REPUBLIC OF NIGER

Fraternitè-Travail-progrès

FINAL REPORT

Rapid Evaluation

OF THE IMPLEMENTATION OF FREE HEALTH CARE FOR WOMEN OF CHILDBEARING AGE AND CHILDREN AGED 0 TO 5 IN THE DOSSO REGION

September 2022

HCME Haut Commissariat à la Modernisation de l'Etat

With the financial support of

unicef & TWENDE MBELE

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ACRONYMS

AFD	French Development Agency
ANC	Antenatal consultations
CDP	Community Development Plan
COGES	Management Committee
DEP	Department of Studies and Programming
DGT/CP	General Department of the Treasury and Public Accounting
DH	District Health Hospital
DRSP	Regional Department of Public Health
DOW	Doctors of the World
ECOWAS	Economic Community of West African States
EDSM	Demographic Health and Household Survey
ENABEL	Government Cooperation Programme Belgium-Niger
GDP	Gross Domestic Product
HCME	High Commission for the Modernization of the State
HD	Health District
HDI	Human Development Index
HDP	Health Development Plan
HELP	German non-governmental humanitarian organization
IHC	Integrated Health Centre
IHS	Integrated Health Centre
MCHC	Mother and Child Health Center
MSF	Doctors without borders
MSP	Ministry of Public Health
MDGs	Millennium Development Goals
NGO	Non-governmental Organisation
NIS	National Institute of Statistics
PAGIPG	Integrated package of the Free Access for pregnant women and health care for children from 0 to 5 years of age
PNC	Postnatal Care
PTF	Technical and Financial Partners
RDP	Regional Development Plan
SD	Statistics Department
SDDDCI	Strategy for Inclusive Growth and Sustainable Development
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

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INTRODUCTION

Located in the heart of West Africa and the Sahel, between 11°30' and 23°North latitude and 00°and 16°East longitude, Niger is a vast landlocked country[1] with an area of 1.267.000 km2 and 3/4 of which are in desert area. It is bounded to the north by Algeria and Libya, to the south by Benin and Nigeria, to the west by Burkina Faso and Mali and to the east by Chad. The country comprises 8 administrative regions, 36 departments and 255 municipalities.

Niger's annual population growth rate is one of the highest in the world. It rose from 3.3% (in 2001) to 3.8%[(2)] in 2021. The population is estimated at 25 million in 2021, up from 3,2 million in 1960. Mostly young (more than 60%) and rural (84%), this population is concentrated mainly in the southern strip of the country (1/4 of the national territory) where the ¾ of the population live. The rate of population growth exceeds that of the growth of agricultural production in the country. This report results in recurrent food and nutrition crises that keep the country chronically food unsecured in some parts of the country.

According to the national poverty profile, 86% of the poor live in rural areas, of which 66% are below the poverty line. Women and youth are the most affected by rural poverty.

The health situation in Niger remains mixed despite a significant improvement in some maternal and child health indicators. Health service utilization is relatively low due to the persistence of difficulties related to financial and geographic accessibility. Limited accessibility to health facilities, the high disparity between urban and rural areas, difficulties in the supply of medicines, the shortage of qualified material and human resources, the high prevalence of nutritional and infectious diseases, etc., are the main characteristics of the health situation in Niger.

In response to this situation, the Government of Niger, together with its development partners, has undertaken numerous reforms to improve the health of the population, including the policy of free access for certain categories of the population, particularly women and children under five (5) years of age, from 2006. This free access policy is based on a strategy of pre-financing the costs of care provided to the target groups by health facilities, followed by reimbursement of these health facilities. The objective is to contribute to the achievement of the Millennium Development Goals (MDGs 4 and 5), related to the reduction of maternal and infant mortality.

The policy of free health services for women consists of the provision of health services without payment for the following services: family planning, prenatal consultation, caesarean section/ectopic pregnancy/uterine rupture, and management of gynecological cancer. For children under five (5) years of age, free health care covers all preventive and curative care. However, the implementation of this policy has proved laborious and difficult.

[1] the nearest port to the capital is located more than 1.000 km from the sea.

2 this rate was 3,9% (RGPH, 2012).

In July 2022, the High Commission for the Modernization of the State (HCME), in collaboration with the Ministry of Public Health, Population and Social Action (MSP/P/as), decided to conduct a rapid evaluation of this measure in the Dosso region.

The objective of this rapid evaluation of the free access policy is to assess the uptake by the beneficiaries and actors of the implementation of the free access policy. This exercise seeks to determine to what extent the free health care policy has achieved its primary objectives of: (1) improving access to care; (2) reducing child mortality; (3) strengthening partnerships to deliver quality health services; (4) improving the efficiency and effectiveness of free access approaches; (5) identifying operational policy obstacles and new/revised policies adopted and implemented; (6) supporting local actors, civil society, service providers, local authorities in promoting the policy of free health care; (7) documenting and disseminating lessons learned from adaptation and implementation processes and experiences; and (8) identifying and coordinating the needs of partners and national drug management committees. This rapid evaluation, led by the Government of Niger, complements rapid evaluation efforts already implemented by other partners.

The rapid evaluation report of the implementation of the free health care policy for women of childbearing age and children aged (0) to (5) years is structured in four (4) chapters. The first chapter deals with the description of the policy and its rationale. The second presents the objectives of the rapid evaluation and the methodological approach adopted. Chapter 3 presents the results and Chapter 4 is devoted to recommendations.

1. DESCRIPTION OF THE POLICY

1.1. Context

The free maternal and child health care policy involves providing healthcare services to the target population, i.e., children aged 0 to 5 years, pregnant women, women wishing to have space between births (pregnancies), women undergoing caesarean sections and women suffering from gynecological cancers without their financial participation.

The free health care measure has been introduced since 2006 by the Government of Niger for the benefit of certain categories of the population with the aim of facilitating their access to health care.

There were several elements that informed this policy decision:

- **The 2005 food crisis**: Niger is a country that is experiencing recurrent food deficits. In particular, the food crisis of 2005, which aggravated chronic child malnutrition, the persistence of which led NGOs, rather specialized in emergencies, to implement free health care for children aged 0 to 5 in certain areas of the country, With the support of the State, before the latter officially implements this free service on a national scale. There are two international NGOs who implemented this with State support: Médecins du Monde (MDM) and HELP (Ridde, 2007).

- **Cost recovery shortcomings**: Niger had introduced the health care cost recovery system since 1999. The implementation of this health policy has led to the introduction of partial payment of the costs of care by the user in the country and has allowed a regular supply of generic medicines to health facilities at more affordable costs than specialties. However, the 2006 Demographic Health and Household Survey (EDSM) showed that 29,4% of the population do not have access to health services because of costs. “The cost recovery system is a barrier to the use of health services and especially for the most vulnerable groups, namely women and children who have no income or whose decision to use a health service depends on the head of family or a third person” (DEP/MSP). The emergence of free health care in Niger was also encouraged by a context of poverty estimated at 63% of the population.

- **Health indicators and the achievement of the Millennium Development Goals**: Socio-health indicators remain weak in terms of performance and have not seen a significant improvement despite the various reforms undertaken by the State (the generalization of cost recovery, hospital reforms, restructuring of the pharmaceutical sector for better access to generic medicines, etc.), since independence. In 2005, the infant and child mortality rate was 274 per 1000 (27,4%) and the maternal mortality rate was 700 per 100 000 births (0,7%). This is why the Ministry of Public Health has defined a comprehensive policy called the Health Development Plan (PDS) 2005-2010, which derives its source from the Poverty Reduction Strategy Paper (PRSP 2002-2015), in order to improve health indicators.

The first text adopted on free access was the Decree No. 2005-316/PRN/MSP of 11 November 2005 granting free access to caesarean sections provided by public health institutions. For many officials of the Ministry of Public Health, this was a decision taken to meet the commitments of the Niger authorities to reduce maternal and infant mortality as part of the achievement of the MDGs. Niger was also asked to give a positive signal with a view to preparing the next negotiations with the World Bank (WB).

For the World Bank, the provision of free caesarean services and contraceptives was insufficient to enable Niger to access financial assistance from them. Payment for other health services for the population had yet to be abolished. This is how Order No. 079/MSP/LCE/MFE of 26 April 2006 instituting free prenatal consultation and care for children aged 0 to 5 years was issued.

1.2. DESCRIPTION OF THE POLICY

The objective of the policy is to improve access to health care for the most vulnerable groups (women of childbearing age, pregnant women and children of zero (0) to five ((5)) years)

1.3. Legal frameworks mandating free health care

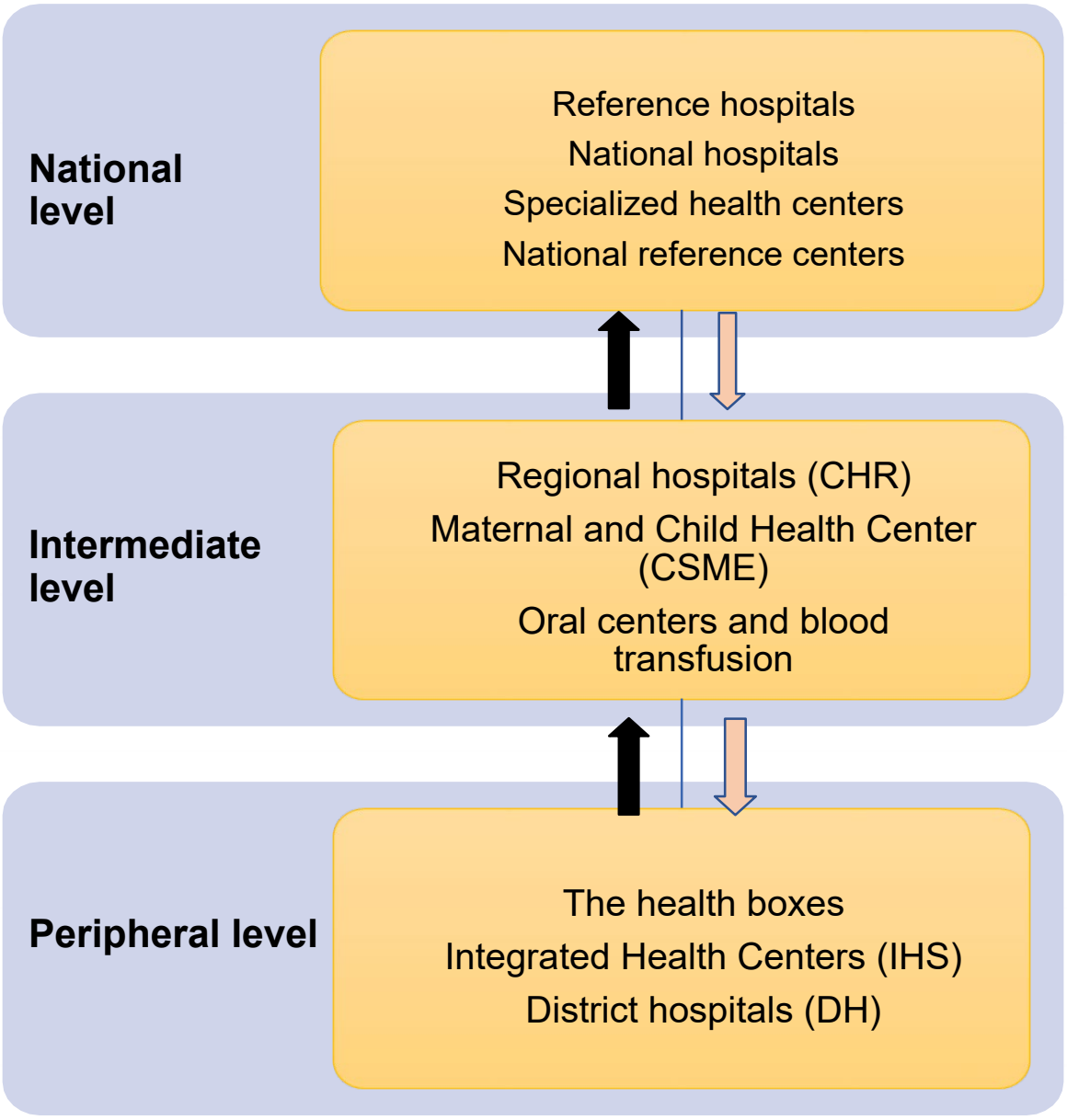
The legal framework for the free access measure is based on the following regulatory texts:

- The first text adopted on free access was Decree No. 2005-316/PR/MSP of 11 November 2005 granting free access to caesarean sections provided by public health institutions
- Decree No. 2007-261/PRN/MSP of 19 July 2007 instituting free services for female cancers provided by public health institutions
- Order No. 0015/MSP/LCE/DGSP of 27 January 2006 on the modalities of application of the Decree of caesarean section
- Order No. 65/MSP/DGSP/DPHL/MT of 7 April 2006 granting free contraceptive and condom products
- This is how Order No. 079/MSP/LCE/MFE of 26 April 2006 instituting free prenatal consultation and care for children aged 0 to 5 years was issued.
- Order N°0219/MSP/DGSP/DOS of 27/08/2007, establishing, organizing and Responsibilities of the unit for coordination and monitoring of free health care services.
- Order N°132/MSP/DGSP/DOS/CGS of 07 May 2010 establishing a steering and monitoring committee for the implementation of free health care.
- Order N°121/MSP/SG/DGSP/DOS of 29 March 2012, creating the Committee in charge of the implementation of the recommendations of the conference on free health care
- Order N°132/MSP/SG/DEP/DF of Friday, December 19, 2014, establishing a steering and monitoring committee for the implementation of free health care.

It is worth mentioning the holding of a National Conference from 13 to 15 March 2012 to strengthen free health care in Niger. This conference resulted in strong recommendations. Order No. 121/MSP/SG/DGSP/MSP of 29 March 2012, establishing the Committee responsible for monitoring the implementation of the recommendations of the conference on free health care.

1.4. Organization of the care delivery system

The health system in Niger is organized as follows:



If a level is limited to support health care, it is referenced to the next level.

1.5. Information of the actors on the policy

An adequate communication framework has been put in place. The main channels of communication used are workshops, television radio awareness campaigns. Thus, the information of the actors was carried out through:

- **The workshop "on strategies for access to health care in Niger"**, held from 21 to 23 June 2006 in Zinder, which recommended, among other things, the full implementation of the various measures taken regarding free health care. These meetings, which brought together several socio-professional layers, allowed participants to express their concerns regarding the functioning of a health system in which free access to care is introduced for certain services;

- **A note on the management arrangements (management tools) for free access** has been drawn up and sent to the various stakeholders concerned;
- **A communication plan** has been drawn up by the MSP to inform and sensitize the population and all the actors involved in the effective implementation of free health care;

- **The official launch of free access** was held in Zinder on August 1, 2007 in the presence of the Minister of Public Health. Then followed the awareness campaign throughout the country;

- **Word of mouth system.**

1.6. Implementation of the free health care package

The implementation took place as follows:

1.7. The financing of the measure of the free access' package

The free health care policy is financed by the following parties:

- **The State:** Following the 2006 budget discussions, the MSP obtained in its favor the creation of a budget line "free access". In 2007 the Finance Act provided a budget of 3 billion West African CFA franc in favor of free health care through the budget line "free access";
- **Technical and financial partners**: These are mainly AFD, UNFPA, UNICEF and the Global Fund;
- **NGOs** : HELP, Médecins du Monde (MDM) and Médecins Sans Frontières (MSF). Their support is sometimes in kind.

1.8. The free access package

The package covers curative and preventive care for pregnant women, children from zero (0) to five (05), family planning, female cancers and caesarean section. The State, as guarantor of the health of the population, has replaced itself as a third party paying for these services provided free of charge. The care package is provided according to the level of care.

1.9. The financing of the measure of the free access package

Before any care is taken, it is first checked whether the patient does not have access to healthcare of a company, an organization or health insurance. If he/she has one, the expenses to be reimbursed relate only to the part of the cost of care borne by the patient (example 10%, 20%). A procedure manual is being developed to describe the free access treatment process. It presents the monitoring tools of the free access package, the mechanism for monitoring and processing cases, internal control, external audit, as well as the rapid monitoring and evaluation mechanism.

1.10. The theory of change of the policy free healthcare access

The theory of change in the measure of free access describes how it is supposed to work to produce the desired results under given assumptions. As it was not developed when the measure was defined, it was reconstructed during this rapid evaluation.

Indeed, based on the worrying levels of maternal and infant mortality rates in 2005 in relation to the MDG targets at the time and given the alarming level of poverty indicators, The Government of the Republic of Niger has undertaken the implementation of the free access policy. To this end, it has mobilized adequate human, financial, organizational and informational resources to conceptualize and implement this major reform. It has been implemented through a package of actions, in particular the development of the free access procedure, the establishment of a free access unit, the training of the actors implementating the policy, the mobilization of the State and partners and the organization of information campaigns for the benefit of the populations.

This should give rise to a framework of governance of a functional free access, to the State and partners mobilized to accompany the reform so that the populations are informed and sensitized on free access to care.

