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Abolishing user fees for patients in West Africa:

lessons for public policy

Valéry RIDDE
CRCHUM and University of Montréal
Jean-Pierre OLIVIER de SARDAN
LASDEL

afd
AGENCE FRANÇAISE DE DÉVELOPPEMENT

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Valéry RIDDE
CRCHUM and University of Montréal
valery.ridde@umontreal.ca

Jean-Pierre OLIVIER de SARDAN
LASDEL
olivierdesardan@lasdel.net

CONTACTS
Pascal BROUILLET
Agence Française de Développement
brouilletp@afd.fr

Corinne de PERETTI
Agence Française de Développement
deperettic@afd.fr

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[Foreword]

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Introduction

This work is based on a dossier of five articles on the subject of health with a specific focus on three poor West African countries, notably Mali, Niger and Burkina Faso. The issues addressed are, more precisely, free healthcare, the targeted clientele, actual implementation procedures, difficulties encountered and, *in fine*, the results obtained. Responses from the research community are all the more interesting in that they combine two types of approach, one questioning public health policy and the other deriving from several socio-anthropological field studies.

Of all the goals usually assigned to the process of social and economic development, the topic of health is central in two respects. On the one hand, improving a population's health situation is a goal in itself and a marker of development. It is also part and parcel of the Millennium Development Goals. On the other, it is a domain where states are required to do their best to ensure that this goal be respected as it constitutes an essential service they owe the population on a par with, for example, the protection of people and their property or universal schooling.

A rapid glance on health policy in French-speaking Africa since independence shows three successive historical phases. The first – consistent with colonial tradition – posits free healthcare for all, in imitation of the metropolitan model. In reality, accomplishing this was far from easy and swathes of the population, particularly in rural areas, did not benefit at all.

The second led to the Bamako Initiative at the end of the 80s, once it was realized that there was a strong misalignment between the objectives set and what, in reality, the states could actually do as they were already weakened in their ability to take action, notably because of structural adjustment programs. The Bamako Initiative acknowledged the incapacity of the states to ensure free healthcare for all and consequently advocated ways in which these costs could be partially recovered. The problem then arose of the poorest, most vulnerable populations who were *de facto* excluded from access to healthcare. This gave birth to a new paradigm, bringing in the third phase, which was selective, free healthcare, or as the authors of these articles would put it, systems and terms of user fee exemption from healthcare.

Mali, Niger and Burkina Faso have all implemented health policies founded on this paradigm and have been confronted, to varying degrees, with more or less the same

difficulties. The roots of these difficulties lay in the decision-making process itself which was the product of a mix of domestic political calculation at high-level government and pressure from external stakeholders, of whom important multilateral aid donors. The result was hasty decisions. No feasibility studies were carried out nor pilot actions undertaken. Neither the professionals involved, nor future users, were sufficiently implicated, if they were implicated at all, and a rigorous examination of the capacity of the states to bide by their commitments was totally neglected. The result was a triple breakdown, technically, financially and in communication.

One of the most interesting points is the one concerning the selection of those groups being able to benefit from the new system, *i.e.* those selected for free healthcare. Field studies have revealed that any possible concerns about discrimination towards those that would not benefit from free healthcare were most often unfounded, but only provided that the choice of the beneficiary selection was conform to the community's perception of equity or that this choice was widely accepted by the population and was thus conform to community values.

On the whole, for the three countries involved, the process of beneficiary selection, which mainly targeted pregnant women and young children as well as the indigent, was not among the causes that explained the difficulties encountered in applying this new policy. On the other hand, lack of preparation before making a decision, particularly concerning the alignment between the targeted goals and the technical, financial and organizational means to be mustered, had multiple negative effects.

These were as follows: effective access to healthcare by the selected population; the quality of the care and sometimes an unavailability of medicine; financial stability of health institutions; and healthcare personnel workload. All this was conducive to the setting up *de facto* of a two-tier medical system with a good quality, fee-paying, private system for the rich on one side and free healthcare, albeit of inferior quality, for the poorest populations on the other.

These difficulties, however real, should not lead to an outright rejection of these new health policies. Indeed, on the one hand, ingenuity and various other ways tending to make free healthcare not entirely free allow the system to function as best it can. On the other hand, and this is the most important, the probability that these policies have contributed to improving the health situation of the populations is real if the strong increase in the number of patients treated is anything to go by. Proof also of this is that endemic diseases such as malaria or aids are on the decline as are the rates of morbidity and mortality. Real headway has been made but this does not mean that

one can be content with this situation and shy away from pursuing improvement to the health system, either through the current set-up or by adding to it by using tools such as obligatory health insurance, complementary insurance, or micro-insurance health schemes.

Jean-Bernard Véron, AFD

1. Contradictions and inconsistencies in public policies. An analysis of healthcare fee exemption measures in Burkina Faso, Mali and Niger

J.P. Olivier de Sardan (LASDEL) and
V. Ridde (Montréal University Hospital Research Center)

Abstract:

To deal with difficulties in accessing care that arise in the context of cost recovery programs, many African countries are now implementing user fee exemption policies for certain vulnerable population groups. Based on a study of public policies and socio-anthropological fieldwork, this article presents a comparative analysis of the situation in Burkina Faso, Mali and Niger, which have chosen to apply relatively different exemption measures. However, the problems encountered in the design and implementation of these policies are very similar. Exemption measures are often adopted on the basis of a mix of internal political calculations and external pressures. Due to the lack of preparation, communication, effective management and most of all, adequate funding, the operation of measures is chaotic and inconsistent in most cases. Many unexpected effects were revealed by the research, notably the fact that quality of care is far from reliable due to shortages in supplies.

Introduction

There is growing support for universal health coverage that provides equitable access to modern healthcare for all, regardless of the ability to pay (WHO, 2010). The 65th World Health Assembly, held in May 2012, had a generally galvanizing effect on health ministers in terms of this issue. While universal coverage is now beginning to appear on the political agenda of a number of international organizations and African countries (Robert *et al*.), it remains a relatively distant prospect. Going down that road will require the adoption of a range of transitional measures, a gradual reform of health systems and the development of stable funding mechanisms. Given that public policies in most African countries are beset by numerous difficulties at both the development and implementation stages, this is no easy task. healthcare policies are a case in point.

It is in this context that we must consider healthcare fee exemptions, which have risen significantly in virtually all African countries over the past decade, as we attempt to learn some lessons for the future.

In one sense, the recent reforms close the consensual chapter based on the Bamako Initiative, which had placed a threefold mission at the centre of African health systems since the late 1980s: i) partial recovery of costs at the delivery point of services; ii) use of essential generic medicines; and iii) community participation. The results of the Bamako Initiative have been mixed. On the one hand, medicines have become available at all the health centres; on the other hand, for financial reasons treatment has remained inaccessible to the most vulnerable sectors of the population (McCoy *et al*., 2011; Balique *et al*., 2001; Gilson *et al*., 2000 and Ridde, 2012). Access to treatment remains extremely unsatisfactory: the rate of curative consultations rarely exceeds 0.5 consultations per person per year. Although management committees give clients some potential control over healthcare workers, the way these committees work results in many problems.

Hence, in terms of healthcare, Africa faces four major challenges today, none of which has been successfully met by the partial cost-recovery policies of the last 30 years: (a) health indicators, which leave Africa trailing behind the rest of the world, have only marginally improved, and the Millennium Development Goals will not be achieved by 2015; (b) a high percentage of the population still does not have access to the modern healthcare system, especially the most vulnerable groups; (c) quality of care delivered by the public health system is uniformly poor (Jaffré and Olivier de Sardan, 2003), with human resources sometimes being inadequate and always unevenly

distributed geographically; and (d) the slice of national budgets allocated to healthcare is notoriously insufficient and in most countries falls well short of the declaration of intent at Abuja (15%) (Ridde, 2012; WHO, 2011).

Free healthcare policies constitute an attempt to address the first two challenges. As we shall see, however, their implementation runs counter to the last two challenges.

On the face of it, these free-treatment policies, or more precisely exemption from fees at the point of service delivery, have indeed appeared to offer relatively straightforward solutions that theoretically make it possible to remove financial barriers to accessing healthcare, as addressed in a number of studies over the last 20 years. In 2008, the WHO Commission on Social Determinants of Health noted the need to eliminate out-of-pocket expenditures at point of service. That same year, the WHO Ouagadougou Declaration on Primary healthcare and Health Systems in Africa stressed the importance of equity. In 2010, African heads of state advocated free care for pregnant women and children under five years of age, following in the footsteps of United Nations agencies that had taken that position in 2009 (cf. Robert *et al*.).

Three Sahel countries – Burkina Faso, Mali and Niger – serve as examples for analyzing the modalities of these new public-health policies. In recent years, all three countries have developed and implemented a series of either total or partial user fee exemption measures for certain categories of the population or for certain medical services. However, each country has taken its own particular approach. Based on a comparative analysis of research undertaken in the three countries as part of a research program coordinated by LASDEL (Niger) and CRCHUM (Canada),[1] we will present a comparative assessment of the three main strands of all public policies (Lemieux, 2002): (a) development; (b) implementation; and (c) effects.

Our own scientific approach complements a series of recently published analyses of user fee exemption policies (Meessen *et al*., 2011; Ridde and Morestin, 2011). However, these analyses pay scant attention to West African countries or to socio-anthropological fieldwork (Olivier de Sardan, 2008). Moreover, the publications stress the need for new empirical data to be produced via in-depth field studies of the kind we have already undertaken.

[1] See the various articles in this issue, and for more detailed accounts Niger, cf. Diarra, 2011; Kafando, Mazou, Kouanda and Ridde 2011; Ousséini, 2011*a* and *b* (all available for downloading at www.lasdel.net). A more detailed version of this article may be found in Olivier de Sardan and Ridde, 2011 (www.lasdel.net)

Up to the end of the last decade, most of the research carried out on free healthcare policies focused on how they affected use of services and eased families' financial burden (Ridde and Morestin, 2010; Meessen *et al*., 2011; Lagarde and Palmer, 2011). In the absence of impact studies, which are very difficult to carry out from a methodological point of view, these analyses were small in scale or relied on modelling. They all revealed positive effects, clearly confirming much earlier studies showing the ineffectiveness and unfairness of direct fees (Evans, Barer and Stoddart, 1993). Our research, on the other hand, fills a gap in examining the pattern of emergence and implementation of free healthcare policies in Africa, the difficulties they encounter and stakeholders' perceptions of them. It focuses on the procedural aspects of these policies, takes systems approaches into account (Ridde, Robert and Meessen, 2012) and uses mixed interdisciplinary methods (Gilson *et al*.). We will begin by describing the context and content of the policies studied.

1.1. The context and content of exemption policies

The removal of the user fee paradigm, translated by each country into its own terms, was recently introduced in a healthcare context common to all three countries, with two basic features: (a) the existence of a general policy of partial cost recovery; (b) poor health indicators.

1.1.1. A similar national and international health context

In the French colonial era, the healthcare system was the same everywhere (Yaogo *et al*., 2012): "free healthcare"[2] for the user at the point of service delivery, funded from the colonial state's budget.[3] However, in practice it was either reserved for an urban minority or limited to vaccinations and the fight against serious endemic diseases and epidemics (Bado, 1996; Van Lerberghe and de Brouwere, 2000). With independence, the number of healthcare centres rose dramatically, especially in rural areas, and the principle of free healthcare remained in force. However, in the early 1980s, when African states suddenly found themselves in serious financial trouble and were weakened by structural adjustment policies, this system underwent a deep crisis: consultations remained free, but healthcare centres no longer had supplies of medicines available. Hence, they issued prescriptions for medicines that had to be

[2] "Free healthcare" is the widely used term; however, the appropriate technical term is "user fee exemption."

[3] To the extent that the French colonies were supposed to fund their budgets from their own resources, this "free healthcare" was largely paid for by taxes.

purchased at high prices from pharmacies that were sometimes located a long way away.

In the wake of the Bamako Initiative (BI) in the late 1980s, the three countries introduced a partial cost-recovery policy that is still the official system today: proceeds collected by healthcare centres at the point of service delivery are used to buy essential generic medicines (EGM) and cover various running costs. Health committees composed of representatives from the local population manage the system, which has provided relatively satisfactory access to medicine in geographical terms.

However, cost recovery has always been subject to exceptions in certain areas: vaccinations, the treatment of tuberculosis and leprosy and the fight against certain types of epidemics (e.g. cholera, meningitis) have been free of charge.

In the first decade of the new millennium, cost recovery became the target of serious criticism. For one thing, the accompanying measures for protecting the worst-off never materialized (Ridde, 2008; Gilson *et al*., 2001). For another, the aims of the Millennium Development Goals (MDG) in the field of health remained beyond reach. Burkina Faso, Mali and Niger were all dogged by the same public-health problems.

In the same decade, a new paradigm emerged in support of user fee exemption measures linked to the long-term aim of establishing universal access to the healthcare system. The paradigm combined an "equity" argument in support of the most vulnerable and the poorest with a "leverage" argument to the effect that fee exemptions would give a significant boost to general access to and use of health centres by removing financial barriers.

1.1.2. Exemption policies in Burkina Faso, Mali and Niger

Under the influence of this paradigm, a series of user fee exemption measures was implemented in all three countries from the middle of the decade on. However, they were implemented in piecemeal fashion, one after the other, without any real overarching strategy and without provisions being made in healthcare policies or other health development plans.

The following categories were added in fits and starts to the old pathology-based exemptions: management and prevention of HIV/AIDS and administration of antiretroviral drugs (ARTs) (free in all three countries); caesarean sections (free in Mali

and Niger, subsidization and free provision subsequently planned in Burkina Faso); deliveries (subsidized in Burkina Faso, free provision planned in Niger); treatment of pregnant women and children under five (free care in all areas of treatment in Niger; free anti-malarial care in Mali; free care for the worst cases of malaria and subsidized anti-malarial drugs in Burkina Faso; free insecticide-treated bed nets in all three countries); treatment of female cancer patients and provision of contraception (free care in Niger).

Nevertheless, in all three countries, delivery of care is still officially based on recovery of costs, in which exemption measures are "embedded." In other words, these countries have seen the establishment of two sub-systems that co-exist side by side. On the one hand, there are chargeable consultations and medicines for non-exempt categories, and on the other hand, there are free consultations and medicines for exempt categories. The two schemes co-exist, each with its own complex and distinct structures.

However, exemption measures sometimes affect the equilibrium of the system as a whole, especially measures covering pregnant women and children under five, who account for the majority of first-level consultations and therefore most of the income generated by consultations. Malaria is by far the most common reason for seeking medical care for children under five years of age.

In reality, the exemption mechanisms adopted differ widely from country to country, as does the extent to which they are integrated into the countries' health policies. While Burkina Faso has taken things one step at a time, Niger has been extremely ambitious in its choice of options. Mali tends to steer a middle course.

Burkina Faso

In Burkina Faso, policies have favoured subsidies over free healthcare, leaving the patient to make a small contribution towards the cost. However, this has gradually given way to free care in some areas of treatment.

In the battle against malaria, ACTs (artemisinin combination therapies) have been heavily subsidized (for example, XOF 100 for the under-fives). A scheme to distribute ACTs at this price was launched nationwide by community health workers (CHWs) in 2011. The management of severe malaria cases has been free of charge since 2005. Insecticide-treated bed nets have also been distributed countrywide, free of charge, since 2010.

In the domain of maternal health, a subsidy (60 to 80 percent, depending on services and level of access to care) is given for normal deliveries and caesarean sections. The expenditure is borne by health centres, which are then reimbursed by the state, initially in the form of a flat-rate payment (an amount that has never been calculated with any accuracy (Ridde *et al*., 2011) but is now based on the actual expenditure (invoices). A report recommending free care for normal deliveries and caesarean sections was adopted by the Council of Ministers in September 2010; however, implementation is still under discussion.

In contrast to this "step-by-step" approach, Mali and Niger have introduced a raft of exemption measures in one go that apply to the sector as a whole and the entire country.

Mali

Mali has simultaneously opted for two distinct types of measures. The first includes a policy of free anti-malarial care targeting pregnant women and children under five, with free supplies of anti-malarial drugs, rapid diagnostic tests and insecticide-treated bed nets. These products are made available to health centres in kit form by the state. There is still a charge for consultations.

Second, free care is provided for caesarean sections in the form of products available as kits. The state also reimburses the hospitals (centres de santé de référence, i.e. referral health centres) for their operations, hospitalization costs and pre-operative examinations. It took another four years after the decision, however, for a ministerial order to specify methods of reimbursement.

Niger

Niger has opted for total exemption from the cost of consultations and medicines for children under five and for prenatal consultations, family planning services and caesarean sections. The state is involved as a third-party payer that reimburses the health centres on the basis of a flat-rate payment. Payment for caesarean sections includes the operation, hospitalization costs, pre-operative examinations and pharmaceutical products. For children under five, the payment includes consultation and medicines, and varies according to the level on the health pyramid.

1.2. Convergent development and decision-making processes

While exemption arrangements differ significantly in the three countries, there is an astonishing number of convergences in the ways they have developed and decided on policies. Decisions on exemptions are based on a paradoxical combination of presidential voluntarism and external pressure, characterized by a lack of preparation and communication.

1.2.1. Presidentialization

In all three countries, exemption measures have been closely linked to the person of the President of the Republic, albeit to a lesser extent, perhaps, in Burkina Faso. Presidential announcements that came out of the blue went right over the heads of health experts. Against a background of elections and presidential ambitions, "exemptions" were packaged as a "present" from the President to the people, accompanied by distinctly moral discourse around the fight against poverty, the generosity of the head of state and the national – really nationalistic – nature of the measures adopted.

1.2.2. External pressures

At the same time, because all three countries were lagging behind in meeting the Millennium Development Goals, there was a great deal of external pressure from international organizations to promote such measures.

Burkina Faso had already eliminated charges for prenatal consultations and infant welfare in negotiations with the World Bank in 2002. Under similar pressure from the World Bank, the country introduced a high level of subsidies or fee exemptions in the area of maternity care, especially for procedures considered to be part of the "quick impact" model (Richard *et al*., 2011).

After Mali's previous failure to qualify, the need for Global Fund eligibility played a key role in the move to free care, which focused specifically on anti-malarial measures.

In the case of Niger, exemption measures strongly advocated by the World Bank were agreed to in negotiations with the Bank, apparently with undue haste.

1.2.3. Lack of technical and financial preparation

The user fee exemptions were national decisions, declared to be of sovereign status and put in place by home-grown technical staff, with no particular help from outside the country, a circumstance that is quite uncommon in health-policy history. However, the measures were rushed through. The decision to adopt them was more political than technical. They were announced suddenly and publicly, surprising not only people working in the field but also specialized staff in the ministries, who were caught completely off-guard. This was not so much the case in Burkina Faso, where those involved contributed extensively to formulating policies designed to subsidize births and ACTs. In Mali and Niger, however, specialized staff suddenly had to spring into action and hastily define mechanisms, procedures and texts on a piecemeal and usually incomplete basis and, in some instances, belatedly. The development and distribution of instructions on the application of the measures and procedural handbooks sometimes took months or even years from the launch of these measures, if they happened at all.

The sheer scale of the practical problems caused by these decisions was completely underestimated. Full-scale implementation was decided on without forethought, without completing any pilot studies in advance. Tests had been carried out by some NGOs, but decisions were made before the tests could be evaluated.

In Mali, the decision to purchase millions of doses of a particular ACT was made without any testing for side effects, which subsequently proved to be adverse and hence dissuaded many patients and healthcare workers from using them. Exemption from import duties for the bed nets that were to be distributed free of charge was not obtained until two years after the decision. Even in Burkina Faso, which was more prudent and progressive in the measures it took, there were plenty of examples of poor preparation and improvisation. The bed nets arrived far too late, for instance, and malaria had already reached its peak by the time they were distributed. There was also evidence of serious shortages of ACTs, and no funding had been set aside to support the implementation of the policy of subsidizing deliveries. However, the most revealing case in terms of lack of preparation was Niger.

Niger had the most ambitious policy, especially the total fee exemption for children under five. However, this was also the most expensive policy – and the most poorly planned. No budget studies or feasibility studies were carried out ahead of time (the study by experts from the World Bank, which highlighted the considerable cost of

these measures and the many conditions that would have to be met, was dismissed by the Ministry of Health). It took a good deal of improvisation and tireless efforts by those involved to do the best job possible in the shortest possible time by setting up the extremely complex organizational, technical and financial mechanisms required to apply the exemption decisions (Ousséini, 2011*a*).

The declaration by the President at the time that a sovereign decision had been made that would be supported by national funding collided with state structures that were in no way prepared for such a decision and the state's inability to honour its financial commitments. It should also be noted that technical and financial partners in the health sector were not notified in advance of these measures (except for the World Bank, which in point of fact had not given any funding for the exemptions, even though it had promoted them).

1.2.4. Poor communication

Although several information workshops were held at the outset in Burkina Faso, they were not available to everyone and were never repeated, so healthcare workers in all three countries were suddenly confronted with a fait accompli, with no prior discussion or preparation. A communication exercise finally undertaken after the event was generally considered to be incomplete and inadequate. Although there were some brochures and fliers, some of which were very informative, they often appeared late and were seldom translated into the national languages. The lack of information available to service users in the three countries led to deep dissatisfaction.

1.3. The processes of implementing the exemption policies

We will start this section by discussing various comparative elements that show certain convergences in relation to the implementation of user fee exemptions in Mali and Niger, both of which opted to introduce free healthcare for a relatively wide range of services. We will then return to the case of Burkina Faso.

1.3.1. Mali and Niger: eight similarities and two differences

Shortages and delays

The very different arrangements made in the two countries are prone to the same kind of bottleneck, i.e. delivery of a service that is free to users is jeopardized by frequent shortages of inputs (Mali) and lengthy delays in the reimbursement of bills,

preventing the service from stocking up on products (Niger). In Mali, serious delays have been observed in the sector subject to reimbursements (fees for caesarean sections), creating management problems. In both cases, such shortages and delays in reimbursement have clearly caused major malfunctions in the system.

Bureaucratic complexity

Another common characteristic is the highly complex nature of procedures and the accounting operations developed for managing exemptions in the cost-recovery program. There is a whole series of unwieldy management tools requiring mountains of cards, records, invoices and slips of paper for various purposes. This bureaucratic complexity is a burden on both health-centre staff who deal with benefits and to administrative staff at the intermediate and national levels. These additional bureaucratic tasks are not funded by free healthcare policies.

The fuzzy edges of free healthcare

Users are never quite sure where charges for services end and free treatment begins. The respective areas covered by the two models (recovery/exemption) frequently overlap, and the overall picture is very complicated. Even under the "free healthcare" category, users never quite know whether they are exempted from fees and to what extent. In Mali, there is a charge for consultations for children under five but anti-malarial medicines are free, while medicines for other diseases (sometimes co-occurring with malaria) are not. Caesarean sections are free, but not the medicines prescribed for any complications or interventions that are needed in ectopic pregnancies. In both Niger and Mali, when medicines are out of stock, patients end up having to pay for prescriptions. In Niger, there is still a charge for health cards and it is an established practice in most districts to levy a supplementary local tax ("centimes additionnels") of XOF 100 to pay for gas for "referral-evacuation" ambulances, even for patients who attend for "free" consultations (cf. Diarra, in this issue). On top of all this, the cut-off point of five years of age is clearly arbitrary and there is a widespread tendency on both sides to ignore or blur it.

Inconsistent half-measures: the example of medical evacuations

Transportation by ambulance is not included in the package of services covered by exemptions. This poses a serious problem, since speedy evacuation in cases of obstructed labour, i.e. dystocia, constitutes a crucial factor in the fight against maternal mortality and is inextricably entwined with surgical intervention. The problem is that evacuation can easily cost as much as or even more than the caesarean section, and the cost must still be borne by families, who have to raise substantial sums in such

emergency situations.[4] Certain partial funding arrangements do exist at this level, however, and they function to a greater or lesser extent.

