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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.

Table 2
Number of meetings by group of actors.

	Individual interviews			Group interviews			Overall total
	Men	Women	Total	Men	Women	Total	
Policy-makers	16	1	17	2(7[a])	0	2[b] (7)	24
Implementers	55	26	81	3 (12)	1(6)	5 (18)[c]	99
Beneficiaries	16	32	48	3(27)	3(23)	6 (50)	98
Total	87	59	146	8 (46)	4 (29)	13 (75)	221

[a] Number of persons at the focus groups.
[b] Number of focus group.
[c] One focus group in Keita was done with men and women.

makers. Altogether we encountered 221 people, of which 40% were women. The average number of persons at the focus groups was 5.7 (Table 2).

All the individual and group interviews were carried out by the authors of this article using the same guides. Those conducted in the local language were carried out by MM and translated into French to facilitate analysis with VR and AD. In the health posts and district teams, all the health workers and decision-makers who were present and available were interviewed. For the beneficiaries, we randomly selected from among those present at the time of our visit. In some villages, women's groups were helpful in creating focus groups of women who were not at the health centre. The characteristics of all the persons selected responded to the need for triangulation in order to select a diversified sample of people. In every site, we stopped interviewing when we had reached a point of empirical saturation, based on discussion among the researchers.

Notes were taken systematically of all interviews, and many of them ($n = 167$ persons) were recorded and transcribed using word processing software. The content analysis approach was used to analyze the data [20]. The study was authorized by Niger's Ministry of Health.

4. Results

4.1. Launch

Once the State decreed its new policy (October 2006), implementation was carried out progressively. In Keita, the policy started immediately in October 2006 because the NGO provided the inputs and a premium to cover cost-recovery losses: "*At first, it was the NGO that started; they provided medicines and at the end of each month they gave us a lump sum*" (IHC manager, Keita). It was only in March 2007 that the State began allocating resources to the districts, and thus, that abolition began in Abalak. At that point, the NGO stopped providing inputs to Keita except for medicines, for reasons explained hereafter.

4.2. The relevance and the perceived impacts of the exemption

All the actors considered abolition to be noble and beneficial. It was perceived positively because it was aimed at a vulnerable fringe group of the population. Abolition brought relief to poor families. People no longer hesitated to come: "*Free services are a good thing, because not everyone has what they need to bring a sick child to the IHC*" (IHC manager/Abalak). Healthcare workers noted that utilization increased in both districts, but also that children were brought earlier than before: "*Now women don't hesitate to come, since it's free*" (IHC manager/Keita). However, "*now that services are free, there are fewer serious cases*" (IHC manager/Keita). The users perceive free services as State action: "*It's the government that reduced the burden for us; where before you had to pay 1,000 F to 2,000 F, now you pay nothing*" (person accompanying a patient/Abalak).

4.3. The fixed-rate reimbursement system

Our respondents considered the fixed rates "*reasonable*". There were some losses, but also gains, so "*it balances out*". In fact, there were "*cases that do not exceed 200 F CFA* [0.3 €]. *If we respect the guide, there is no problem*" (IHC manager/Abalak).

Without being able to specify its various steps, IHC managers and COGES members described the reimbursement system as a vague process. For them, it was a mechanism developed by "*those over there*", i.e., at the central level, who "*don't really know much*" (president of a COGES/Abalak). On the other hand, DMT members, particularly in Keita, could describe the process more clearly. Health posts send their invoices to the IHCs, which forward them to the DMT. The district sends everything to the Regional Public Health Department, which verifies, corrects and transmits the documents to the central level. Then the Ministry of Public Health submits the invoices to the Ministry of Finance, which receives all the country's invoices. Reimbursements are then deposited into accounts at the district banks and made available to the IHCs.

In the following sections, we highlight the main strengths and weaknesses of the policy's implementation.

4.4. Implementation strengths

4.4.1. Information

In both districts, healthcare workers received information on abolition at meetings organized by the DMT and at supervision visits. Most workers were well informed, but they were not consulted when mechanisms for the policy's implementation were being defined. Local authorities also helped disseminate information. Still, information was better disseminated in Keita thanks to the NGO's resources.

4.4.2. Medicine supply

In Keita, the NGO played a central role in supplying medicines; it often ensured the delivery of medicines and continued to provide them even during State shortages. In Keita, the community pharmacy proved a dependable partner; "*with it, we have no shortages here in Keita*" (COGES/Keita).

4.4.3. Reorganization of the work of healthcare workers

Abolition led to an increase in service utilization. Healthcare workers had to organize themselves. The NGO instituted a triage system that helped identify urgent cases, especially when crowds arrived during market days and when epidemics broke out (an epidemic occurred during the study). On these occasions, CHWs came to the IHCs to help the nurse and to get more training, since "*when we go help the nurse and we see a new case we don't understand, we ask and the nurse explains. This is how we learn. . .*" (CHW/Abalak). The NGO also helped improve pharmacy management.