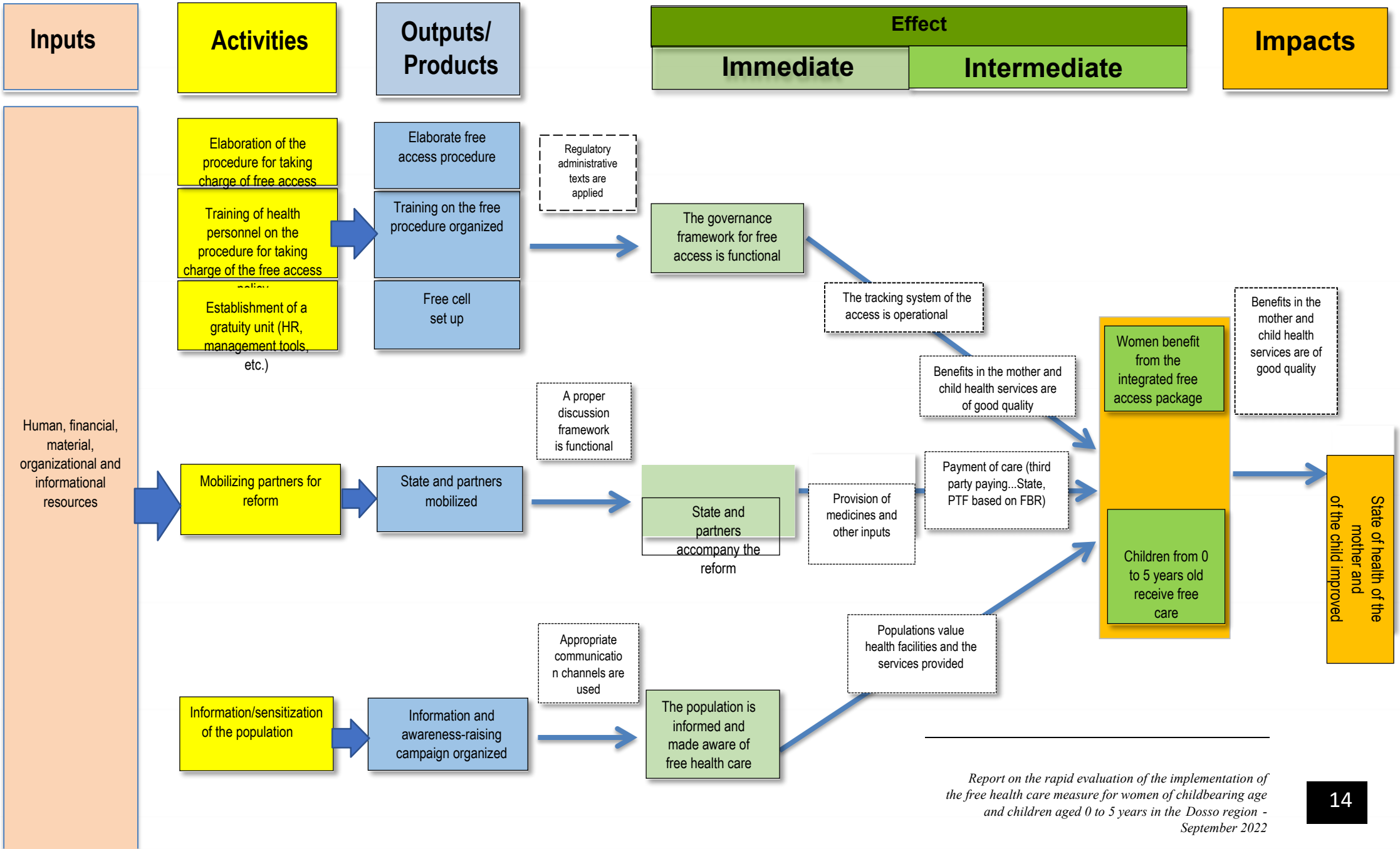
Thus, women of childbearing age and children from zero (0) to five (5) years of age will benefit from the measure and will ultimately see their health status improved. It should be noted, however, that the materialization of the virtues of the free access depends on a set of critical conditions or hypotheses that condition the realization of the successive changes envisaged by the reform. These include:

- The regularity of the reimbursement of benefits by the State and other paying third parties;
- availability of medicines and other inputs;
- the quality of care and care services in mother and child health services;
- the valorization of health services by the populations.

The logic model that materializes the theory of change is presented in the diagram below.

Theory of change of the integrated package of free health care for pregnant women and children aged 0-5 years

Reason for Action: Worrying levels of maternal and infant/child mortality rates in 2005 in relation to the MDG targets



2. EVALUATION OF THE MEASURE

2.1. Objectives of the Evaluation

The objective of this rapid evaluation is to contribute to the improvement of governance in the public health sector by providing evidence to assess the implementation of the free health policy in the Dosso region.

Specifically, the objectives are to:

- Undertake a rapid evaluation of the implementation of free health care at the level of the various public health institutions in the Dosso region;
- analyze the level of effectiveness of free healthcare access at the level of the target groups;
- analyze the actual costs of the free access
- identify the contribution of the State, and technical and financial partners;
- analyze the mechanisms for preparing and managing the free access policy;
- Study the adequacy of this measure with the health care against the needs of populations in the Dosso region;
- examine the results of the free healthcare policy;
- assess the resources deployed for reform in relation to the results obtained;
- identify the inadequacies and difficulties inherent in the implementation of the free access policy;
- Effects induced by the implementation of the measure
- propose mechanisms for the sustainability of policy achievements;
- make operational recommendations for improving the implementation of this policy.

The rapid evaluation of the free access measure covers its implementation from 2006 to 2021.

2.2. Methodological approach

The methodological approach adopted within the framework of this mission is structured in six (6) steps: (i) technical and operational planning of rapid evaluation, (ii) design of data collection tools, (iii) data collection and processing, (iv) rapid evaluation specifications, (v) rapid evaluation strategy, (vi) report development and validation.

2.2.1. Technical and operational planning of the evaluation

The first phase of the mission provided the framework for the rapid evaluation. It is a technical document that guides the rapid evaluation team and all stakeholders in the methodological choices taking into account perspectives and context of the rapid

evaluation of the policy. It includes the development of the theory of change, evaluative questions, indicators and the evaluation strategy.

The design of the evaluation reference framework mobilized documentary resources related to the free access policy and the organization of a technical workshop on methodological design. The workshop held on July 1 and 2, 2022 in Dosso, allowed the technical committee, under the direction of the facilitator consultants, to refine the theory of change in the measure of free access, to refine the Evaluation questions, develop the rapid evaluation matrix and design data collection tools.

2.2.2. Design of data collection tools

For the purposes of the rapid evaluation and in accordance with the rapid evaluation matrix, two types of tools are used, namely the interview guide and the household questionnaire. The interview guide is intended for health workers in IHSs, district hospitals and regional hospitals as well as health center managers (managers, tax collectors, etc.). The other is designed for Community actors (COGES, NGOs, traditional authorities) and TFPs. The household questionnaire is intended for women of childbearing age who will be interviewed in the households to be visited.
All the tools designed have been digitized on *KoboToolbox*.

2.2.3. Data collection and processing

- *Sampling procedure*

It should be noted that four (4) free healthcare services were taken into The free health care services include:

- Family planning (FP);
- Cesarean section;
- Antenatal care (CNPR1)
- Care for children under 5 years of age (CNPR4).

The optimal size of our sample is the one that allows us to reproduce at the sample level, the statistics obtained at the population level. The different components of the free access package give rise to different sample sizes, the statistical law instructs to take the sample with the highest number of samples calculated according to the prevalence of the different interests of the free access package.
Applying this formula and in accordance with the law of sample statistics allows us to retain the sample size **594**, as shown in the following table:

Table 1: Estimation of sample size

The free access package	Prevalence (%)	Sample size
FP	56.6	594
Cesarean section	1.6	39
CNPR1	78	415
CNPR4	35	551

Source: *Data from the study, from statistical yearbooks*

IHS were considered sampling areas in each Health District (HD). Indeed, we have listed the number of Integrated Health Centres (IHS) by HD. This made it possible to distribute the sample according to the weight of the districts in IHS, these being the point of supply of the free package.
The number of IHS to be sampled per Health District is determined by the weight of the District in IHS. All health districts have been systematically included. The sampled ISCs are randomly selected within the districts. The number of sample observation units to be considered per IHS is determined by the method developed by the Afrobarometer network. This method consists in taking an average of eight (8) surveyed by IHS. This led us to distribute the sample as follows:

- The household draw was done inside the city/village district housing the IHS.
- The method of drawing households within villages/city districts is the systematic method of purposive sampling.
- A sampling step is defined in each village/town area by relating the size of the village in eligible population to the sample size of the village or township, which in this case is equal to eight (8). Survey step information is provided to investigators.

More specifically, the sample consists of the following IHS:

Table 2: Distribution of the sample

TEAM 1	TEAM 2	TEAM 3	NB: All HD and CSME will be systematically interviewed						
			Interviews					Focus	
			Head IHS	Manager	COGES	PTF	NGOS	Community	Total
IHS Banikane	IHS Birni 2	IHS Afole	1	1	1	1	1	1	6
IHS Bella II.	IHS Fabidji	IHS Doumega	1	1	1	1	1	1	6
IHS Hanam Tombo	IHS Haoulawal	IHS Fadama	1	1	1	1	1	1	6
	IHS Kanaré		1	1	1	1	1	1	6
IHS Kigoudou Koira	IHS Kankandi	IHS Kanda							
IHS Moribane	IHS Tinoma	IHS Kore Mairoua							
IHS Nakin Fada	IHS Goubezeyno	IHS Lido							
IHS Kigoudou Koira	IHS Falmey	IHS Nassaraoua							
IHS Bagna Gondi	IHS Bellande	IHS Bakin Tapki	1	1	1	1	1	1	6
IHS Goumande Seyni	IHS Irrah	IHS Dankatsari	1	1	1	1	1	1	6
IHS Tondobon	IHS Kotaki	IHS Goubey	1	1	1	1	1	1	6
IHS Babadey	IHS KOUBI SORI	IHS Kieche							
IHS Mayakidey	IHS Saboula	IHS Makourdi							
IHS Tessa	IHS Tchankargui	IHS Matankari							
IHS Toulmey	IHS Tiguey	IHS Birni 2							
IHS Gawassa	IHS Deytagui Attili	IHS Bouki	1	1	1	1	1	1	6
IHS Kassadebi	IHS Djambabadey	IHS Dar Salam	1	1	1	1	1	1	6
IHS Koutoumbou	IHS Mokko	IHS Kouro Beri							
IHS Tchangalla		IHS Madou							
IHS Yeldou	IHS Kouro Beri	IHS Kigoudou Koira	1	1	1	1	1	1	6
IHS Youmbou	IHS Yeni	IHS Doutchi North							

TEAM 1 TEAM 2 TEAM 3			NB: All HD and CSME will be systematically interviewed						
			Interviews					Focus	
			Head IHS	Manager	COGES	PTF	NGOS	Community	Total
IHS Angoual Doka	IHS Zouzou Saney	IHS Sarkin Yara Koira							
IHS Dioundou	IHS Lacouroussou	IHS Tegueze koara	1	1	1	1	1	1	6
IHS Adiga Lele									
IHS Albarkaize			1	1	1	1	1	1	6
IHS Gaya 1			1	1	1	1	1	1	6
IHS Gaya 2			1	1	1	1	1	1	6
IHS Gaya 3									
IHS Kouara N'Débé			1	1	1	1	1	1	6
IHS Niakoye Tounga									
IHS Bengou									
Total									**90**

Source: *Data from the study, 2022*

NB:

- Household surveys were carried out in all villages hosting the IHSs present in this sample.
- The Health Agents, Focus Group villagers and COGES questionnaires were administered in the IHSs in the sample.

- *Data collection and analysis*

Once the data were collected and compiled, they were processed and analyzed to produce results that would enable the evaluation questions to be answered. The data processing tools used for this purpose are Stata and Excel software.

2.2.4. Rapid evaluation criteria

The rapid evaluation criteria constitute an analytical framework developed to appraise the implementation and outcomes of the free maternal and child healthcare policy. Below are the criteria of this rapid evaluation

- *Policy relevance and consistency*

The rapid evaluation of relevance makes it possible to assess the policy in its intentions, objectives, and the extent to which it is responsive to target beneficiaries' needs. In terms of consistency, the rapid evaluation also examines the theory of change and how it relates to how the policy has been implemented in reality and the results achieved.

- *Policy efficiency and consistency*

The evaluation of the efficiency criterion of the policy has made it possible to measure the results obtained from its implementation relative to resources expended, and to identify the effects recorded from the point of view of improving the health status of women and children aged 0 to 5.

Since the reform is applied to all of these targets in a systematic way, the rapid evaluation model that has been adopted is the implicit model, as there is no different reference group (control group) than the beneficiaries.

- *Sustainability measurement model*

In order to reflect the sustainability of the achievements made in the context of the implementation of the policy and its provisions, a sustainability analysis was carried out. This analysis consisted in identifying the positive effects of the measure and in assessing the factors of the health system affected by the measure of the free access in terms of sustainability.

2.2.5. Rapid Evaluation strategy

The rapid evaluation estimate, the data collection and analysis methods related to the rapid evaluation questions reflect the rapid evaluation strategy including the summary is presented through the rapid evaluation matrix (**see annex 1**). It provides a synoptic view of the technical and operational planning of rapid Evaluation.

2.2.6. Development of the rapid evaluation report

The preparation of the draft report took place on 20 and 21 August 2022 during a dedicated workshop. The workshop involved the processing and analysis of primary data from household surveys and interviews as well as secondary data from the exploitation of statistical yearbooks. This led to the proposal of answers to the evaluative questions and the preparation of the rapid evaluation report. The report was compiled and finalized by the team of facilitators consultants.

2.2.7. Shortcomings of the study

The methodological choices used in this rapid evaluation mission have some limitations that need to be noted. The analysis of induced effects as presented could lead to the assumption of a causality analysis. However, this is basically a contribution analysis, since the policy of free access cannot be entirely attributed to the changes observed in health indicators.

The nature of the secondary data resulting from the exploitation of statistical yearbooks, in particular their method of calculation and the number of missing data, do not make it possible to make an adequate trend analysis over the period of implementation of the reform. This has somewhat watered down the informational potential of secondary data.

3. RESULTS OF THE EVALUATION

3.1. Relevance and consistency of the policy

i. Analysis of relevance

The relevance of the measure of free health care for women and children from 0 to 5 years of age is assessed in relation to the adequacy of the measure to the needs of the target populations (women and children aged 0-5).

A preliminary question for this investigation is whether the reform is known to the population.

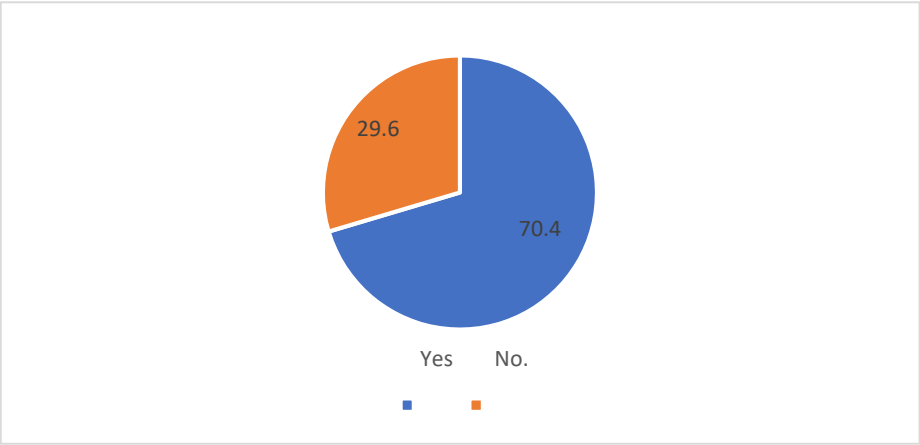
- ***The knowledge of the population of the existence of the policy***

The results of the analysis of the collected data show that almost the entire population surveyed is aware of the measure of free health care. For the COGES and community stakeholders, all the localities concerned stated that they were aware of the policy on free health care. As for the households met, 97,6% said they were aware of the package of free care in health facilities.

- ***The adequacy of the measure of free access with the health needs of the population***

In terms of the adequacy of the package of free care with the real needs of the population, the data reveal that 70,4% of the population surveyed say that the packages of free care meet their real needs against 29,6% who claim the opposite.

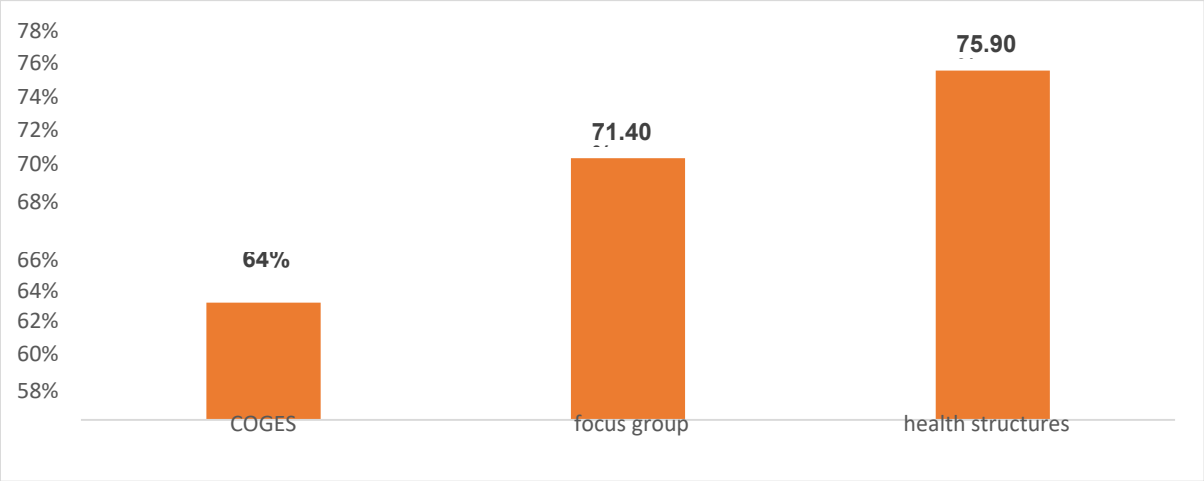
Figure 1: Distribution of the population surveyed according to their point of view on the adequacy of the free access package with their needs.



Source: *Data from the study, 2022*

If we are interested in stakeholder groups, opinions are divided as can be seen in the figure below:

Figure 2: *Distribution of the population surveyed by group of actors according to their point of view on the adequacy of the free access package with the needs of the populations*



Source: *Data from the study, 2022*

At COGES level, 64% of these actors recognize the adequacy of free access packages with the real needs of the population. It is important to note that the Tibiri and Dioundiou COGES have affirmed that there is a total mismatch between the offer of free access and the real needs of the population.