A system of solidarity funds for evacuations exists in Mali; however, the fee-exemption decision has caused strain, as many people who believed that the exemption also applied to contributions to the fund stopped contributing.

In Niger, districts were provided with ambulances under the former special President's program. However, no provision was made for gas or for paying the drivers – in other words, nearly the whole cost of the evacuation had to be paid. The informal and widespread adoption of the "additional centimes" tax then appeared as a palliative solution. This led to a modest tax being levied on all health-centre users to set up a fund that could be used to pay for evacuations, which became free as a result. While the funds did make it possible to provide a number of free evacuations, they were also hoarded by the health committees, as were the cost recovery funds before they were depleted by delays in reimbursement (Kafando *et al.*, in this issue). The Ministry of Health ruled that officially exempted users should not pay the "additional centimes" tax. Hence, it prohibited the health centres from levying the XOF 100 on consultations for the under-fives. In no time at all funds dried up, since most of the consultations involved that age group. The Ministry intervened without formulating any official alternative. In other words, a measure introduced in the name of official consistency for a public policy ended up blocking an initiative aimed at offsetting an inconsistent application of this very policy – without offering any solutions.

Latent opposition

Healthcare workers everywhere are mystified by or even hostile to the exemption policies. We did not encounter any systematic support for exemption as it is currently implemented. healthcare workers in both Mali (cf. Touré, in this issue) and Niger complain about the added workload it involves for them, with no extra pay (the perennial problem of "incentives," i.e. bonuses). Another reason for their misgivings is the matter of "informal payments" (unofficial levies on patients, illegal sales of medicines, extorted gifts, etc.), which have become more difficult to collect. Finally, tensions between healthcare staff and users are exacerbated by confusion over what is and is not free of charge, especially when there are product shortages. Users are quick to accuse staff (in general unjustly) of creating these shortages themselves, or

[4] A research study in Kayes, Mali, showed that the increase in the number of caesarean sections since the introduction of free healthcare has been of greatest benefit to women living in locations in which the service is available (Fournier *et al.*, 2011).

in any case exploiting them to hold back free products for their relatives, friends and acquaintances, or to sell or get others to sell other chargeable products in their place. This is the case in Mali where, in the absence of kits for severe malaria cases, equivalent anti-malarial replacements are sold. It also arises in Niger when health centres do not have medicines due to delays in state payments, so staff members issue prescriptions for medicines that will have to be bought.

No proper monitoring

There is no rigorous, independent system for monitoring and evaluating exemption measures. The only data used by health administrations to report on these exemption policies are the not always reliable figures that can be extracted from reports provided by healthcare centres and management boards. Although they show the rising number of visits to health centres (often failing to make comparisons with data previous to the implementation of the exemption policies over a sufficiently long time frame for any real changes in trends to be detected), they systematically gloss over all the problems encountered in the field. For instance, stock shortages and the serious consequences of delayed reimbursements, which vary widely from centre to centre, are hardly ever featured in the reports. The quality of free healthcare is never evaluated, nor is the real nature of reimbursed medical procedures.

Healthcare centres that benefit from injections of support – and the rest

A new kind of inequality between healthcare centres has emerged, between those that are sustained by "projects" that support free care (with funding or technical assistance to avoid stock shortages) and those that do not enjoy such advantages.

In Mali, an experiment involving first targeted and then universal free healthcare in the Kangaba district was conducted by MSF-OCB (Médecins sans frontières-Brussels Operational Centre) from 2006 to 2011, using operational strategies that could not be taken over by the state: medicines from Europe, remuneration and incentives for community health workers and healthcare workers paid for by the NGO, etc. In Niger, various NGOs (Help, Médecins du Monde) have provided financial and technical support for health by shielding health districts from the consequences of late reimbursement. It should be stressed that the user fee exemption arrangements run by NGOs in all three countries are experiments that benefit from high levels of subsidies, funded entirely from outside the country and extending beyond user fee exemptions (training staff, monitoring and supervision, rehabilitation, incentives, etc.). Consequently, they are not indicative of the state's capacity to operate a free healthcare system on its own.

Above and beyond NGOs' intervention in the area of free health care, there is a huge range of donations in kind received by individual health centres, contributing to inequalities between centres. For instance, in Niger in 2009-2010, donations of medicines received by the Loga health district came to XOF 41 million, compared to less than XOF 2 million received by the neighbouring district of Doutchi (Kafando *et al*., 2011; Ousséini, 2011 b). Another source of inequality between health centres in Niger involves reimbursements. Based on criteria that are incomprehensible to health-care workers, certain districts obtain reimbursement at rates that are distinctly higher than other districts, albeit admittedly after some delay. Between 2006 and 2010, the rate of reimbursement to the Loga district was 72%, compared with 51% to Doutchi and 32% to Dosso (Kafando *et al*., 2011; Ousséini, 2011 b).

Exemptions versus decentralization?

Ironically, while official statements promote deconcentration and decentralization, exemption strategies, which are highly vertical, result in re-centralization and re-concentration. They weaken the decentralized community management structures that have been in place for the last 20 years. It sometimes seems that vertical programs have made a comeback despite the fact that their integration into the healthcare system has been a subject of debate in public-health circles for years. Although the communes have on paper been given many powers in health-related matters, they have been completely sidelined.

Two differences in structural design and funding arrangements

Two sets of elements appear to differ in Mali and Niger when it comes to the organizational and financial structures established to implement free healthcare.

1. Anti-malarial measures in Mali are now managed by a department at the Ministry. The old anti-malarial program, which was in charge of the supply of ACTs, has become a branch of the central government. The Pharmacie Populaire du Mali (PPM, People's Pharmacy of Mali) is now responsible for product procurement and distribution through a specific network for free ACTs (as distinct from the network for chargeable medicines, which are also supplied to healthcare centres by the PPM). Although the system in Niger is more cumbersome and goes through a lot more money, it is managed, paradoxically, by a very small team set up for that specific purpose, with no resources to speak of. It reports to the Direction de l'Organisation des Soins (DOS, Department for Healthcare Organization), which in turn reports to the Direction Générale de la Santé (Directorate-General of Health). This team has not had either decent premises or sufficient staff for three years, and the reimbursement channels are extremely complex.

2. The Malian system is much less of a burden on the national budget and receives international funding for its battle against malaria. In contrast, the Niger system, which covers all infant pathologies, is a big financial drain on resources. The cost of free healthcare today is thought to be around XOF 10 billion annually. However, the state did nothing from 2006 to 2011 to cover that figure. And since it is only reimbursing healthcare centres partially and slowly, the amount owed by the state rises year after year, currently standing at close to XOF 20 billion. Today, the problem of delayed reimbursements risks bringing the entire health system to a standstill in Niger.

1.3.2. Burkina Faso

The policy pursued here in terms of the relationship between cost recovery and user fee exemption has been quite different and sometimes paradoxical. The authorities have largely prioritized subsidies over exemptions, leaving users to pay part of the cost of services, since many policy-makers and clinicians believe that it is important for users to feel that they are taking responsibility for themselves by making that payment. At the same time, however, they have accepted the total elimination of healthcare fees by NGOs in two regions with nearly 2 million inhabitants (2008), free distribution of bed nets countrywide (2010) and the elimination of the flat-rate fee for ARVs (2010). The proportion of the cost that falls on users' shoulders has become progressively smaller in priority areas of care, but it has not disappeared completely. A single ACT dose costs XOF 100 for children under five; however, as in Mali, the consultation must be paid for, except when ACTs are distributed by community health workers as part of the recently introduced program that now covers the whole country but is prone to serious stock shortages. ARVs have only very recently been made available free of charge. Until 2009, patients had to pay a flat-rate fee of XOF 1,500 CFA for these drugs (Ridde *et al*., 2012).

Hence, the approach adopted in Burkina Faso appears to be far more practical than what is being done in Mali and Niger. More thought has been given to the preparation and development stages. A budgetary policy devised for each stage remains realistic in terms of the national budget. That policy and the reimbursement system have been implemented through the routine structures.

However, aside from that obvious and important difference in the way that health policy is conducted, various parallels can be drawn with Mali and Niger.

The first stage of subsidizing deliveries was not evaluated before proceeding to the second stage, and the rapid extension of the measure in 2007 was carried out against

the advice of World Bank experts who were providing support (Ridde *et al*., 2011). The program for the distribution of ACTs by community health workers was launched at the national level before the evaluation results for pilot sites were available. The policy of subsidizing emergency obstetric and neonatal care (EmOC) was announced before technical arrangements for implementation were fully in place. Moreover, it was introduced at the national level without being tested at pilot sites (the results of several experiments in subsidization were taken into account, but they only involved caesarean sections (Richard *et al*., 2008), without a proper understanding or harmonization of management procedures). The flat-rate fee for deliveries was too high, and reports demonstrating that finding were ignored. Information was provided late and was quite inadequate. In 2005, the allocation of free medicines to the most vulnerable groups, organized by the same national directorate that dealt with EmOC subsidies, was undertaken at the national level without any guidance from the ministry on methods of distribution. The one black mark against the policy remains the management of assistance for vulnerable groups. A budget was approved to grant full exemption from paying delivery costs to the poorest households (20% of deliveries), removing the financial barrier completely. However, most healthcare workers are not aware of the measure and no support system designed to help healthcare centres select the most vulnerable has been proposed, despite the fact that trials conducted along those lines in the interior of the country have for the most part received positive reviews from national policy-makers (Bicaba *et al*., 2010).

1.4. Some unintended effects

The primary aim of the exemption measures was to promote access to healthcare by removing financial barriers. That aim has clearly been achieved: an increase in the number of health centre visits has been confirmed everywhere. Abundant statistics on the subject from all three countries speak for themselves.[5] We will not dwell on this fact, which has already attracted a considerable number of comments from official organizations.

Another point equally worth noting is the fact that there has been an even greater rise in the numbers of visits to health facilities supported by pilot projects promoted by NGOs from the northern hemisphere. However, we may well ask whether NGOs also give users additional warranties of quality, which public health centres that lack outside support are unable to do.

[5] For the quantification of these effects, see the following studies: Heinmüller *et al*., 2012; Ridde and Queuille, 2010; De Allegri *et al*., 2011; Ridde *et al*., 2009; Barroy and Laouali, 2012; Haddad *et al*., 2011.

Indeed, in Mali and Niger, exemption measures are often perceived as leading to a decline in quality – one of their unintended effects.

We will now focus on five of these unintended effects, as identified in the course of our research.

Not really "free" healthcare

Healthcare is far from being totally free for users, who still have to pay: (a) direct costs not covered by the free package; (b) indirect costs (transportation, caregivers and food); (c) under-the-counter costs (bogus invoices, "gifts" for healthcare staff, illegal sales of medicines and favours, bribes, etc.). In all three countries and in areas of care that benefit from exemptions or subsidies, healthcare is in fact never really free for users, who continue to pay, albeit significantly less than under the cost-recovery system with no exemptions.

Shortages and delays

Shortages in the supply of free medicines and delays in reimbursing healthcare centres have the same negative impact: the lack of resources means that medicines are not delivered. When free medicines are not available, healthcare staff provide prescriptions for chargeable medicines, which are sometimes sold in the health-centre pharmacy, sometimes in outside pharmacies, and even illegally by healthcare workers (who take them from official kits or acquire them in various other ways). This tends to create confusion over the dividing line between recovery and exemption. It also generates suspicion and increases tensions between users and healthcare workers.

The disappearance of syrups

Pediatric formulations (syrups) have been considered too expensive since user fee exemptions were introduced. This creates a number of difficulties for mothers, who are forced to divide pills into quarters or halves, store the contents safely and administer them. It also leads to problems with deposits and residues of the active ingredient that are left behind on the spoon or in the glass, not swallowed.

The undesirable side effects (nausea, vomiting and diarrhea) of ACTs when they were first distributed in Mali also put mothers off healthcare centres. Adverse effects from the transfer of clients to higher-level clinics that are better equipped have also been recorded. In Dosso, Niger, children under five who are taken to a Centre de Santé Intégré (CSI, integrated health centre) are routinely referred to a Centre Hospitalier Régional (CHR, regional hospital), which can deliver the antibiotics and syrups that cannot be obtained from the CSIs; however, the CHRs are swamped as a result.

A perceived decline in quality

A decline in quality associated with user fee exemptions is often *perceived* not only by users but also by healthcare workers (in the case of Mali, see Touré, in this issue). This decline in quality may be linked to product shortages, as in Niger, and to the discontinuation of various laboratory tests because the money is not available to purchase the necessary reagents. It may also be due to excessive staff workloads caused by increased numbers of visits, although this has not necessarily been substantiated (Kouanda *et al*., in this issue), or the staff's lack of motivation for the free treatment system.

The recent anti-malaria program in Burkina Faso, where initial observations indicate that hastily trained community health workers routinely administer ACTs to children who come to the villages for consultations (a practice that is not risk-free in terms of developing resistance to the drug), may also illustrate the problem of quality of care, not to mention the stock shortages currently being recorded.

However, the problem of assessing quality of care is a daunting one. Our qualitative research techniques only allow us to measure quality "as perceived" by the user. Current monitoring methods are ill-adapted to the serious technical and professional evaluation of quality of care, so the issue of quality of services provided remains to be documented.

Palliative tinkering

In defiance of the malfunctions in the system generated or exacerbated by exemption policies, there is evidence of widespread "tinkering" in an attempt to keep the system running by every possible means (cf. Olivier de Sardan, 2011). Two common strategies may be cited by way of example.

The first involves making users pay for products when free supplies are exhausted or when kits are incomplete so that the necessary care can be delivered all the same. This "stop-gap" fee may even be requested as a preventive measure, as happens in Niger through the "additional centimes" tax levied in most districts to make sure that medical evacuations can take place and that the cost does not fall on the patient's shoulders.

The second strategy involves informally devised allocation systems to deal with shortages. Bed nets are given as a "reward" to women who have made three prenatal visits (Burkina Faso), and there are wide variations in reimbursements made to healthcare centres, with no indication of the criteria used (Niger).

Conclusion

Although the rise in the number of visits to healthcare centres is unquestionably a positive outcome of various exemption measures adopted in the three countries under examination, conditions surrounding the implementation of the policies, especially in Mali and Niger, are posing serious problems regarding the reliability and sustainability of these systems on the one hand and the quality of care delivered on the other. The two issues are connected.

The same problems that are observed in the area of healthcare are found more generally in all public policy fields in Sahel countries: measures are announced as a political strategy, without conducting any feasibility studies or pilot projects, without technical support being ready, without either users or professionals having been consulted or sufficiently involved and without the state being in a position to honour its commitments. Hence, measures are dependent on the good will of funding bodies or northern NGOs. Restoring the population's confidence in the state, which has been damaged by problems with implementing policies and by broken promises, thus appears to be a crucial issue for public policies. The primary challenge for African states is therefore to guarantee the financial sustainability of exemption measures and to stand by their commitments in the matter.

As might be expected, the exemption for children under five in Niger has clearly improved healthcare centre attendance by removing the financial barrier. However, this progress has undoubtedly been achieved at the cost of the quality of the free healthcare delivered, at any rate in places where there are no NGOs to support the healthcare centres. The results of the NGO pilot projects in the three countries are revealing: user fee exemptions were accompanied by multiple measures that made it possible to meet increased demand without compromising quality of care; in fact, care actually improved in these cases.[6] However, this required a significant contribution of resources and expertise from outside the countries.

This paradox of healthcare centres serving as a showcase for a new public policy or a demonstration of the solidity of its principles because, unlike other healthcare centres, they benefit from direct external aid, is not new. The same thing happened (the irony of history) when the Bamako Initiative was set up: certain aid-assisted experiments in Cameroon and Niger showed that if cost recovery came with multiple

[6] For example, a study in Burkina Faso demonstrated quantitatively that the quality of medical prescriptions (an aspect of healthcare quality) issued by healthcare workers had not deteriorated; see Atchessi *et al*, 2012.

support measures, it did not lead to a reduction in the use of services (Litvak and Bodart, 1993; Diop *et al*., 1995). External aid was just as important in these experiments, and the challenges that arose were also widely discussed by francophone authors a very long time ago (Dumoulin and Kaddard, 1993).

The assessment of a public policy (whether it concerns the Bamako Initiative or free healthcare) should therefore be undertaken based on real-world situations, which are referred to in public-health terms as natural experiments (in this case, healthcare centres that are not sustained by injections of external aid). As far as the policy of cost recovery is concerned, it should unquestionably be given full credit for making medicines available nationwide in the countries in question; however, this has been achieved at the expense of access to healthcare, especially for the poorest people. As for the policy of exemption, it is clear that the removal of financial barriers has contributed to the spectacular increase in the use of these services. On the other hand, it has also given rise to acute problems in terms of logistics, planning, information and finance. These problems existed before the implementation of exemption policies, but such policies have sometimes made matters worse.

The final aspect for consideration is the issue of healthcare quality. Here too, poor quality predates exemption policies. However, in some cases these policies have caused a further decline in quality.

For African states and their partners, therefore, a second challenge arises – one that is not given sufficient consideration in various respects – and that is to back up exemption measures, regardless of their nature, with measures that will guarantee and improve healthcare quality.

What can be done to improve geographical accessibility on the one hand and financial accessibility on the other without lowering the quality of care – possibly even improving it? This is undoubtedly the main question posed by policies for both the extension of healthcare coverage (geographical accessibility) and user fee exemption (financial accessibility).

The unintended adverse effects of policies must not be allowed to lead to a two-tier medical system: healthcare that is certainly free (at least to a large extent) for the most needy but of poor quality, and healthcare that is paid for but of better quality for everyone else. This is the general trend in urban society in the Sahel, where the upper (and sometimes middle) classes are turning away from the public system in favour of private clinics. The public-health system must not in turn promote

disparities within its own structures between the treatment of the most disadvantaged and the rest, or between NGO-backed healthcare centres and the rest. The various solutions for fostering a greater degree of fairness in health matters and greater financial accessibility to care (subsidies, across-the-board or selective sectoral exemptions, funds to support those in need, mutual insurance companies, insurance policies, etc.) should also be considered with a view to improving healthcare quality within the public system on a sustainable basis.

In other words, exemption policies and, in the longer term, policies leading to universal coverage should be adapted to African healthcare systems as they exist in the real world and not on paper, with due attention paid to malfunctions, difficulties, obstacles and bottlenecks. All too often, new policies discount routine practices and presuppose an ideal healthcare system – and state – far removed from the realities of everyday life.

References

Atchessi, N., V. Ridde and S. Haddad (In press), "Combining user fees exemption with training and supervision helps to maintain the quality of drug prescriptions in Burkina Faso", *Health Policy & Planning*, Oxford.

Bado, J.P. (1996), *Médecine coloniale et grandes endémies en Afrique, 1900-1960. Lèpre, trypanosomiase humaine et onchocercose*, Karthala, Paris.

Balique, H., O. Ouattara and A. Ag Iknane (2001), « Dix ans d'expérience des centres de santé communautaire au Mali », *Santé Publique*, 13(1), 35-48.

Barroy, H. and B. S. Carasso (2012), "Assessing the Effects of Removing User Fees in Zambia and Niger", *Journal of Health Services Research & Policy,* 17, 30-6.

Bicaba, A., L. Ouedraogo and M.P. Biao (2010), *Plan national de développement sanitaire (PNDS). Evaluation finale*, Ouagadougou: Ministère de la santé, SERSAP.

De Allegri, M., V. Ridde, M. Sarker, O. Muller, A. Jahn, V. Louis and J. Tiéndrebeogo (In press), "The impact of targeted subsidies for facility-based delivery on access to care and equity - Evidence from a population-based study in rural Burkina Faso", *Journal of Public Health Policy.*

Diarra, A. (2011), « La mise en œuvre de la politique d'exemption de paiement dans les districts sanitaires de Gaweye et de Say », *Etudes et Travaux du LASDEL*, N° 96.

Diop, F., A. Yazbeck and R. Bitran (1995), "The impact of alternative cost recovery schemes on access and equity in Niger", *Health Policy and Planning*, 10, 223-40.

Dumoulin, J. and M. Kaddar (1993), « Le paiement des soins par les usagers dans les pays d'Afrique subsaharienne: rationalité économique et autres questions subséquentes », *Sciences Sociales et Santé*, 11(2), 81-119.

Evans, R., M. Barer and G. Stoddart (1993), "User Fees for healthcare: Why a Bad Idea Keeps Coming Back", Toronto: CIAR Program in Population Health, *Working Paper* 26, August.

Fournier, P., C. Tourigny, A. Philibert, A. Coulibaly, A. Dumont, K. Sissoko and M. Traore (2011), « Qui bénéficie de la gratuité de la césarienne dans les pays à faibles ressources ? Une étude en milieu rural à Kayes (Mali) », 3rd International Conference Health Financing in Developing and Emerging Countries, CERDI (11 – 13 May 2011), Clermont-Ferrand.

Gilson, L. and D. McIntyre (2005), "Removing user fees for primary care in Africa: the need for careful action", *British Medical Journal*, 331, 762-765.

Gilson L, D. Kalyalya, F. Kuchler, S. Lake, H. Organa and M. Ouendo (2001), "Strategies for promoting equity : Experience with community financing in three African countries", *Health Policy*, 58(1):37-67.

Gilson, L., D. Kalyalya, F. Kuchler, S. Lake, H. Organa, and M. Ouendo (2000), "The equity impacts of community financing activities in three African countries", *International Journal of Health Planning and Management*, 15, 291-317.

Gilson, L., K. Hanson, K. Sheikh, I.A. Agyepong, F. Ssengooba and S. Bennett (2011), "Building the field of health policy and systems research: social science matters", *PLOS Med*, 8(8), e1001079.

Haddad, S. and V. Ridde (2011), « Plus les coûts sont subventionnés, plus les femmes du Burkina Faso accouchent dans les centres de santé », CRCHUM/HELP/ECHO/FRSQ. 4 pages,
http://www.vesa-tc.umontreal.ca/pdf/2011/juin/Note_ExemptionAA_Burkina_Mai11_fr.pdf.

Heinmüller R., Y.A. Dembélé, G. Jouquet, S. Haddad and V. Ridde (In Press), « Les effets sur la fréquentation des centres de santé de la gratuité des soins pour les enfants de 0 à 4 ans avec une ONG ou l'État au Mali », *Field Actions Science Reports*.

Jaffré, Y. and J.P. Olivier de Sardan, (eds) (2003), *Une médecine inhospitalière. Les difficiles relations entre soignants et soignés dans cinq capitales d'Afrique de l'Ouest*, Karthala, Paris.

Kafando Y., B. Mazou, S. Kouanda and V. Ridde (2011), « Les retards de remboursements liés à la politique de gratuité des soins au Niger ont des effets néfastes sur la capacité financière des formations sanitaires », *Etudes et Travaux du LASDEL*, N° 99.

Kafando, Y. and V. Ridde (2010), « Les ressources financières des comités de gestion du Burkina Faso peuvent améliorer l'équité d'accès au système de santé », *Cahiers Santé*, 20, 153-161.

Lagarde, M. and N. Palmer (2011), "The impact of user fees on access to health services in low- and middle-income countries", Cochrane Database of Systematic Reviews. 4. Art. N°: CD009094. (DOI: 10.1002/14651858.CD009094).

Lemieux V. (2002), *L'étude des politiques publiques, les acteurs et leur pouvoir,* Les Presses de l'Université Laval, Québec, 195 p.

Litvack, J. I. and C. Bodart (1993), "User fees plus quality equals improved access to healthcare: results of a field experiment in Cameroon", *Social Science and Medicine*, 37(3), 369-383.

