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RAPPORT PROVISOIRE

Evaluation

OF THE IMPLEMENTATION OF FREE HEALTHCARE FOR WOMEN OF CHILDBEARING AGE AND CHILDREN AGED 0-5 IN THE MARADI REGION

HCME Haut Commissariat à la Modernisation de l'Etat

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unicef & TWENDE MBELE

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ACRONYMS

AFD	French Development Agency
CEDEAO	Economic Community of West African States
CNPR/CPNR	Prenatal Consultation
COGES	School Management Committee
CPoN	Post-natal consultation
CSI	Integrated Health Center
CSME	Mother and Child Health Center
DEP	Direction des Etudes et de la Programmation
DGT/CP	Treasury and Public Accounting Department
DRSP	Direction Régionale de la Santé Publique
DS	Statistics Department
DS	Health District
EDSM	Demographic Health and Household Survey
ENABEL	Belgium-Niger Governmental Cooperation Program
ENAFEME	National Survey on Fertility and Mortality of Children under 5
FNUAP	United Nations Population Fund
HCME	High Commission for State Modernization
HD	District Hospital
HELP	German Humanitarian Non-Governmental Organization
IDH	Human Development Index
INAM	Institut National d'Assistance Médical
INS	National Institute of Statistics
MDM	Médecins du Monde
MSF	Médecins Sans Frontières
MSP/AS	Ministry of Public Health and Social Action
OMD	Millennium Development Goals
OMS	World Health Organization
ONG	Non-Governmental Organization
PDC	Communal Development Plan
PDR	Regional Development Plan
PDS	Health Development Plan
PIB	Gross Domestic Product
PTF	Technical and Financial Partners
SDDCI	Sustainable Development and Inclusive Growth Strategy
UNICEF	United Nations Children's Fund

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EXECUTIVE SUMMARY

The free health care package measure introduced by the Government of Niger in 2006 is part of the country's general policy of strengthening human capital. It has been implemented in all regions of the country, with varying degrees of success and implementation challenges. The evaluation of the measure in the Maradi region was conducted to provide an analysis of its design, its implementation approach, the level of achievement of the expected results and to identify the main difficulties encountered. The evaluation mission based on the criteria of relevance, coherence, effectiveness, efficiency, impact and sustainability was conducted following a highly participatory and inclusive approach.

The free health care measure was implemented in the Maradi region, which has a young population (50% under 15 years old) and a growth rate of 3.7%. In the area of health, the rate of births attended by qualified personnel, which was 47.88% in 2016, fell to 33.4% in 2020 after having reached 48% in 2017. The malaria incidence rate per 100,000 inhabitants has fallen substantially. It fell from 79.41 in 2016 to 55 in 2020. The use of health services is on an upward trend, even if its evolution is erratic between 2016 and 2020. The performance in education is quite encouraging, as are the sanitation efforts in the region.

The evaluation exercise revealed a number of findings with regard to the various evaluation criteria criteria used as a prism for analysis.

The free health care measure is relevant and coherent given its role in facilitating access to health services for vulnerable populations. It is among the national priorities and can be found in the main national and sectoral policy documents and is also in line with the African Union's agenda 2063 and the United Nations' agenda 2030. By its design and implementation framework, it is expected to improve maternal, child and newborn health indicators.

In terms of the effectiveness of the measure, its implementation has been effective given the free care provided to the target people. The population was regularly informed about the measure and used the services offered. They are satisfied with the services offered, although shortcomings have been noted in the supply of inputs due to the irregularity of the reimbursement of service invoices.

The analysis of the efficiency of the measure revealed a low rate of reimbursement of invoices for free health care, which leads to shortages of pharmaceutical products at the level of health facilities, thus reducing the capacity of the latter to give full satisfaction to the populations in the quality of the care offered. Despite this handicap, the majority of the target populations recognise the effectiveness of the free health care measure and are satisfied with its implementation.

Effects, although not exclusively attributable to the measure, are observed, including a decrease in the maternal mortality rate from 106‰ in 2006 to 60‰ in 2021. However, the implementation of the measure has caused an overload of work among health personnel.