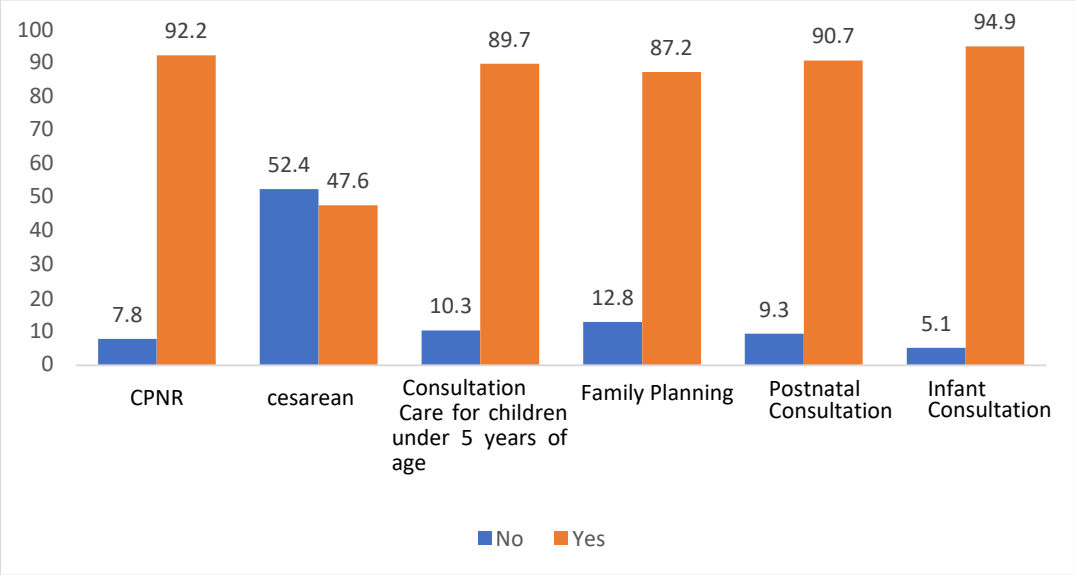
At the community level, 71,4% responded that free health care packages are adapted to the population's demand for health care. Furthermore, 75,9% of health workers said that free health care packages perfectly meet the needs of the population.

Health workers in the districts of Boboye, Dioundiou and Loga are unanimous that the adequacy of free care packages corresponds with the demand of the population of these localities. If we look at the nature of the free access or service, from the household perspective, the following emerges:

- For the CPNR, 92,2% said that the offer is adapted to their needs.
- As for the free caesarean section, 52,4% of households said that this package does not meet their expectations. In Loga, Dosso and Boboye, the proportions of households that reported that their expectations for free caesarean section were not met are 90,3%, 86,1% and 87,5% respectively.

- Regarding curative consultation for children under 5 years of age, 89,7% of households said expectations are met.
- Regarding free family planning, 87,2% of households reported that their needs are met by the provision of services.
- Finally, the postnatal consultation and the consultation of infants, households gave their satisfaction levels which are respectively 90,7% and 94,9%.

Figure 3: *The degree of adaptability of free health care packages in relation to the expectations of the households surveyed*



Source: *Data from the study, 2022*

ii. Analysis of the consistency of the measure

The analysis of the consistency (coherence) of the measurement of free health care for women of childbearing age and children aged 0 to 5 is based on the evaluation questions contained in the rapid evaluation matrix on the one hand and on the linkage with sectoral health strategies (Health Development Plan, Health Policy) and the Economic and Social Development Plan, on the other hand.

The process of assessing the consistency of free access is of two types of analysis: the analysis of external consistency and the analysis of internal consistency, which highlighted respectively the extent to which free care meets national health priorities and the way in which its technical implementation elements are articulated to achieve the objectives fixed.

- ***External consistency***

At the international level, the policy of free access is in line with international commitments including SDG 3 of the United Nations Agenda 2030, Objective 3 of the African Union Agenda 2063 and Pillar 1 of ECOWAS Vision 2020, etc.

At the national level, all multisectoral strategic documents have always put the free access policy at the center of their priorities. There is a perfect alignment between the reform and the Poverty Reduction Strategy (PRS-PRSP) and the Sustainable Development and Inclusive growth Strategy (SDDCI) Niger 2035, This is implemented through five-year Economic and Social Development Plans (ESDP), the first of which is the ESDP 2017-2021. As such, strategic axis 2 of the PDES 2017-2021 is devoted to the development of human capital and demographic transition. Similarly, the measure of free health care is contained in the various PDS (2011-2015, 2017-2022)) and is taken into account in regional development plans (RDPs) and communal development plans (CDP).

- ***Internal consistency***

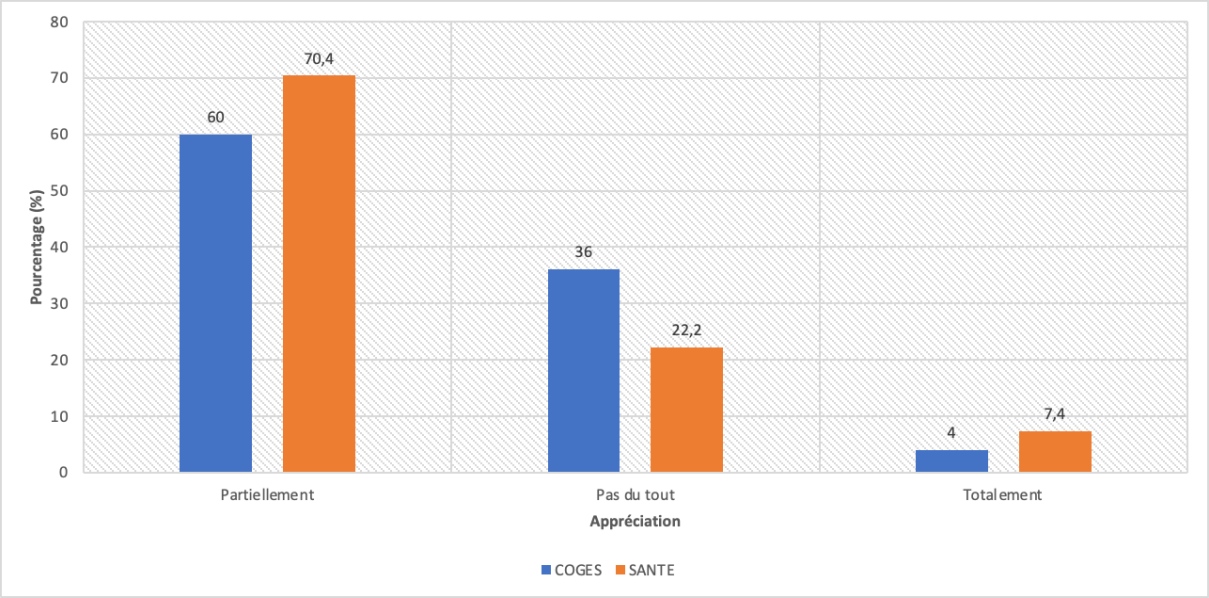
As part of the preparation for the implementation of free health care, a policy management manual was drawn up in 2007. Several texts, including orders and decrees, have been adopted to strengthen the legal framework. These texts include: (i) Decree No. 2005-316/PR/MSP of 11 November 2005 granting free caesarean section services provided by public health institutions, (ii) Decree No. 2007-261/PRN/MSP of 19 July 2007 instituting free services related to female cancers provided by public health institutions, (iii) Order No. 0015/MSP/LCE/DGSP of January 27, 2006 on the implementation of the Caesarean section decree. Similarly, the funding channels for the policy have been identified, including a “free access” budget line and contributions from technical and financial partners (AFD, UNFPA, UNICEF, the Global Fund and NGOs). In addition, a mechanism for coordination and rapid monitoring and evaluation has been set up for this purpose.

Match between the resources allocated to the free access policy and the benefits offered

More than half of the actors (COGES and health workers) interviewed stated that the match between the resources allocated to free care and the services offered is

partial. These proportions vary according to the actors. 60% for COGES and 70,4% for health workers. On the other hand, a small percentage of these actors stated that the resources allocated were perfectly matched with the provision of services. These proportions are 4% for COGES and 7,4% for health workers.

Figure 4: Adequacy between allocated resources and delivery

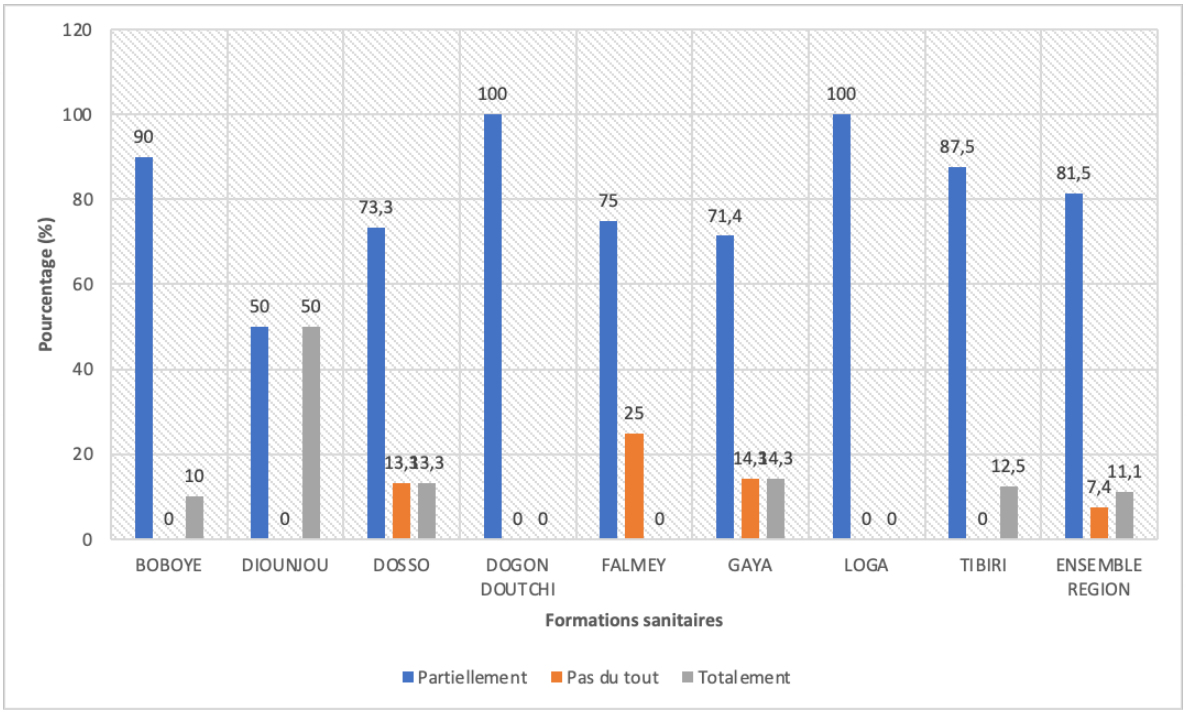


Source: *Data from the study, 2022*

Adequacy between resources and demand for service

Overall, more than 3/4 of the health workers interviewed judged the adequacy between means and partial demand for service delivery. In addition, disparities are observed between health districts. The adequacy between the means and the demand for service was considered 100% in the health districts of Dogon Doutchi and Loga, while in Gaya this rate is 71,4%.

Figure 5: Adequacy between resources and demand for service



Source: *Data from the study, 2022*

Box 1: Relevance and consistency of the measure

The measure of gratuity is relevant given its role in facilitating access to health services for vulnerable populations. The latter believe that its content meets their needs. It appears in successive national and health sector policy documents. By its design and implementation framework, it is expected to improve population indicators. However, the allocation of resources and the provision of resources (health inputs and medicines), and supply of health services, have not matched the demand of the population for these health services.

3.1. Effectiveness of the free access measure

In this section, we present some stylized facts about the use of free services by the population, the dynamics of evolution of certain indicators reporting on the state of health of the populations of the Dosso region and the analysis by stakeholders of the effectiveness of the implementation of the free access measure.

3.1.1. Use of free health services in the Dosso region

3.1.1.1. Family planning

This analysis focused on the last five (5) years. This choice is justified by the availability of data by Health District in the statistical yearbooks of the Directorate of Statistics (DS) of the Ministry of Public Health, Population and Social Action (MSP/P/as).

The table below shows that Boboye Health District had the lowest average use of family planning services compared to Fawley Health District, which had the highest average. These averages are 41,22% and 140,32% respectively. In addition, these two districts also have minimum and maximum standard deviations, 4,58% and 192,19% respectively. This explains why Boboye District has less disparity of sightings than Falmey District. The upward trend over the past 5 years is observed in the districts of Dioundiou, Dogon Doutchi, Dosso, Falmey and Gaya. On the other hand, the downward trend is observed in the health districts of Boboye, Loga and Tibiri.

Table 3: Summary of FP utilization rate by District over the last 5 years

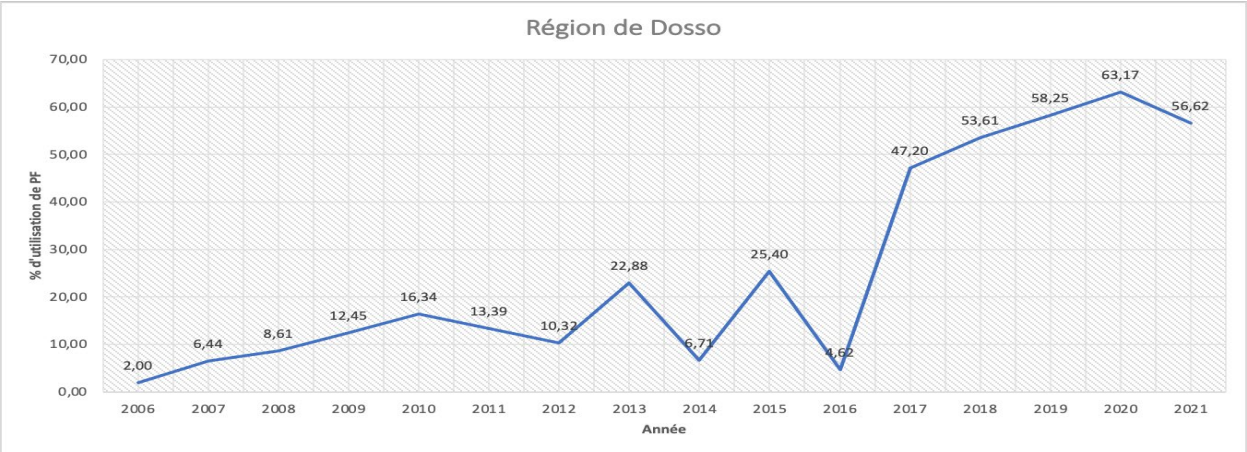
Year/ District	Boboye.	Dioundiou	Dogon Doutchi	Dosso	Falmey	Gaya	Loga	Tibiri	Dosso region
2017	39.84	48.28	37.86	47.51	483.97	57.43	57.19	51.87	**47.20**
2018	43.91	57.66	42.12	54.36	46.05	66.57	62.11	60.32	**53.61**
2019	44.90	64.57	43.92	60.11	54.27	72.13	65.30	67.81	**58.25**
2020	43.64	73.24	50.58	64.42	61.15	80.41	68.01	72.90	**63.17**
2021	33.78	69.02	45.37	53.84	56.14	80.24	53.38	72.25	**56.62**
Mean	**41.22**	62.55	43.97	56.05	**140.32**	71.36	61.20	65.03	**55.77**
Standard deviation	**4.58**	9.85	4.65	6.47	**192.19**	9.72	5.94	8.91	**5.91**
Minimum	**33.78**	48.28	37.86	47.51	46.05	**57.43**	53.38	51.87	**47.20**
Maximum	**44.90**	73.24	50.58	64.42	**483.97**	80.41	68.01	72.90	**63.17**
Trend	Decrease	Increase	Increase	Increase	Increase	Increase	Decrease	Decrease	**Increase**

Source: *Statistical Directory, SD*

The following graph shows that the rate of family planning use has tended to increase from 2006 to 2010. However, from 2010 to 2016, we observe a sawtooth evolution (periods of increase and decrease in use of family planning services). But, from 2016 to 2020, the results show a peak in the use of family planning. These results are explained by a widespread awareness of the population and also a massive acceptance of the family planning policy.

In addition, the availability of free inputs has played an important role in contraceptive use. Moreover, the communication strategy put in place has brought its building blocks in the acceptance of the system and the improvement of the health of women and children. Finally, we can say that the family planning policy is a success in the Dosso region because it shows an overall upward trend despite some declines observed over some years.

Figure 6: Overall utilization rate of FPs in the Dosso region



Source: *Statistical Directory, SD*

The table below shows that Boboye Health District had the lowest average compared to Fawley Health District, which had the highest average. These averages are 14,53% and 74,66% respectively. In addition, the District of Dosso has the lowest standard deviation (2,02%) compared to the District of Falmey with the highest standard deviation (126%). This explains Dosso District has less disparity of observations than Falmey District.

The upward trend over the past 5 years is observed in the districts of Dioundiou and Gaya. On the other hand, the downward trend is observed in the health districts of Boboye, Loga and Tibiri.