McCoy, D., J.A. Hall and M. Ridge (2011), "A systematic review of the literature for evidence on health facility committees in low- and middle-income countries", *Health Policy Planning*. doi: 10.1093/heapol/czr077. First published online: December 8, 2011.

Meessen, B., D. Hercot, M. Noirhomme, V. Ridde, A. Tibouti, C.K. Tashobya and L. Gilson (2011), "Removing user fees in the health sector: a review of policy processes in six sub-Saharan African countries". *Health Policy and Planning (Supplement 2), 26, ii16-ii29*.

Olivier de Sardan, J.P. (2008), « La crise alimentaire vue d'en bas. Synthèse des recherches menées sur sept sites au Niger », *Afrique contemporaine*, 225: 217-294.

Olivier de Sardan, J.P. (2008), *La rigueur du qualitatif. Les contraintes empiriques de l'interprétation socio-anthropologique*, Academia Bruylant, Louvain-la-Neuve.

Olivier de Sardan, J.P. (2011), "Local powers and the co-delivery of public goods in Niger", *IDS Bulletin*, 42 (2): 32-42.

Olivier de Sardan, J.P., N. Bako Arifari and A. Moumouni (2007), « La corruption dans le domaine de la santé », in Blundo and Olivier de Sardan (eds), *Etat et corruption en Afrique. Une anthropologie comparative des relations entre fonctionnaires et usagers (Bénin, Niger, Sénégal)*, Karthala, Paris.

Olivier de Sardan, J.P. and V. Ridde (2011), « Une comparaison provisoire des politiques d'exemption de paiement dans trois pays sahéliens (Burkina Faso, Mali, Niger) », *Etudes et Travaux du LASDEL*, N° 89

Ousséini, A.(2011*a*), « Une politique publique de santé au Niger. La mise en place d'exemptions de paiement des soins en faveur des femmes et des enfants », *Etudes et Travaux du LASDEL*, N° 91.

Ousséini, A. (2011*b*), « Exemptions de paiement des soins en faveur des femmes et des enfants de moins de 5 ans. Mise en oeuvre dans la région sanitaire de Dosso », *Etudes et Travaux du LASDEL*, N° 92.

Ponsar, F., M. Herp (Van), R. Zachariah, S. Gerard, M. Philips and G. Jouquet (2011), "Abolishing user fees for children and pregnant women trebled uptake of malaria related interventions in Kangaba, Mali", *Health Policy & Planning* 26 (suppl 2): ii72-ii83.

Richard, F., D. Hercot, D. Ouédraogo, T. Delvaux, S. Samaké, J. Olmen (Van), G. Conombo, R. Hammonds and J. Vandemoortele (2011), "Sub-Saharan Africa and the health MDGs: the need to move beyond the 'quick impact' model", *Reproductive Health Matters*, 19, 42-55.

Richard F, C. Ouedraogo, J. Compaore, D. Dubourg , V. Brouwere (De) (2007), "Reducing financial barriers to emergency obstetric care: experience of cost-sharing mechanism in a district hospital in Burkina Faso", *Trop Med Int Health*. 12(8):972-81.

Richard F, S. Witter, V. Brouwere (De) (eds) (2008), *Réduire les barrières financières aux soins obstétricaux dans les pays à faibles ressources,* (SHSOP 25), ITG Press, Antwerp.

Ridde, V. (2012), *L'accès aux soins de santé en Afrique de l'Ouest. Au-delà des idéologies et des idées reçues,* Presses de l'Université de Montréal, Montréal.

Ridde, V., P.-A. Somé and C.M. Pirkle (2012), "NGO-provided free HIV treatment and services in Burkina Faso: scarcity, therapeutic rationality and unfair process", *International Journal for Equity in Health*, 11. 11.

Ridde, V. and F. Morestin (2011), "A scoping review of the literature on the abolition of user fees in heathcare services in Africa", *Health Policy and Planning*, 26, 1-11.

Ridde V, F. Richard, A. Bicaba, L. Queuille, G. Conombo (2011), "The national subsidy for deliveries and emergency obstetric care in Burkina Faso", *Health Policy and Planning* (Supplement 2), ii30-ii40.

Ridde, V., E. Robert and B. Meessen (2012), "A literature review of the disruptive effects of user fee exemption policies on health systems", *BMC Public Health*, 12:289.

Ridde, V., and L. Queuille (2010), « L'exemption du paiement : un pas vers l'accès universel aux soins de santé. Expériences pilotes au Burkina Faso », UdeM/CRCHUM/HELP, Ouagadougou.
http://ec.europa.eu/echo/files/aid/countries/ExemptionPiloteBurkina2010_fr.pdf

Ridde V. and A. Diarra (2009), "A process evaluation of user fees abolition for pregnant women and children under five years in two districts in Niger (West Africa)", *BMC Health Services Research,* 9(89).

Ridde V. (2008), "The problem of the worst-off is dealt with after all other issues": The equity and health policy implementation gap in Burkina Faso", *Social Science & Medicine*, 66:1368-78.

Van Lerberghe, W. and V. Brouwere (De) (2000), « Etat de santé et santé de l'Etat en Afrique subsaharienne », *Afrique Contemporaine*, 195, 175-190.

Yaogo M., R. Zerbo and V. Ridde (2012), *L'histoire de la gratuité des soins de santé au Burkina Faso*, rapport de recherche, Programme Gratuité, AFRICsanté, Bobo-Dioulasso, 50 p.

WHO (2011), *World Health Statistics* (p. 149), World Health Organization, Geneva.

WHO (2010), *The World Health Report. Health systems financing: the path to universal coverage*, WHO, Geneva.

2. The social desirability of selective free healthcare in Burkina Faso

Oumar Mallé Samb and Valéry Ridde
CRCHUM and University of Montréal

Abstract

The imposition of user fees as part of the Bamako Initiative limited access to healthcare for the poorest and most vulnerable groups. In response, many authors have recommended the implementation of social-targeting policies in order to provide free healthcare for these two groups. Above and beyond its effectiveness, however, social targeting poses many problems in terms of acceptability, the difficulty of correctly identifying beneficiaries and the possibility of social stigma. Using a qualitative approach, this study investigates the social desirability of the selective free healthcare provided to women, children and the indigent in Burkina Faso. The results show that selective free healthcare is accepted socially, although the choice of groups may be called into question. Furthermore, our findings show that community involvement in beneficiary selection plays a major role in the acceptability and effectiveness of these policies and, in particular, reduces the risk of social stigmatization of the indigent.

Keywords: Free healthcare, targeting, Burkina Faso, communities, social values

Introduction

The difficult economic climate of the 1980s was a major factor in the deterioration of health services in most African countries. Most countries were forced to impose user fees that required patients to pay for access to health services. However, experience has shown that obliging patients to make a financial contribution blocks access to healthcare for vulnerable groups such as women (Nanda, 2002) and the indigent (Stierle, *et al*. 1999). The poor are chiefly characterized by their permanent exclusion from health services.

Consequently, since 2000 many countries have decided to implement user-fee exemption policies targeting the poorest and most vulnerable groups. Two targeting approaches are generally used in the context of selective free healthcare policy. In the first approach, the targeting of individuals or households is based on a direct assessment of revenue, either in monetary terms (means testing) or by means of a score that assesses their essential standard of living (proxy means testing). The second method is demographic targeting, which focuses on segments of the population considered to be most vulnerable (women, children and the elderly) (Hanson, *et al*. 2008). In Burkina Faso, where the present study was conducted, both of the above methods were used.

Literature on demographic-targeting programs remains scant (Coady, *et al*. 2004). Most of the research on the subject is limited either to studying the effectiveness of targeting policies, specifically their success in reaching beneficiaries, or to highlighting targeting errors (Hanson, *et al*. 2008), and therefore too often overlooks the social aspect. In Africa, targeting experiments are still rare and often have not been sufficiently studied (Coady, *et al*. 2004), particularly in relation to their social impact, which is linked to community values and preferences.

The aim of this article is to foster greater understanding of the social desirability of the targeting process, primarily in the African context of Burkina Faso. Our main focus here will be the social desirability of selective free healthcare in two programs in Burkina Faso.

2.1. Context and selective healthcare interventions

Burkina Faso is a country in the Sahel region with a population of some 15 million, most of whom (77%) live in rural areas. It is among the poorest countries in the world, with low life expectancy (57 years in 2008) and high mortality rates (Hill, *et al*. 2007).

The country's healthcare system has a pyramidal structure, with health and social service centres (centres de santé et de promotion sociale, CSPS) where people can access primary care services (health and maternity care) at the base. Each health centre is overseen by the local community through a COGES or management committee. Under the supervision of a head nurse, the COGES ensure that health centres are kept fully supplied thanks to profits from the sale of essential generic medicines and curative consultations.

We examined the social desirability of interventions in three districts targeting three different social groups (Table 1). In 2006, the government introduced an 80% subsidy for emergency obstetric and neonatal care (soins obstétricaux et néonataux d'urgence, EmOC) (Ministère de la santé, 2006). In 2008, an international NGO decided to complement the government strategy by funding the 20% share that women were required to pay in the Dori and Sebba districts of the Sahel region, making healthcare totally free for women. The NGO also introduced free healthcare for children under the age of five. The intervention is based on the "third-party payer" principle. The NGO and the state reimburse the COGES for care provided free of charge. This project runs alongside an intervention providing community-funded healthcare for the indigent, which was launched in 2007 in the district of Ouargaye and extended to the districts of Dori and Sebba in 2010.

This is the first attempt to provide free healthcare in Burkina Faso, where the absence of both a definition and criteria for identifying the indigent has always been advanced by the authorities to explain why the poorest do not receive free healthcare. In the above-mentioned districts, free healthcare for the indigent is covered by the COGES with their own funds, as stipulated by the Bamako Initiative, and targets the poorest people, who have been selected through a community-based process. Village selection committees have been set up in every village, with representatives drawn from different segments of the community (women, religious orders) (Ridde, *et al*. 2010). After identifying and selecting the indigent in their villages in accordance with a consensual community-based definition of poverty, the village selection committees submit the list of beneficiaries to the village chiefs, the local authorities (mayor and councillors) and the COGES in their health districts for a final decision. To avoid the risk of collusion, COGES members and village chiefs are not included in village selection committees.

Table 1 *Selective free healthcare interventions and the context in 2010*

SELECTIVE FREE HEALTHCARE INTERVENTIONS				
Exempt social groups	Pregnant women		Children under 5	Indigent
Districts and rate of exemption	Dori and Sebba (100%)	Ouargaye (80%)	Dori and Sebba (100%)	Dori, Sebba and Ouargaye (100%)
Funding	State + NGO	State	NGO	Communities
SOCIAL CONTEXT				
Districts	Dori	Sebba	Ouargaye	
Main social group	Peulh	Peulh	Mossi	
Number of CSPS	17	11	25	
Number of inhabitants	290	170	260	
Key economic activities	livestock	livestock	agriculture	

Source: MS/DEP Annuaire statistique 2008 (yearbook 2008).

2.2. Theoretical framework

A review of the literature highlights the importance of values in public policy-making. In Africa, where the impetus for formulating public policy is chiefly of external origin, i.e. driven by international organizations, research suggests that policy-makers often fail to consider the question of values and local concepts of solidarity (Standing 2002; Ridde 2006).

There are two main opposing theories on the definition of values. Those who advocate a subjective approach posit that values are the product of the interests and emotions of the agent, while objective theories stress the stability of values and their independence from short-term interests (Massé and Saint-Arnaud 2003). The second

approach forms the basis of the definition used in this study and presents values as "socio-cultural constructs which are shared (to varying degrees) by the members of a community. They can, therefore, be seen either as criteria used to justify behaviour, or as benchmarks against which the meaning of an action will be judged" (Massé and Saint-Arnaud 2003). A number of contradictory values can exist in a given society. Those that prevail at a particular time constitute the preferred solution that a society advocates when making social decisions (Kluckhohn and Strodtbeck 1961; Meessen, *et al.* 2006).

The fact that values are rarely taken into consideration when reforms are being developed creates a situation in which public policies are doubly remote and out of touch, hidden behind a barrier erected by experts who claim that they alone can determine what is good for society, and a further barrier erected by the ruling elite, who act as if they alone can rationally explain the constraints on social cohesion (Jobert 1992). According to Amartya Sen, the success of a public policy depends largely on taking values into account and specifically how equity, in our case access to healthcare by the most vulnerable groups, is perceived by the population:

"For the making of public policy it is important not only to assess the demands of justice and the reach of values in choosing the objectives and priorities of public policy, but also to understand the values of the public at large, including their sense of justice" (Sen 1999). p274

It follows from this concept that equity cannot be decreed, but rather emanates from social representations. The question of values is therefore central.

This insistence on values does not mean that Sen believes no other motivations come into play in an individual's decision-making, but simply that he wishes to illustrate

"The significance of norms and values in behaviour patterns that may be crucial for the making of public policy " (Sen 1999) p 280

The originality of Sen's theoretical propositions lies in the recognition that the coherence of public policies does not stem purely from their internal rationality but also from the meaning assigned to them by the population. In order to be meaningful, policies should be tailored to values, and interventions must also be adapted and appropriate to the locations where they are delivered. The resulting degree of consistency will largely determine whether the population takes ownership of policies and, above all, whether the policies are relevant (Sen 1999).

We will use Sen's theoretical propositions as a theoretical basis for assessing the social desirability of selective free healthcare interventions in Burkina Faso, focusing on the various social players involved in implementing the interventions in order to explore their perceptions, representations and preferences for social targeting. We will ask how selective free healthcare for the indigent, pregnant women and children fits in with the population's values and beliefs.

2.3. Methodology

To answer this question, we have adopted a multiple case study research strategy based on the use of qualitative data (Yin 2003). Cases were drawn from the three selective free healthcare interventions (pregnant women, children under five and the indigent). The population in the survey relies on the eight health centres where interventions take place. For Dori and Sebba the choice was limited, as only four CSPSs provide free treatment for the indigent. In Ouargaye, however, 10 CSPSs were involved. The four CSPSs where the study took place are ethnically homogeneous (the same Mossi social group is dominant in each).

Qualitative data were gathered with three data collection tools (individual interviews, group interviews and documentation) during a field study that lasted for six months in 2010. Individual interviews (n=104) and group interviews (8: n=36) were conducted with the main stakeholders in the interventions (Table 2), with the assistance of an interpreter when necessary. To select participants, all of the groups were initially identified (standardization sampling) and then the people with the most varied profiles in each group were selected in order to generate an exchange of views (internal diversification) (Pires 1997). The interviews focused on the following themes: social values, social organization, social justice, perceptions of targeting, social stigma and preferences. The documentary survey concentrated on national health policies and activity reports by the NGO and the districts studied.

All of the interviews were retranscribed into French from digital recordings. A thematic approach (Miles and Huberman 2003) was taken to organizing the material, using QDA-Miner[t] software. The research method was approved by the ethics committees at the Université de Montréal (CRCHUM) and Burkina Faso.

Table 2 *Characteristics of participants and data collection tools*

Tools/groups	Members of COGES	Service users and non-users	Administrative authorities	Health workers
Profiles of interviewees	Chair and paymaster of COGES	Farmers Housewives Indigent people	Prefect Sub-prefects	Head nurse
In-depth interviews (total) = 104	16 (M:15) (F:1)	72 (M:32) F:40)	8 (M:7) (F:1)	8 (M:8) (F:0)
Dori and Sebba (n=52)	8	36	4	4
Ouargaye (n=52)	8	36	4	4
Group interviews/ number of people	8 (N=36)			

NB: M: male, F: female
Source: authors.

2.4. Results

2.4.1. Validity and social desirability of selective free healthcare

In the three districts studied, a large majority of those interviewed believed that selective free healthcare for the indigent, pregnant women and children is fair and socially accepted: "The people who are helped belong to the same families as those who don't receive help, so it all amounts to the same thing. If you don't get help for your own child, your wife gets help or a close relative's child is helped," a farmer said.

The general pattern that emerges is that the preferential treatment given to these sectors of the community is not an issue: "We are not equal, everyone can't be equal. We have five fingers and they aren't all the same size. Old age is one factor and illness is another, so it's quite natural to take these groups and help them," said another farmer.

One of the reasons advanced to explain the acceptability of social targeting is the vulnerability of the targeted groups: "Among the members of the community, some social groups are better off than other sectors of the population which are more vulnerable, for instance elderly people, pregnant women and those with small children and the indigent," a housewife commented.

Values were also mentioned by most interviewees in support of the appropriateness of targeting in the context: "You know, even with the zakat (Islamic alms) we give preferential treatment to the poor. Religion advocates this, so no one can fail to agree that we should come to the aid of the poorest first," said a COGES member about targeting the indigent. On that subject in particular, the participatory, community-based approach appears to have had a significant impact on the remarks made by a COGES chair: "We took the initiative to meet the imams and all the key contacts in the commune to ask them to provide us with lists of people they know are living in extreme poverty. They went into all the villages and drew up lists according to the number of people that we could pay for."

Some people do have reservations, such as a public official, who believes that selective care gives rise to social tensions: "I find it unjust – even with vaccinations, it's always the same people: elderly people have complained and they've found that it continues and that their complaints are ignored."

2.4.2. Perceptions and preferences

There was moderate opposition to the choice of social groups for targeted interventions in Dori and Sebba and stronger opposition in Ouargaye.

In Ouargaye, the vast majority of those belonging to the four groups believe that the priority social groups are women and children, followed by the indigent.

At the time of our survey, there was no program in place to exempt children from user fees in the district of Ouargaye. Consequently, a large proportion of the social players expressed the belief that children should be included in the target groups or, failing that, that children should replace the indigent: "I choose children, because they will die without care," said a COGES member.

In Dori and Sebba, the majority were in favour of the current targeting. Nevertheless, a considerable number of people believe that the elderly should be among those who benefit from free healthcare. Expanded targeting was the preferred option; however, if they were forced to choose, some people would consider replacing the indigent with the elderly, whom they believe to be a higher priority: "These old women brought us into the world. That's why we should start with them," said a district prefect. The reasons advanced in support of the elderly in Dori and Sebba can broadly be said to be of a humanist and moral nature rather than health-oriented: "Elderly people need special help. We have a moral obligation to ensure they don't

feel forgotten. We must think about them, if only in terms of healthcare" (health worker). In Ouargaye, however, reasons for preferences varied according to social status. Health workers and COGES members justified their choice of children largely on the grounds of public health: "Children aged 0 to 5 are a priority. The majority of medical evacuations involve children. The big problem is the delay in consulting a doctor due to financial accessibility," said a health worker. Conversely, other members of the community used humanist arguments: "You don't know what a child will become in the future, he could be president. What's more, the foundations of poverty are laid in early childhood," said a farmer. Although targeted interventions were viewed positively by most of the social players, having selective free healthcare as a public health policy is not their preferred option for the long term: "We should help everyone as a matter of course, because no man is an island; in the same way that I want people to help me, I want others to be helped as well. Everyone is poor here, you know," said a farmer.

However, administrative authorities, COGES members and health workers remained strongly committed to the principle of payment, as summed up in these remarks by a health worker: "I think the idea of making the community contribute towards the cost of their healthcare is no bad thing. It will help them to understand that just because products are free doesn't mean they aren't any good. I think it would be good if these people paid a decent amount." There is clearly a preconceived notion that free healthcare is undervalued by patients and that there is a need to "foster their sense of responsibility," to quote officials at the Ministry of Health (Ministère de la santé, 2010).

The indigent and social stigma

We did not encounter any sense of shame or embarrassment among the indigent people we met who had been selected to receive free healthcare: "There are no drawbacks and being selected is a real blessing," said one indigent person. Penniless and often isolated from the rest of society, the indigent interpret free healthcare as an expression of community solidarity towards them: "I've lost my husband and I'm alone. I was offered help and I gladly accepted it". Similarly, none of the indigent reported feeling stigmatized or being treated discourteously by other members of society: "As far as my neighbours are concerned, I often hear them say that someone in my state really deserves help and that they agree with it".

There was no indication that the indigent failed to seek help from any sense of shame: "Now, every time I'm ill, I go to hospital for treatment," said an indigent person. According to a health worker, the indicators for the use of healthcare services by the indigent have improved: "Nowadays, when a indigent person is ill, it's getting to the

hospital that's the problem, because once they arrive they are taken care of. That means that those who were ill and previously stayed at home now come to hospital".

Despite the fact that user fees have been removed, access to healthcare remains difficult for the indigent, some of whom, due to their age and associated mobility problems, are unable to reach the health centres: "If I go there, I can get medication, but I can't get to the dispensary. I can't ride a bike either. I wanted to send a child to fetch my medicine, but I was told that wasn't possible," reported one indigent person.

There was no indication that other respondents felt jealous or unfavourably treated, despite the fact that free healthcare for the indigent was only made possible by imposing user fees, a small part of the profit from which was used to fund the exemption. On the contrary, it was felt that the measure was a symbol of community support: "Yes, we agree with paying for the indigent. In fact, it's what we wanted," said a farmer.

The various social players unanimously agreed that the process for selecting the indigent was transparent. According to a health worker, this positive view of the approach helped to ensure that there was no social conflict between those who benefited and those who did not: "I have to say that the key factor was the way we selected the indigent. I believe it was harmonious and transparent. The community was given free rein to choose the indigent and they did so completely objectively". Some people were dissatisfied, as they found the selection process too restrictive: "I've got no complaints about the validity of the selection process. But even so, a lot more indigent people should have been picked up. The atmosphere isn't the same as if help were being given to a lot more people," said an indigent person who had not been selected. COGES members explained that selection was harsh due to their limited resources: "Many people say that it's a good initiative but the numbers are too low. But we have to make a selection in accordance with our budget. They want us to take hundreds, but in a single year we simply can't," said a COGES member.[7] The issue of poverty did not appear to be of concern to everyone. Some officials were still clearly reluctant to consider it a high-priority public issue: "I think we should help those who are productive as well. I don't say - it's a bit embarrassing to say that we should abandon the indigent - that means that they should just go off and die, it's a bit difficult to say that. I think we need to be a lot better off in economic terms before we pay for them".

[7] It should be pointed out here that – taking into account the fact that, for reasons of sustainability, the COGES had been asked to finance free healthcare for the indigent alone, without external financial aid – this experiment ensured that no more than three indigent people per 1,000 inhabitants were selected (Ridde et al., 2010).

Table 3 summarizes the empirical results that emerged from the qualitative research.

Table 3 *Summary of results by subject and strategic actor*

DISTRICTS / TOPICS DISCUSSED	DORI AND SEBBA	OUARGAYE
Perception of current selective free healthcare	**General trend**: positive perception **Basis for justification:** vulnerability of groups chosen; compatibility with values; participative and inclusive approach to selection of indigents **Position of respondents:** broadly in agreement **Against:** could generate social conflict (some officials)	
Position of respondents, choice of social groups and arguments in support	**General trend:** moderate opposition to choice of groups; preference for elderly people to be included **Basis for justification:** moral obligation to help them (all respondents)	**General trend:** strong opposition to choice of groups; preference for children to be included **Basis for justification:** vulnerability of this social group (health workers, COGES members; moral considerations - members of community)
Targeting the indigent and social stigma	**General trend:** No disrespect or social conflict **Basis for justification:** selection seen as expression of community solidarity; selection initiated and led by communities **However:** criticism of harshness of selection; poverty not considered a public issue (some administrative officials)	

Source: authors.

2.5. Discussion

The presence of an NGO intervention (Dori and Sebba), which involves part of our research, may have introduced an element of bias, i.e. social desirability, into our research. In other words, respondents may have adapted their answers to our questions in an effort to ensure that the NGO's intervention was perceived as perfect so that it would continue in the long term. In order to limit that impact, we stressed that we were not connected with the NGO and made it abundantly clear that the interviews would have no influence on the decision whether to continue to provide free healthcare services (Boutin, 1997). Our data were obtained from a small number of people, which may limit our ability to extrapolate the results to other districts. However, the fact that the research results are broadly similar despite the heterogeneous social contexts reinforces the internal validity of the study.