4.4.4. Stronger commitment from COGESs

COGES members were involved in managing this policy. They kept receipts, made payments, and were involved in managing medicines. Some COGESs adapted their activities to deal with the crowds of patients: "*every day, one member of the COGES who is available comes to help the preceptor*" (COGES/Keita).

4.4.5. The NGO reinforcing the DMT's work

In Keita, the DMT manages the policy rather well, because in part, "*MDM encourages the DMT and stimulates it, plays a catalytic role*" (DMT/Keita). The NGO actively supports DMT supervisions by providing both vehicles and fuel. It facilitates communication between the DMT and the IHCs by transmitting information.

4.5. Implementation weaknesses

4.5.1. Information

After more than two years, information in Abalak was unevenly received: "*They don't know it's free. Where they are, radio doesn't reach, or they don't listen. But those living near IHCs are aware*" (IHC director).

4.5.2. Problems of access and utilization in the healthcare pyramid

Often the "local ambulance" (a mule-drawn cart) is the only means of transporting the sick. Public transportation vehicles may be used on market days. The problem is more severe in Abalak, where populations are sometimes very distant from health facilities and the health posts do not really function: "*it's as if people didn't really want to give any importance to health posts*" (IHC director/Abalak).

4.5.3. Poor management of medicines

Most IHC managers in Abalak had a negative perception of the community pharmacies' ability to ensure their medicine supply, given the increase in demand and the crisis that the central purchasing office (ONPPC) was experiencing. They complained of "*abusive shortages*" that resulted in their not receiving everything they ordered. Some turned to the private sector, which "*sells at the same price as the community pharmacy*" (IHC manager/Abalak) or was sometimes geographically closer. "Independent" suppliers, generally not accredited by the State, were also used. These suppliers went from village to village, proposing a 10% kickback on the prices of medicines. Thus, "*In Abalak, there isn't even one community pharmacy worthy of its name. There are in Keita*" (IHC manager/Abalak). In addition, at the time of our surveys, Coartem®, the standard prescription for malaria in children, had been stocked out from the IHCs in both districts. In Abalak, "*we have no more Coartem, we have gone back to chloroquine*" (IHC director). Healthcare workers refuse to order amoxycillin syrups because, while mothers appreciate them, they are too costly in relation to the reimbursement system. Here, in the very specific situation of these syrups, the "balancing out" system does not work because, to cope with delays in reimbursement, the IHCs prefer to order less expensive forms of medicine. It is also not unusual for healthcare workers to be faced with expired medicines, especially in Abalak where, in IHCs, the stock pharmacy is not separated from the dispensing pharmacy.

4.5.4. Administrative documents

Administrative supports, such as monthly free services summary sheets for obtaining reimbursements or invoices, are considered "*very useful*" tools (manager/Abalak). However, the problem lies in being able to purchase these supports with community funding (they are not provided by the State), given reimbursement delays (see below). Thus, COGESs purchase these documents in small amounts. Sometimes, as in Abalak, they do not have the resources to purchase them.

4.5.5. Reimbursement delays

Reimbursements are the glitch in the system, bringing the abolition process to a near-standstill. In Keita, reimbursements were six months in arrears; since the policy's launch, delays ranged between three and six months. In Abalak, health facilities had received no reimbursement since the policy's implementation two years earlier. A first payment had arrived at the district, but at the time of our study, no funds had been transferred to the IHCs' accounts. The amount received from the central level being far less than was needed, one nurse reported that the district medical officer said he did not know "*how to distribute this meagre sum among all the IHCs*" (IHC manager/Abalak). The DMTs acknowledged that delays were not produced only at the higher level. In Keita, delays were caused by the three-month absence of their manager and by an error in the invoices. In Abalak, there were both errors in invoices and delays in submission. Healthcare workers and COGES members were not aware of the reasons for the delays and said they had sent in their invoices on time. One nurse who had worked in Keita expressed her confusion: "*In Keita, we were reimbursed every time, but here, I don't know where the money goes*." (nurse/Abalak).

Table 3
Comparison of implementation in the two districts.