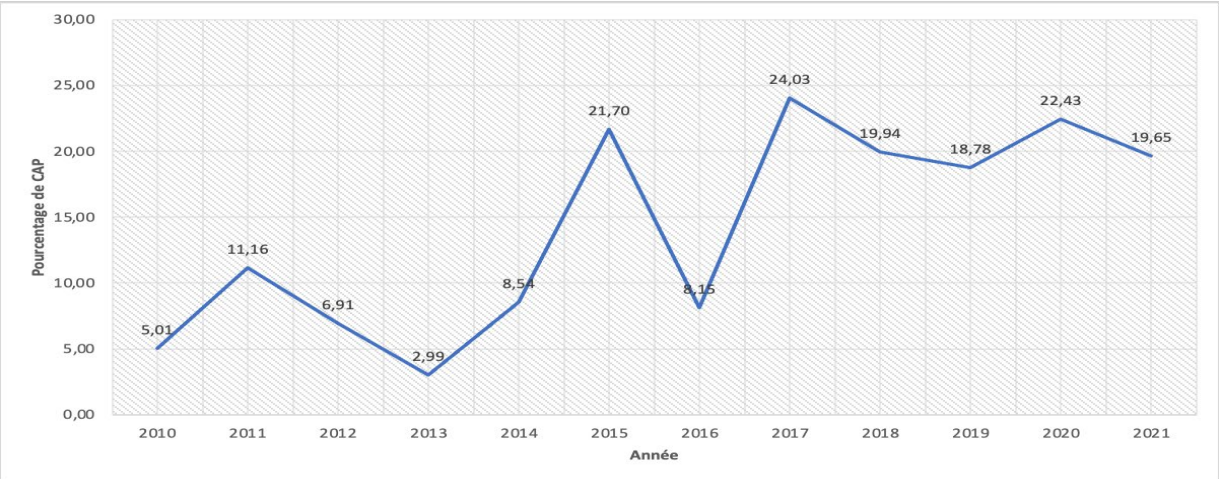
Table 4: Summary of percentage of couples in year of protection by District over the last 5 years

Year/ District	Boboye	Dioundiou	Dogon Doutchi	Dosso	Falmey	Gaya	Loga	Tibiri	Dosso region
2017	18.81	13.99	32.09	17.15	299.93	22.27	20.07	36.94	24.03
2018	16.53	14.59	20.41	12.28	13.19	21.63	42.66	23.99	19.94
2019	14.51	13.10	18.60	15.39	23.90	29.54	10.48	23.76	18.78
2020	12.99	21.04	28.65	15.05	21.00	41.19	9.30	26.66	22.43
2021	9.80	18.01	19.25	12.69	15.28	49.99	8.02	22.64	19.65
Mean	**14.53**	16.14	23.80	14.51	**74.66**	32.92	18.10	26.80	20.97
Standard deviation	3.43	3.31	6.15	**2.02**	**126.00**	12.37	14.53	5.86	2.19
Minimum	**9.80**	13.10	18.60	12.28	13.19	21.63	8.02	**22.64**	18.78
Maximum	**18.81**	21.04	32.09	17.15	**299.93**	49.99	42.66	36.94	24.03
Trend	Decrease	Increase	Decrease	Decrease	Decrease	Increase	Decrease	Decrease	**Decrease**

Source: *Statistical Directory, SD*

The availability of the data allowed us to consider the series from 2010 to 2021 from the statistical yearbooks of the MSP/P/as SD. The results show that overall, the trend of year protection torques is increasing from 2010 to 2021 despite the sawtooth evolution of the curve. However, the amplitude of the variability is more observed from 2010 to 2017. On the other hand, the evolution is more stable from 2017 to 2021.

Figure 7: Percentage of couple year Protection in Dosso region



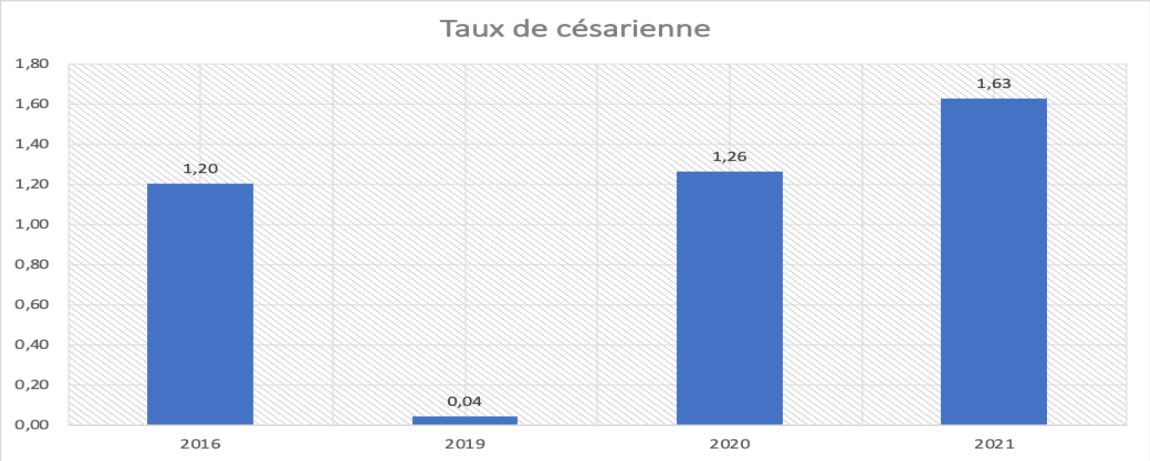
Source: *Statistical Directory, SD*

3.1.1.2. Cesarean section

The use of the caesarean section service applies to the years 2016, 2019, 2020 and 2021 with regard to the data available in the statistical yearbooks.

The graph below shows that in 2019, the rate of caesarean section fell drastically compared to 2016. This explains by the advent of the COVID-19 pandemic that has negatively influenced the attendance of ICCs. But we note that despite the non-effectiveness of the caesarean section kit, free access has increased attendance of health facilities which de facto allows health workers to identify the needs of caesarean section.

Figure 8: Caesarean section rate in Dosso region



Source: *Statistical Directory, SD*

3.1.1.3. Deliveries

As shown in the table below, the Dioundiou Health District has the lowest average rate of births attended by skilled personnel, while Gaya has the highest rate. The highest standard deviation is that of Dioundiou against that of Tibiri with the lowest standard deviation. This explains why Tibiri District is full of the slightest disparity in rates. The districts of Dioundiou, Dogon Doutchi and Falmey have an upward trend in the rate of births assisted by skilled personnel, while the districts of Boboye, Dosso, Gaya, Loga and Tibiri have a downward trend. However, this decline does not explain the decline in health care but the increase in the health coverage base, the evolution of which is disproportionate.

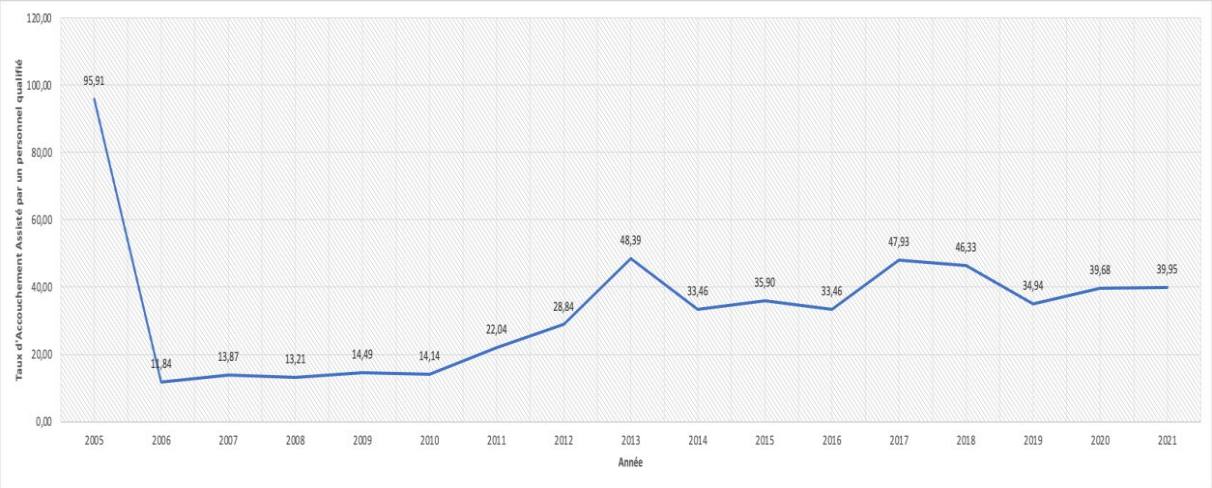
Table 5: Rate of births assisted by qualified personnel over the last 5 years

Year/ District	Boboye	Dioundiou	Dogon Doutchi	Dosso	Falmey	Gaya	Loga	Tibiri	Dosso region
2017	59.59	1.59	44.19	46.26	36.10	60.20	50.30	42.80	47.93
2018	50.80	35.69	39.51	35.69	42.20	62.05	42.85	47.96	46.33
2019	37.16	21.93	39.41	26.22	25.72	46.27	29.40	33.60	34.94
2020	40.33	28.19	44.75	30.14	35.73	50.40	33.78	37.84	39.68
2021	38.04	33.82	47.85	30.42	41.80	52.37	33.87	41.93	39.95
Mean	45.18	**24.24**	43.14	33.74	36.31	**54.26**	38.04	40.83	41.77
Standard deviation	9.72	**13.76**	3.64	7.76	6.66	6.68	8.42	**5.41**	5.32
Minimum	37.16	**1.59**	39.41	26.22	25.72	**46.27**	29.40	33.60	34.94
Maximum	59.59	**35.69**	47.85	46.26	42.20	**62.05**	50.30	47.96	47.93
Trend	Decrease	Increase	Increase	Decrease	Increase	Decrease	Decrease	Decrease	**Decrease**

Source: *Statistical Directory, SD*

Rate of births assisted by qualified personnel has decreased from 2005 to 2006. But, since 2006 with the implementation of free care, childbirth assisted by quality staff has increased. This shows the undeniable contribution of free health care in the increase of births assisted by qualified personnel.

Figure 9: Rate of births assisted by qualified personnel



Source: *Statistical Directory, SD*

3.1.1.4. Services for children from 0 to 5 years of age

Table 6 shows the evolution of the infant consultation coverage rate over the period 2017-2021. It highlights the following: Loga Health District has the lowest average and standard deviation proportionally at 74,73% and 2,91% against Dioundiou Health District with the highest average and standard deviation of 112,07% and 19,54%. The districts of Boboye, Dioundiou, Dogon Doutchi and Tibiri recorded downward trends in infant consultations, while the health districts of Dosso, Falmey and Loga recorded upward trends over the past 5 years. Overall, over the past 5 years, the trend in infant consultation coverage has been constant.

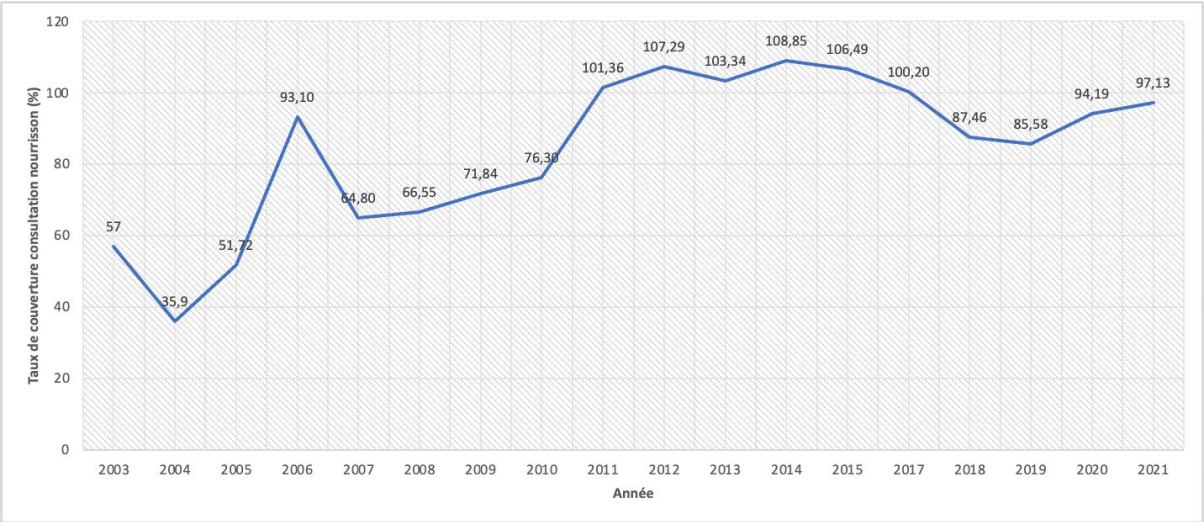
Table 6: Infant healthcare consultation coverage rate over the last 5 years

Year/ District	Boboye	Dioun diou	Dogon Doutchi	Dosso	Falmey	Gaya	Loga	Tibiri	Dosso region
2017	84.24	138.04	116.88	82.83	119.70	112.99	73.15	106.16	100.20
2018	103.91	91.51	88.57	79.81	81.29	87.20	73.72	94.43	87.46
2019	81.61	94.39	93.73	75.12	97.59	84.03	72.39	99.08	85.58
2020	86.57	113.56	103.41	88.23	93.57	99.40	74.69	99.45	94.19
2021	86.64	122.84	99.03	89.47	114.86	110.85	79.72	99.12	97.13
Mean	88.60	**112.07**	100.32	83.09	101.40	98.89	**74.73**	99.65	92.91
Standard deviation	8.81	**19.54**	10.80	5.95	15.78	13.23	**2.91**	4.19	6.24
Minimum	81.61	91.51	88.57	75.12	81.29	84.03	**72.39**	**94.43**	85.58
Maximum	103.91	**138.04**	116.88	89.47	119.70	112.99	**79.72**	106.16	100.20
Trend	Decrease	Decrease	Decrease	Increase	Increase	Increase	Increase	Decrease	**Constant**

Source: *Statistical Directory, SD*

As shown in Figure 10 below at the regional level, there was a peak in infant consultations in 2006 compared to previous years. This peak is explained by the implementation of the free health care system in this year. However, there was a decrease in 2007, followed by a gradual increase in the consultation rate from 2007 to 2014. The overall trend in infant consultation rates is increasing from 2006 to 2021. This explains the contribution of free care on the consultation of infants. This free access has increased the attendance of women in health facilities.

Figure 10: Infant healthcare consultation coverage rate



Source: *Statistical Directory, SD*

The use of health services by children aged 0 to 5 in the different districts of the Dosso region is presented in the table below.

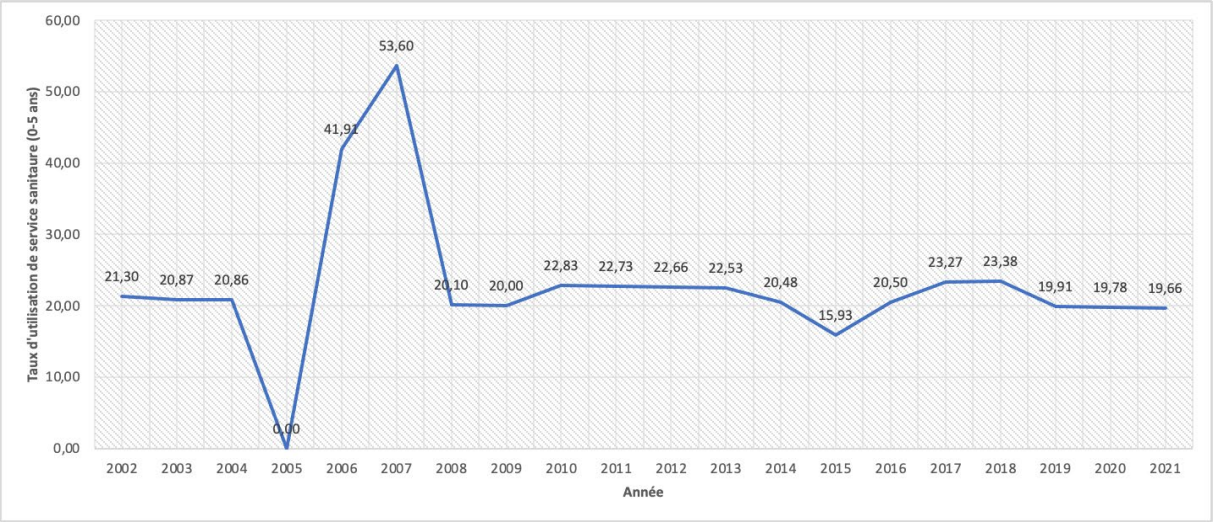
It should be noted that Gaya recorded the lowest average of 18,90% against the other districts, recording an average of 21,20%. In addition, Boboye District has the lowest standard deviation of 1,67% compared to other districts with a uniform standard deviation of 1,94%. Thus, a downward trend is observed over the past five years in all health districts except Gaya District. The overall trend of the Dosso region in the use of health services for children under 5 years of age over the past 5 years has declined. However, this decrease is not due to the attendance of users but it is linked to the increase in the base of service seekers.

Table 7: Rate of use of free healthcare services (0-5yrs)

Year/ District	Boboye	Dioundiou	Dogon Doutchi	Dosso	Falmey	Gaya	Loga	Tibiri	Dosso region
2017	19.34	23.27	23.27	23.27	23.27	23.27	23.27	23.27	23.27
2018	23.38	23.38	23.38	23.38	23.38	11.87	23.38	23.38	23.38
2019	19.91	19.91	19.91	19.91	19.91	19.91	19.91	19.91	19.91
2020	19.78	19.78	19.78	19.78	19.78	19.78	19.78	19.78	19.78
2021	19.66	19.66	19.66	19.66	19.66	19.66	19.66	19.66	19.66
Mean	20.41	21.20	21.20	21.20	21.20	**18.90**	21.20	21.20	21.20
Standard deviation	**1.67**	1.94	1.94	1.94	1.94	**4.21**	1.94	1.94	1.94
Minimum	19.34	19.66	19.66	19.66	19.66	**11.87**	19.66	19.66	19.66
Maximum	23.38	23.38	23.38	23.38	23.38	**23.27**	23.38	23.38	23.38
Trend	Decrease	Decrease	Decrease	Decrease	Decrease	Increase	Decrease	Decrease	**Decrease**

Source: *Statistical Directory, SD*

Figure 11: Rate of use of services (0-5yrs)



Source: *Statistical Directory, SD*

The above graph shows that the health coverage rate for children under 5 years of age declined from 2002 to 2005. But with the implementation of free health care in 2006, the use of services by children in this age group has increased significantly between 2006 and 2007. There was a decline in this rate in 2008. However, from 2008 to 2021, there was almost constant use of services by children under 5 years of age.