Selective versus universal free healthcare

The current targeting of the interventions studied here is based on a Rawlsian vision of social justice, whereby the most vulnerable are treated differently and favourably (Massé and Saint-Arnaud, 2003). This concept of social justice does not appear to be shared by the majority of people in the communities we studied, where by contrast, egalitarian values that advocate "equal access to healthcare for all" appear to predominate (Ridde 2006). How then do we explain the resulting paradox, given that the communities in our study overwhelmingly support the current system of selective free healthcare?

There are three possible explanations. First, it could be argued that selective free healthcare is accepted because it is viewed as something that helps to strengthen social cohesion. In a country in which widespread poverty renders communities incapable of ensuring the social protection of their members (Savadogo, 2010), free healthcare for the most vulnerable sectors of the population can only be welcomed or, at the very least, not criticized. Second, it could be said that the growth in the number of user fee-exemption programs has led to a greater acceptance of the principle of selective free healthcare. Thus, the sudden "conversion" of advocates for user fees, such as healthcare professionals, to free healthcare in Burkina Faso (Kagambega 2010) and Congo (Tanon 2011) clearly shows that a "revolution" is in progress, even if it is as yet taking place on the margins. Finally, the acceptance of social targeting may be engendered by pragmatic arguments. Communities are aware that the state does not have the means to provide universal free healthcare when it struggles even to implement targeted interventions properly. The shortcomings observed when emergency obstetric and neonatal care (EmOC) was set up (Ridde, *et al.*, 2011), for example, reinforce this perception and help to explain why people are reluctant to think about universal measures until targeted measures are organized effectively.

The need to rethink health program management in Africa

The targeting carried out in the three districts has been called into question by social players. In Dori and Sebba, the communities believe that elderly people are a priority group and should be included in targeting, whereas in Ouargaye demand is focused on free healthcare for children.

Despite innovations introduced in anti-poverty policies advocating that particular attention should be paid to communities when reforms are being developed (Razafindrakoto and Roubaud 2005), few countries follow these recommendations. Moreover, a survey showed that only 2% of the population in eight major African

cities were involved in drafting the strategic poverty reduction document (Razafindrakoto and Roubaud 2005). This failure to take account of people's concerns when developing reforms explains why there is often a marked contrast between the values promoted in policies and local values. Our findings reconfirmed this, demonstrating that the definition of vulnerability that led to the choice of groups was based on public health considerations, which are certainly important to the players but not sufficient in themselves. In Dori and Sebba, for example, those who promoted the elderly put forward almost exclusively social arguments. In these societies, the social prestige enjoyed by elderly people is such that society has a moral obligation to take care of them (Roth 2010). This explains why certain countries, such as Senegal, have chosen to provide free healthcare to people over the age of 60 (Aboderin 2010). The same moral considerations seem to have influenced the selection of children in Ouargaye. Children are certainly very important in rural African societies. The attention given to them is certainly justified by their vulnerability, but also, if Dujardin is to be believed, because they give their parents hope of financial assistance and are the foundation on which the future of society is built (Dujardin 1987). Besides these practical examples, our results confirm what other research has already shown, namely the failure to take sufficient account of the values of beneficiaries when developing policies in Africa (Long 1994; Standing 2002). The main reason for this appears to be that a top-down approach, which ignores local concepts of fairness, is often favoured (Ridde 2006; De Herdt and D'Exelle 2007).

Targeting the indigent and social stigma: the importance of the selection process

We believe that the absence of social stigma or social conflict (Warin 2010) in relation to targeting the indigent is due to the community-based approach that was adopted for selection. The community approach, in fact, is renowned for its ability to identify beneficiaries with far greater ease than do social workers or administrative officers (Hanson, *et al*. 2008). It is also better accepted socially (Conning and Kevane 2002). As part of the process of establishing free healthcare initiatives for the indigent, the village selection committees, which identified the indigent in each village, made every effort to ensure that all the different sectors of the community (e.g. women, members of religious orders) were well represented. The literature indicates that balanced representation among the community members who actually carry out selection is crucial. In addition to the fact that it means opportunities arising from the context can be seized, such as the presence of different social sensibilities, it also helps to boost the population's potential confidence in targeting policy (Noirhomme and Thomé 2006). With respect to selecting the indigent, this has translated into a positive view of the soundness of the community-led process and general acceptance by other

members of the community of the resulting selections. Our results confirm the link between a positive view of the transparency of the process for selecting the indigent and people's acceptance of it, a link that has already been established in numerous studies. In Cambodia, the fact that the process was entrusted to reliable community-based actors played a major role in fostering both a positive attitude to and acceptance of the Kirivong health equity funds[8] (Taylor and Marandi 2008). A review of six health equity funds in the same country confirmed that the perceived transparency of the process for selecting the indigent had played a key role in achieving greater community ownership of health equity fund programs (Men and Meessen 2008). In Afghanistan, a free healthcare program evaluation points to using trusted members of the community, such as imams, as one of the project's major strengths and one of the reasons for its acceptability (Steinhardt and Peters 2010). Moreover, it can be argued that community-based selection prevents the indigent from feeling ashamed, since they no longer have to publicly identify themselves to an administrative officer, as is the case with means testing (Coady, *et al*. 2004). This constitutes a further reason for believing that indigent people selected in this way are less likely to lose their self-esteem and feel that they are being stigmatized. Some authors maintain, in fact, that the selection processes in aid programs that rely on means testing carry more of a stigma because those seeking aid often have a bad experience (Stuber and Schlesinger 2006).

Moreover, it could be argued that because poverty is so widespread in these three contexts, being categorized as poor is not felt to be shameful, in contrast to developed countries where poverty is sometimes demeaning (Paugam 2005) and social stigma appears to be the punishment meted out on the poor (Warin 2010). In the case of Cambodia, some authors advance the same arguments to explain the absence of social stigma observed when selecting indigent people to benefit from health equity funds (Men and Meessen 2008).

Conclusion

The aim of the research carried out in the three health districts in Burkina Faso was to study – to our knowledge for the first time – the social implications of selective free healthcare. The results indicate that even if the choice of groups is sometimes questioned, the provision of free healthcare to certain sections of the population,

[8] Health equity funds were launched in Cambodia at the beginning of the century. The system is a perfect example of poverty targeting based on a third-party payer body that identifies the poor and exempts them from user fees by reimbursing those who provide free services.

rather than to everyone, is socially accepted. Although egalitarian values hold sway, communities are not opposed to preferential treatment being given to the most vulnerable sectors of the population. This is no doubt because it is believed that these policies help to strengthen social cohesion. However, although the principle of selective free care is accepted, the categories chosen to benefit from free provision are called into question. A large number of social players, for example, invoke humanist and moral considerations to explain why certain sections of the population, such as children and the elderly, should be included in current targeting programs. On the issue of social stigma, the data do not lead us to believe that targeting, as carried out in Burkina Faso, has caused the indigent to be stigmatized. The fact that the selection process was inclusive, transparent and entirely local (including funding) made targeting more acceptable, both to the communities and to the indigent themselves, as they did not lose their self-esteem. The results will certainly challenge the lingering idea that certain communities and individuals do not accept being classified as poor. We can conclude from the research that the crucial factor that determines whether targeting is accepted or rejected is not so much the terms used to categorize people, but rather the beneficiary selection process. In this respect, the community-based approach has clearly demonstrated its social desirability. Of course, in order to be used effectively, it must take the context into account – it is most suitable at the local level – and, above all, respect certain criteria relating to democratic transparency to avoid being hijacked by elites, as sometimes occurs (Pan and Christiaensen, 2012). Finally, the study again demonstrates how important it is for the population to be involved in developing and implementing reforms that concern them. The results call for the management of health programs in Africa to be reconsidered, with more thought given to people's concerns and values, as this could help to improve the effectiveness of public policies. However, it appears that a number of different questions relating to selective free healthcare interventions need to be considered in depth, particularly their impact on community empowerment and also on the autonomy and bargaining power of women beneficiaries within their households, even though they often do not have much authority in making decisions.

References

Aboderin, I. (2010), "Understanding and advancing the health of older populations in sub-Saharan Africa: Policy perspectives and evidence needs", *Pub Health Rev* 32: 357-376.

Boutin, G. (1997), *L'entretien de recherche qualitatif,* Presses de l'Université du Québec, Québec.

Coady, D., M, Grosh and J, Hoddinott (2004), *Targeting of Transfers in Developing Countries : Review of Lessons and Experience*, The World Bank, Washington.

Conning, J. and M. Kevane (2002), "Community-based targeting mechanisms for social safety nets: A critical review", *World Development* 30(3): 375-394.

De Herdt, T. and B. D'Exelle (2007), « La vulnérabilité vis-à -vis d'autres personnes: leçons pour les interventions contre la pauvreté », *Mondes en développement* 140(4): 101.

Dujardin, B. (1987), « L'aide internationale et les problèmes de santé en Afrique, l'offre correspond-t-elle aux besoins ? », *Politique Africaine* 28: 65-80.

Hanson, K., E. Worral and V. Wiseman (2008), "Targeting services towards the poor: A review of targeting mechanisms and their effectiveness", in *Health, Economic Development and Household Poverty - From Understanding to Action,* S. Bennett, L. Gilson and A. Mills, Routledge, London.

Hill, K., K. Thomas, C. Abouzahr, N. Walker, L. Say, M. Inoue and E. Suzuki (2007), "Estimates of maternal mortality worldwide between 1990 and 2005: an assessment of available data", The Lancet - British Edition 370(9595): 1311.

Jobert, B. (1992), « Représentations sociales, controverses et débats dans la conduite des politiques publiques », *Revue française de science politique* 42(2): 219-234.

Kagambega, A. (2010), *Emergence et mise en œuvre de la gratuité des moustiquaires et de la subvention des ACT dans deux districts sanitaires de la ville de Bobo-Dioulasso, Rapport d'enquête phase 1*, programme « Abolition du paiement des services de santé en Afrique de l'Ouest », Ouagadougou.

Kluckhohn, F. R. and F. Strodtbeck (1961), *Variations in value orientations*, Evanston, IL: Row, Peterson.

Long, N. (1994), « Du paradigme perdu au paradigme... retrouvé ? Pour une sociologie du développement orientée vers les acteurs », *Bulletin de l'APAD* 7. Consulté le 29 avril 2013. URL : http://apad.revues.org/2183

Massé, R. and J. Saint-Arnaud (2003), *Ethique et santé publique: enjeux, valeurs et normativité,* Les Presses de l'Université Laval, Québec.

Meessen, B., W. Damme (Van), C. Kirunga Tashobya and A. Tibouti (2006), "Poverty and user fees for public healthcare in low-income countries: lessons from Uganda and Cambodia", *The Lancet* 368(9554): 2253-2257.

Men, C. and B. Meessen (2008), "Community perceptions of pre-identification result and methods in six health equity fund areas in Cambodia", in Meessen B, Pei X, Criel B, Bloom G, eds. "Health and social protection: experiences from Cambodia, China and Lao PDF", *Studies in Health Services Organisation & Policy*; 23, ITGPress; Antwerp: 409-36.

Miles, M. and M. Huberman (2003), *Analyse des données qualitatives*, De Boeck, Paris.

Noirhomme, M. and J. Thomé (2006), « Les fonds d'équité, Une stratégie pour améliorer l'accès aux soins de santé des plus pauvres en Afrique ? », *in L'assurance maladie en Afrique francophone; améliorer l'accès aux soins et lutter contre la pauvreté*, G. Dussault, P. Fournier and A. Letourmy, Banque internationale pour la reconstruction et le développement, World Bank: 431-452, Washington.

Pan, L. and L. Christiaensen (2012), "Who is Vouching for the Input Voucher? Decentralized Targeting and Elite Capture in Tanzania", *World development* 40(8): 1619-1633.

Paugam, S. (2005), *Les formes élémentaires de la pauvreté*, Presses universitaires de France, Paris.

Razafindrakoto, M. and F. Roubaud (2005), « Gouvernance, démocratie et lutte contre la pauvreté en Afrique: Le point de vue de la population de huit métropoles Enquêtes 1-2-3, premiers résultats », DIAL, DT 2005-18, Paris.

Ridde, V. (2006), « Appréhender les conceptions locales de l'équité pour formuler les politiques publiques de santé au Burkina Faso. » *Promotion & Education* 2006, XIII (4), 252-6.

Ridde, V., F. Richard, A. Bicaba, L. Queuille and G. Conombo (2011), "The national subsidy for deliveries and emergency obstetric care in Burkina Faso", *Health Policy and Planning* 26(suppl 2): ii30-ii40.

Ridde, V., M. Yaogo, Y. Kafando, O. Sanfo, N. Coulibaly, P.A. Nitiema and A. Bicaba (2010), "A community-based targeting approach to exempt the worst-off from user fees in Burkina Faso", *Journal of Epidemiology and Community Health* 64(01): 10-15.

Roth, C. (2010), « Les relations intergénérationnelles sous pression au Burkina Faso », *Autrepart* 53(1): 95-110.

Sen, A. (1999), *Development as Freedom*, KNOPF, New York.

Standing, H. (2002), "An Overview of Changing Agendas in Health Sector Reforms", *Reproductive Health Matters* 10(20): 19-28.

Steinhardt, L. C. and D. Peters (2010), "Targeting accuracy and impact of a community-identified waiver card scheme for primary care user fees in Afghanistan", *International journal for equity in health* 9(1): 28.

Stierle, F., M. Kaddar, A. Tchicaya and B. Schmidt-Ehry (1999), "Indigence and access to healthcare in sub-Saharan Africa", *The International Journal of Health Planning and Management* 14(2): 81-105.

Stuber, J. and M. Schlesinger (2006), "Sources of stigma for means-tested government programs", *Social science & medicine* 63(4): 933.

Tanon, A. (2011), *Programme de gratuité partielle dans la province Maniema-république démocratique du Congo*, Mid-term evaluation report, Merlin, Kinshasa.

Taylor, S. and A. Marandi (2008), "Social determinants of health and the design of health programmes for the poor", *British medical journal* 337(jul09 3): a290.

Warin, P. (2010), « Ciblage de la protection sociale et production d'une société de frontières », *SociologieS*.

3. Perceptions of healthcare fee exemption policies in Mali: Is a decline in quality the price to be paid for improved access to care?

Laurence Touré, MISELI

Abstract

The aim of this article is to show that the 'commodification' aspect of essential services has been neglected in attempts to define these free healthcare policies. Hence, the policies appear as much drivers of improved access to healthcare as causes of – real or perceived – decline in the quality of treatment.

Introduction

The conditions governing access to basic infrastructure in Mali are exacerbating inequalities and seriously jeopardizing the attainment of Millennium Development Goals by 2015. In the area of health, despite a perceptible improvement in health coverage, the rate of attendance at health facilities is well short of expectations.[9] This outcome is widely attributed to a health sector policy commonly referred to as the 'Bamako Initiative', which made cost recovery the norm without, however, the 'equity' dimension that provided for user fee exemption measures in the case of the worst off being applied (Ridde, 2004).

This was the context in which the Malian government decided to introduce user fee exemption policies in a bid to target some of the more acute problems facing public health:

- free healthcare for HIV/AIDS sufferers in 2004 (screening, ARV drugs, biological monitoring, treatment of opportunistic infections);
- free Caesarean sections in 2005 (evacuation and referral, hospitalization, surgery and preoperative tests, surgical intervention kit and postoperative treatment);
- free treatment of malaria (simple and severe forms) for pregnant women and children under five in 2007.

An increasing number of research studies focus on user fee exemption policies, including, in recent years, such policies in West Africa (Ridde *et al*, 2010). They are especially concerned with the impact of these policies on attendance at health centres and on the funding of centres (ATN/USAID, 2011; Fournier *et al*, 2012), and usually highlight the need to incorporate complementary measures, without which the quality of care would be in danger of deteriorating (Richard *et al,* 2008; Ridde *et al*, 2011). They also indicate that users approve of the existence of these policies and that healthcare personnel are fairly critical of the decision process and implementation stages (Witter *et al*, 2007; Walker *et al*, 2004; Mbaye, 2011).

The success of a public health policy depends to a large extent on what the actors directly affected by it think of it, and on their degree of involvement in the decision-making process (Ridde, 2011). Therefore, we considered it appropriate to examine in

[9] Attendance for primary curative consultations rose from 0.18 new cases per inhabitant per year (NC/inhab/year) in 1998 to 0.35 NC/inhabitant/year in 2010 (source Ministry for Public Health (MSP) 2010)

depth how the last three free healthcare policies were received and perceived in Mali a few years after their introduction by systematically comparing the opinions of four categories of actors who are, by definition, strategic groups[10] in this matter:

- users;
- community representatives and local elected representatives;
- healthcare personnel;
- socio-medical officials.

3.1. Methodology

To that end, we selected three locations for our research: Commune 1 of Bamako district, Sikasso circle, in the cotton-growing region, a frequent pilot site for health projects, and Kita circle in the Kayes region where a Canadian team is already carrying out quantitative public-health studies on maternal health and the free provision of Caesarean sections. In each location, we selected two community health centres (CSCOM), the referral health centre (CSREF) and the hospital.

In order to obtain a complete picture and responses in a single format with regard to the issues addressed, we decided on a questionnaire-based approach. To enable the widest possible range of views to be expressed and compared, we opted for a purposive sample that would take account of the different levels of the health pyramid and decentralization, different categories of healthcare personnel, different social groups and the urban/rural divide (Table 4).

Two hundred users, 79 community representatives or elected representatives, 277 health staff and 36 health officials were given the questionnaire, for a total of 592 informants. The informants' profiles were adequately diverse in terms of gender, age, position on the health pyramid, and the qualifications and status of health professionals. However, people from urban areas were over-represented (79%) since the majority of our subjects lived in the regional or circle capitals (Table 5).

[10] A strategic group is a "collection of individuals who all have the same attitude to the same problem, an attitude determined largely by a similar social relation to the problem" (J.P Olivier De Sardan, 2008, p81).

Table 4 *Description of the persons included in the survey and the sampling procedures*

	Service/authority	Sampling method
Health officials	- Regional Health Authority (Direction Régionale de la Santé, DRS) - Hospital management - Referral health centre (Centre de Santé de Référence, CSREF)	A purposive choice of the senior officials in each service - Regional Director of Health - Heads of the health, planning and pharmacy divisions - The hospital administrator and his deputy - Trade union officials representing the healthcare personnel - Free healthcare focal points - District executive team (CSREF)
Healthcare personnel	- Hospital - Referral Health Centre (CSREF) - 2 Community Health Centres (CSCOM) per location	Updated list of staff in each facility - Random selection of 20 to 30 individuals for each category of staff (status and function), depending on workforce numbers - At the hospital, the departments involved in free healthcare and two that were not - All CSCOM staff - All district managers present during a meeting at the CSREF
Local elected representatives and community representatives	- Regional Assembly - Circle Council - Commune - Community health associations and their local and regional Federations - CSREF management committees - Hospital board	Purposive choice - Local authority offices (chairperson and officials with responsibility for health matters) - Chairpersons and paymasters of community bodies - Chairs/deputy chairs of the hospital board and of CSREF management committees
Actual and potential users	- Hospital, CSREF and CSCOM (2 of these per site) users - Market (stallholders) - School (teachers) - 'Grin' groups for young people - Local tradesmen's association - Producers' Association	Random choice - among actual users (patients and carers) admitted the day before the survey - in the case of potential users, one in every four persons encountered who fitted the desired profile

Source: author.

Table 5 *Profile of respondents*

	Staff	Health officials	Politicians/com. reps	Users
Numbers	***277***	***36***	***79***	***200***
Men	58%	80%	86%	53%
Women	42%	20%	14%	47%
-35 years old	47%	3%	4%	54%
36-50 years old	44%	56%	43%	32%
Over 50 years old	9%	41%	53%	14%
Commune/Cscom	34%	-	60%	-
Circle/CSREF	28%	38%	27%	-
Region/hospital	38%	62%	13%	-

Source: author.

Since these user fee exemption policies conflict with the existing policy of cost recovery, we sought the opinions of the four groups of actors on this institutional context. In addition, we analyzed perceptions of the principle of paid-for care and free care, current charging methods (including informal practices) and how they impact on inequalities. Finally, we focused on how widely known these policies were and how people rated their fitness for purpose, the manner in which they were implemented and their impact.

Apart from the descriptive analyses, a statistical analysis of the results, carried out using a chi-square test, highlighted the existence of significant differences between the types of actors.[11]

The results we present here come mainly from the quantitative study undertaken in 2011. We have added comments collected during the qualitative research carried out at the same time and in the same locations, during prolonged immersion (a minimum

[11] I am grateful to Dr Drissa Sia, MD,Ph.D. for this analysis.

of three months attendance and observation) in each health facility. A total of 189 formal or informal interviews were conducted with the different categories of staff involved in free healthcare policies (Table 6). We also studied the management of a range of malaria and Caesarean cases, hence of interactional situations between actors, and used those occasions to collect users' views. Lastly, we reviewed the available documentation.

Table 6 *Interviews conducted in the context of the qualitative research*

Interviews conducted / Research locations		Number of interviews		Case studies users	
		Health actors	Elected representatives	Malaria	Caesarean
Bamako	CSREF/commune	15	2	8	12
	CSCOM 1	9	2	10	-
	CSCOM 2	6	1	6	-
Sikasso	Hospital /region	17	3	-	9
	CSCOM1/commune	6	3	12	-
	CSCOM2 /commune	5	2	10	-
Kita	CSREF	8	1	4	12
	CSCOM 1	5	2	7	-
	CSCOM 2	4	2	6	-

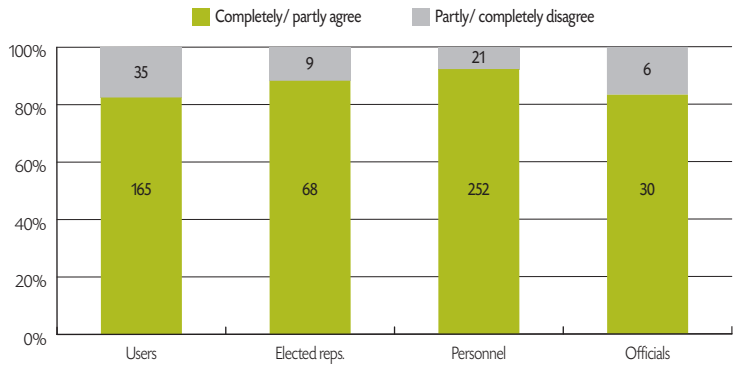
Source: author.

3.2. Results

3.2.1 Charging practices determine access to quality care

Payment as a condition of access to care is standard practice, even in the case of traditional medicine, and nearly 90% of our respondents considered this normal (Figure 1).

Figure 1 *Opinions on the proposition that having to pay for treatment is normal*



Source: author.

For the majority of informants, payment reflects the respect and gratitude due to the person who has treated the patient for the service rendered. It also has a positive effect on the behaviour of users (better compliance). Furthermore, payment for treatment is seen as the best guarantee of the quality of services and gives users more of a say.

> If you pay, you get good care. If you don't pay, if you are treated badly, you can't say anything because you haven't spent any money (Female user).

> Because there is a fee for treatment, people are more demanding. Since people are being charged, they are entitled to results (hospital health official).

Certain practices also illustrate the effect of payments on quality, especially the widespread practice of under-the-counter payments in the public services, and even in the private domain. Ninety percent of users and those who represent them (elected representatives and members of community health associations) agreed with the proposition that "giving a present or making an additional payment to healthcare workers entitles you to a better standard of treatment." This was confirmed by more than half of the healthcare personnel and by 47% of health officials.