	Keita	Abalak
Start of abolition	October 2006, with NGO support	March 2007, by the State
Information	Pyramidal process, relatively in-depth	Some users in remote villages still not informed Few activities to generate awareness
Drugs	Few stock shortages, and NGO donations to compensate for shortages	Numerous stock shortages and no partner to compensate
	Very dynamic ONPPC manager	Very ineffective ONPPC manager
	Deliveries facilitated by the NGO	Drugs ordered from non-accredited suppliers
	Effective community management	Deliveries difficult
		Poorly organized community management
Reimbursements	9-month delays for the IHCs	24-month delays for the IHCs
	Relatively proper functioning	Very critical financial situation for IHCs
	NGO follow-up at the central level	No technical support to follow up invoices
	Delays related to errors in completing forms and to management problems	Delays related to errors by district management
District management team	Relatively good functioning	Mediocre functioning and internal conflicts'
	Stimulated by the NGO	Very little supervision of the IHCs
	Team fully staffed and relatively long-standing in office	New team in place
	Relatively good knowledge of the files and monitoring of IHCs	
Health evacuation system	Household pays IHC and IHC pays district hospital No direct payment to the regional hospital	System of payment for treatment
Perception of the healthcare workers	Significant impacts on patients, with some harmful behaviours	Significant impacts on patients, with some harmful behaviours
	Impacts on their work seen as mostly negative	Impacts on their work seen as mostly negative Major difficulties with reimbursement
Unexpected impacts	Sense of ownership of the healthcare system by the population	Resumption of cost recovery practices Legitimization of unofficial payments
	Coping strategies by groups not targeted for the exemption	Coping strategies by groups not targeted for the exemption

Sources: Survey data.

4.5.6. Decapitalization of the IHCs

Reimbursement delays had emptied the IHCs' accounts: "*We have had to bend over backwards to get medicines on credit*" (IHC director/Keita). The situation was so serious that, at the end of February 2009, four IHCs in Abalak had no money left in the bank and the others had positive balances that were relatively low (between 3500 F CFA and 550,000 F CFA). In Keita, most healthcare workers mentioned the importance of the NGO: "*The last reimbursement was in June. We didn't close, thanks to the NGO's support*" (IHC manager/Keita). This support to Keita seemed also to be indispensable at the central level: "*Thank goodness, the NGO is always at the Ministry to follow up on the documents*" (DMT/Keita).

4.5.7. Ineffectiveness of the DMT

In Abalak, the new DMT did not have a good picture of what was going on. The previous team had not worked well, supervisions were not done regularly, and the team had created reimbursement delays. The new team required some time to coalesce, as the changeover had affected half the positions, "*Everything here must be rebuilt*", a member of the new team told us. Meanwhile, however, we noted that their workday did not begin before 10:00 a.m., and the place was nearly deserted each time we visited, quite unlike the ambiance at Keita.

4.5.8. The legitimization of standard practices

Some IHC managers adopted coping strategies to deal with non-reimbursement. A few decided to reinstate user fees: "*I adopted a strategy; each patient coming for a visit pays a fee of 100 F CFA for the booklet, whether it's a paying adult or a beneficiary of free services*" (IHC manager/Abalak). Another IHC stopped ordering administrative supports but purchased school notebooks that they cut into three. When free services first began, nurses concealed their parallel strategies for covering "losses", but now these were done openly. The absence of reimbursement therefore legitimized what had been hidden and not discussed: "*Otherwise we couldn't manage, with reimbursements that never come*" (IHC manager/Abalak).

Table 3 presents a summary comparison of the situations in the two districts.

5. Discussion

User fees abolition appears to have contributed to the achievement of the intermediate objectives of the 2005–2010 Health Development Program [16]. However, this study provides a better understanding of this policy's implementation in Niger [6].

5.1. Methodological strengths and limitations

Because this study was conducted in only two districts of a country as vast as Niger, it is not possible to generalize all our conclusions to the entire territory. In fact, the two districts were not chosen to be representative of all districts in Niger—an ambition that would have been beyond our means—but rather to provide situations that were sufficiently contrasted to expand our capacity to understand the phenomenon studied. Nevertheless, the strength of our conclusions was reinforced by the depth of analysis, the triangulation of data and of sources, as well as the valida-

tion of results by the key stakeholders [19,21]. The NGO in Keita district had no influence on the evaluation process. In addition, the results of this study confirm the analyses done by national authorities [22,23] and outside experts [16,24], as well as the preliminary results of studies under way [13,14]. The use of two contrasted cases provides some elements of replication logic and strengthens the "analytic generalization" [19] of the difficulty of implementing the public policy.

5.2. Integration within an existing system

One great strength of this policy of abolishing user fees for children under age five was that it was perfectly integrated within the existing healthcare system. The cost recovery and community management systems set up in the 1990s, even if imperfect [15], were respected. Unlike what happened in Uganda [25], the management committees were involved in the policy, since they (theoretically) received the reimbursements for services provided free of charge.