3.1.1.5. Overall situation of use of services

The use of health services over the past five years in the Dosso region has been increasing significantly. Looking at the situations of health districts, we note that Dioundiou Health District recorded the lowest average in the region compared to Gaya District, which recorded the highest average. These averages are 42,38% and 57,74% respectively. In addition, Loga District has a lowest standard deviation of 0,93% compared to other districts with a uniform standard deviation of 1,20%. An upward trend has been observed over the past five years in the health districts of Boboye, Dogon Doutchi, Dosso, Gaya, Loga and Tibiri, and a downward trend is observed in the districts of Dioundiou and Falmey.

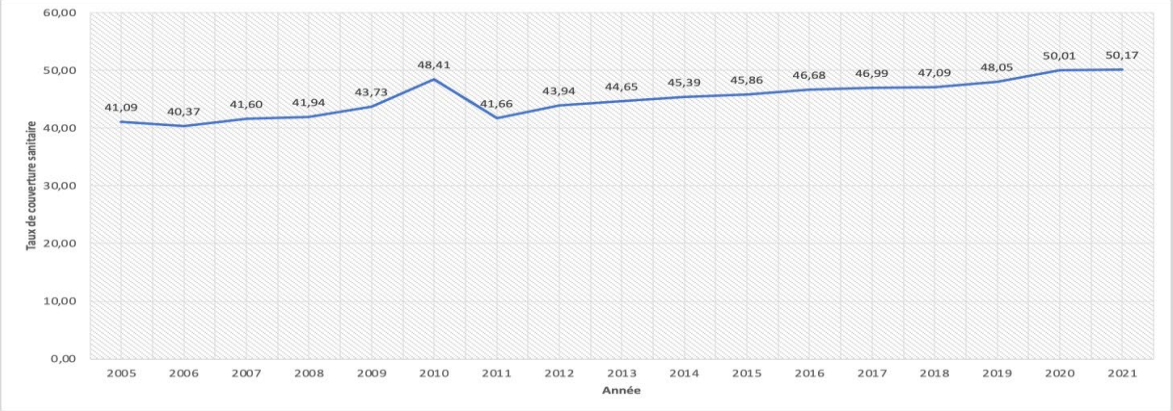
Table 8: Overall rate of use of maternal and child healthcare services

Year-District	Boboye	Dioundiou	Dogon Doutchi	Dosso	Falmey	Gaya	Loga	Tibiri	Dosso region
2017	45.10	52.82	43.57	45.16	52.01	51.89	51.10	45.10	46.99
2018	50.05	37.11	43.28	45.98	40.26	58.08	51.11	44.96	47.09
2019	50.91	37.11	43.96	46.55	45.52	58.00	51.11	47.52	48.05
2020	52.99	38.63	45.76	48.45	47.37	60.37	53.19	49.46	50.01
2021	52.99	46.25	45.76	48.14	47.37	60.37	51.11	49.46	50.17
Mean	50.41	**42.38**	44.47	46.86	46.51	**57.74**	51.52	47.30	48.46
Standard deviation	3.23	**6.95**	1.20	1.41	4.24	3.47	**0.93**	2.22	1.54
Minimum	45.10	**37.11**	43.28	45.16	40.26	**51.89**	51.10	44.96	46.99
Maximum	52.99	52.82	**45.76**	48.45	52.01	**60.37**	53.19	49.46	50.17
Trend	Increase	Decrease	Increase	Increase	Decrease	Increase	Increase	Increase	**Increase**

Source: *Statistical Directory, SD*

The analysis of the use of health services since the introduction of the free access measure shows a gradual evolution over the whole period 2005-2021; except for a slight decrease observed in 2011.

Figure 12: Overall rate of use of services



Source: *Statistical Directory, SD*

3.1.2. Evolution of some health indicators

3.1.2.1. Death rate at birth

Death at birth is experienced variously in all districts of the Dosso region. The largest mean and standard deviation are observed at the Mother and Child Health Centre (MHCS). In contrast, Tibiri district has the lowest rates in the region. These results of MSC-E are due to the fact that this health training welcomes the complicated cases referred by the IHS. The majority of the cases referred are in a critical situation. That explains the high rate of infant mortality observed at the level of MHCS.

The results also show a downward trend over the last five years at the level of the MHCs, the health districts of Boboye and Dioundiou, unlike the health districts of Dogon Doutchi, Dosso, Falmey, Gaya, Loga and Tibiri, recording an upward trend in infant mortality at birth. This can be explained by the often shortages of medicines observed at the level of these health facilities making ineffective the care of patients from vulnerable families.

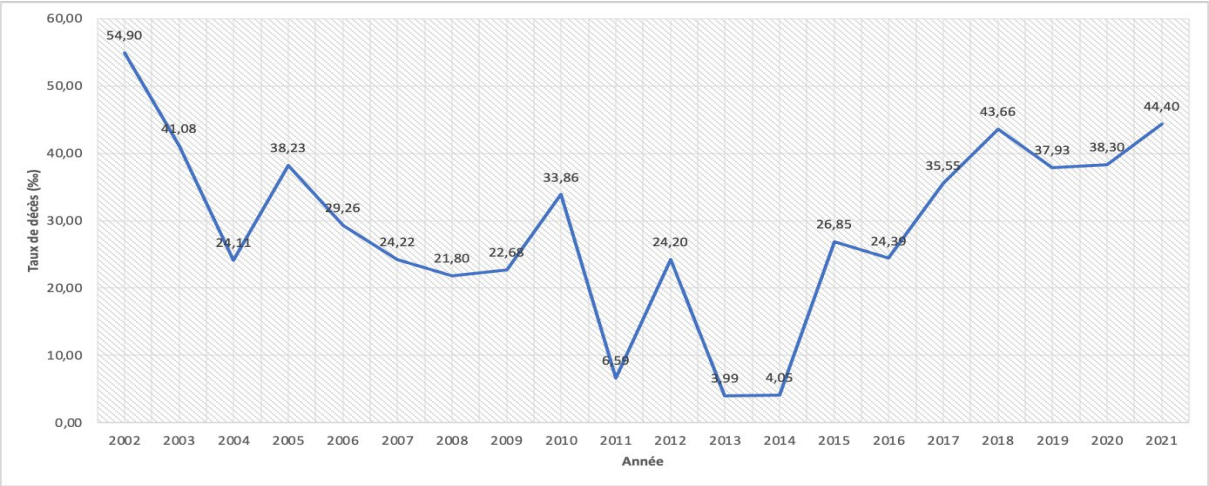
Table 9: Death rate at birth over the last five years

Year/ Structure	MCHC Dosso	Boboye	Dioundiou	Dogon Doutchi	Dosso	Falmey	Gaya	Loga	Tibiri	Dosso region
2017	185.67	65.96	28.71	29.60	14.53	19.39	31.80	38.87	14.44	35.55
2018	210.16	53.18	53.61	45.66	23.76	15.33	42.47	36.14	17.69	43.66
2019	155.24	44.60	44.22	35.08	14.89	19.77	51.11	32.43	14.97	37.93
2020	169.95	38.20	35.20	37.88	24.78	31.51	43.64	41.47	15.62	38.30
2021	185.83	35.85	35.92	46.28	19.08	37.51	66.04	52.88	24.67	44.40
Mean	**181.37**	47.56	39.53	38.90	19.41	24.70	47.01	40.36	**17.48**	39.97
Standard deviation	**20.50**	12.29	9.61	7.11	4.80	9.37	12.67	7.76	**4.20**	3.86
Minimum	**155.24**	35.85	28.71	29.60	14.53	15.33	31.80	32.43	**14.44**	35.55
Maximum	**210.16**	65.96	53.61	46.28	24.78	37.51	66.04	52.88	**24.67**	44.40
Trend	Decrease	Decrease	Decrease	Increase	Increase	Increase	Increase	Increase	Increase	**Increase**

Source: *Statistical Directory, SD*

The graph below shows the evolution of the birth death rate since 2002. Overall, it appears that mortality at birth declined from 2002 to 2004. An increase is observed in 2005. But with the implementation of free health care in 2006 we have seen a gradual decline in infant deaths at birth until 2008. In contrast, from 2008 to 2016, the results show a sawtooth change in infant mortality rates at birth. This can be explained by the shortage of medicines, personnel and facilities observed in districts that weaken the effectiveness of free health care. These breaks are due in the majority of cases to the non-reimbursement of the costs generated by the free access which led to the over-indebtedness of the health facilities.

Figure 13: Death rate at birth



Source: *Statistical Directory, SD*

3.1.2.2. Maternal mortality rate

Analysis of the maternal mortality rate over the past five years shows that this indicator is increasing in the Dosso region. Dosso Health District has the lowest average maternal mortality rate compared to Gaya, which has the highest rate. The disparity in maternal death rates is much more evident in the Falmey Health District

Table 10: Maternal mortality rate (‰)

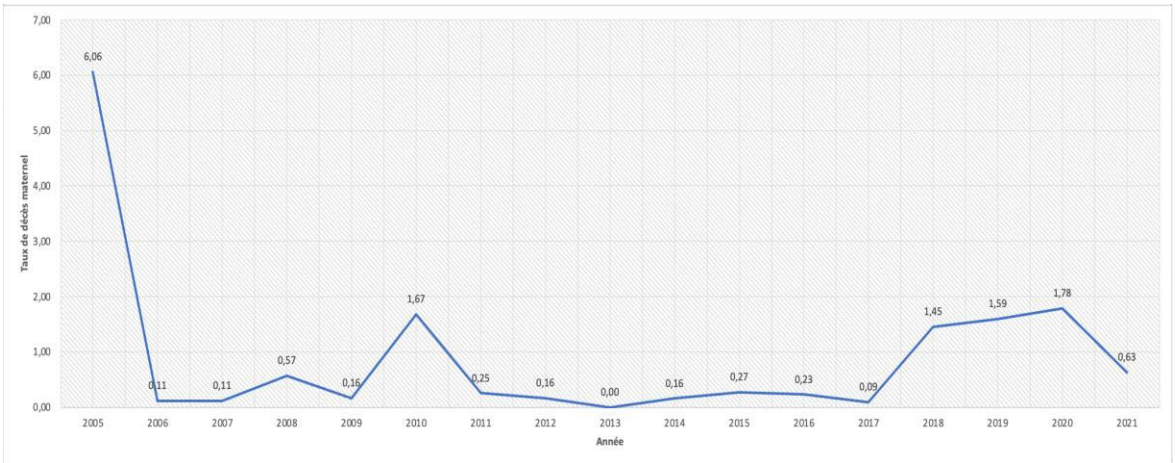
Year/ District	Boboye	Dioundou	Dogon Doutchi	Dosso	Falmey	Gaya	Loga	Tibiri	Dosso region
2017	0.00	0.00	0.14	0.00	0.00	0.00	0.00	0.07	0.09
2018	1.51	0.00	1.40	0.04	0.67	1.26	1.58	0.00	1.45
2019	1.26	1.19	1.32	0.06	0.28	2.87	0.74	0.48	1.59
2020	3.83	0.00	0.94	0.03	3.67	2.09	1.76	0.00	1.78
2021	1.24	0.00	1.46	0.03	0.26	0.94	0.78	0.00	0.63
Mean	1.57	0.24	1.05	**0.03**	0.98	**1.43**	0.97	0.11	1.11
Standard deviation	1.39	0.53	0.55	**0.02**	**1.52**	1.10	0.71	0.21	0.72
Minimum	0.00	0.00	0.14	0.00	0.00	0.00	0.00	0.00	0.09
Maximum	**3.83**	1.19	1.46	**0.06**	3.67	2.87	1.76	0.48	1.78
Trend	Increase	Constant	Increase	Increase	Increase	Increase	Increase	Decrease	**Increase**

Source: *Statistical Directory, SD*

Analysis of this indicator for the period 2005-2021 reveals that the maternal mortality rate was high in 2005 before the implementation of free health care. As a result of the reform, a drastic fall in this rate was observed in 2006. However, despite some

increases observed between 2006 and 2021, the maternal mortality rate remains lower than before free health care.

Figure 14: Maternal mortality rate (‰)



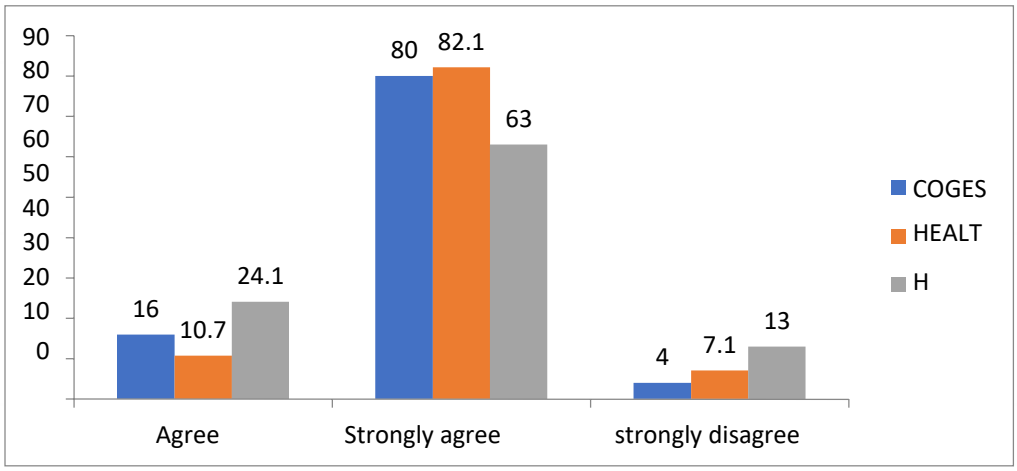
Source: *Statistical Directory, SD*

3.1.3. Evaluation of the efficiency of the free health care measure

3.2.2.3. Effectiveness of free health care

The effectiveness of the measure of free health care is recognized by all stakeholders in the Dosso region whether they are health workers, the community and COGES actors, the majority agree that the services are free. However, signals of disapproval are noted at 4%, 7,1% and 13% respectively for COGES, the community and health workers.

Figure 15: Effectiveness of free health care



Source: *Data from the study, 2022*

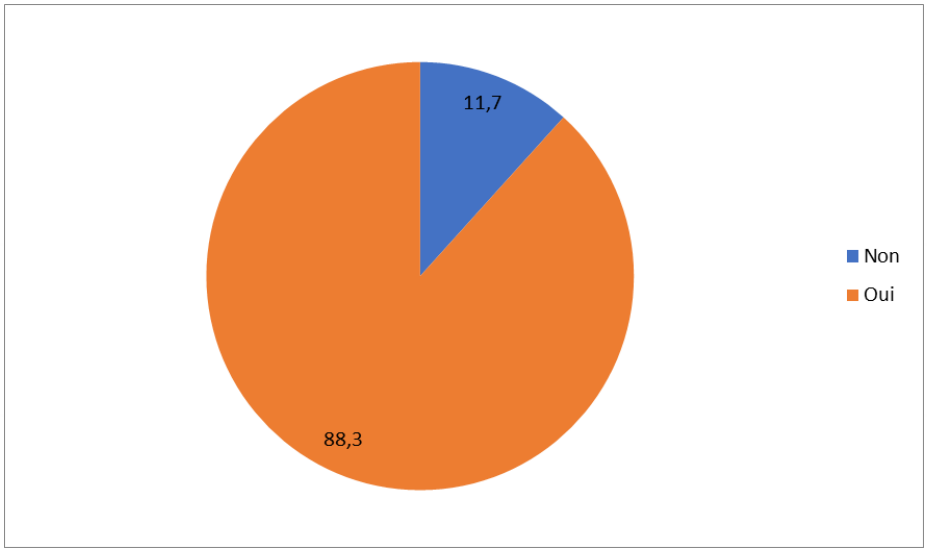
3.2.2.4. Evaluation of the actions implemented in the framework of the policy

The implementation of the policy required a number of actions and conditions to assess the achievement.

3.2.2.4.1. Raising awareness about free access

88,3% of the population of the Dosso region claims to be aware of free health care compared to 11,7% who say no.

Figure 16: Effectiveness of free health care

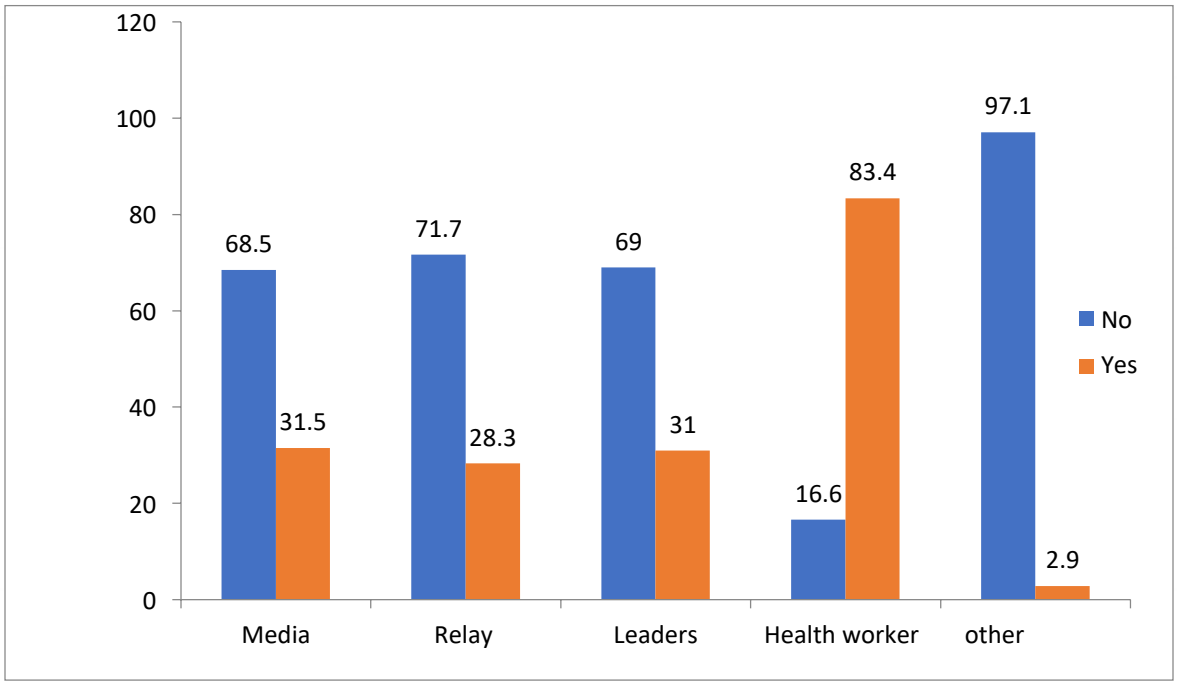


Source: *Data from the study, 2022*

For the population having been sensitized, the claim to access information through several channels.