Finally, in order to perpetuate the achievements of the reform, interventions in the Maradi region must be based on the regularity of reimbursements and the strengthening of the technical facilities (infrastructure and health inputs) of the health facilities. The sufficient involvement of certain strategic actors, the effectiveness of the monitoring system, sufficient communication and the mastery of procedures by certain agents are also elements that will ensure the success of the measure.

The evaluation mission, in view of the results obtained, highlighted a set of operational recommendations. These recommendations are addressed to the various stakeholders, notably the government, the technical and financial partners and the health facilities, with the aim of improving the implementation of the measure. Among others, the following recommendations can be noted :

- Take the necessary steps to clear the accumulated arrears of reimbursement to all health facilities and systematically pay current bills;
- Reinvigorate the monitoring of the free health care policy by the central team in charge of the central team in charge of free health care (provide more financial and human human resources);
- Reinvigorate the monitoring mechanism of the free health care policy by the central team in charge of free health care at the deconcentrated level (provide more means);
- Respect the alignment of support with the objectives defined by the Ministry of Health in the framework of the free health care measure;
- Support the pooling of resources in the health system for better care;
- Respect the eligibility criteria for free health care.

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 continental country1 with a surface area of 1,267,000 km2 , three quarters of which is in desert areas. It is bordered 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 eight (08) administrative regions, sixty-three (63) departments, seven (07) regional and local authorities and 255 communes, including four (04) communes with a special status or town.

The annual growth rate of the Nigerien population is one of the highest in the world. It has risen from 3.3% (in 2001) to 3.8%2 in 2021. The population is estimated to be 25 million in 2021, up from 3.2 million in 1960. Mostly young (more than 60%) and rural (84%), this population is mainly concentrated in the southern strip of the country (1 /4 of the national territory) where ¾ of the population lives. The population growth rate exceeds the growth rate of the country's agricultural production. This ratio translates into recurrent food and nutritional crises that keep the country in a state of chronic food insecurity in certain parts of the country.

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

The health situation in Niger remains mixed, despite a significant improvement in certain maternal and child health indicators. The use of health services is relatively low due to the persistence of difficulties related to financial and geographical accessibility. The limited accessibility to health structures, the strong disparity between urban and rural areas, the difficulties in supplying medicines, the shortage of material and qualified 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, accompanied by technical and financial partners (TFP), has undertaken numerous reforms to improve the health of the population, including the policy of free health care for certain categories of the population, particularly women and children under five (5) years of age, from 2006. This policy of free health care is based on a strategy of pre-financing the costs of care offered to target groups by health structures, then reimbursing these health structures by the state and/or the PTFs and NGOs. The objective is to contribute to the achievement of the Millennium Development Goals (MDG 4 and 5), related to the reduction of maternal and infant mortality.

This free measure consists of providing women with health services without payment: family planning, prenatal consultation, caesarean section/extra uterine pregnancy/uterine rupture, gynaecological cancer treatment.

[1] Le port le plus proche de la capitale est situé à plus de 1.000 Km de la mer.

[2] Ce taux était de 3,9% (RGPH, 2012).

As for children under five (5), free care concerns all preventive and curative care. However, the implementation of this policy has been laborious and difficult.

In July 2022, the High Commission for State Modernisation (HCME) in collaboration with the Ministry of Public Health, Population and Social Action (MSP/AS), deemed it useful, in the absence of an evaluation of the implementation of the reform throughout the country, to carry out an evaluation of this measure in the region of Maradi following the example of the region of Dosso.

The objective of this evaluation is to assess the beneficiaries' and actors' appreciation of the implementation of the free health care measure. This exercise allows us to determine to what extent the free health care policy has achieved its primary objectives of (1) improve access to health care; (2) reduce child mortality; (3) strengthen partners to provide quality health services; (4) improve the efficiency and effectiveness of free health care delivery approaches; (5) identify operational policy obstacles and new/revised policies adopted and implemented; (6) support local actors, civil society, service providers, local authorities in promoting the free health care policy; (7) document and disseminate lessons learned from adaptation and implementation processes and experiences; and (8) identify and coordinate the needs of partners and national drug management committees. This evaluation, conducted by the Government of Niger, complements the studies already carried out on free access with the support of other partners.