The advantage of this practice was aptly summed up by one visitor (female) encountered at a health centre as follows:

> An unofficial payment has more of an effect on the behaviour of staff than an official fee. The member of staff is forced to look after you properly because he doesn't want anyone to know about the payment. So if the patient isn't happy, he's going to make a fuss.

Conversely, 78% of our sample (and close to 50% of health professionals) felt that "users cannot realistically demand quality in healthcare when they're not paying for it." The idea of free healthcare is associated with a loss of quality, in terms of both relations with staff and the effectiveness of treatment. Hence, more than two-thirds of users, community representatives and elected representatives thought that "someone who enjoys officially free healthcare and someone who pays for it are not viewed in the same light by the healthcare personnel," an opinion shared by 35% of health professionals. Finally, between 40% and 60% of our informants, depending on the group, thought that "an officially free service cannot be of the same quality as a service that you pay for."

Interviews conducted with service users and healthcare personnel also revealed a mistrust of anything free.

> Actually, healthcare workers were a bit annoyed at the beginning. Health is priceless. When healthcare doesn't cost anything at all, you often think to yourself: when I go and see someone and he treats me free of charge, has he done a good job? (CSCOM healthcare worker).

> I didn't know there was such a thing as free healthcare. But I think it's a good thing and I like the idea, providing they are good products. I'm not convinced by anything that's free. Whatever it is, you should have to pay something, even if it's not very much (CSCOM user).

3.2.2 A keen and shared awareness of unacceptable inequities in access to free healthcare

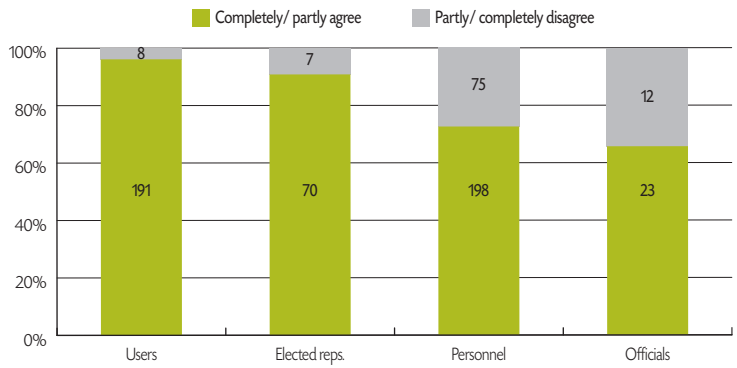
Fees are also seen as a barrier to access to care for the worst off and therefore as a cause of exclusion. Private care is reserved for the rich and chargeable public healthcare is governed by commercial considerations (cf. informal payments). Both are particularly unfair today:

- the worst off are denied care. More than 80% of users and elected representatives, and up to 40% of health professionals approved of the idea that "the poor should not be treated in health centres if they cannot pay;"

- users who have the money can buy access to better quality treatment (informal payments, attempts to arrange special deals) (Figure 2).

  For informal payments, healthcare workers do not set a fixed rate; this is negotiated according to your social relations and also your family income. Follow-up care for a boss's wife will cost more but it will also be of a better quality (CSREF user).

Figure 2 *Opinions on the proposition that it is easier for the well off than the poor to make a deal with health staff*



Source: author.

Our informants were very clear about the consequences of this system:

- the worst off have to rely on the generosity of third parties for their treatment (78%);

- there is a delay in treating poor patients (81%);

- health centres are poorly attended: according to 42% of our informants, a drop in attendance at health centres is one of the negative consequences of the introduction of cost recovery; and for 75% of our sample, the main

> cause of under-attendance at health facilities is that a large proportion of the population simply cannot afford treatment.

The wish to see financial barriers to healthcare access lowered is equally strong among all actors. However, when it comes to finding solutions, opinions differ radically. On the one hand, health professionals suggest organizing access to care through a system of insurance (compulsory medical insurance or a mutual benefit system). On the other hand, users envisage either free healthcare measures or facilities for the worst off, or else a reduction in some rates considered to be beyond the means of most people. In most cases, it was a question of cautious adjustments to the existing system rather than replacing it outright.

On the whole, the informants agreed with the idea that "it is fair that certain categories of individuals or patients should enjoy free treatment." Hence, perceptions are that the principle of free healthcare should be confined to three categories: hardship cases excluded from health services, children and the elderly, who are too vulnerable to cope with waiting for treatment.

Certain reservations may be observed, however, when it comes to discriminating positively in favour of the poor. According to 53% of health officials, 41% of both healthcare workers and elected representatives, and 27% of users, "it is fair for the same rates to be applied to the poor and to the rich."

Inequalities are, after all, the work of God and, while it may seem legitimate to correct them, the threat of disturbing the social order is evoked. At the same time, informants stressed the difficulty of targeting those who are genuinely poor (there is always a risk of cheating), on the one hand, and getting the wealthy to give up their privileges, on the other.

> You have to treat everyone the same, put social harmony first, which means no favours for the poor. The rich are not going to accept it if they don't get priority treatment or better healthcare. And the poor don't have a voice to make themselves heard. The point is this: if you create a system that favours the poorest, then everybody's going to cheat and pretend to be poorer than they really are (CSCOM user).

The small minority of actors who suggested totally free care for everyone defended their choice precisely because they did not want to see a system introduced that involved preferential treatment.

3.2.3. The institutional context is characterized by a succession of reforms, the consistency of which is difficult to identify

The socialist and then military governments implemented a policy of totally free healthcare up to the 1990s. Very few healthcare personnel and even fewer users (only 22% in the case of the latter) had any recollection of this policy. Since then, the area of health has been the subject of significant reforms, the main ones being:

- the twofold process of decentralization, both institutional and sectoral, which took the form of the State's withdrawal of its financial commitment and a transfer of responsibility to new actors at the local level (Community health associations and decentralized local authorities);

- the application of the cost recovery policy (the Bamako Initiative, BI), hence direct payment at the point of service delivery.

All four types of respondents thought that the State was persuaded to introduce the principle of healthcare fees, and, as a corollary, the transfer of responsibility to communities, for two main reasons:

- its inability to cope with the growing needs of the population (an increase in numbers and higher standards of care); this reason was given mainly by health professionals;

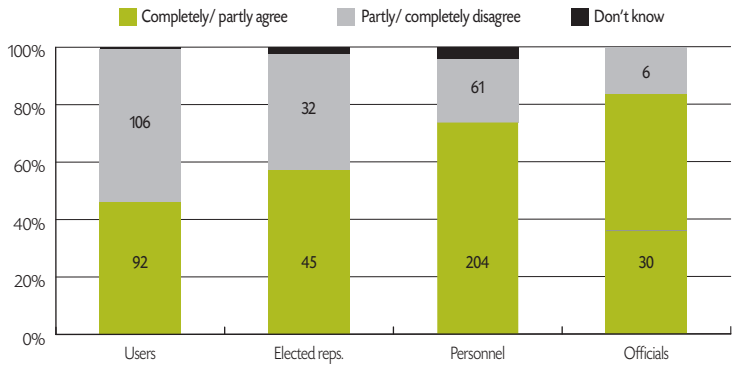
- the poor performance of the existing system (medicine shortages and staff absenteeism); this reason was favoured by users and their representatives.

It will be noted that 65% of our sample said they were in favour of the BI reform, which is part of the social argument that by paying a fee you acquire certain entitlements (Figure 3). However, significant statistical differences emerge between the groups ($p<0.01$).

Those who were not in favour of this policy, the majority of whom were users, pointed to the difficulties it creates for the poor in terms of accessing healthcare. The supporters of the BI (health professionals for the most part) saw cost recovery as the only guarantee of the health system's financial viability and effectiveness.

This was the context in which the State introduced user fee exemption policies. For all four categories of actors, the introduction of these free services was motivated by

Figure 3 *Opinions on the proposition that the reform introducing cost recovery was a good thing*



Source: author.

the desire to restore a degree of equality to access to healthcare or by a concern for public health. However, between 20% and 36% of informants, depending on the group, claimed the motives were purely political.

Although these targeted policies were not spontaneously cited as a solution to the problem of the inequity of access to healthcare, they won 90% approval. Nevertheless, stakeholders remained sceptical about the State's ability to provide free treatment, which represents a real financial challenge and presupposes a capacity for organization and control which they feel the State does not have. As we shall see, the conditions under which these policies were implemented lend support to this opinion.

3.2.4. The entitlements created by the exemption measures are not always fully mastered, even by the healthcare personnel

The information about the decisions on the sectoral measures for user fee exemption soon spread very quickly. Nevertheless, it appears that users were not convinced that free healthcare existed until they experienced it firsthand. This is evident from the remarks of the following user, who had just benefited from the new system:

> I heard about free healthcare on TV, but this is Mali; nothing's real here, so I didn't believe it. Now I'm convinced, and I'm pleased about it. Look, I've got

> 50,000 francs in my pocket. I thought I was going to be charged a lot. Instead, it didn't cost me anything, apart from the consultation fee (CSREF user).

At the same time, health officials felt that these measures had been inadequately publicized, irrespective of the type of free care, in particular because of the vagueness of the information provided. Moreover, 32% of healthcare personnel and up to 53% of users thought that the information campaigns did not enable the worst off to access the information in question ($p<0.01$).

Finally, the majority of individuals who did know about the existence of these exemption measures, especially users, still had very little idea of their basic content:

- the knowledge that treatment was free for opportunistic diseases associated with HIV varied significantly with the status of respondents ($p<0.01$). Fewer users (54.25%) and elected representatives (66.67%) knew about free treatment;
- users were largely unaware of the fact that treatment was free for severe cases of malaria ($p<0.01$);
- very few actors knew that the complications involved in the management of Caesareans, the additional examinations, tests and even hospitalization were all free. For example, in contrast to other categories of actors who were better informed, only three users in ten knew that hospitalization was free for Caesarean cases, ($p<0.01$).

3.2.5. The unsystematic application of these free healthcare policies does not facilitate their appropriation

Over 70% of respondents thought that these three policies were actually being implemented in Mali. A significant difference emerged, however, between views on free care for Caesarean sections and for malaria in this regard (Table 7). A quarter of users and their representatives thought that the free care did not apply in the latter case. Therefore, one might justifiably wonder how it is being implemented.

With regard to AIDS, few people contested the implementation of the free healthcare policy in this area. However, a large number of users stated they had not been informed to that effect. This is probably due to the rare and private nature of the disease.

Table 7 *Percentage of actors claiming that each free healthcare policy was actually being applied*

	All groups	Users	Elected reps.	Personnel	Officials
Free management of AIDS	**80%**	55%	85%	88%	92%
Free management of Caesarean sections	**86%**	79%	80%	91%	92%
Free malaria treatment for pregnant women and children under five	**74%**	59%	61%	84%	92%

Source: author.

In addition, stakeholders also referred to two significant problems in the application of these policies:

the inadequate definition of their scope and the vagueness of the information provided on the subject make it impossible to apply them unambiguously. They give extensive room for manoeuvre to local prescribing actors and undermine all attempts by the State to monitor or regulate the situation;

frequent shortages of free products (medicines, kits and consumables) are observed and users are unable to identify where the responsibility for these shortages lies.

This state of affairs has a prejudicial effect on the ownership of these policies and highlights the lack of information and confidence among users, eroding their ability to exercise their rights. Indeed, we observed that only 34% of users and 48% of representatives felt that "users do not hesitate to demand free treatment from staff" *($p<0,01$)*. There are good reasons for this, since, as one representative noted, "people are afraid of healthcare workers and keep quiet about things. In the minds of users, healthcare workers do not have to answer to anyone. So you have to accept things the way they are and try not to rock the boat."

3.2.6. The impact of these policies is viewed as both negative and positive

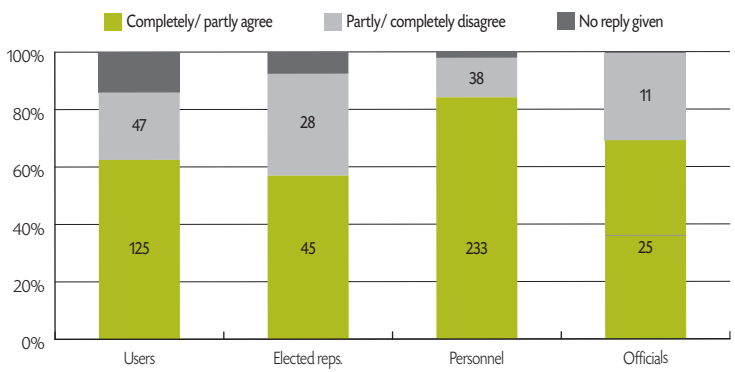
Over 80% of actors acknowledged that these policies have solved certain problems or brought about positive changes. In particular, they promote access to care and

enable better disease management through recourse to health facilities as soon as the first symptoms appear and through the availability of medication (especially ARV drugs). Eighty-four percent of our informants declared that these policies have increased service uses and 92% stressed that the policies also benefited the worst off. However, it also emerged that not everyone agreed that free healthcare has had a positive impact on informal payment practices; 75% of users and nearly 40% of health officials did not think that the policies have succeeded in reducing these practices ($p<0,01$).

Worse still, for 40% of actors, the implementation of the policies has created new problems or exacerbated some old ones. The negative impact of all three types of free treatment on the quality of care was very much in evidence. For example, 74% of users and close to 50% of the other groups did not think that these policies had made relations between users and health workers any easier. Over 50% of users and healthcare personnel maintained that "free healthcare policies have brought about a loss of confidence in healthcare personnel on the part of users," compared to only 8% of health officials ($p<0,01$). Healthcare personnel are suspected of engineering stock shortages in order to be able to charge users for medication.

Finally, free healthcare policies are seen as having caused a deterioration in working conditions for healthcare personnel (Figure 4). According to 69% of respondents and

Figure 4 *Opinions on the claim that healthcare personnel now have heavier workloads since the implementation of free healthcare policies*



Source: author.

over 80% of personnel, "healthcare workers now have heavier workloads since the implementation of free healthcare policies" (p<0,01).

Healthcare workers expressed their views very forcefully on this question:

"Free healthcare is a load of rubbish. There's no let-up, especially on reports, there's just too much to do. Get rid of this free healthcare business and we'll have a quiet life" (CSCOM healthcare worker).

Finally, 63% of all informants across all the groups felt that "healthcare workers have lost certain financial incentives on account of free healthcare policies" (p>0,01). An indirect consequence appears to be the temptation on the part of staff to "offload non-chargeable medical acts onto junior staff." Thirty-seven percent of workers, who are directly affected, and nearly 60% of both elected representatives and users believed this to be the case, as opposed to only 14% of health officials (p<0,01).

> "We all know that Caesarean sections are free whereas before they could cost more than 100, 000 francs. The State has now made them free whereas the practitioner used to be able to make something on the operation. If he makes nothing at all, then he may be tempted to act unprofessionally. And that could mean that the lady who's supposed to benefit suffers if the operation is not done properly" (elected representative).

3.2.7. The prospect of a possible universal free healthcare system confirms the difficulty of reconciling accessibility with the quality of care

Eighty-five percent of actors thought that free care for everyone would have a positive impact on access to healthcare but would also mean:

- a decline in the quality of care;
- a weaker health system or even its demise (a reduction in revenue and bankruptcy, the end of self-management);
- its abandonment, the State being deemed incapable of sustaining it.

3.3. Discussion

Our method of sampling does not allow us to extrapolate statistically from the results to the population as a whole. Also, certain questions, which were lacking in detail, do not enable a comparative analysis of perceptions of the three kinds of free healthcare in question (Caesarean sections, anti-malarial treatment for children under five and ARV medicines).

On the other hand, the high degree of consistency in the data strengthens the internal validity of the investigation and confirms the fitness for purpose of the four strategic groups chosen with these different types of free healthcare in mind. Taken as a whole, health professionals adopted a position that was statistically different from that of users and their representatives. Also, health officials differed from healthcare personnel and local representatives and politicians differed from users in terms of being better informed and using a more normative discourse.

A comparative analysis of opinions brings the divergent interests of these categories of actors to the fore. Admittedly, all four actor groups had a common vision of the prevailing social and institutional context when these pockets of free healthcare were introduced and of the unacceptability of inequities in access to care. However, their positions diverge when certain principles relating to the day-to-day operation of health centres are broached. Thus, a very clear division of opinion was observable between users and their representatives, on the one hand, and health professionals, on the other, who had difficulty in acknowledging the operational shortcomings that were highlighted, yet again, by the policies of free healthcare.[12]

The analysis confirms that users endorse these policies and are intent on improving conditions of access to healthcare, results that have already been widely highlighted. A study undertaken in sub-Saharan Africa (Abiola S. *et al*, 2008) shows that, in terms of improving health services, public opinion measures a government's commitment primarily by the effort it is willing to make to facilitate access to healthcare. Most of the studies carried out on free healthcare policies (El Khoury *et al*, 2011; El Khoury *et al.*, 2012;Witter *et al*, 2007) indicate users' satisfaction with these policies. The attention users pay to the quality of the services offered in their health centres and to how much it influences their perception of free healthcare measures are less in evidence. However, what one does find is that users remain sceptical about the State's capacity to enforce these user fee exemptions and even more sceptical about

[12] For an analysis of these shortcomings, see Y. Jaffré and J.P. Olivier de Sardan, 2005.

healthcare workers' willingness to accept them. Users are particularly sensitive to the negative consequences these policies can have on the quality of care due to the perceived deterioration of operational shortcomings and their increased mistrust of healthcare professionals.

Another factor that should be highlighted is that the healthcare professionals' endorsement of these policies appears rather superficial. A study of the implementation of free Caesarean sections in Kayes (S. Cissé, 2007) stresses that for healthcare professionals, the decision to remove user fees is "a political decision with no scientific basis." In our own study, we found that specialist workers distance themselves not only from decision makers, to whom they rightly attribute the creation of these initiatives (Tchiombiano *et al*, 2012), but also from the responsibility for all the problems encountered in their application. Their position in the context of this study is a very ambivalent one: they approve of the policies but feel a deep sense of frustration with the State, which imposed these measures. They overwhelmingly support the cost recovery policy, but want to leave it to the State to settle the difficult question of accessibility to healthcare by means of insurance schemes that are proving difficult to set up, while focusing their own thoughts on improving their pay and working conditions. If the opinions of health professionals determine the nature of their involvement, then one could be forgiven for wanting to know a little more about how the free healthcare measures are being implemented. Our studies on this subject (Touré 2011, Touré 2012) reveal certain strategies on the part of the personnel to thwart or at least limit the extent of these policies and a concerted attempt to steer health centre operations not towards the providers' interests rather than those of the users. A study carried out in Senegal on the free provision of Caesarean sections (Mbaye, 2011) shows that the concern for public health professed by healthcare workers is often no more than a mask that conceals their own self-interest, sometimes to the detriment of women's health.

Aware of the healthcare workers' lack of involvement, numerous studies conclude that more human and financial resources are needed to satisfy them. These complementary measures could probably limit some of the disruptive effects of the exemption policies on other parts of the health systems in the countries in question (Ridde, 2010). However, in our opinion, they do not appear sufficient to counter the basic opposition of healthcare workers to the very principle of free healthcare. An anthropological approach to these public policies of free healthcare (Fred Eboko, 2005) shows how they have gradually been absorbed into the pattern of 'routine malfunctions' that plague the health services. And if, as some authors believe (Ridde *et al*, 2012), these policies provide an opportunity for strengthening healthcare

systems, it is important to grasp this opportunity and to focus attention on the original causes of these serious malfunctions and try to remedy them. The daily clash between user and healthcare worker interests in health centres cannot continue unchecked without robust arbitration by the State and its partners, which, judging by the prevailing state of democracy in Mali in 2012, is by no means a certainty.

Conclusion

The appropriation of exemption measures by public opinion has come up against structural obstacles, which are due as much to the context in which these policies have been set (notably, the deep-rooted perception that fees are a necessity, together with the persistence of unofficial practices in the hope of improving the quality of service delivery) as to the conditions that govern the emergence and implementation of public policies:

- the break with the system established around the Bamako Initiative was a relatively sudden U-turn, not only in terms of evolving medical norms and practices, but also in terms of the ideological discourse on the role of the State and its citizens;

- the measures were neither adequately defined nor adequately communicated, either in their spirit or in their broad outlines; nor were they adequately implemented, becoming, as a result, a source of frustration and tension;

- healthcare professionals feel threatened by the measures, and users are unsettled by them and are unclear about the implications of exemptions and the conditions governing their implementation. All of this has unfolded in a context in which the relations between the State, the medical profession and users are dogged by mistrust and suspicion.

The fact is that while the cost recovery policy has enhanced the availability of medicines to the detriment of equity, free healthcare policies are improving the accessibility of treatment to the detriment of its perceived quality. They expose, and sometimes exacerbate, the operational shortcomings of the health system (a lack of control and supervision, and the arbitrary management of human resources). They upset health professionals without convincing users of their fitness for purpose in the current context and of their sustainability.

One might well wonder, therefore, whether the State is not faced with a dual priority: on the one hand, the need to strengthen the health system; on the other, the need to find combinations of different forms of funding which will enable progress towards universal coverage (compulsory medical insurance, a medical assistance scheme, a support fund or mutual benefit arrangements), can be exploited to safeguard the quality of care, and in which free healthcare policies should ultimately be embedded.

References

ATN, USAID (2011), « Etude de l'effet de l'introduction d'une prise en charge financière des enfants de moins de cinq ans dans les formations sanitaires publiques et privées au Mali », Report.

Cisse, S.B. (2007), « Analyse de la mise en œuvre de la gratuité de la césarienne à l'hôpital Fousseyni Daou de Kayes au Mali », Mémoire de master en population et santé, université de Ouagadougou, Burkina Faso.

Eboko, F. (2005), « Politiques publiques et sida en Afrique. De l'anthropologie à la science politique », *Cahiers d'études africaines,* 178, 351-387.

El Khoury, M., T. Gandaho, A. Arur, B. Keita and L. Nichols (2011), « Améliorer l'accès aux services de santé maternelle qui sauvent la vie, effets de l'exemption des frais liés à la césarienne au Mali », Bethesda, MD : *Health Systems* 20/20, Abt Associates Inc.

El Khoury, M., T. Gandaho and L. Hatt (2012), "User fee exemptions and equity in access to caesarean sections: an analysis of patient survey data in Mali", *International Journal for Equity in Health*, 11:*49*.

Fournier, P., A. Philibert, C. Tourigny, A. Coulibaly, M. Traoré and A. Dumont (2012), « La gratuité de la césarienne sauve des vies, surtout dans les villes », note de synthèse.

Jaffré, Y. and J.P. Olivier de Sardan (2003), *Une médecine inhospitalière. Les difficiles relations entre soignants et soignés dans cinq capitales d'Afrique de l'Ouest*, Apad, Karthala.

Mbaye, E. M. (2011), « En faire plus pour gagner plus. La pratique de la césarienne dans trois contextes d'exemption des paiements au Sénégal », *Santé Publique*, 3 (Vol. 23), 207-219.

Olivier de Sardan, J.P. (2008), « La rigueur du qualitatif, Les contraintes empiriques de l'interprétation socio-anthropologique », *Anthropologie prospective* N°3, Academia-Bruylant.

Richard, F., S. Witter and V. Brouwere (De), eds. (2008), « Réduire les barrières financières aux soins obstétricaux dans les pays à faibles ressources », *Studies in Health Services Organisation & Policy,* 25.

Ridde, V., E. Robert and B. Meessen, (2012), "A literature review of the disruptive effects of user fee exemption policies on health systems", *BMC Public Health*, 12:289.

Ridde, V. (2011), « Politiques publiques de santé, logiques d'acteurs et ordre négocié au Burkina Faso », *Cahiers d'études africaines,* LI (1), 115-143.