The graph below shows that the majority of the population (84,4%) was sensitized by health workers. However, information also reached them by the media (31,5%), leaders (31%) and community relays (28,3%)

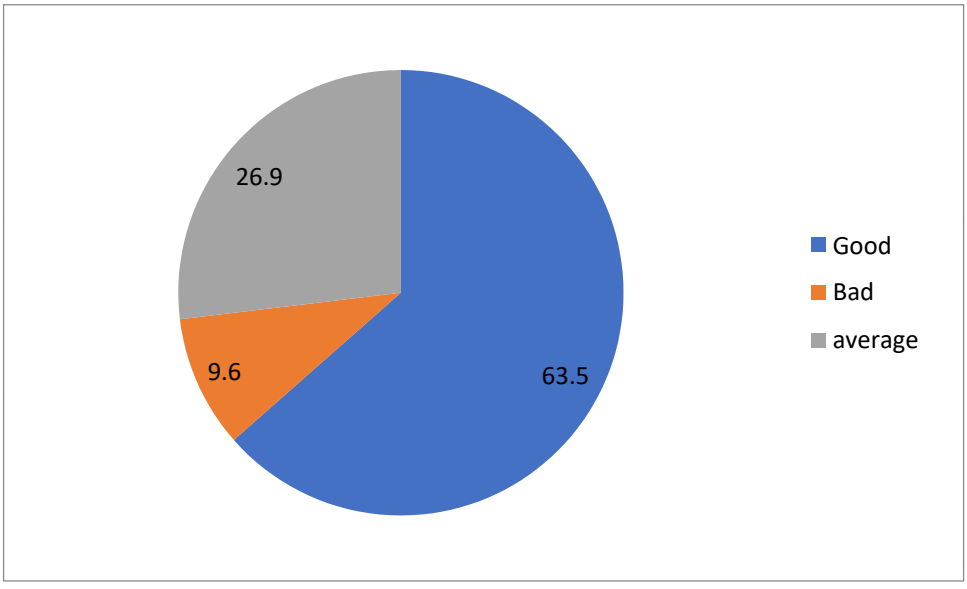
Figure 17: Communication channels used



Source: *Data from the study, 2022*

The graph shows that 63,5% of households find the efficiency of communication channels good. 26,9% find them average and 9,6% consider the efficiency of communication channels poor.

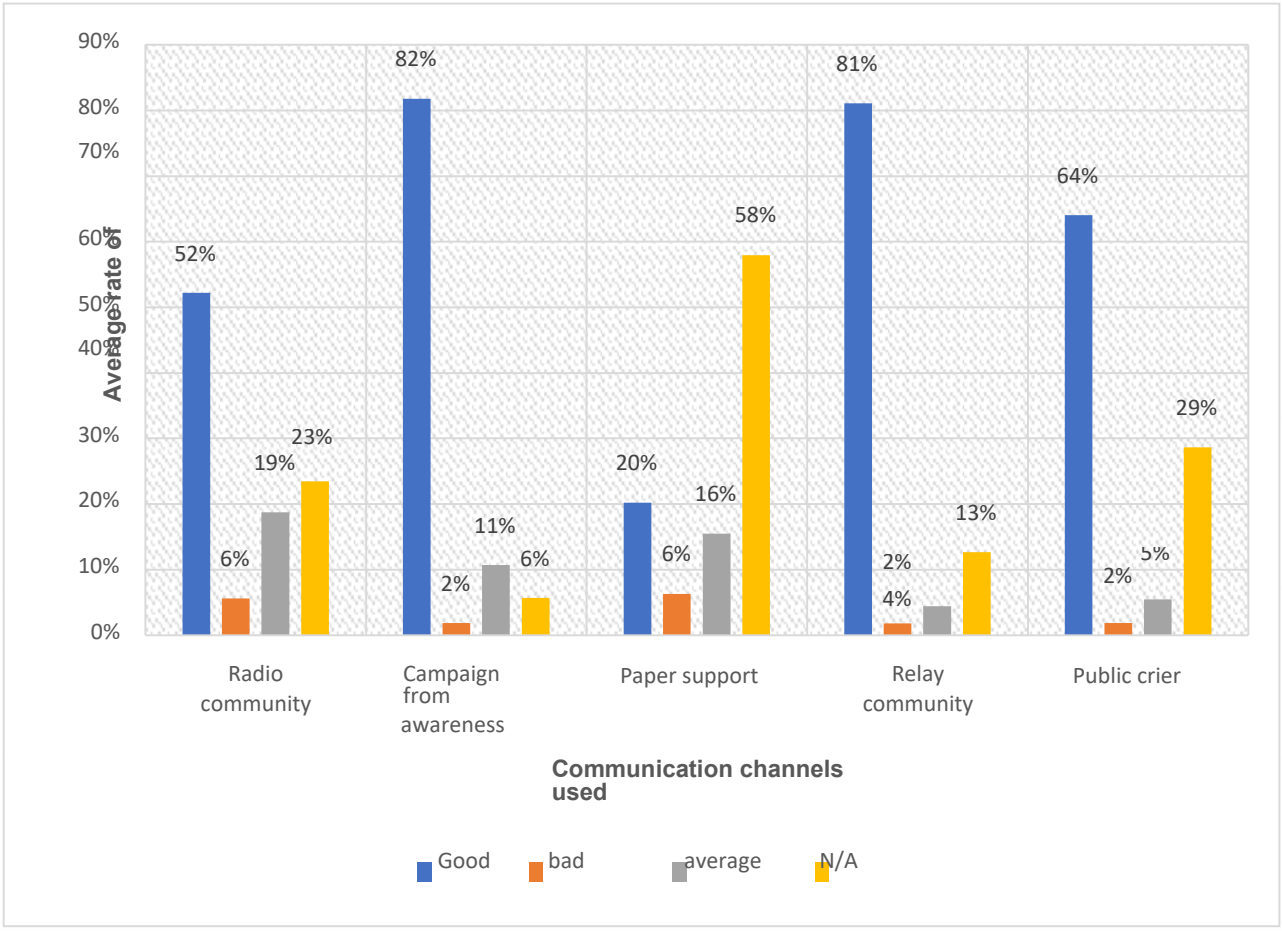
Figure 18: Overall effectiveness of communication channels on free health care



Source: *Data from the study, 2022*

When this Evaluation is made on a specific channel, it appears that three channels are considered to be the most effective in facilitating information at the level of the Dosso region. These are the awareness campaign, community relays and public criers.

Figure 19: Specific evaluation of the communication channels used



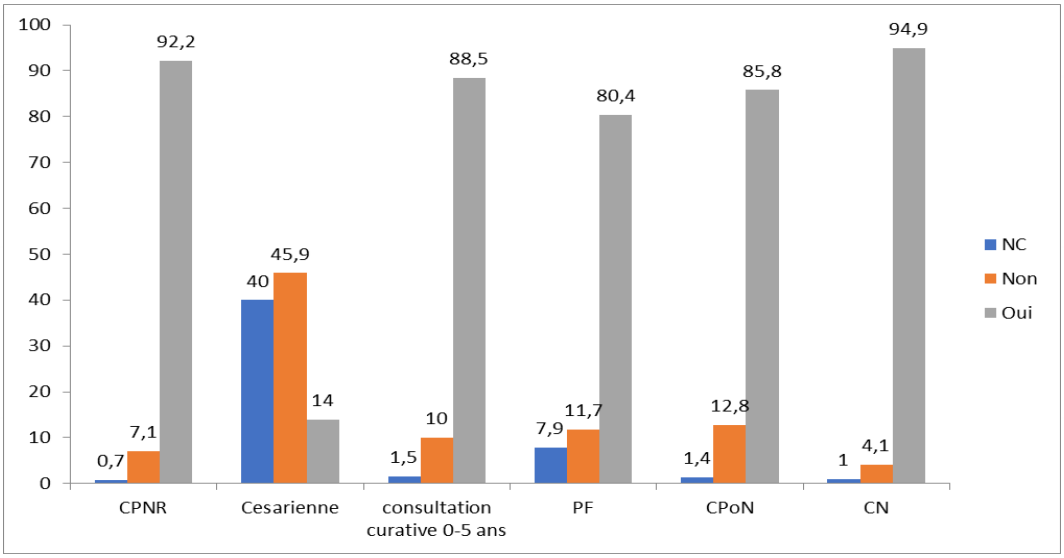
Source: *Data from the study, 2022*

3.2.2.4.2. Effectiveness of free health care

The graph below shows the households that have benefited from the free health care package.

Thus, the majority of the households surveyed say that they have benefited from free care such as: CPNR, curative consultation of children under 5 years of age, family planning, post-natal consultation and infant consultation respectively to the tune of 92,2%, 88,5%, 80,4%, 85,8 and 94,9%. On the other hand, 14% of households benefited from cesarean section.

Figure 20: Among the package of free health care, which did you benefit from



Source: *Data from the study, 2022*

3.2.2.4.3. Evaluation of the functioning of the implementing bodies of the free health care measure

The table below shows the waiting time observed by the population before being taken care of at the level of the ISCs of the Dosso region. It appears that 71,1% of the women surveyed say they are taken care of in less than an hour, 18,4% are taken care of between 1h and 3hrs and 10,5% are taken care of beyond 3hrs.

Table 11: Average time spent by users before being taken care of for the service

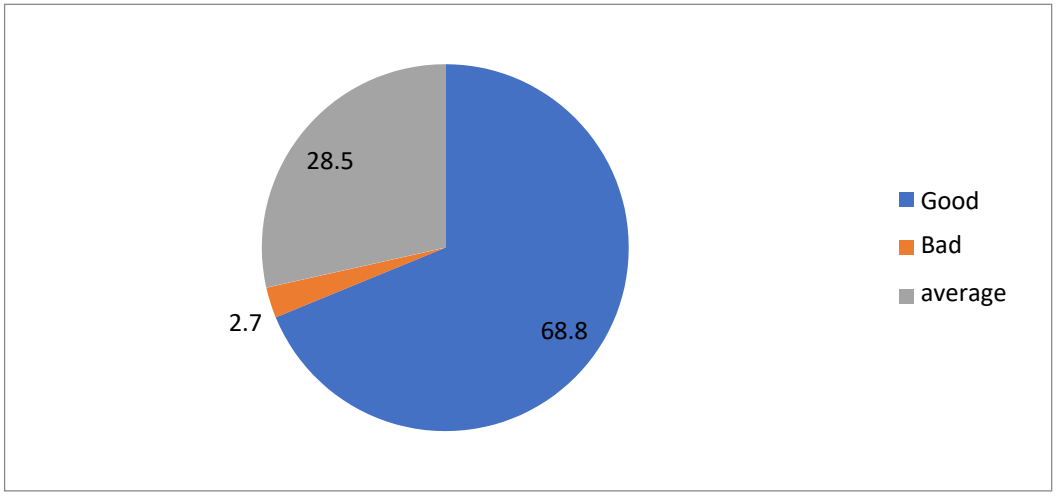
Department	Less than 1h	From 1h to 3h	Greater than 3 hours
Boboye	95.8	4.2	0
DIOUNDIOU	50	44.6	5.4
DOSSO	79.8	17.4	2.8
DOUTCHI	85.9	12.5	1.6
FALMEY	95	5	0
GAYA	17.2	43.8	39.1
LOGA	36.2	23.6	40.3
TIBIRI	100	0	0
Region set	**71.1**	**18.4**	**10.5**

Source: *Data from the study, 2022*

3.2.2.4.4. *Evaluation of the functioning of the implementing bodies of the free health care measure*

As the first-ranking beneficiaries of the free access measure, it is important to gather the point of view of households as to the organization put in place to carry out the policy. The chart below shows that 68,8% of households consider the organization good, 28,5% consider it average and 2,7% consider it bad.

Figure 21: Evaluation of the functionality of healthcare institutions according to households



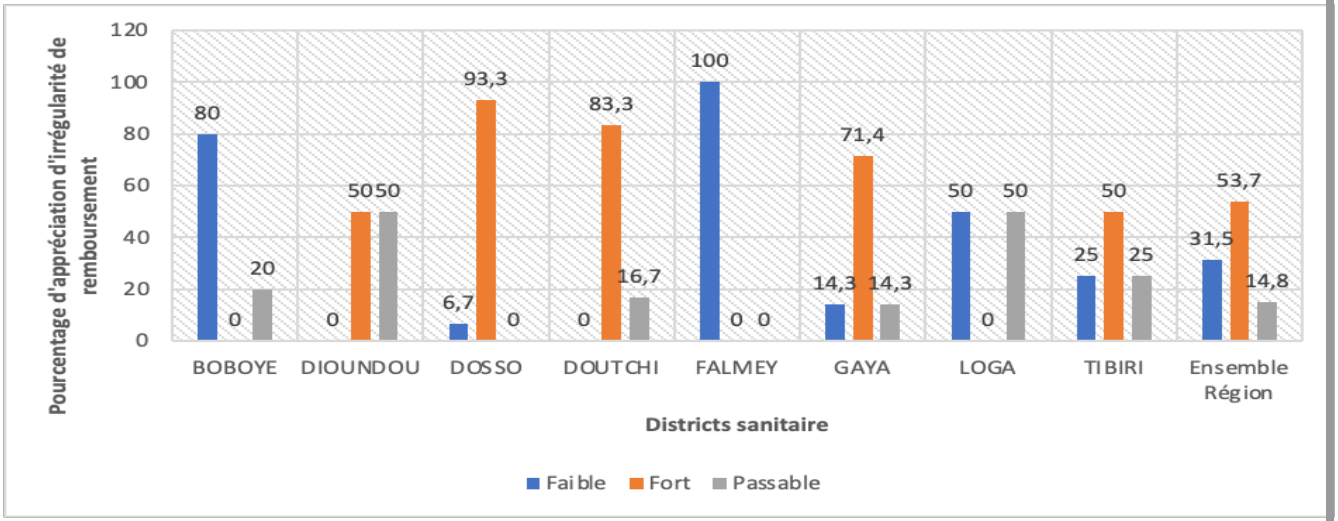
Source: *Data from the study, 2022*

3.2.2.4.5. *Evaluation of the availability of funding and medicines*

- **Regularity of reimbursement**

Primary data collected from COGES and health workers show that overall, the irregularity of reimbursements is strong. Indeed, the majority of interviewees stated that there is an irregularity in reimbursement.

Figure 22: Evaluation of irregularities in refunds

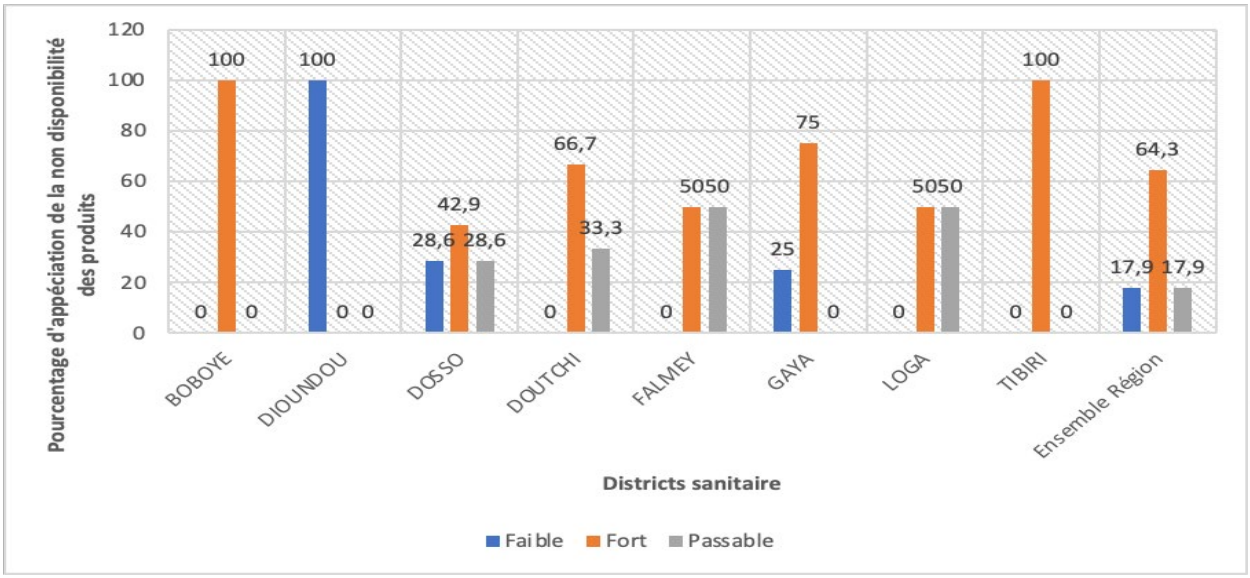


Source: *Data from the study, 2022*

- **Availability of medicines**

The graph below shows that the majority of respondents report a significant disruption in pharmaceutical products and medicines. This shortage is linked to the gradual accumulation of recorded debts at the level of health facilities. This shortage is strong in all health districts except Dioundiou District.