This evaluation report is structured in five (05) chapters. The first chapter presents the socio-economic situation of the Maradi region. The second chapter describes the measure and its rationale. The third presents the objectives of the evaluation and the methodological approach adopted. Chapter 4 presents the results and Chapter 5 is devoted to recommendations.

1. PRESENTATION OF THE SOCIO-ECONOMIC SITUATION IN MARADI

The information contained in this section and the data sources are taken from the Contribution of the MARADI Region to the elaboration of the PDES 2022-2026, September 2020, Minister of Community Development and Land Use Planning (MDC/AT). To be referenced in footnote.

Located in the centre-south of the country, the MARADI Region covers a total area of 41796 km2 characterised by a Sahelian type of climate with irregular and poorly distributed rainfall in time and space. The climatic variability causes recurrent phenomena such as droughts and floods, with the corollary of production deficits in the rural sector and chronic food insecurity.

The MARADI Region has an estimated population of 4,523,438 inhabitants in 2020, with a density of 108.23 hbts/Km² against 17.96 hbts/Km2 for the country. The majority of this population is rural, with 87% of inhabitants, compared to 13% in urban areas. Women represent 50.8% of the population with 2,297,969 women in 2020. It is also noted that the population of the MARADI Region is particularly young (50% under 15 years of age) and is growing at a rate of 3.7% compared to the national average of 3.9%.

In recent years, the Region has been facing the recurrent problem of insecurity particularly linked to the actions of armed bandits along the border with Nigeria.

Agriculture, livestock, trade and handicrafts are the main economic activities in the region. Agriculture alone accounts for more than 95% of the rural population. On another level, there is an emergence of the agri-food industry, the exploitation of quarries and a progressive development of activities in the tertiary sector, notably trade, crafts, transport, communication, hotels, banking, insurance and services.

In the area of health3 , the situation established in connection with the policy of free care shows a Penta 3 coverage rate for children aged 0-11 months which fell slightly during the period 2016-2020. This rate went from 132% in 2016 to 110% in 2020.

On the other hand, the situation of assisted childbirth by health personnel has deteriorated in the same period. Indeed, the rate of births assisted by qualified personnel, which was 47.88% in 2016, fell to 33.4% in 2020 after having reached 48% in 2017.

Over the period 2016-2020, the ANC4 utilisation rate increased from 34.81% in 2016 to 44% in 2019 before falling back to 35% in 2020.

The under-five mortality rate increased from 0.01 ‰ in 2017 to 0.05‰ in 2020.

The malaria incidence rate per hundred thousand population has declined substantially. It fell from 79.41 in 2016 to 55 in 2020.

In addition, the density of health personnel per thousand inhabitants improved from 0.01 in 2017 to 0.33 in 2020. The rate of rupture of molecules has gone from 3.28% in 2016 to 19% in 2020 and the rate of delivery haemorrhages in health facilities has gone from 0.85% in 2016 to 1.80% in 2020.

[3] *Ministre du Développement Communautaire et de l'Aménagement territoire et du développement communautaire (MDC/AT) : Contribution de la Région de MARADI à l'élaboration du PDES 2022-2026, Septembre 2020*

Life expectancy at birth in the Region was 56.5 years in 2011. It is the lowest in the country and can be explained by the precariousness of household living conditions, poor access to basic social services such as health, education, access to drinking water and sanitation, etc. The poor access to public services in all these sectors is due to the inadequacy of the resources allocated to them, the poverty of the population and its perception of the importance of these sectors.

In the area of education, we note that over the period 2016-2020, access to primary education has evolved significantly, even if it has progressed in fits and starts. Indeed, the gross rate of children admitted to the first year of primary school has evolved from 80.7% in 2015/2016 to 105.5% in 2019/2020.

