); (ii) the beneficiaries; and (iii) the policy-

Table 1
Some indicators of the two districts.

Indicators	Keita	Abalak
Number of District Hospital (2007)	1	1
Number of type 1 IHCs (2007)	7	8
Number of type 2 IHCs (2007)	4	2
Number of health posts (2007)	57	26
Number of physicians (2007)	2	1
Number of midwives (2007)	3	1
Number of nurses (2007)	33	27
Total number of inhabitants (2007)	266,014	98,416
Rate of utilization of curative services (2007)	0.29	0.39
Percentage of the population living within 5 km of an IHC (2007)	35%	27%
Geographic accessibility	Moderate	Difficult
Percentage of low-birth-weight children seen in the IHCs (2007)	8%	9%
Rate of BCG vaccination (2007)	109%	74%
Rate of assisted deliveries (2007)	16%	7%
Majority group	Haussa	Kel Tamshek
Population types	Mostly settled	Nomadic and semi-nomadic
Primary economic activity	Agriculture	Livestock farming
Landscape	Rocky hills	Semi-desert plains

Source: SNIS 2007, Human Development Report 2004.