5.3. The NGO's key role in compensating for the State's shortcomings

Clearly this study was not based on a controlled design in which districts were randomly selected. Aside from socio-demographic characteristics that scarcely influence policies, the two districts are very contrasted, even in terms of the NGO's presence in the healthcare system organization. The results related to these conditions have been specified above. That being said, comparing the two districts' situations with a case study in which all health centres were visited allowed us to show, on one hand, the great difficulties in both districts associated with implementing the policy and, on the other, the NGO's central role in compensating for the State's shortcomings.

The presence of the NGO prevented the collapse of the system in Keita District and highlighted the geographic disparities created by an implementation that depended on an NGO. The core issue is certainly that of access to medicines, as was clearly shown in the abolition experiences of South Africa, Kenya, and Madagascar [9,26,27]. What is the good of abolishing user fees if patients cannot obtain medicines? As UNICEF did at the policy's launch, the NGO made up for the stock shortages produced by reimbursement delays and the lack of preparation by the ONPPC, whose structure is notoriously vulnerable, when the increase in demand became apparent by early 2008 [28]. The State is aware of this problem, since in 2009 it drew up a national drug supply strategy. Meanwhile, however, Abalak's children have once again been required to pay (officially or not) part of their care, or use the private sector, as in Uganda [29,30]. This situation was also seen in Ghana, where reimbursement delays associated with national insurance explained, in part, the unofficial fees that may have been less prevalent previously, under the cost-recovery system [31]. In Niger, some have called this the "*illegal but necessary resumption of payment for services*" [16].

5.4. Reimbursement modalities in a centralized State

Unlike Mali or Senegal, Niger—like Burkina Faso and Ghana—chose not to provide inputs to ensure free services, but rather to reimburse health facilities on a fixed-rate basis. Even though there is still insufficient evidence to promote one model over another (input- vs. output-based financing) [32], it was certainly a technical decision meant to simplify the process, although it is unfortunate that fixed rates in Niger were not rigorously calculated, being based on 1999/2000 financial estimates. After Ghana and Burkina Faso, this represented a new attempt on a national scale to test the fixed-rate reimbursement approach such as promoted in Rwanda [33]. Unfortunately, unlike in Burkina Faso, where it worked well [34], it cannot be said to have succeeded in Niger, despite the fact that a management cell was created that focused specifically on free services, as experts recommend [6,32]. Reimbursements were delayed, producing a policy implementation gap [35], and what was planned was not implemented, leading to all the consequences observed for families and their access to medicines. Already in 2008, a study confirmed this situation. In Dosso health district, only 31% of the amounts declared had been reimbursed by May 2008, while in a district of the capital, the reimbursement rate was 9% [22]. Thus, in one year, the situation had not improved. This was also confirmed by evaluators at the end of 2008 [16]. The Ministry of Health has attested to the situation, which seems to have further deteriorated, since authorities stated, at a national conference in January 2010, that 6.6 billion F CFA remained to be paid for the period 2007–2009 [23]. They even added that as of "*January 10, 2010, no invoice submitted in 2009 had been reimbursed*" [23].

The present study highlights delays at the district level, our level of analysis. These were administrative and related to errors in completing documents that had even been simplified in comparison with Ghana or Burkina Faso [34,36]. However, these were also human errors, insofar as the chief medical officer's leadership and the professionalism of accountants are essential in such a context. We did not document errors at the central level. However, we know the delays are also partly attributable to the reimbursement system's central bureaucracy [14]. As much as the forms are simple for the peripheral actors to complete, the reimbursement process is long and complex at the central level [16]. Moreover, the administration has remained mired in a process of accounting control rather than adapting to an output-based financing type of operation [32,33]. The same situation exists in Burkina Faso [34], which might be explained in part by a bureaucratic functioning that is proper to this region and thus resistant to fixed-rate payments. Rather than controlling signatures on papers, the administration should rather verify the authenticity of the acts for which the health centres request reimbursement.

6. Conclusion

Everyone recognizes that the decision to abolish user fees for children under age five in Niger was largely political in origin. Although the decision was technically useful (*relevance*) in lifting the financial barrier and improving

children's access to care, it was perhaps not contextually appropriate (*responsiveness*). Thus, there was a lack of technical preparation and insufficient funding, especially since the political context at that time was relatively unsettled. The present study shows that ensuring access to medicines and reinforcing the supply system are crucial to the success of such a policy. Moreover, the lessons drawn from a pilot project by another NGO in two districts [12] before the policy was rolled out nationwide were not sufficiently considered. For this type of exemption policy to be adequately implemented, as promoted by world leaders [37], it is urgent that solutions be applied to prevent reverting to user fees (official or unofficial), since people do not understand why a policy that is so beneficial for them would not be fully implemented.

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