This increase is greater for girls (41.2%) than for boys (23.4%) during this period. This is the result of all the strategies put in place for schooling, through awareness campaigns and other support programmes for the girl child. This has made it possible to reduce the disparity in terms of access between girls and boys, where the gap between the two rates falls from 19.1% in 2015-2016 to 10.9% in 2019-2020, a reduction of 8.2 percentage points. The same situation is observed in rural areas where the disparity between girls and boys is reduced in terms of percentage points.

The gross enrolment rate (GER), which is the ratio of the number of children enrolled in school to the population of official school age (7-12 years), is the indicator used to assess overall educational provision. Thanks to the efforts made to universalise primary education through the implementation of the PSEF, the MARADI Region has made significant progress. Indeed, the gross enrolment rate rose from 80.0% in 2015/2016 to 81.2% in 2019/2020, i.e. an increase of 1.2 percentage points. Nevertheless, this rate hides a significant gap between girls and boys. The gap in the GER for boys compared to girls, which was 22.3 percentage points in 2015-2016, has narrowed to 15.9 points in 2019/2020, i.e. a reduction of 6.4 percentage points. This is essentially due to the multiple awareness-raising actions to raise the level of literacy and reduce parental poverty and socio-cultural constraints (forced marriage of children and/or unwanted pregnancies, etc.), the retention of young girls in school, the improvement in the provision of reception infrastructure (canteens, classrooms, latrines) and equipment (the proportion (89%) of schools with no latrines in 2013 has been reduced to 30.9% in 2019. On the other hand, the regional ratio, which was 5 pupils per bench in 2013, will be 6.2 pupils per bench in 2020.

Consequently, despite these multiple efforts to increase school enrolment, particularly for girls, much remains to be done to of girls, much remains to be done to effectively achieve the goal of universal schooling. schooling.

The disparity of GERs at the level of the departments remains visible. Thus, in 2019, departments such as Guidan Roumdji, Aguié, Madarounfa and the town of MARADI recorded GERs above the regional average (77.9%). However, the departments of Bermo, Dakoro, Gazaoua, Mayahi and Tessaoua remain below this average.

In terms of girls' schooling, particular attention is paid to the departments of Mayahi and Bermo, as indicated by their parity indices which are higher than the regional average, despite their low school enrolment rates of 55.9% and 44.9% respectively (Contribution of the MARADI Region to the development of the PDES 2022-2026, September 2020).

[4] *Source : DSI/MEN*

In the areas of water and sanitation, the Theoretical Access Rate (TAt) 5of the MARADI Region (51.2%) is higher than the national average rate (46.85%). This rate has improved significantly over the period 2016-2021 and is still below the regional target of raising this rate above 56%, while the national target since 2015 is to raise this indicator above 58%.

In urban areas (leasing centres), the rate of service has evolved in fits and starts. In fact, in the MARADI Region, over the period 2016-2019, an average of 693.73% of the inhabitants theoretically have access to drinking water. This rate of access to drinking water masks the existence of a disparity between the concession centres. In fact, with the exception of the Dan Issa centre, all 10 centres managed by SEEN have a service rate of over 80%. In 2019, only two centres out of the 10 did not reach the rate of 100%, namely GUIDAN-ROUMDJI with 96.8% and DAN ISSA which records the lowest rate (61.83%) at the level of the Region.

As for sanitation, the basic activities can be summarised as i) the construction of latrines, ii) the promotion of hygiene and sanitation practices with the support of certain partners in the region through awareness-raising and training activities and the launching of the ATPC.

Nationally, the breakdown rate in 2016 was 8.5%. This rate dropped in 2019 to 7.9%. MARADI with a rate of 5.1% is significantly better than the national level, it is very close to the national target of 5%.

The geographical coverage rate of the MARADI Region is 80.6% in 2019. This rate is higher than the national average (71.77%).

As for the theoretical access rate, it is higher (51.2%) than the national average (46.85%). This rate is below the regional target (56%) set in 2015.