Figure 23: Evaluation of non-availability of medicines

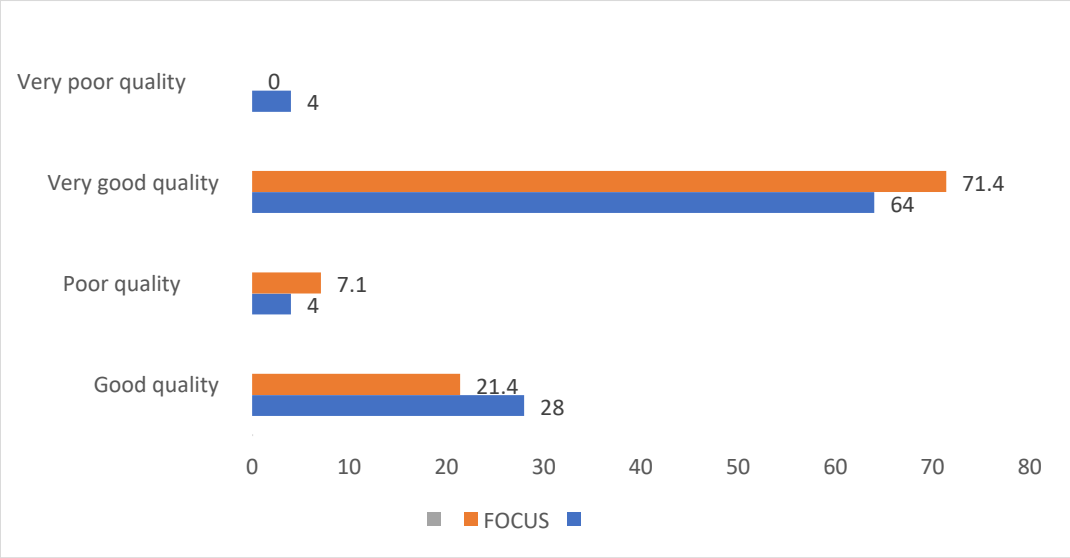


Source: *Data from the study, 2022*

3.2.2.4.6. Quality of the reception in the health facilities

The population interviewed is satisfied (45,1%) or very satisfied (43,6%) with the quality of reception in health facilities. The opinion of the rest of the population is divided between low satisfaction (10,5%) and dissatisfaction (0,8%).

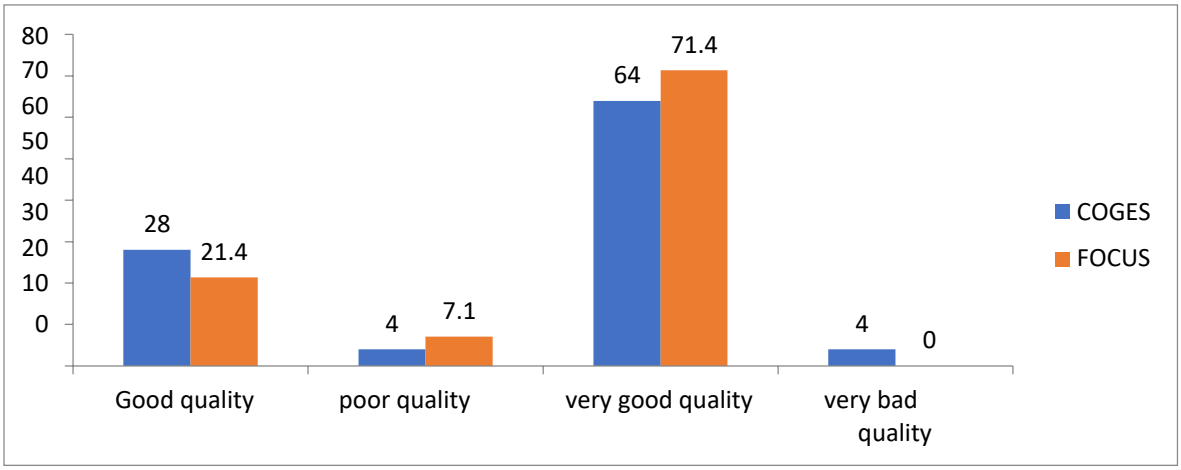
Figure 24: Appreciation of reception in health services by populations



Source: *Data from the study, 2022*

COGES members and community members find the reception of very good quality at 64% and 71,4% respectively.

Figure 25: Appreciation of reception in health services by other stakeholders



Source: *Data from the study 2022*

3.2.2.4.7. *Quality of the healthcare services in health facilities*

More than half (53,7%) of the population is satisfied with the quality of care in health facilities. 38,9% is very satisfied although there are some pockets of low satisfaction or minor dissatisfaction in departments. The provision of care is unsatisfactory in Dosso and Gaya at 1,4% and 1,6% respectively.

Table 12: Quality of health care provision in health facilities

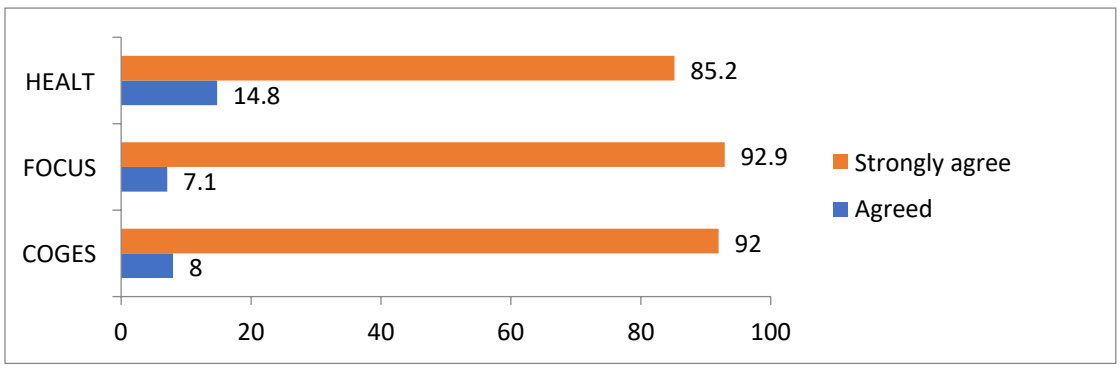
Department	Not satisfactory	Somewhat satisfactory	Satisfactory	Very satisfactory
Boboye	0	2.1	63.5	34.4
DIOUNDIOU	0	10.7	17.9	71.4
DOSSO	1.4	6.9	63.9	27.8
DOUTCHI	0	1.6	12.5	85.9
FALMEY	0	0	95	5
GAYA	1.6	7.8	75	15.6
LOGA	0	20.8	56.9	22.2
TIBIRI	0	3.6	35.7	60.7
Region set	**0.5**	**6.9**	**53.7**	**38.9**

Source: *Data from the study, 2022*

3.2.2.4.8. *Evaluation of attendance at health facilities for free prenatal consultations by pregnant women*

The stakeholders interviewed fully agree that free access has increased attendance of health facilities for prenatal consultations in the Dosso region. As shown in the chart below, 92% of COGES members, 92,2% of communities surveyed in focus and 85,2% of health workers share this view.

Figure 26: Attendance at health facilities for prenatal consultations at the regional level

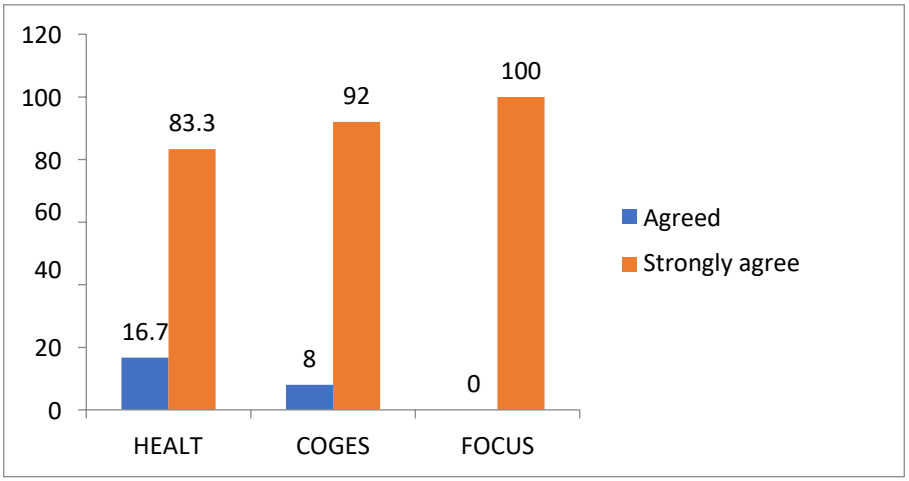


Source: *Data from the study,* ***2022***

3.2.2.4.9. *Evaluation of attendance at health facilities for free care by children from 0 to 5 years of age*

All stakeholders agree with the improvement of the attendance of health facilities by the population as part of the policy of free health care. Indeed, the community questioned through the organized focus groups is unanimous on these findings. More than eight out of ten health workers (83,2%) and 92% of COGES members also share this view.

Figure 27: Attendance at health care facilities for children aged 0 to 5 in the Dosso region



Source: *Data from the study, 2022*

3.2.2.4.10. *Enhancement of health facilities and the services provided*

The previous observation is corroborated by the beneficiaries of the measure of free health care facilities, which are their first recourse for the majority of the sick population. Indeed, 89,6% use health facilities in case of illness. However, in the department of Doutchi, 29,7% use traditional practitioners and one in four people use self-medication in Tibiri.

Table 13: 1st recourse in health matters by the populations

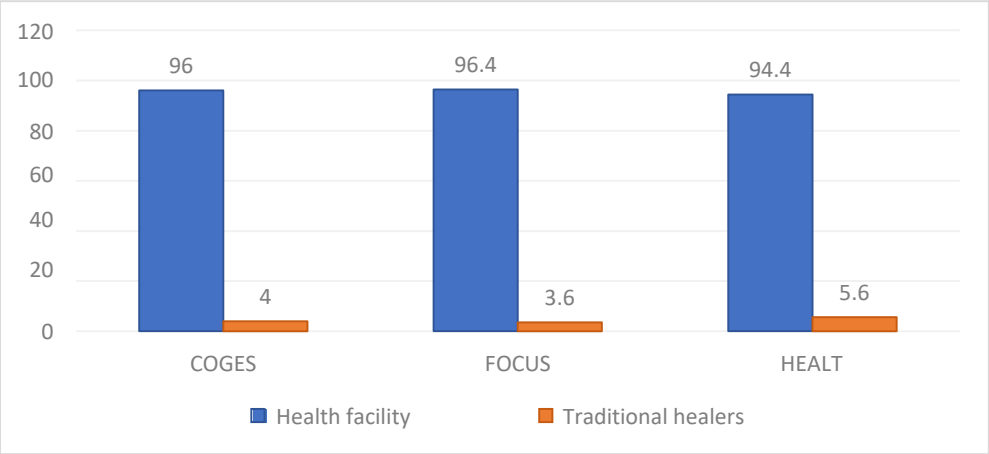
Department	Self-medication	Health facility	Traditional practitioners
Boboye	2.1	95.8	2.1
DIOUNDIOU	**0**	**100**	**0**
DOSSO	6.3	93.8	0
DOUTCHI	6.3	64.1	29.7

Department	Self-medication	Health facility	Traditional practitioners
FALMEY	2.5	97.5	0
GAYA	10.9	89.1	0
LOGA	4.2	95.8	0
TIBIRI	23.2	76.8	0
Region set	**6.6**	**89.9**	**3.5**

Source: Data from the study, 2022

The other stakeholders (COGES, Communities and Health workers) are all unanimous on the use of health facilities by the population in case of illness.

Figure 28: 1st recourse in health matters by the populations



***Source:** Data from the study, 2022*

Box 2: Effectiveness analysis

The implementation of free care has been effective. The targeted populations have benefited from the free package but deplore the frequent disruption of health inputs and the functioning of the free implementation mechanism. There is room for improvement in the availability of health inputs, which is dependent on the regularity of reimbursement by the State of the bills of benefits and inbound

3.3 Efficiency of the free health care measure

To conduct an efficiency analysis according to the rules of the art, we must have a costing of the measure to fully satisfy the population to benefit from the reform at the level of health facilities. We must then assess the funding mobilized in connection with the free service offered in the light of this standard. If this standard is not available, efficiency is assessed in terms of the adequacy of the resources allocated to the services actually offered, according to the modalities of free care.

What is the situation of reimbursement of bills for care services related to free care?

The table below shows the status of reimbursements from 2007 to 2022. It appears that the reimbursement rate for bills related to free health care in the Dosso region is 38%. However, there are disparities in reimbursement between health facilities. Indeed, the highest rate of reimbursement is observed in Dogon Doutchi (52%) while the lowest is recorded in Falmey (4%).

Table 14: Reimbursement status of the free access from 2007 to June 2022 by structure

Health structures	The total amount of invoices sent	The total amount of invoices sent	Amount to be recovered	Regularity of reimbursement
Boboye	1,284,716,930	423,627,347	861,089,583	33%
DIOUNDIOU	67,994,820	///	///	///
DOGON DOUTCHI	1,514,384,285	794,554,735	719,829,550	52%
DOSSO	1,272,449,465	439,188,942	833,260,523	35%
FALMEY	30,899,210	1,267,500	29,631,710	4%
GAYA	1,819,045,460	715,736,460	1,103,309,000	39%
LOGA	530,230,550	217,636,561	312,593,989	41%
TIBIRI	69,379,001	///	///	///
CHR	1,813,305,000	921,928,469	891,376,531	51%
MCHC	1,367,729,250	186,060,000	1,181,669,250	14%
TOTAL	**9,770,133,971**	**3,700,000,014**	**6,070,133,957**	**38%**

Source: *Data from the study, 2022*

When we put this reimbursement rate in relation to the stakeholders' evaluation of the effectiveness of the measure, we note that for a reimbursement rate of 38%, 80%, 82%, 1% and 63% respectively of the members of the COGES, The Community and health workers fully agree on the effectiveness of the free access measure. It thus emerges that with the modest funding, the measure was offered to populations even though they are dissatisfied with the provision of care (38,9%)

Box 3: Effectiveness and efficiency analysis

In terms of efficiency, we can say that despite the low rate of reimbursement of invoices, the target populations have recognized in their majority the effectiveness of the measure of gratuity. However, the over-indebtedness of health facilities, due to these arrears of bills, does not allow these health facilities to adequately and regularly provide the whole package associated with free health care in order to satisfy the beneficiaries. This problem of reimbursement is the main source of medicinal shortages and also affects the ability of health facilities to provide complete satisfaction to the population with regard to the quality of consultations and care offered.

3.4. Effects induced by the implementation of the measure

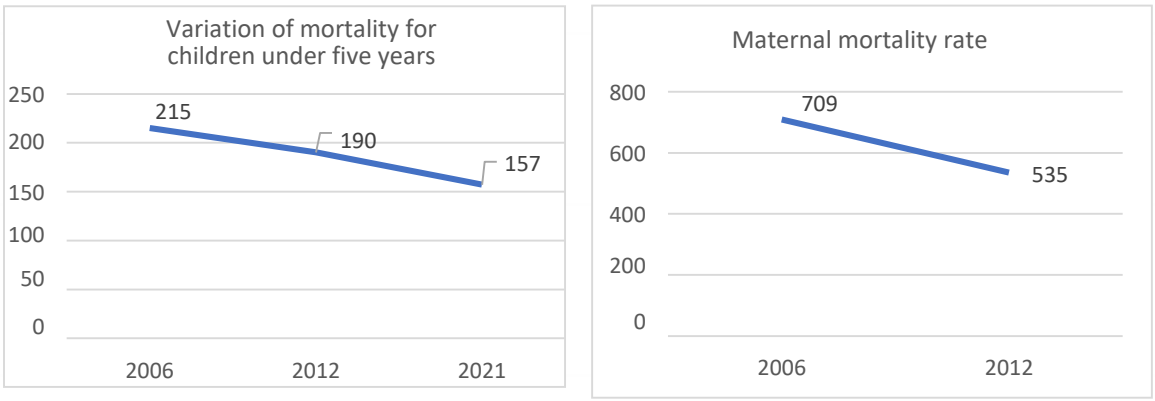
3.4.1. Effects induced by the implementation of the free access measure on the reduction of maternal and infant mortality

Based on survey data and data from the national statistics system, the impact of free health care will be analyzed on the reduction of maternal and infant mortality. An effect is also observed on the workload of the agents.

- **Trends in maternal and infant mortality:**

There has been a significant decline in the mortality rate of children under five years of age in the Dosso region between 2006 and 2021. The mortality rate for children under five fell from 215 per 1,000 in 2006 to 190 per 1,000 in 2012 and 150 per 1,000 in 2021, a drop of 30 per cent. Regarding maternal mortality, the rate estimated at EDSN-MICS IV (2012) is lower than that estimated at EDSN-MICS III (2006 (535 ‰ against 709 ‰), a decrease of 25%.

Figure 29: Trends in maternal and under-5 mortality rates (per 1000 and 100 000 births respectively)

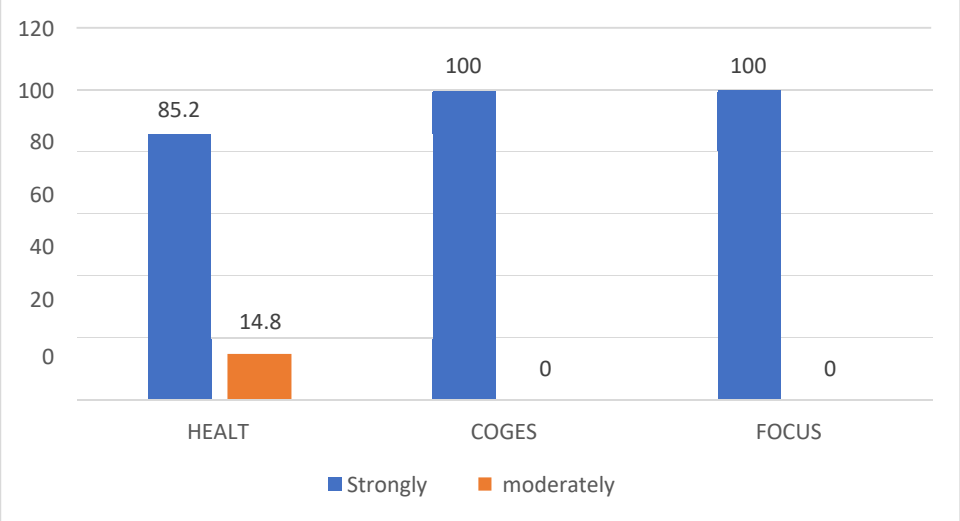


Source: *EDSN 2006 and EDSN 2012 and ENAFEME 2021*

- **Evaluation of the induced effects of the implementation of the free access measure:**

All COGES officials (100%) thought that free health care has greatly contributed to the reduction of maternal and infant mortality in the Dosso region. Similarly, the results of the focus group showed that the reduction of maternal and infant mortality is linked to free health care. Indeed, 100% of respondents felt that free health care had a strong impact on the level of maternal and infant mortality. However, 85,2% of health center officials believe that free health care has a strong impact on reducing maternal and infant mortality, while 14,8% believe that free health care has an average impact on reducing maternal and infant mortality.