Ridde, V., B. Meessen and S. Kouanda (2011), « L'abolition sélective du paiement direct en Afrique subsaharienne : une opportunité pour le renforcement des systèmes de santé ? », *Santé publique,* volume 23, N°1.

Ridde, V., F. Morestin and L. Belaid (2010), « Politiques contemporaines de gratuité des soins en Afrique », dans Sanni, Y. (ed.) *Les maux et les choses de la santé : Acteurs, pratiques et systèmes de santé dans le tiers-monde,* Presses de l'Université d'Ottawa, Ottawa.

Ridde, V. (2004), *L'initiative de Bamako 15 ans après. Un agenda inachevé.* The International Bank for Reconstruction and Development, The World Bank, Washington.

Tchiombiano, S., Y.F.Koné, A. Prévalet and E.H. M'baye (2012), *Émergence, formulation et mise en œuvre au niveau national des politiques d'exemption de paiement des soins de santé au Mali : synthèse du volet institutionnel*, Research report, Miseli.

Touré, L. (2011), *La mise en œuvre de la politique de gratuité du traitement du paludisme pour les enfants de moins de 5 ans et les femmes enceintes, Le cas de Bamako*, Research report, Miseli.

Touré, L. (2012), *La mise en œuvre de la politique de gratuité de la césarienne, Etude comparative dans 3 sites d'enquête*, Research report, Miseli.

Walker, L. and Gilson L. (2004), "We are bitter but we are satisfied: nurses as street level bureaucrats in South Africa", *Social Science and Medicine,* 59, 1251-61.

WITTER, S., A. KUSI AND M. AIKINS (2007), "Working practices and incomes of health workers: evidence from an evaluation of a delivery fee exemption scheme in Ghana", *Human Resources for Health*, 5:2.

4. The effects of the healthcare fee exemption policy on the financial capacity of management committees in Niger

Abdoulaye Ousseini, LASDEL, and Yamba Kafando, IRSS/CNRST

Abstract

Since 2005, the authorities in Niger have implemented a series of user fee exemption measures in its health service, which are available to pregnant women and children under five years of age. However, the formulation and implementation of this policy were rushed and poorly prepared. This article is concerned with the difficulties involved in implementing this policy, and its effects on the financial capacity of the management committees in the health district of Dosso.

A mixed methodological approach was adopted involving the validation of the concerns of the relevant actors raised during qualitative interviews, through the use of quantitative data obtained from management documents.

The actors expressed concern about the deterioration in the availability of medication and the persistent delays in the reimbursement of the management committees for the healthcare services provided free of charge. Only 30% of their bills have been paid. The actors also felt that health budgets had diminished considerably with the implementation of the policy: five years after the introduction of the policy, the decrease in the budgets is estimated at 80%. Donations and support from external partners are integral to the functioning of health centres. The health district received donations of over XOF 70 million in medicines.

The implementation of free healthcare has negative impacts on the functioning of the health system. Nevertheless, the policy of free healthcare provision could be beneficial if, and only if, the State regularly pays the bills for this free care.

Introduction

The cost recovery measures implemented in the 1990s in Sub-Saharan African countries did not improve the populations' access to health services (Foirry, 2001; Tizio and Flori, 1997). Like the majority of African countries, Niger introduced healthcare fee exemption measures for vulnerable groups, in particular pregnant women and children under five years of age. This policy has been in place since 2005. However, as revealed by an external audit in 2011, the implementation of the policy has been affected by a lack of funding, which is reflected in delays in the payment of bills for the provision of free healthcare to the beneficiaries. This study examines and assesses the consequences of these reimbursement delays for the financial capacity of management committees in the context of the free healthcare policy in Niger.

The healthcare system in Niger has a three-tiered pyramidal structure. The bottom level comprises dispensaries, integrated health centres (Centres de Santé intégré, CSI), and the district hospital (HD). The middle level includes regional hospitals (Centre Hospitalier Régional, CHR) and regional maternity referral hospitals. The top or central level consists of national hospitals (HN), the maternity referral hospital, and national referral centres. Since the 1990s, the health system in Niger has been based on cost recovery, which involves community participation. Thus, at every administrative level (village, department, region), there is a community participation structure called the health committee. At the health district level, the health committee assembly elects a management committee (or *bureau*, COGES) which is responsible for formulating the district's budget with the district executive team (ECD) and controlling the management of the district's financial, human, material and medical resources. At the end of each month, the paymaster and a member of the executive team work their way through the dispensaries and CSIs to collect revenues. They also supply the healthcare structures with medical supplies, management tools and petrol. The revenues collected by the health committees are used, inter alia, to buy drugs and management tools for healthcare facilities, and to pay gratuities to tax collectors and community paymasters.

As an initial measure, the Nigerien government decided to provide free Caesarean sections in November 2005. This was followed by the introduction of free healthcare for children under five years of age in April 2006. Exemption from payment applies to all levels of the healthcare pyramid based on the technical capacity of the healthcare structures. The State was established as the "third-party payer" for all categories of beneficiary exempt from direct payment for healthcare services in Niger. In other words, the benefits provided free of charge to these beneficiaries are billed

to the State by the healthcare facilities. The State then pays for them and allows the management committees to use the resources to pay for operational expenses and for the purchase of medicines.

To facilitate the payment of the healthcare facilities, the Ministry of Public Health established a reimbursement system. A bill for the services provided is issued at the end of the month by the health centres, based on a scale of charges determined at central level. The bills are initially collected at the level of the regional health system before being forwarded to the team that deals with free healthcare at the Ministry of Public Health, which is located in Niamey. The team checks the bills and transmits them to the Ministry of Economics and Financial Affairs, from where they are forwarded to the National Treasury which transfers the payments to the accounts of the health committees.

In theory, the time scale for the reimbursement of a bill is one month. However, in practice, due to the inadequacy of the allocated funding and the complexity of the reimbursement system, the process can take several months or, in some cases, several years (Ousseini, 2011).

4.1. Methodology

This study was carried out in the health district of Dosso, one of five districts of the health region of Dosso. This location was selected for a number of reasons. This health region is one of the research sites of LASDEL (Laboratoire d'études et de recherche sur les dynamiques sociales et le développement local) where qualitative studies have already been conducted. Furthermore, the launch of the healthcare fee exemption policy was very controversial in this region, which has proved helpful in terms of studying the difficulties involved in its implementation. Data were collected in a variety of ways (Ridde and Olivier de Sardan, in this issue) and in two successive phases.

The first stage involved the collection of qualitative data between July 1 and August 31, 2010 by means of a series of in-depth interviews. In total, 31 interviews were held with healthcare personnel, members of the district executive team, community representatives and officials from the regional health authority (Direction régionale de la santé, DRSP). The study was undertaken in the regional health authority, then at the level of the health district and, finally, in three of the district's 37 integrated health centres (CSIs), two of which were urban and one rural.

At the DSRP, data were collected from the main manager and from the two focal areas for free healthcare provision and cost recovery. In the health district, we interviewed members of the district management team, the paymaster, who manages the health district's finances, and the manager of the pharmacy. At the CSIs, we interviewed three strategic groups. We began by interviewing health personnel: the head of a CSI and two nurses from the urban CSIs, who were selected on the basis of their extensive experience in the service, and the head and a nurse from a rural CSI. We then interviewed two community tax collectors. Finally, eleven users (pregnant women receiving consultations, and the parents of children under five years of age) were interviewed as they were leaving consulting rooms.

The duration of the interviews varied from one to two hours. Some actors were interviewed twice to fill gaps in the information obtained. Many issues were broached: the introduction of the fee exemption policy, data on the revenues and expenditures of healthcare structures, medications and other inputs. The diversity of the strategic groups enabled us to cross-reference the data in accordance with the triangulation principle (over time, the interviews no longer provide any new information on the issues under discussion: Olivier de Sardan, 2008). The majority of the interviews (28/31) were recorded. The remainders were documented in note form. All of the recorded interviews were transcribed in full. The collected data were analyzed on the basis of the subject matter.

During the second phase of the study, quantitative data were collected using a method already tried and tested in Burkina Faso (Kafando and Ridde, 2010). These data concerned expenditures, revenues and donations received by the health districts, gaps in the supplies of drugs, and cash flows and the reimbursements provided by the State (Table 8).

These data were collected using data sheets. To facilitate the assessment of the effects of the fee exemption policy, the quantitative data covered the periods before (year -1, year -2 etc.) and after (year 1, year 2, etc.) the introduction of the policy (year 0). The window of observation covered six years (May 2004 to April 2010); i.e. three years prior to the introduction of the policy and three years following its implementation.[13] The unit of data collection here is the year.

[13] The fee exemption policy was not implemented on the same date all over the country. Although, the health district of Dosso introduced it in June 2006, it was forced to abandon the policy three months later and reintroduce it in early of 2007 (source: PDSDS Dosso, 2008-2010).

Table 8 *Composition of expenditure and revenue*

Data on	Description
Expenditure	• Drugs and medical consumables (purchases) • Management tools (data sheets, notebooks etc.) • Salaries and bonuses (salaries paid to maintenance personnel: labourers, caretakers) • Other expenses (petrol, costs of meetings, general meeting etc.)
Revenue	• Cost recovery (consultation fees and drugs) • 'Centime additionnel' (local tax of XOF 100 collected from each patient for an emergency medical evacuation fund)
Support	• Donations of drugs or consumables received by the health district from technical and financial partners and other parties
Shortages of medication	• Shortages of products in the health district's pharmaceutical depot over a specified period, measured in days
Reimbursements	• Reimbursements of fees for the free treatment of children under five years and Caesarean procedures
Cash flows	• All sums available in the bank or at the disposal of the district paymaster

Source: adapted from Kafando and Ridde, 2010.

Methodological limitations

Due to the unavailability of certain actors during the study, certain key actors were not interviewed: e.g., a CSI community paymaster and an 'historical' healthcare worker (i.e. someone who had worked at a CSI for a significant period of time). Due to the incomplete nature of some of the quantitative data, only 30 of the 37 CSIs in the district are included in the analysis. It was not possible to record data on variations in the stocks of essential generic drugs because the data sheets for the drug stocks are not regularly completed by the managers of the pharmaceutical depots. Furthermore, the inventories of these depots are not regularly updated – which in itself says much about the management of medical supplies.

4.2. Results

A shaky start for free healthcare

The early days of the implementation of the free healthcare policy were controversial in the health region of Dosso. In effect, while all the other health districts in the region

decided to boycott its launch, the district of Dosso alone opted for its rapid adoption. As a result the actors responsible for the implementation of the new system were not trained and did not have the necessary management tools available to them. These difficulties resulted in the temporary halting of the policy's implementation:

"We began without any training. We even had difficulties filling in the management forms. We did not know how to complete them because some people told us to put zero francs on the consultation register or on the receipt, whereas others told us to put the amount. It was a very difficult situation, and we abandoned the policy for some months. Then another internal memo arrived telling us to continue with the free healthcare" (Manager of a CSI, Dosso).

The difficulties encountered in the implementation of the policy

The implementation of the free healthcare policy generated an array of difficulties for the healthcare facilities.

Shortages in the supply of drugs

The availability of drugs in healthcare facilities is a key element of the healthcare system and was one success of the Bamako Initiative. The creation of district pharmacies managed by communities was indicative of the desire to keep the health centres well supplied with essential drugs. However, the implementation of the free healthcare policy led to numerous gaps in the availability of drug supplies.

> "The nurse told me that there was no drug and refused to fill my prescription" (a user).

The analysis of shortages in the supply of ten principal drugs in the health district demonstrates that the fee exemption policy led to or exacerbated the shortages in certain products. This is particularly evident in the case of five of the ten main drugs used (aspirin tablets, chloroquine tablets, iron tablets, injectable ampicillin and cotrimoxazole tablets). The average number of days on which these five products were out of stock more than doubled, going from 116 days before the implementation of the policy to 312 after its introduction. There are two primary reasons for these shortages: the demand for drugs has increased significantly, particularly for the paediatric forms of the drugs, and the delays in the reimbursement of fees have drained the accounts of the management committees (COGES).

Delays in reimbursement

The government of Niger undertook to repay the healthcare facilities for services provided in association with the fee exemption for children under five years of age on the basis of a lump sum payment for each treatment administered, which varied according to the level of the establishment within the healthcare pyramid. For example, XOF 500 should have been repaid to health centres on the bottom tier for each curative consultation of a child under the age of five. However, the healthcare facilities experienced enormous difficulty in obtaining reimbursements for these consultations.

> "Truly, the heart of the problem is that for all of 2009, we did not receive a single franc in repayment" (Member of the ECD).

This observation is confirmed by the data provided by the quantitative research. At the time of data collection, on average only 30% of the bills forwarded since the introduction of the policy had been reimbursed by the State (Table 9).

Table 9 *Situation regarding reimbursements in the health district of Dosso*

Year	Bills submitted for reimbursement (XOF)	Amount reimbursed (XOF)	Percentage reimbursed (%)
2007 – 2008	52,841,200	54,057,300	102
2008 – 2009	85,516,650	20,490,750	24
2009 – 2010	89,724,250	0	0
Total	**228,082,100**	**74,548,050**	**33**
Average	**76,027,367**	**24,849,350**	**33**

Source: district of Dosso.

Moreover, the reimbursement system is complicated and unreliable and has yet to be mastered by the actors involved in its implementation. It also gives rise to inequalities among the healthcare facilities.

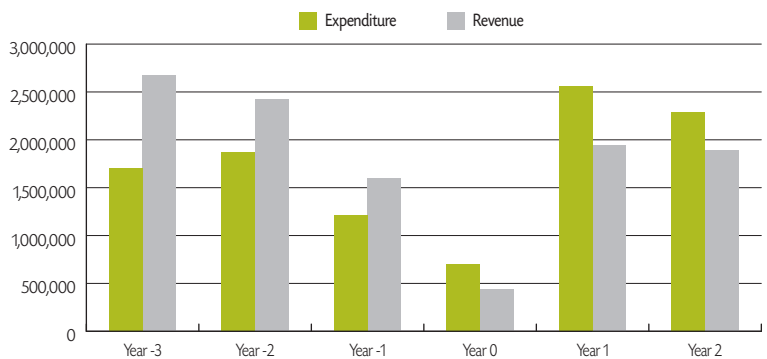
> "It is completely random! You could find yourself with lots of funds and all of your invoices reimbursed, but there'll always be someone who hasn't had a single bill paid" [Health District Manager].

According to the actors, the considerable drop in health revenues is due to the introduction of free healthcare.

> "To be completely honest with you the district is managing very badly because free healthcare accounts for two-thirds of our revenue" (Member of the ECD).

These statements are corroborated by the quantitative data findings. Since the introduction of the policy, the level of income (which had exceeded expenditure before the implementation of the fee exemption policy) has fallen below that of expenditure.

Figure 5 *Development of average expenditure and revenue in the district of Dosso (in XOF)*

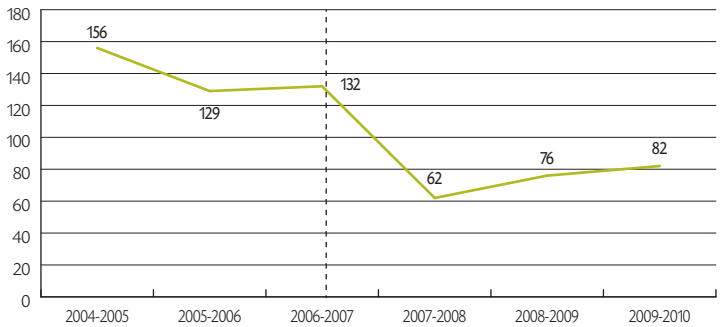


Source: district of Dosso.

Similarly, the recovery rate of costs, which here refers to total revenue as against expenditure during the same period (due to the inability to take the variation in the value of the drug supplies into account), was largely positive prior to the implementation of the exemption policy. It decreased sharply over the years and stabilized at less than 100% in 2010 (see Figure 6). In other words, since the introduction of the free healthcare policy, for the most part revenue has been lower

than expenditures, thereby forcing management committees to dip into their reserves (see below) to meet their operating expenses.

Figure 6 *Development of recovery rates in the district of Dosso*



The dotted line represents the introduction of the free healthcare policy
Source: district of Dosso.

As such, the provision of free healthcare decapitalized the COGES, forcing them to finance their expenditure using significant sums that had been hoarded from cost recovery during past years.

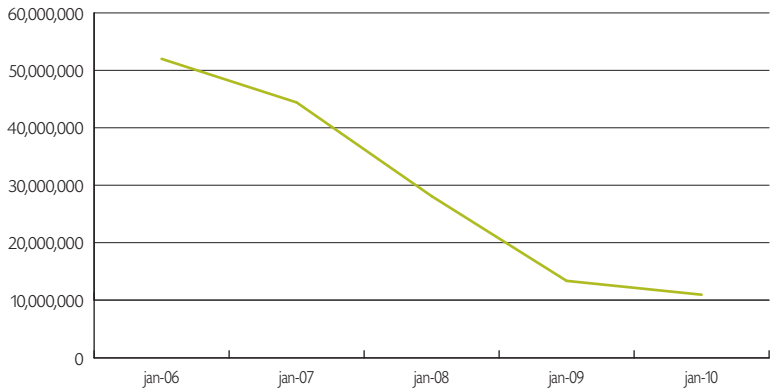
> "Now we're having difficulties because we have exhausted the resources we had before the introduction of the fee exemption policy. This policy further eroded our resources and, unfortunately, the reimbursements are causing problems... We are spending, but we're not receiving anything" (Health District Manager).

This process of decapitalization to meet irreducible expenditures is reflected in the significant decline in the district's coffers (Figure 7) since the introduction of the free healthcare policy.

This situation has arisen because the State has only repaid 30% of the sums owed to the district since the introduction of the policy. The district of Dosso received no reimbursement whatsoever in 2011 (Table 9).

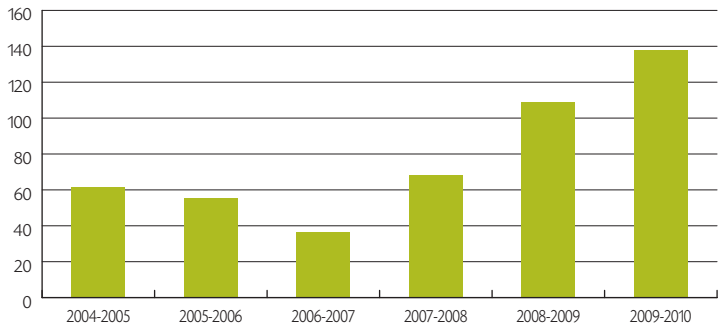
However, the recovery rate of costs in the health district would be broadly positive if the revenues arising from the free healthcare policy were to be taken into account (see Figure 8).

Figure 7 *Development of the finances of the district of Dosso from 2006 to 2010 (in XOF)*



Source: district of Dosso.

Figure 8 *Development of total hypothetical revenue (in million XOF) in the health district of Dosso between 2004 and 2010*



Source: district of Dosso.

The total hypothetical revenue has increased from less than XOF 50 million before the introduction of free healthcare to close to XOF 140 million three years after its implementation.

Donations and support: an important contribution to health services

In addition to the revenue accruing from cost recovery and the reimbursement of bills for free healthcare provision, Niger's healthcare facilities also receive donations and support from technical and financial partners that enable them to operate despite the delay in repayments. When the partner in question is local, this support may be sporadic or regular. The actors' views regarding the importance of these contributions vary. Some feel that the donations do not meet the demand:

> "The partners mostly donate large quantities of oral rehydration solution. You very rarely see donations that meet our requirements, antibiotics or other supplies" (DRSP official).

However, others view these donations as being integral to the functioning of the health centres:

> "At the moment if these programs did not exist, we would have to close. For example, the malaria program provides drugs for malaria, one of our most common conditions" (Health District Manager).

Table 10 *Development of donations/support provided to health districts between 2004 and 2010*

	Year	Value (XOF)
BEFORE	2004-2005	80
	2005-2006	218,625
	Total	**298,625**
	Average	**149,313**
AFTER	2006-2007	4,704,850
	2007-2008	72,680,619
	2008-2009	92,982,503
	2009-2010	118,645,463
	Total	**289,013,435**
	Average	**72,253,359**

Source: district of Dosso.

Donations and support from technical and financial partners and from certain individuals are very important and have been increasing since the introduction of the free healthcare policy (Table 10)

4.3. Discussion

The fundamental problems with the free healthcare policy as identified by the research are: lack of preparation, lack of funding and the complexity of the reimbursement system.

Lack of preparation

The policy initiated by the President was not adequately prepared in technical, financial or communicative terms. The decision was presented by the official propaganda as a gift from the President to the women and children of Niger. The 'presidential' nature of this initiative to provide free healthcare was not specific to Niger. In Burundi, the new President elect Pierre Nkurunziza immediately launched an appeal for the abolition of healthcare fees for children under five years of age and for pregnant women (WHO, 2011), and in Senegal free healthcare for the elderly is rooted in a clientelist process (Mbaye *et al*., 2011).

The free healthcare policy also appears to be external in origin. The Nigerien government was under pressure from the World Bank, which made its loans conditional on the immediate provision of free healthcare for children under five. In Burkina Faso, the World Bank similarly played a key role in the policy of providing midwifery services, which is viewed as an intervention that yields rapid benefits (Ridde *et al*., 2011a). This approach is viewed favourably on the international stage. There is increasing international pressure to reach the targets set by the Millennium Development Goals (MDGs) and to implement free healthcare policies. Thus, institutions like the World Bank, UNICEF, the European Union and NGOs increasingly support and encourage the abolition of healthcare fees (Robert and Ridde). Furthermore, this policy is also consistent with decisions made by the African Union (African Union, 2010).

However, the policy of free healthcare for children from birth to five years old in Niger was introduced at the national level without the implementation of pilot tests in control areas and without waiting for the results of experiments carried out with NGOs (Help) in the health districts of Mayahi and Téra (Ridde and Diarra., 2009).

As is the case in many countries, there was a lack of accompanying measures in Niger (Meessen *et al*., 2011) – in contrast to Uganda where the salaries of healthcare personnel were increased (Nabyonga-Orem *et al*., 2008) and to Ghana where financial incentives were put in place (Witter *et al*., 2007a b).

The under-financing of free healthcare and the complexity of the reimbursement system

In Niger, the reimbursement of bills is financed from two sources: State funds and emergency budgetary aid granted by France between 2006 and 2010. However, not only are the reimbursements insufficient relative to the costs each year, but the State does not honour its commitments. In 2007, XOF 3 billion were assigned under the Finance Act for an estimated requirement of XOF 8 billion. Only 37% of this amount has been disbursed.[14] This under-financing of the free healthcare policy, which is not specific to Niger, was nonetheless widely acknowledged by authorities during the national conference on the policy organized in March 2012. In Ghana, Witter *et al*. (2007ac) noted that the financing of the free healthcare policy was insufficient and irregular, necessitating a return to the charging of medical fees to users in certain districts. In Kenya, Mwabu *et al*. (1995) reported a lack of government funds to continue the fee exemption policy. In addition, the reimbursement system is very complex and slow, with controls at many different levels (Ministry of Public Health [MSP], Ministry of Economics and Finance [MEF], Agence Française de Développement [AFD], etc.), which are often useless and redundant according to treasury officials. Furthermore, bills often sit for months in healthcare units before being submitted for reimbursement. At the MEF, the submitted bills are paid as a function of available funds.

The consequences of delayed reimbursements

The problems of implementing the policy in Niger are clear to see and inextricably linked to the reimbursement delays and shortages of medication. When the free healthcare policy was first introduced in Burundi, there were reimbursement delays of six to nine months between 2006 and 2007 (WHO, 2011). Witter *et al*., (2008) noted a significant reimbursement delay in Senegal for the free provision of Caesarean procedures. More recently, a study revealed that in 2010, the Senegal State was over XOF 14 million in arrears to hospitals for its obligations under this policy and for free healthcare for the elderly (Mbaye *et al*., 2012).