5 Source : Direction Régionale de l'Hydraulique – Maradi

[6] Source : rapport des indicateurs MHA 2019

2. MEASUREMENT DESCRIPTION

2.1. Context

Free health care consists in providing health care services to the target population, i.e. children aged 0 to 5 years, pregnant women, women wishing to space their births, caesarean sections and women suffering from gynaecological cancers, without them having to contribute financially.

The measure of free health care has been introduced since 2006 by the government of Niger for the benefit of certain categories of the population in order to facilitate their access to health care.Several elements were taken into account in the decision:

- The 2005 food crisis: Niger is a country that recurrently experiences food deficits. In particular, the 2005 food crisis aggravated chronic child malnutrition, the persistence of which led NGOs, rather specialised 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 implemented this free care on a national scale. These are two international NGOs: Médecins Du Monde (MDM) and HELP (Ridde, 2007).

- The limits of cost recovery: Niger has had a system of cost recovery for health care (per episode of illness) since 1999. The implementation of this health policy has led to the introduction of partial payment of health care costs by the user in the country and has enabled a regular supply of generic drugs to health facilities at more affordable costs than specialities. However, the 2006 Household and Demographic Health Survey (HDHS) showed that 29.4% of the population do not have access to health services because of costs. "The cost recovery system constitutes a barrier to the use of health services, especially for the most vulnerable groups, i.e. women and children who have no income or whose decision to use a health service depends on the head of the family or a third person" (DEP/MSP). (DEP/MSP). The emergence of free health care in Niger was also favoured by a context of poverty estimated at 63% of the population.

- Health indicators and the achievement of the Millennium Goals: social and health indicators remain weak in terms of performance and have not improved significantly despite the various reforms undertaken by the state (the generalisation of cost recovery, hospital reform, restructuring of the pharmaceutical sector for better access to generic drugs, etc.) since independence. In 2005, the infant and child mortality rate was 274 per 1000 and the maternal mortality rate was 700 per 100,000 births. This is why the Ministry of Public Health has defined a global policy called the Health Development Plan (PDS) 2005-2010, which is based on the Poverty Reduction Strategy Paper (PRSP 2002-2015), with a view to improving health indicators.

The first text taken on the issue of gratuity was the decree n° 2005-316/PRN/MSP of 11 November 2005 granting gratuity for services related to caesarean sections provided by public health establishments. For many agents of the Ministry of Public Health, this was a decision taken in response to the commitments of the Nigerien authorities to reduce maternal and infant mortality in order to achieve the MDGs. It was also a way for Niger to give a positive signal in preparation for the next negotiations with the World Bank (WB).

Indeed, for the World Bank, free caesarean sections and contraceptive products were insufficient measures for Niger to access financial aid from them. The payment of other health services for the population had to be abolished. This is how order n°079/MSP/LCE/MFE of 26 April 2006 instituting free prenatal consultation and care for children from birth to five years old was issued.

2.2. Objective of the measure

The aim of the measure is to improve access to health care for the most vulnerable groups (women of childbearing age, pregnant women and children under the age of five). vulnerable groups (women of childbearing age, pregnant women and children aged 0-5 years).
(0) to five (5) years)