Figure 30: Evaluation of the effects of stakeholders

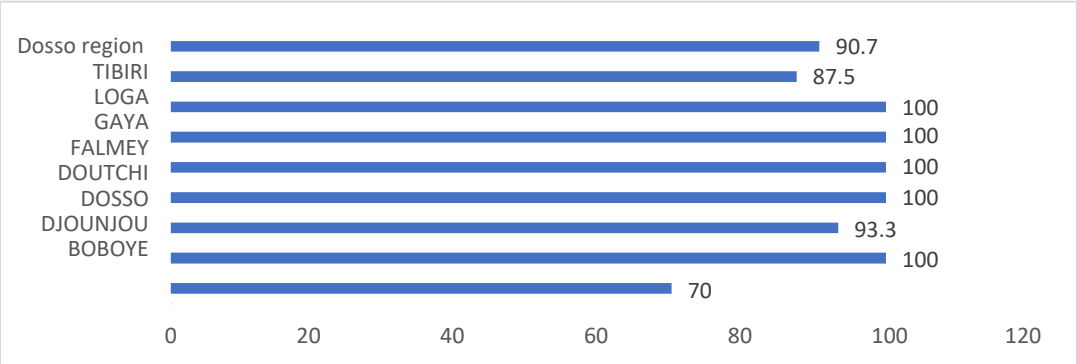


Source: *Data from the study, 2022*

3.4.2. Effects on the workload

The majority of health center managers (90,7%) believe that the measure of free health care has increased their workloads. On the other hand, 9,3% of these officials continue with the same workloads despite the implementation of the measure of free health care.

Figure 31: Perception of the impact of the measure on the workload of health workers



Source: *Data from the study, 2022*

Box 3: Effects induced by the implementation of the policy

The implementation of free care is associated with a reduction in the maternal mortality rate and the mortality rate of children aged 0 to 5. It is also supported by the attendance of health facilities by the target populations and the systematic recourse of the populations to health facilities in the event of illness.

3.5. Sustainability of the achievements of the free access measure

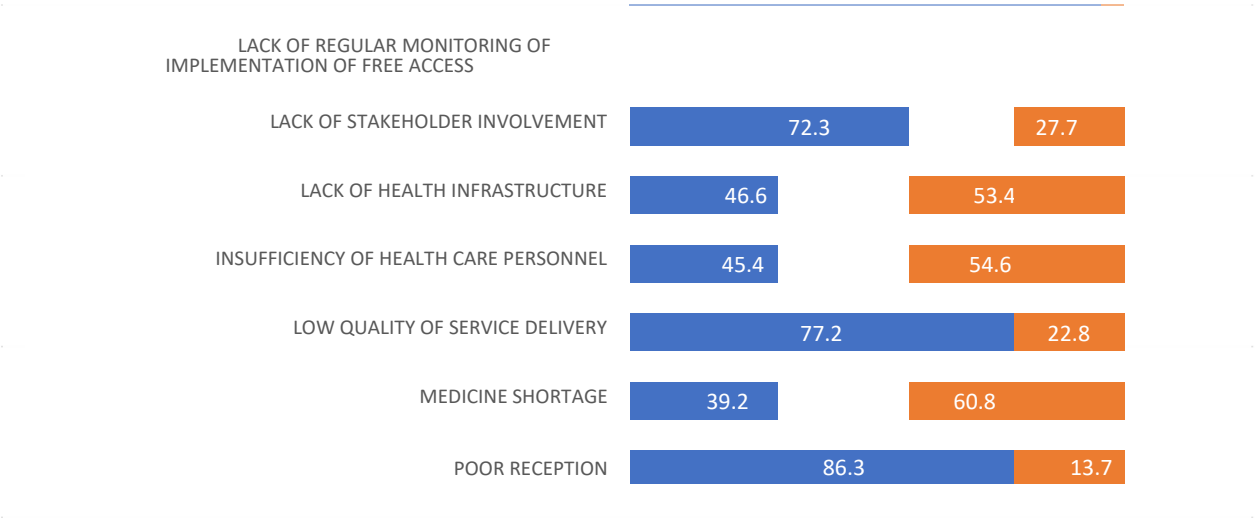
This exercise consists in assessing as a whole the viability of the measure of free care for children aged 0 to 5 years and care for women, as well as the sustainability of the mechanisms put in place to identify best practices. It is a question of providing answers to a number of questions. These questions are necessary because the answers provided would make it possible to determine whether the effects of the measure of free health care could continue.

3.5.1 Constraints to the implementation of the free access measure

Constraints are potentially multiple and are analyzed with regard to their occurrence from a list of constraints identified by previous studies. These constraints are appreciated by health workers, COGES members and the Communities.

As shown in the graph below, the disruption of medicines (60,8%), the shortage of health personnel (54,6%) and the lack of health infrastructure are considered the major constraints to the implementation of the measure. The lack of monitoring of this implementation of free care (38,5%) and the lack of involvement of stakeholders in free care are also mentioned as constraints but rather to a lesser extent.

Figure 32: Constraints to the implementation of the free access measure



Source: *Data from the study, 2022*

3.5.2. Incentive measures to encourage the use of health facilities

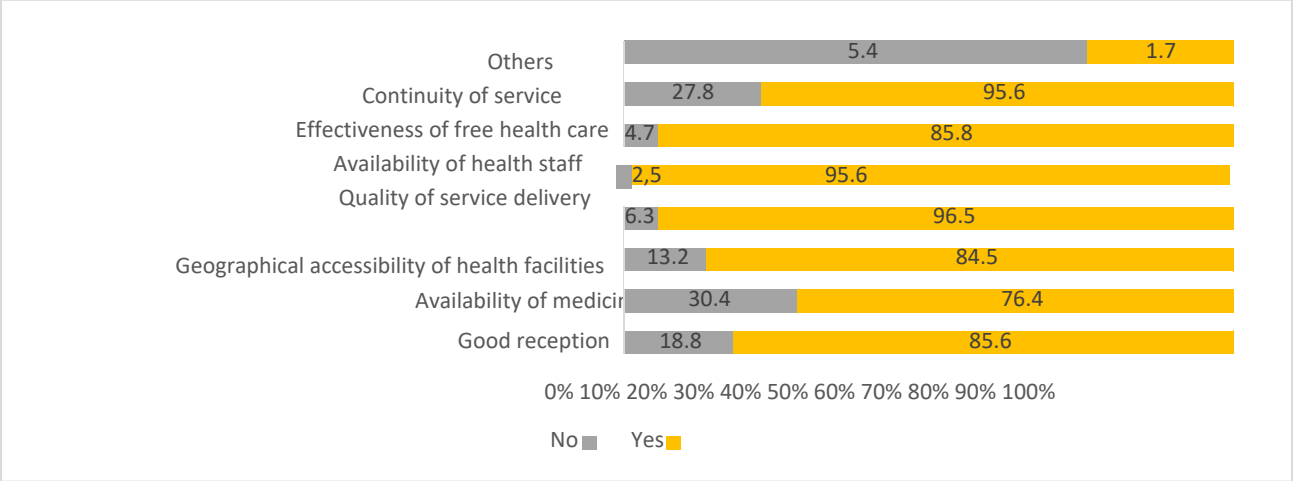
This section makes it possible to assess the incentive measures put in place as part of free health care to encourage the attendance of health facilities by the beneficiaries. It is apprehended by the households interviewed.

These questions are important because the answers provided will contribute to improving the quality of the services contained in the measure of free care for children aged 0 to 5.

The reasons for attending health facilities are encouraged by the following:

- Quality of service (96,5%)
- Continuity of service (95,6%)
- Geographical accessibility of health facilities (84,5%)
- Good reception (85,6%);
- Medicine availability (76,4%).

Figure 33: Incentives for free healthcare



Source: *Data from the study, 2022*

Box 4: Sustainability analysis

The implementation of the measure of free health care, increases the demand for health services by the population. In this respect, the service offer must adapt to meet this demand. An adequate technical platform (infrastructure and health inputs) and sufficient staff at the level of health facilities are levers for success of the measure of free health care. The good reception, the availability of health workers for patients, the quality of services and the accessibility of health facilities are factors of success of the measure.

4. RECOMMENDATIONS OF THE EVALUATION

In order to improve the policy of free health care in the Dosso region and make it viable and sustainable for the well-being of the target populations, the evaluation recommends that the implementing bodies of the policy do the following:

- ***The Government:***
  - take the necessary steps to reimburse, as soon as possible, the accumulated arrears with respect to the various health facilities;
  - To make operational the National Institute of Medical Assistance (INAM) with decentralized bodies;
  - to set up an operational mechanism for better monitoring of the policy of free health care by the central team responsible for free health care (to put more financial resources and human resources);
  - to create a framework for communication and consultation between the Ministry of Public Health, Population and Social Action and the Ministry of Finance;
  - Involve the Ministry of Finance at all levels in the management of the policy of free health care, particularly in terms of control;
  - consider deconcentrating of the payment circuit;
  - strengthen the capacity of health personnel in the preparation of invoices;
  - To value the contributions of technical and financial partners by counting them in the global base of free health care in Niger,
  - to find a sustainable system of financing free access;
  - Capitalize on the reform of free care through INAM which will develop a strategic purchase (quantity control, quality control and the voice of the community).

- ***Technical and financial partners:***
  - Align their support with the objectives defined by the Ministry of Health in the context of the measure of free maternal and child healthcare;
  - support the pooling of resources in the health system for better care.

- ***Health facility managers:***
  - to respect the targets of the free access policy.

5. GENERAL CONCLUSION

Since 2006, Niger has been implementing the measure of free health care. This includes providing free health services for certain categories of the population, particularly children under five (5) years of age and women, including: Family planning, prenatal consultation, caesarean section/ectopic pregnancy/uterine rupture, and gynecological cancer. For children under five (5) years of age, free health care covers all preventive and curative care.

HCME in collaboration with the Ministry of Public Health, Population and Social Action commissioned a rapid evaluation of the measure of the free health care package in the Dosso region with the financial support of TWENDE MBELE and UNICEF to assess the implementation of this intervention.

This evaluation revealed certain shortcomings in the implementation of this measure of the free care package, namely:

- the delay and/or non-reimbursement of a critical mass of invoices to health facilities;
- lack of human resources and medicines;
- a massive influx of patients to health centers;
- a reduction in the quality of services;
- a lack of sustainable sources to guarantee sustainable funding for the policy of free health care;
- the existence of major problems with the reliability and sustainability of the care exemption system on the one hand, and the quality of care provided on the other;
- the impossibility of tracking the traceability of reimbursements received by health facilities and of determining the exact proportion of free care in the operation of health services.

However, the policy of free health care in Niger has significantly improved the access of vulnerable populations to health care and services. It has improved the attendance of the population at health facilities and is associated, among other things, with the reduction of maternal mortality rates and of children aged 0 to 5.

Taking into account the recommendations presented above will allow a better implementation of the reform with regard to the new institutional framework for steering coordinated by INAM.

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APPENDICES

Appendix 1:

Evaluation matrix

Evaluation matrix

Criterion Rapid Evaluation	Evaluative questions	Indicators[3]	Data sources	Reference structure[4]	Evaluation Model	Collection/ analysis tools	Methods analysis
Relevance and consistency	How do you rate the adequacy of the measurement of free access with the health needs of the populations		Reform Implementation Document. National and health sector policy documents			Guide/ questionnaire	Meta Document Analysis+ Primary Data Analysis
	How do you appreciate the mechanism of preparation of free access		Stakeholders behind the free provision or actors in the measure			Guide	Meta Document Analysis+ Primary Data Analysis
	How do you appreciate the mechanism of preparation of free access		Practitioners + managers			Guide	Meta Document Analysis+ Primary Data Analysis primaries

3 Here, the indicator refers to the operational means by which responses to the evaluative questions will be addressed.
4 These are the structures from which the information will be collected

Criterion Rapid Evaluation	Evaluative questions	Indicators[3]	Data sources	Reference structure[4]	Evaluation Model	Collection/ analysis tools	Methods analysis
	To what extent the resources allocated to the measure are consistent with the actions envisaged.		Managers +PTF			Guide	Meta Document Analysis+ Primary Data Analysis
Efficiency	How to appreciate the actions implemented as part of the reform in the Dosso region (training, development of procedures, establishment of institutional framework, mobilization of partners, campaigns information)		Managers/health workers/NGOs/beneficiaries			Guide and questionnaire	Meta Analysis of activity reports Health training+, primary data analysis

Criterion Rapid Evaluation	Evaluative questions	Indicators[3]	Data sources	Reference structure[4]	Evaluation Model	Collection/ analysis tools	Methods analysis
	To what extent has the implementation of free education (prenatal consultation, care for children aged 0 to 5 years) been effective in the Dosso region? + planning + caesarean sections		Managers/health workers/NGOs/beneficiaries			Guide/questionnaire	Meta Analysis of activity reports Health training+, primary data analysis
	How do you appreciate the contribution of PTFs in the implementation of the reform (AFD intervention by provision of medicines, FBR etc.)		Managers/Ministry/NGO/Health Officer/Local authorities and+			Guide	Meta Analysis of activity reports Health training+, primary data analysis
	How do you appreciate		Beneficiaries/NGOs/Local authorities and+/PTF/Health Admin			Guide /Questionnaires	Meta Analysis activity reports

Criterion Rapid Evaluation	Evaluative questions	Indicators[3]	Data sources	Reference structure[4]	Evaluation Model	Collection/ analysis tools	Methods analysis
	the functioning of the implementing bodies of the free access measure						health training+, primary data analysis
	To what extent are administrative and regulatory texts applied?		ONG/PTF/health admin			Guide	Meta Analysis of activity reports Health training+, primary data analysis primary data
	How do you appreciate the framework of discussion between the State and the PTFs regarding the reform		ONG/PTF/health admin			Guide	Meta Analysis of activity reports Health training+, primary data analysis primaries
	How do you appreciate the communication channels used to inform the populations on reform		Beneficiaries/NGOs/PTF/health admin/local authorities			Guide /Questionnaires	Meta Analysis of activity reports Health training+, primary data analysis primary data

Criterion Rapid Evaluation	Evaluative questions	Indicators[3]	Data sources	Reference structure[4]	Evaluation Model	Collection/ analysis tools	Methods analysis
	To what extent is the free access tracking system operational?		PTF/managers/health workers			Guide	Meta Analysis of activity reports Health training+, primary data analysis primaries
	How do you rate the availability of medicines at the level of health facilities +Availability PF inputs and caesarean sections		Managers/health workers/NGOs/beneficiaries			Guide /Questionnaires	primary data
	How do you assess the cost of medicines?		Managers/health workers/NGOs/beneficiaries			Guide	primary data
	How do you assess the regularity of the state's payment for care?		Managers/health workers/NGOs/beneficiaries			Guide	primary data

Criterion Rapid Evaluation	Evaluative question	Indicators[3]	Data sources	Reference structure [4]	Evaluation Model	Collection/ analysis tools	Methods analysis
	To what extent do populations value health facilities and the services they provide?		Beneficiaries/NGOs/PTF/ NGOS/local authorities			Guide /Questionnaires	primary data
	What are the Incentive measures to encourage the use of health facilities?		All targets			Guide /Questionnaires	Meta Analysis of activity reports Health training+, primary data analysis primaries
	How good are the services and reception in maternal and child health services?		Beneficiaries/NGOs/local authorities			Guide /Questionnaires	Meta Analysis of activity reports Health training+, primary data analysis
	How do you rate the attendance of		Community (COGES+relay)			Guide	Meta Analysis of activity reports Health primary data analysis Training

Criterion Rapid Evaluation	Evaluative question	Indicators[3]	Data sources	Reference structure [4]	Evaluation Model	Collection/ analysis tools	Methods analysis
	health facilities for free prenatal consultations by pregnant women						health+, primary data analysis
	How do you assess the attendance of health facilities for free care by children aged 0 to 5 years		Community (COGES+relay+)			Guide	Meta Analysis of activity reports Health training+, primary data analysis
Efficiency	To what extent did the resources allocated to the free access reform cover the services?		Managers/Reimbursement Data			Guide	Meta Analysis of activity reports Health training+, primary data analysis
	How do you rate the adequacy of resources with		managers/health workers/PTFManagers/health workers/NGOs/beneficiaries			Guide	Meta Analysis of activity reports Health primary data analysis Training

Criterion Rapid Evaluation	Evaluative questions	Indicators[3]	Data sources	Reference structure[4]	Evaluation Model	Collection/ analysis tools	Methods analysis
	the service provision						health+, primary data analysis primaries
Sustainability of achievements	What are the constraints of the effective setting of the free access measure?		All targets			Guide/questionnaire	Meta Analysis of activity reports Health training+, primary data analysis
	What are the shortcomings inherent in the implementation of the free access measure?		All targets			Guide/questionnaire	Meta Analysis of activity reports Health training+, primary data analysis primaries
	What are the best practices to capitalize on?		managers/health workers/PTFManagers/health workers/NGOs/beneficiaries			Guide	Meta Analysis of activity reports Health training+, primary data analysis analysis

Criterion Rapid Evaluation	Evaluative question	Indicators[3]	Data sources	Reference structure [4]	Evaluation Model	Collection/ analysis tools	Methods analysis
							primary data
Effects induced by the implementation	What are effects induced by the implementation of the free access measure?		Managers/health workers/NGOs/ beneficiaries			Guide	Meta Analysis of activity reports Health training+, primary data analysis primaries

Appendix 2:

Editorial team

Editorial team

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