[14] Notes on free healthcare, December 2008.

The impact of reimbursement delays on the financial capacity of healthcare facilities is considerable. They place a heavy burden on the operation of these facilities, which are no longer able to buy the drugs they require using their own income. They initially continued to purchase the drugs using accumulated earnings so that they could continue to care for patients without waiting for the reimbursements. With time, however, their funds dried up. This financial drain further aggravated drug shortages, and the paediatric versions of more expensive key medications all but vanished from the health centres.

The consequences of the decrease in revenue can also be observed in other cases. In Uganda, government's failure to reimburse bills has rendered the healthcare structures there incapable of paying recurring expenses (Kajula *et al*., 2004), which has resulted in a shortage of medication and led laboratories to cease their operations (Pariyo *et al*., 2009). Dosso's healthcare community has developed coping strategies in response to drug shortages (see Diarra, in this issue). These strategies include the use of duplicate prescriptions, whereby patients are given a prescription for medicines that are not currently available despite the fact that they have already paid the fixed fee covering both the consultation and medication. Moreover, healthcare users are now turning to services that can provide them with the medication they require. In addition, healthcare facilities are incurring significant debts to the central pharmacies and printing companies for the provision of required management tools. Similar strategies have also been developed to deal with drug shortages in other locations. In Kenya and Ghana, healthcare fees have been reintroduced (Mwabu *et al*., 1995; Witter *et al*., 2007). In Uganda, there is a trend for heavy reliance on private pharmacies and laboratories (Pariyo *et al*., 2009).

However, free healthcare could be beneficial to healthcare facilities if the government honoured its commitment to reimburse the charges. According to our calculations, health districts' recovery rate would be positive if revenue accruing from free healthcare were taken into account. In fact, the (hypothetical) recovery rate would increase from an average of 140% prior to the implementation of the free healthcare policy to almost 220% on average since its implementation – a logical consequence of the increase in the use of the service (Barroy and Carasso, 2012) due to the removal of fees at the point of healthcare delivery. In Burkina Faso, where the problems with reimbursement are less extensive, healthcare facilities have managed to maintain a positive recovery rate (on average 104%), even after the implementation of the subsidized childbirth policy (Kafando and Ridde, 2010).

The importance of medical donations and support

Donations and the support of partners are crucially important in the context of the drain on the finances of the healthcare facilities caused by the implementation of the free healthcare policy. In Dosso, donations of drugs increased significantly after the introduction of the policy. Other studies in Niger show that the health centres that receive aid from an NGO appear to be better able to maintain the provision of free healthcare than those that do not receive any such support (Ridde *et al*., 2011b; Diarra, in this issue). However, the pressure generated by the build-up of unpaid bills has led the government of Niger to enquire into the value of medical donations received by the health facilities in the hope of subtracting this amount and hence reducing the State's debt. In light of the fact that this measure greatly displeased the management committees and posed numerous practical problems, it was eventually suspended.

The sustainability of free healthcare

The free healthcare policy was technically and financially underprepared in Niger. Moreover, due to the personal link with the President, the debate surrounding the difficulties involved in its implementation has remained taboo. However, the national conference on free healthcare, held from March 13 to 15, 2012 prompted a change in the situation. The preliminary results of an external audit of the policy presented at the conference showed that it was not working well. First, it suffers from underfunding, which has led to an accumulation of unpaid bills and the bankruptcy of some health centres. Second, the free healthcare unit that is supposed to ensure the control and monitoring of the policy does not have sufficient resources, which appears to be the norm rather than the exception in Africa (Meessen *et al*., 2011). The audit revealed over XOF 400 million in bills issued in duplicate. Finally, the reimbursement system is modelled on public expenditures, which has proven to be very slow and complicated.

The free healthcare policy could, however, benefit healthcare structures if it were correctly implemented (Figure 8). However, given that the debt to the health centres was estimated at over XOF 20 billion in 2012 by the Ministry of Health, it is unclear whether the State has the will or the capacity to pursue its free healthcare policy. For a healthcare policy intended to provide access to healthcare to the most vulnerable sectors of society, it is urgent that solutions be found before this state of affairs cripples Niger's entire health system.

Conclusion

Although qualitative and quantitative methods sometimes conflict with each other, in this case we believe that they are complementary (Pluye, 2012, Ridde and Olivier de Sardan, 2012). In this study, we initially undertook qualitative surveys. The qualitative information collected from actors regarding their views of the impacts of delayed reimbursements on health centres provided the basis for a quantitative study that explored these issues further. An analysis of the convergence/divergence of results is central to this type of mixed approach (Pluye *et al*., 2009). As such, the results of the quantitative study enabled us to confirm the findings of the qualitative research. For more detailed results and analysis of the qualitative components of the research, see Ousseini 2011, and for corresponding results and analysis of the quantitative aspects, see Kafando *et al*., 2011.

References

African Union (2010), Actions on Maternal, Newborn and Child Health and Development in Africa by 2015.

Asante, F. A., C. Chikwama, A. Daniels and M. Armar-Klemesu (2007), "Evaluating the economic outcomes of the policy of fee exemption for maternal delivery care in Ghana", *Ghana Medical Journal 41(3): 110-117.*

Barroy, H. and B. S. Carasso (2012), "Assessing the Effects of Removing User Fees in Zambia and Niger", *Journal of Health Services Research & Policy*, 17, 30-6.

Foirry, J-P. (2001), « L'initiative de Bamako : quels bénéfices pour les populations africaines. La santé au risque du marché : incertitudes à l'aube du XXIe siècle », *Nouveaux cahiers de l'IUED,* Presses universitaires de France, Paris/Genève.

Kafando, Y. and V. Ridde (2010), « Les ressources financières des comités de gestion du Burkina Faso peuvent améliorer l'équité d'accès au système de santé », *Cahiers Santé*, 20(3):153-161.

Kafando, Y., B. Mazou, S. Kouandaand and V. Ridde (2011), « Les retards de remboursements liés à la politique de gratuité des soins au Niger ont des effets néfastes sur la capacité financière des formations sanitaires », *Etudes et Travaux du LASDEL* N°99.

Kajula, P.W., F. Kintu, J. Barugahare and S. Neema (2004), "Political analysis of rapid change in Uganda's health financing policy and consequences on service delivery for malaria control", *Int J Health Planning Manage* 19 (S1):133-153.

Mbaye, E.M., A. Dumont, V. Ridde and V. Briand (2011), « En faire plus, pour gagner plus : la pratique de la césarienne dans trois contextes d'exemption des paiements au Sénégal », *Santé Publique*, 23 (3) :207-219.

Mbaye, E., O. Kâ, and C.T. Bâ (2012), « Le Plan sésame: une initiative d'exemption des paiements pour les personnes âgées affectée par sa mise en œuvre », in *Capitalisations de politiques publiques d'exemption du paiement des soins en Afrique*

de l'Ouest, Edited by Ridde, Queuille, Kafando, CRCHUM/HELP/ECHO; 2012:183-210, Ouagadougou.

Meessen, B., D. Hercot, M. Noirhomme, V. Ridde, A. Tibouti, C.K. Tashobya and L. Gilson (2011), "Removing user fees in the health sector: a review of policy processes in six sub-Saharan African countries", *Health Policy and Planning (Supplement 2)*, 26:ii16-ii29.

Nabyonga-Orem, J., H. Karamagi, L. Atuyambe, F. Bagenda, S. Okuonzi and O. Walker (2008), "Maintaining quality of health services after abolition of user fees: A Uganda case study", *BMC Health Services Research 8(1):102*.

Olivier de Sardan, J.P. (2008), *La rigueur du qualitatif. Les contraintes empiriques de l'interprétation socio-anthropologique,* Academia-Bruylant, Louvain-La Neuve.

Ousseini, A. (2011), « Une politique publique de santé au Niger. La mise en place d'exemptions de paiement des soins en faveur des femmes et des enfants », *Etudes et travaux du LASDEL* N°91.

Pariyo, G.W., E. Ekirapa-Kiracho, O. Okui, M.H. Rahman, S. Peterson, D.M. Bishai,. H. Lucas and D.H. Peters (2009), "Changes in utilization of health services among poor and rural residents in Uganda: are reforms benefitting the poor?", *International Journal for Equity in Health 8(39),* doi:10.1186/1475-9276-8-39.

Pluye, P. (2012), « Les méthodes mixtes pour l'évaluation des programmes », in Ridde V., Dagenais C., Eds, *Approches et pratiques en évaluation de programme* (Seconde édition), Presses de l'Université de Montréal, Montréal, 125-143.

Pluye, P., R.Grad, A. Levineand and B. Nicolau (2009), "Understanding divergence of quantitative and qualitative data (or results) in mixed methods studies", *International Journal of Multiple Research Approaches*, 3, 58-72.

Ridde, V. and F. Morestin (2011), "A scoping review of the literature on the abolition of user fees in heathcare services in Africa", *Health Policy Plan* 2011, 26(1):1-11.

Ridde, V., F., Richard, A. Bicaba, L. Queuille and G. Conombo (2011*a*), "The national subsidy for deliveries and emergency obstetric care in Burkina Faso", *Health Policy and Planning,* Supplement 2**,** ii30-ii40.

Ridde, V., A. Diarra and M. Moha (2011*b*), "User fees abolition policy in Niger: comparing the under five years exemption implementation in two districts", *Health policy*, 99, 219-225.

Tizio, S., Y-A. Flori (1997), « L'initiative de Bamako : santé pour tous ou maladie pour chacun ? », *Tiers Monde,* vol. 38, n°152, pp. 837- 858.

Witter S., M. Armar-Klemesu and T. Dieng (2008), "National fee exemption schemes for deliveries: comparing the recent experiences of Ghana and Senegal", *in* Richard, F., S. Witter and V. de Brouwere, ed. *Reducing financial barriers to obstetric care in low-income countries*. Antwerp, ITGPress, 167-198.

Witter, S and S. Adjei (2007*c*), "Start-stop funding, its causes and consequences: a case study of delivery exemptions policy in Ghana", *International Journal of Health Planning Management 22:133-143*.

Witter, S. M. Aikins and A. Kusi (2007*b*), "Working practices and incomes of health workers: evidence from an evaluation of delivery fee exemption scheme in Ghana", *Human Resources for Health*, 5(2):1-10;

Witter, S, D.K. Arhinful, A. Kusi and S. Zakariah-Akoto (2007*a*), "The experience of Ghana in implementing a user fee exemption policy to provide free delivery care", *Reproductive Health Matters, 15(30): 61-70*.

WHO (2011), *Success stories of health financing reforms for universal coverage (Burundi)*, World Health Organization 2011, 8p.

5. A socio-anthropological approach to the action dynamics in the implementation of user fee exemption measures for children under five and pregnant women in three health districts in Niger

Aïssa Diarra, LASDEL

Introduction

Beginning in 2005, health centres in Niger were persuaded to apply several targeted user fee exemptions (Olivier de Sardan and Ridde, 2011; Ousseini, 2011; Olivier de Sardan *et al*., 2010). The scheme initially involved Caesarean sections only, but subsequently included complete coverage for children up to the age of five, prenatal consultations, contraceptives, and cancers in women. This "free healthcare policy" is based on a system of third-party payments: the State makes a flat-rate payment to the health centres as reimbursement for the free healthcare provided to eligible recipients. As one might expect, from the outset, there was a significant increase in people using health services, and diseases were diagnosed earlier. However, malfunctions have also been observed in the scheme's implementation. These difficulties have yet to be resolved and could risk compromising the advances made (Diarra, 2011). These malfunctions have three distinct causes: inadequate financial resources to cover the budgetary requirements indispensable to any system of free

healthcare; a medication policy that is not adapted to current public-health priorities; and inefficient management tools. These phenomena are not peculiar to Niger; numerous other countries that have introduced user fee exemption policies are faced with them (Pearson *et al*., 2011, Witter *et al*., 2007, Macha *et al*., 2012, Olivier de Sardan and Ridde, 2011).

Although these problems exist on a national scale, some qualification is necessary when the situation is viewed in terms of individual districts. Not all districts have the same capacity for dealing with the constraints imposed by the implementation of free healthcare. The presence of non-government organizations (NGOs) is seen as one factor that makes a big difference to a health district (district sanitaire, DS). As early as 2008, the results of a study carried out in Niger on the process of implementing free healthcare measures revealed the positive contribution by the NGO Doctors of the World-France (Médecins du Monde-France, MDM-F) in the Keita health district, where it plays a major role, in comparison to another district where it provides much less support (Ridde and Diarra, 2009).[15] This article builds on this study and focusses on three districts: Keita, the health district supported by MDM-F, and Gaweye and Say, two other health districts that receive no NGO support, and which, therefore, implement the free healthcare policies under the conditions prevailing elsewhere in the country.

However, an action never occurs in isolation but interacts with other actions, and it is the diversity of these interactions that ultimately determines the strategic choices made in a given situation (Crozier and Friedberg, 1977). Consequently, we analyze the dynamics of actions that shape the implementation of exemption measures in the health districts studied and try to identify the factors that facilitate or hinder implementation.

5.1. Methodological framework

The Keita health district is a rural area. Its departmental capital (the town of Keita) is 418 km from Niamey and 56 km from Tahoua Regional Hospital, the regional hospital (RH) that serves it. The district was only recently given its own district hospital (DH) (in 2010). There are 16 integrated health centres (IRS) (four of them Type II and eleven Type I) and 55 health dispensaries. The Keita health district is run on a system of autonomous funds, with each IRS being financially independent of the district. The income generated by each CSI through the recovery of costs under the Bamako

[15] See also Ridde *et al*., 2007.

Initiative remains in the coffers of the management committee (Comité de gestion, COGES) and is used mainly to purchase essential generic drugs and to offset some of the centres' operating costs. The MDM-F NGO began its activities in this district in October 2006 with a twofold mission: to support the district in its implementation of the exemption measures; and to give general support to the district executive team (DET) in improving the quality of the services offered.

The Gaweye health district is located in the capital and as such enjoys a distinct advantage in terms of human resources and health infrastructure. It is home to the only district hospital in the region. There are seven IRSs, two of them Type II and five Type I.

The Say health district is a semi-rural district. Its capital is 54 km from Niamey. It has 22 IRSs, 18 of them Type II and four Type I, and 63 dispensaries.

These two health districts, which are not supported by an NGO, have a single fund system, meaning that the funds generated by health centres through the Bamako Initiative cost recovery program are centralized in the district (and held by the district hospital). This common fund is managed by the district management committee and is used for the same purposes as those mentioned earlier in connection with the "autonomous funds" system. The implementation of free healthcare started in 2007, a few months later than in the Keita health district (*i.e.*, March in Say and July in Gaweye).

We took a socio-anthropological approach to our research using intensive qualitative methods of field data collection. Our surveys, carried out in two phases, lasted on average two months per district. In the Gaweye health district, investigations were conducted in May and again in July 2010. In the Say health district, they took place in January and February 2011. In the Keita health district, the periods involved were May and August 2011. The research was carried out in all three health districts and in thirteen IRSs, selected for their geographical accessibility (urban and outlying) and the type of population they served (poor and fairly well off). Research was also carried out among the local populations in the local neighbourhoods, and took the form of semi-structured interviews, an analysis of field documents and on-site observations. The interviews were one-to-one, followed by interviews with focus groups. Interviewees were selected on the basis of a greater or lesser degree of involvement in the free healthcare scheme. Accordingly, we identified five strategic groups: (1) care givers of all grades; (2) manual workers and paramedics; (3) members of management committees (COGES); (4) fee-paying service users; and (5) fee-exempted users. This

wide range of strategic groups allowed us to collate a diversity of viewpoints. The interviews took place both at the health centres and in the homes of interviewees. Audio recordings were made of the interviews and notes were systematically taken, with French being the language used for both activities. Table 11 below provides a summary of the interviews.

Table 11 *A Summary of the interviews with each strategic group*

	Individual interviews	Group interviews	Total
Care givers	36	8	44
Management committee members	29	9	38
Manual workers and paramedics	8		8
Fee-paying users	10	13	23
Beneficiaries of free healthcare (Caesarean patients and parents of children up to 5 years old)	26	9	35
Grand total	**109**	**39**	**148**

Source: author.

The documents consulted were wide-ranging in nature: record cards for supervision, supplies and identification of hardship cases, order forms for materials, consumables and essential generic drugs, treatment guides, logbooks, receipts, call-out registers, prescription ledgers, free healthcare records and registries for the use of essential generic drugs (Registres d'utilisation des médicaments essentiels génériques, RUMEG). Observations were carried out on health service premises and focused on the practices of carers and their interactions with users. They enabled us to compare words with deeds. The complete set of essentially qualitative data collected via these empirical investigations was processed with the utmost regard for rigour and quality (Olivier de Sardan, 2008).

5.2. Initiating the implementation of exemption measures

Health actors felt that the announcement of free healthcare had come without any warning. However, we noted a systematic difference between the two types of district in the ways in which they responded to the announcement.

Information that came out of the blue in Gaweye and Say

Regional officials chose to communicate this information to health actors at a General Meeting. In the Niamey region, the announcement was made during a General Meeting held at the Palais des Sports in 2007. This meeting, which was scheduled to last four days, brought together all of the health officials from the Niamey region: the Regional Public Health Authority (Direction régionale de la santé publique, DRSP), the district executive teams, and the members of the management committees (COGES) and health committees (Comités de santé, COSA). However, the meeting's main purpose was to report on the results of audits carried out in the various health facilities. The information on free healthcare was presented at the end of the meeting, under "Other business". A member of the management committee described the situation as follows:

> "It [i.e. the assembly] was not [held] to talk to us specifically about free healthcare, there were audits that had taken place in districts 1, 2 and 3. They presented the auditors' reports, and they only talked to us about free healthcare after that" (Management committee member, Gaweye Health District).

The news caused widespread anxiety, as evidenced by actors' reactions. In the words of our interviewee:

> "People asked quite a lot of questions. I myself asked who would pick up the bills for everything the hospitals spent on medicines, or on management tools or other things" (Management committee member, Gaweye Health District).

The replies were quite evasive since the officials themselves were not sufficiently informed to answer the questions raised. A general sense of uncertainty hung over the meeting and of embarking on an unknown adventure. In fact, only the authorities had the information and "it was a matter of everyone just applying it."

In the Say district, it was again during a regional general assembly that the information on free healthcare was communicated to the entire body of health and administrative officials. A peremptory tone was taken to the sceptical and bemused responses. One member of a district executive team described the situation as follows:

> "It was an order, end of story. We all thought that the guidelines would follow. People didn't quite know what to make of it all" (District executive team member, Say health district).

On their return from the general assembly, the team members took the opportunity to inform the district's healthcare workers during supervision sessions.

The local populations in the district received the information mainly via electronic media, by word of mouth or during visits to health facilities. In fact, in contrast to the "assisted" Keita Health District, no particular steps were taken to disseminate the information about free healthcare in the two health districts in question. Communication between health officials at the regional public health authority (Direction régionale de la santé publique, DRSP) and health actors was one of the weak links in the implementation process, a phenomenon that has also been observed in other countries (Walker and Gilson, 2004; Hercot *et al.*, 2011).

A more organized way of disseminating the information in Keita

The health actors in the Keita Health District had the good fortune to be informed about the introduction of free healthcare in a less abrupt manner. MDM-F played a positive interface role in this case. An initial phase of free healthcare had already been implemented by the NGO in the district on an experimental basis. During this start-up phase, the MDM-F spared no effort in disseminating the information among all of the actors (health actors and the population at large) by mobilizing considerable logistical means (vehicles, fuel and communication materials). It also managed to coordinate its efforts well with those of the local officials. It helped the district executive team to organize official meetings and used their supervision activities as opportunities to inform the healthcare workers. The latter confirm that they were fully informed of the methods of implementation. The MDM-F facilitated the role of local government (prefect, local authorities and traditional chiefs) in disseminating information among the local population by making vehicles available to enable officials to visit the villages.

Despite the access difficulties in this rural district, the large-scale communication operation mounted by the MDM-F was successful.

5.3. The supply of essential generic drugs

Throughout the country, two main problems are a serious impediment to the supply of essential generic drugs (EGD) to the health centres. The first of these is delays in reimbursement: from 2006 to late 2010, the reimbursement rate was just 49% (Médecins du Monde, 2011). Reimbursement delays reduced the capacity of management committees to replenish their medication stocks (*cf.* Ousseni and Kafando, 2012). The second problem had its source in the National Office of Pharmaceutical and Chemical Products (Office national de produits pharmaceutiques et chimiques, ONPPC), a public organization responsible for importing EGDs and supplying at low cost to health centres. Long before free healthcare existed, the ONPPC had already experienced financial and organizational problems and, as a result, has been unable to keep pace with the growing, though foreseeable, needs of health centres arising from free healthcare (Aubry, 2008). The ONPPC has not been allocated the necessary financial resources by the State to enable it to cope with free healthcare. Hence, medication shortages have become a frequent occurrence. When they are available, there is evidence of delays in delivery. Health centres have reacted in different ways to these two major difficulties in the procurement of EGDs.

The lowest bidder principle in Gaweye

The Gaweye health district has been a victim of poor financial management (Allasoum *et al.*, 2008). Hence, in the response to the aforementioned procurement difficulties, its procurement strategy has been to adopt the principle of the lowest bidder in both the public and private sectors. This principle flouts official rules, which require health centres to first place their orders with the ONPPC. Only if their order cannot be met by the ONPPC are they then allowed to approach private companies. The healthcare workers are not really insistent on product quality since in their commercial strategy, they are not bothered by the source of drugs, which is practically dominated by the illegal market. The health district often approaches private-sector companies because they offer credit facilities with quite significant discounts and quick and free delivery. One healthcare worker reported to us that "for certain drugs, they can't be beaten compared with the ONPPC" (Gaweye health district).

The Say health district also obtains supplies from private-sector companies. However, it has resisted the temptation of credit, preferring instead to remain within its budget by relying solely on funds on hand, however modest they may be:

> "Here, we make the best of what we've got. We don't want to enter into any credit deals with the local Chinese, who are keen for us to buy on credit" (Member of the Say management committee).

EGD procurement with the support of the MDM-F in Keita

During the six-month period of free healthcare implemented by the MDM-F, the Keita health district enjoyed financial, material and logistical support (Ridde and Diarra, 2009). In addition to this significant amount of support, the district was also able to rely on two kinds of actor. One was the manager of the People's Pharmacy (Pharmacie populaire, PP),[16] who was particularly dynamic. Despite the ONPPC's problems, he always managed to ensure the availability of EGDs at his level. The other was the District Medical Officer (Médecin chef de district) along with the other members of the district executive team, who displayed a strong commitment to improving healthcare provision in the district. These were the circumstances under which the district joined the State system of free healthcare at more or less the same time as the other, unsupported districts. However, it had head start over the other two districts in terms of experience of free healthcare.

However, this efficient procurement system is currently undergoing change at the level of the MDM-F and the People's Pharmacy. MDM-F's policy is now oriented towards community participation.[17] The change is not popular with healthcare workers, who feel that MDM-F has abandoned them. One healthcare worker us in confidence: 'We have the impression that they want to wean us off support" (Keita health district). The situation has changed radically for the People's Pharmacy. The manager in question left Keita in 2009 and has had two successors since then. The first manager, who had previously been in Bouza health district (in the same region as Keita) did not want to be transferred and after a few months managed to return to Bouza, leaving behind the memory of an "uncommitted" manager who showed nothing but "ill will". Healthcare workers view the second manager as a more hopeful prospect since he is the son of the manager who contributed to the initial success of

[16] The People's Pharmacies are branches of the ONPPC in the interior of the country.

[17] It should be stressed that the reason for the NGO's scaling down of its operations was largely due to the problem of personal safety in Niger (*cf.* Le Corre, 2011).

the procurement practices in Keita. They hope he will follow in his father's footsteps. In the meantime, in the wake of these changes to the procurement arrangements, problems of EGD availability and all that they entail are also making themselves felt in Keita. More and more health centres are getting their supplies from private suppliers in other localities, including the illegal market. However, they do not have the credit facilities that Niamey's Chinese suppliers offer health centres close to the capital.

5.4. The service providers' task of adapting

The announcement of free healthcare was not accompanied by material assistance or explanatory guidelines on how health providers should go about providing free treatment for beneficiaries. They had to adapt, using resources on hand, in terms of both administrative procedures and healthcare practice.

Gaweye and Say during the EGD crisis

Healthcare workers in both Gaweye and Say worked with the old cost recovery system for at least three months before the new tools arrived for delivering free healthcare (*cf.* Diarra, 2011). In the Gaweye district hospital, following unaccounted for losses of EGDs, stocks were physically divided into two batches: one for cost recovery (the locally run pharmacy) and the other for free healthcare; each batch was kept in its own storeroom. In Say, there was no such separation.

No one really knew what to do with the receipts made out for free treatment. Healthcare workers carefully filed them away in boxes and, at the end of the month, handed them over to the unit dealing with free care together with summary sheets that served as invoices. Overwhelmed by so many receipts coming from every district, the unit has requested that only the summary sheets be sent to it. A member of the Say district executive team reported:

> "So for three months we operated without proper support, every month we lugged boxes of receipts over to the ministry. Later, we were told that the receipts should stay at the IRSs" (DET member, Say health district).

In addition, there was no single invoice format; each district had its own way of doing things. The Ministry of Health eventually produced templates for both summary sheets and invoices for reimbursement purposes, thereby bringing the districts into line with each other.

To avoid confusion, the next step was to differentiate between the management tools for cost recovery and those for free healthcare by exploiting colour-coding and notifications, as the NGO HELP had done in the Téra and Mayahi health districts in 2006 (Ridde *et al*., 2007).

Managing EGDs was the hardest task to assume. Before the introduction of free healthcare was introduced, healthcare workers put off administrative tasks, allowing them to build up over time. To do so was not a problem at the time because there were fewer patients than at present. However, as patient numbers rose substantially, healthcare workers stuck to their old habits even though the pace of work increased. Consequently, there has been no change in the way EGDs are ordered in response to the increasing needs of patients. As a result, procurement has become haphazard and orders marked as "urgent" have become commonplace when they should remain the exception. "Artificial" stock shortages are also in evidence, especially in the Gaweye health district. They are artificial to the extent that health centres fail to order certain drugs, which then leads to stock shortages despite the fact that the drugs are available at district level. To be sure, the scarcity of EGDs at health centres is partly a consequence of a significant reduction in their financial capacity to replenish their stocks. However, it is also due to mismanagement of their finances and of their drug stocks.

The crisis spreads to Keita but some IRSs keep their heads above water

As was the case elsewhere, in the early stages in Keita, healthcare workers were faced with the task of implementing free healthcare without having the appropriate tools for the job. However, they did not experience any real management problems since they were already operating the system of keeping cost recovery EGDs separate from non-chargeable EGDs. On the whole, EGD orders are better monitored here, owing to a relatively reliable system of record keeping. However, since the scaling down of MDM-F support, the crisis has spread to Keita, and the district now finds itself in virtually the same crisis situation as the other two unsupported districts: stocks frequently need replenishing before the end of the month; they arrive in small quantities; and orders contain more pills than solutions, injectable medicines or syrups as these cost a lot more, even at the district hospital.

However, not all IRSs are in a critical state. Although subject to the same constraints as the others, some actually manage to rise above the others. The actors themselves are very conscious of this and characterize IRSs in two categories: those that are in the

red and those that are not. The question is, therefore, how do some manage to escape relatively unscathed despite an equally difficult environment? According to the responses obtained from the actors themselves, this paradox can be explained by the following factors:

- procurement that meets the unit's immediate needs;
- good management, with regular EGD monitorings;
- reduction in the quantity of drugs prescribed (i.e., a move towards rationalization);
- patients who take large quantities of EGDs are put under observation as a matter of course for economic reasons;
- exchanges of EGDs between IRSs and also with the People's Pharmacy (aspirin for amoxicillin, for example);
- volunteers who can be counted on during peak periods;
- reduction in operating costs;
- reliance on the local population via a regular contribution per family or the collection of bags of onions from local growers that can then be sold to benefit the unit.

These factors amount to attempts at good management coupled with a few survival strategies which certain actors have adopted as an alternative way of coping with the crisis.

5.5. The effects of the user fee exemption policy

Similar effects in all three districts

Of all the recent measures relating to free healthcare in Niger, those aimed at children under five years old stand out because of their considerable positive effects. It has been possible to observe early intervention in relation to the principal causes of infant mortality (Médecins du Monde, 2011) and, in particular, an increase in the number of children under five years old attending health centres. Studies have shown that there

was an immediate increase in the use of health services by this target group following the introduction of free treatment (Barroy and Laouali, 2011; Lagarde *et al*., 2012). This increase was observed in all of the three health districts in our study. Following fee exemption financed initially by MDM-F and then by the State, the number of curative consultations in Keita doubled (Ridde *et al*., 2009). Healthcare workers in Gaweye and Say also had to cope with a huge influx of children in their centres. The IRSs that had previously recorded low rates of attendance very quickly witnessed record figures. This was the experience of Saguia IRS in the Gaweye health district, which was known as the Three-Patient IRS because it never treated more than three patients a day. However, since the introduction of free healthcare, it sees as many as 80 patients on some days, according to one health worker. Similarly, another health worker in the same IRS noted that "All of our indicators have shot up!" The same story is told by the beneficiaries of free healthcare. One satisfied mother from Gaweye said that "We were treated very well; everything possible was done for my child." In fact, the general feeling among users is that free treatment is a welcome relief, especially for poor families. Some would like to see other groups in the population also targeted: "I think it's a good thing. People would like to see it taken further. Applied to the disabled, to schoolchildren and to people in prison" (Chairperson of a management committee in Keita).

However, negative effects have also been noted in all three districts. Although the situation in Keita is not as alarming as in the Gaweye and Say health districts, there has been a gradual loss of the district's initial advantages. The negative effects are felt by health service providers and users alike. Looming large on the provider side is the complaint by care givers that workloads have increased since the implementation of the free healthcare policy. Viewed as excessive, these workloads were measured and confirmed by a study undertaken in the Keita health district. The study also indicated their causes: inadequate human resources; disruptions to the organization of healthcare delivery; and absenteeism among health workers. However, the study also emphasized that complaints by care givers are sometimes exaggerated since the hours they claim to have worked tend to exceed the number they actually worked (Ly *et al*., 2012, in press).

Secondary negative effects involve cost reimbursement delays, which have had further consequences: i) dilution of health centre funds, which have seen their direct revenues fall below 100% (*cf.* Kafando *et al*., 2011) and accumulating debts to their private-sector EGD suppliers; and ii) reduction in EGD procurement, which, in turn, has other negative effects on patient management:

- prescriptions for purchasing drugs outside the health centre are made out to patients entitled to free healthcare;
- certain drugs, such as quinine and some antibiotics, are routinely sold to all patients, regardless of exemption;
- reduction in, or sometimes the termination of the procurement of certain costly products by IRSs, such as paediatric formulations of paracetamol and some antibiotics;
- adult-strength tablets are given to children;
- frequent referrals, because stocks have run out;
- children under five years old are registered as "under observation" because this attracts a higher level of reimbursement.

According to some healthcare workers, these negative effects at the supply end have resulted in a decline in the quality of care. In this regard, they cite two causes: because of frequent shortages of medicines, treatment is interrupted and hence becomes ineffective; and excessive workloads, especially in health centres with few staff members. "'We can't do a proper job, there comes a point when we just try to get rid of patients as quickly as we can," a nurse from Say health district told us.

At the user end, while no one questions the wisdom of free healthcare, the shortcomings in the implementation of the policy have had a negative effect on the use of these free services. Beneficiaries of user fee exemptions complain of being charged for drugs, when treatment is supposed to be free. Some mothers noted that some care givers refuse to issue prescriptions that would enable them to obtain medicine without having to arrange yet another consultation for their children in a different unit. A lack of courtesy was also mentioned, which can discourage patients from using services even when they are free: "Even if you don't pay, if you're not treated politely, then you're not going to go back" (Caesarean patient, Gaweye district). Finally, one informant, also from the beneficiary group, spoke of inequality of treatment between the beneficiaries of free healthcare and other patients, with the former being shown less consideration:

> "When you go and knock on their door at night, they don't even bother to reply, or else they tell you to come back another time – there's no medicine,

> especially if you get it free. But if you're paying for it, then they'll get up, looking disgruntled and resentful to be sure, but at least they'll serve you" (35-year-old housewife and mother of five).

This testimony is evidence of the commercial approach adopted by care givers, as noted above with regard to drug procurement strategies, and which is also adopted in connection with the treatment of patients. Indeed, healthcare workers would like to see a balance between those targeted by free healthcare and those who pay, in order to make up for the "losses" caused by the former. As we were told by one of the nurses:

> "If you have 250 children as patients and 70 adults, it makes a difference. Well, it makes a difference but the consumption of medicines isn't the same. Because an adult may need to take three times as much as a child. Because you might give an adult a dose of twelve units and give a one year old or 18-month old child a dose of three or four units. So there *is* a difference, and that's how you get to balance things out. But supposing you've got 500 children, say, and only 70 adults, then you're in trouble; but if it's 250 children and 70 adults, then that's O.K. You can cope, there's no problem. The trouble starts when there are not enough adults. Lots of children and no adults, that's when you've got problems."

These shortcomings have also had an effect on the cost recovery side of care delivery. Sometimes, the flat-rate payment is just window-dressing. Non-exempted patients explain that, in the past, they only paid the flat-rate fee, which covered all of their treatment, but are now pressed to pay extra for drugs.

Medical evacuations: Keita stands out

The cost of medical evacuations was not taken into account in the free healthcare policy, despite the fact that it is a potential barrier to the use of services that are now free of charge. For 15 years or so, the funds raised from the 'centimes additionnels' system, a supplementary local tax arrangement, enabled some health districts to provide medical evacuations without households feeling the financial effect at the time of the event. The arrangement is a mutual benefit scheme among users, and consists in asking each patient to pay XOF 100 each time they seek medical care so that medical evacuations can be provided free of charge. Up to December 2009, all users contributed to this system and were happy to do so: "It's better to give 100 CFA francs than pay 15,000 CFA francs to come to Say!" (management committee member from Say district).

Thanks to an increase in the number of beneficiaries of free healthcare attending health centres, 'centimes additionnels' revenues rose significantly in the health districts that operated the scheme (*cf.* Kafando *et al.*, 2011). In 2009, the Say health district collected an average of XOF 800,000 per month, which roughly corresponded to the monthly cost of free evacuations. The reserve fund also increased to just under XOF 8,000,000. However, in January 2010, the Ministry of Public Health ruled that the XOF 100 levy should no longer be applied to those targeted by free healthcare. In fact, the Ministry felt that this group's contribution to the system contradicted the principle of free healthcare. The ruling has had serious consequences for the 'centimes additionnels' finances, which soon dried up as the contribution made by the beneficiaries of free healthcare was much bigger than that of the users who paid for treatment. Some health centres, in Say for example, were forced to suspend free evacuations to give themselves time to build up their working capital. In Keita, thanks to MDM-F's financial support and a well-organized system, it was possible to continue with the provision of free evacuations. The district is currently putting its faith in an alternative form of finance by counting on local contributions (from local authorities, management committees, the diaspora and NGOs) to bridge the gap caused by the withdrawal from the scheme of the target groups of free healthcare.

Conclusion

In Niger, as in other poor countries, the health sector, like the development sector, is characterized by a multiplicity of actors and organizations operating in isolation from one another across the entire territory. Health districts that have never received any form of assistance are few and far between. The country abounds with wide-ranging vertical programs implemented by actors for a wide variety of purposes (*cf.* Olivier de Sardan, 1995, Ridde, 2011). Some of these programs are short-term with others providing inputs without trying to influence the way health districts operate. Others have still wider scope and intervene in a number of areas. The reader will need to take these facts into account.

What emerges from our study is that health centres have found it immensely difficult to apply the exemption measures because no provision was ever made for them at either the organizational or financial level. Hence, healthcare workers themselves were left to manage as best they could, and significant variations soon began to appear from one health centre to the next. Indeed, each health district had to make do with what it could muster in terms of the different categories of actor present, their degree of engagement and the possibilities they opened up.

In Keita, the support activities offered by an NGO like MDM-F had a positive and significant impact on the implementation of free healthcare. It took effective action not only in relation to the financial barriers blocking access to healthcare, but also with regard to the quality of the services provided. As the MSF (Médecins sans frontières) pilot project in Kangaba (Mali) has amply demonstrated, such steps are vital to any kind of support in this field (Ponsar *et al*., 2011). Keita's experience in the implementation of free healthcare shows that the successes in a district supported by an NGO are not necessarily attributable to the NGO alone but are the product of positive interactions among the various actors. In other words, the dynamic created among the contributions of the actors coupled with their ability to tackle constraints through the strategies they develop are two factors that promote the implementation of free healthcare. However, a change to the system (mainly on the side of MDM-F and the People's Pharmacy) was enough for the dynamic to collapse like a house of cards. For this reason, and although it was supported by an NGO, the same crisis situation eventually arose in Keita as was the case in the Gaweye and Say health districts (which had had to fend for themselves). This crisis is the direct result of the dilution of their funds brought about by reimbursement delays and their inability to ensure a regular and adequate supply of drugs. An impact on the quality of care then emerges since beneficiaries of free healthcare may well seek treatment outside the public health system when faced with having to pay for prescriptions, with traipsing from unit to unit in search of drugs, and seeing their treatment interrupted. Due to the emergence of a two-tier system of healthcare delivery that discriminates between untargeted patients, who have access to drugs because they pay for them, and beneficiaries of free healthcare, the effects of the crisis also compromise the goal of reducing inequalities in the use of public health services. In Uganda, it is the better off who have cut down significantly on their use of public health services in favour of the private sector (Nabyonga-Orem *et al*., 2011). This desertion of public services has also been noted by Olivier de Sardan and Ridde in three West African countries (Mali, Burkina Faso and Niger itself) where those who can afford it seek treatment in private clinics, while the rest – the poorest – have to make do with public services which are desperately short of drugs (Olivier de Sardan and Ridde, 2011).

In addition, the downturn in Keita's fortunes arising from the substantial reduction in MDM-F support raises the question of the sustainability of NGO activities and of international aid generally. In light of this situation, consideration must be given not only to budgetary matters, but also to human and material resources and to the organizational procedures that keep things on an even keel during the setting-up and familiarization stages of free healthcare systems (Ridde *et al*., 2006). However, in health sector, as is the case in development sector, most of these parameters are more

often than not eclipsed by economic and strategic issues, the spin-off from which is almost negligible by the time it filters down to the beneficiaries among the population at large (Lavigne Delville and Abdelkader, 2010, Olivier de Sardan, 1999). Interventions by NGOs reveal State weaknesses and sometimes make it possible to find solutions (Ridde, 2012: 203-219). However, for the reasons indicated above, it is also important to take account of the adverse effects, of which they are sometimes the unwitting cause.

References

Alassoum, Z., D. Lambert and A. Laminne (de) (2008), *Analyse de la mise en œuvre de la politique de gratuité des soins dans le District Sanitaire III de Niamey au Niger, portant sur la période de juillet 2007 à juin 2008*, Report, ministère de la Santé publique, Direction régionale de la Santé publique de Niamey.

Aubry, L. (2008), *Analyse de la situation et des besoins du système d'approvisionnement et de gestion des produits pharmaceutiques au Niger,* ministère de la Santé publique, Direction générale de la Santé publique.

Barroy, H. and A. Louali (2011), « Gratuité et accès aux soins pour les enfants : une équation à géométrie variable au Niger », in press: N° RESPE-D-10-00063.

Corre le, J. (2011), « Médecins du Monde au Niger: l'hypothèque sécuritaire », *Humanitaire* [On line], 28, available on line as of July 20, 2011, http://humanitaire.revues.org/index1011.html

Crozier, M. and E. Friedberg (1977), *L'acteur et le système,* Seuil, Paris.

Diarra, A., (2011), « La mise en œuvre de la politique d'exemption de paiement dans les districts sanitaires de Gaweye et Say », *Etudes & Travaux du LASDEL*, N° 96, Niamey.

Hercot, D., B. Meessen, V. Ridde and L. Gilson (2011), "Removing user fees for health services in low-income countries: a multi-country review framework for assessing the process of policy change", *Health Policy and Planning*, 26, pp. ii5-15.

Kafando, Y., B. Mazou, S. Kouanda and V. Ridde (2011), « Les retards de remboursements liés à la politique de gratuité des soins au Niger ont des effets néfastes sur la capacité financière des formations sanitaires », *Etudes & Travaux du LASDEL*, N° 99, Niamey.

Kouanda S., LY A., Bonnet E. ET Ridde V (2012), « La charge de travail du personnel de santé face à la gratuité des soins au Burkina Faso », *Afrique contemporaine*, 2012/3 N° 243, 104-105.

Lagarde, M., H. Barroy and N. Palmer (2012), "Assessing the effects of removing user fees in Zambia and Niger", *Journal of Health Research & Policy*, 17 (1), 30-6.

Lavigne Delville, P., A. Abdelkader (2010), « A cheval donné, on ne regarde pas les dents. Les mécanismes et les impacts de l'aide vus par des praticiens nigériens », *Etudes & Travaux du LASDEL*, N° 83, Niamey.

Macha, J., B. Harris, B. Garshong, J. Ataguba, J. Akazili, A. Kuwaenaruwa and J. Borghi (2012), "Factors influencing the burden of healthcare financing and the distribution of healthcare benefits in Ghana, Tanzania and South Africa", *Health Policy and Planning*, 27, pp: 46-54.

Médecins du Monde (2011), « Gratuité des soins au Niger; une option payante à consolider », pdf on line

J. Nabyonga-Orem, F. Mugisha, C. Kirunga, J. Macq and B. Criel (2011), Abolition of user fees: the Uganda paradox, *Health Policy and Planning*, 26, pp. ii41-ii51.

Olivier de Sardan, J.P. (1995), *Anthropologie et développement. Essai en socio-anthropologie du changement social*, APAD – Karthala, Paris.

Olivier de Sardan, J.P. (1999), « L'espace public introuvable. Chefs et projets dans les villages nigériens », *Revue Tiers Monde*, t. XL, 157 : 139-67.

Olivier de Sardan, J.P. (2008), *La rigueur du qualitatif. Les contraintes empiriques de l'interprétation socio-anthropologique*, Academia-Bruylant, Louvain.

Olivier de Sardan, J.P. and V. Ridde (2011), « Une comparaison provisoire des politiques d'exemption de paiement dans trois pays sahéliens (Burkina Faso, Mali, Niger) », *Etudes & Travaux du LASDEL*, N° 89, Niamey.

Olivier de Sardan, J.P., V. Ridde, A. Diarra and A. Ousseini (2010), « Pour une réflexion sur la gratuité des soins au Niger. Programme "Abolition du paiement" », *Note d'information* N° 1, LASDEL, CRCHUM, Niamey.

Ousseini, A. (2011), « Une politique publique de santé au Niger. La mise en place d'exemptions de paiement des soins en faveur des femmes et des enfants », *Etudes & Travaux du LASDEL*, N° 91, Niamey.

Pearson, L., M. Gandhi, K. Admasu and E.B. Keyes (2011), "User fees and maternity services in Ethiopia", *International Journal of Gynecology and Obstetrics*, 115, pp: 310-5.

Ponsar, F., M. Herp (Van), R. Zachariah, S. Gerard, M. Philips and G. Jouquet (2011), "Abolishing user fees for children and pregnant women trebled uptake of malaria related interventions in Kangaba, Mali", *Health Policy & Planning*, 26, pp: ii72-83.

Ridde, V. (2011), « Politiques publiques de santé, logiques d'acteurs et ordre négocié au Burkina Faso », *Cahiers d'Etudes africaines*, LI (1), 201, pp : 115-43.

Ridde, V. (2012), *L'accès aux soins de santé en Afrique de l'Ouest. Au-delà des idéologies et des idées reçues*, Les Presses de l'Université de Montréal, Montréal.

Ridde, V. and A. Diarra (2009), A process evaluation of user fees abolition for pregnant women and children under five years in two districts in Niger (West Africa), *BMC Health Services Research*, 9 (89).

Ridde, V., A. Diarra and M. Moha (2007), *Programme de gratuité de l'accès aux services de santé. Département de Mayahi et de Téra*, HELP evaluation report.

Ridde, V., P. Pluye and L. Queuille (2006), « Evaluer la pérennité des programmes de santé publique : un outil et son application en Haïti », *Rev Epidemiol Santé Publique*, 54 : 421-31.

Walker, L., L. Gilson (2004), "We are bitter but we are satisfied: nurses as street-level bureaucrats in South Africa", *Social Science & Medicine* 59, pp: 1251-61.

Witter, S., D.K. Arhinful, A. Kusi, S. Zakariah-Akoto (2007), "The experience of Ghana in implementing a user fee exemption policy to provide free delivery care", *Reproductive Health Matters,* 15 (30), pp: 61-71.

List of authors

DIARRA Aïssa
Doctor and Phd in social anthropology. Researcher at LASDEL. Since 2001, has been working on health policies and their implementation in Niger through the theme of maternal and infant health

KAFANDO Yamba
Doctoral student at Abomey Calavi University in Benin currently working at the Institute of Health Science Research (IRSS)/CNRST, Burkina Faso

OLIVIER de SARDAN Jean-Pierre
Researcher at LASDEL in Niamey (Niger), Research Director Emeritus at the CNRS and director of studies at EHESS (Paris)

OUSSEINI Abdoulaye
Doctoral student at EHESS Marseille under the tutorship of Professor J.P. Olivier de Sardan. Research assistant at LASDEL, Niamey

RIDDE Valéry
Associate Professor in world health at the University of Montreal and researcher at Montreal University Hospital Research Centre

SAMB Oumar Mallé
Doctoral student in public health at Montreal University Faculty of Medicine. Sociologist by training.

TOURE Laurence
Anthropologist and president of Miseli, a Malian research and training association in the anthropology of local dynamics.

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Tel.: 33 (1) 53 44 31 31 – **www.afd.fr**

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Abolishing user fees for patients in West Africa: lessons for public policy

After 30 years of the spread of direct payment by health service users in Africa, more and more countries are engaging in exemption policies to improve access to health care, with particular attention towards vulnerable groups relative to the Millennium Development Goals (pregnant women, children). While many research studies have focused on the positive effects of this free access to care in terms of visits to health centers, rare are the works which study these public policies as a whole, analyzing notably their implementation, their contradictions, their inconsistencies as well as their perceptions by the actors concerned. Consequently, this file presents some results from a research program (2009 – 2012) which aims to document the emergence, the formulation, the implementation and the effects of these new policies of exemption from payment in Burkina Faso, Mali and Niger. This is an original contribution in francophone countries, associating quantitative techniques and a qualitative socio-anthropological approach in a West African context where these policies have only barely been analyzed from this interdisciplinary angle.

AUTHORS

Valéry RIDDE
CRCHUM and University of Montréal
valery.ridde@umontreal.ca

Jean-Pierre OLIVIER de SARDAN
LASDEL
olivierdesardan@lasdel.net

CONTACTS

Pascal BROUILLET
Agence Française de Développement
brouilletp@afd.fr

Corinne de PERETTI
Agence Française de Développement
deperettic@afd.fr

A SAVOIR

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