2.3. Legal framework for free health care

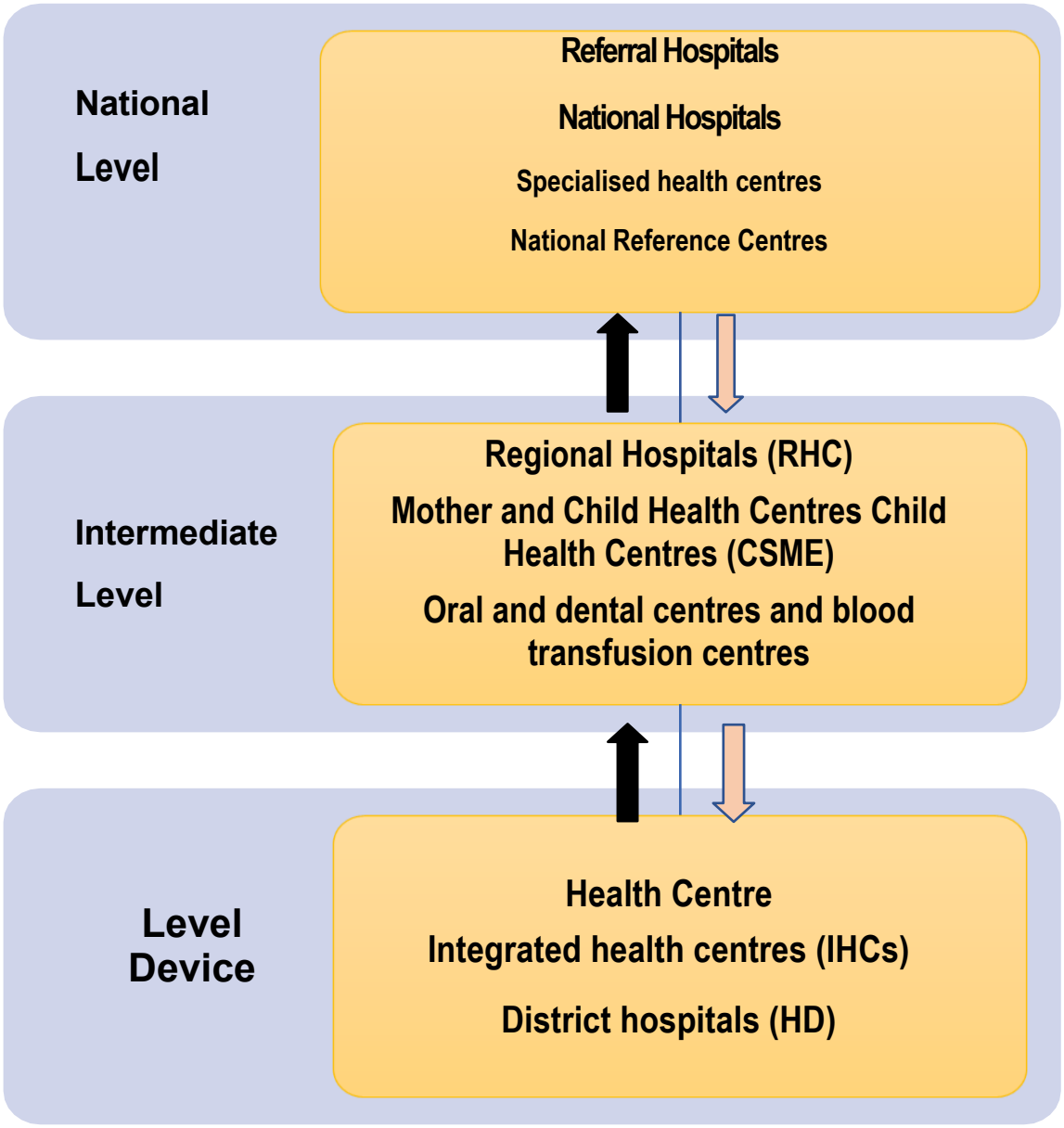
The legal framework of the free-of-charge measure is based on the following regulatory texts:

- Decree No. 2005-316/PR/MSP of 11 November 2005 granting free services related to caesarean sections provided by public health establishments
- Decree N° 2007-261 / PRN/MSP of 19 July 2007 instituting free services related to female cancers provided by public health establishments
- Order N° 0015/MSP/LCE/DGSP of 27 January 2006 on the application of the Decree on Caesarean section
- Order N° 65/MSP/DGSP/DPHL/MT of 7 April 2006 granting free access to contraceptives and condoms
- Order N° 079/MSP/MFE of 26 April 2006 granting free prenatal consultation and care to children aged 0 to 5 years.
- Order N°0219/MSP/DGSP/DOS of 27/08/2007, on the creation, organisation and attributions de la Cellule de Coordination et de Suivi de la gratuité liée aux prestations de santé.
- Order N°132/MSP/ DGSP/DOS/CGS of 7 May 2010, creating 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 free health care conference
- Order N°0425/MSP/SG/DEP/DF of 19 December 2014, creating the Technical Technical Committee in charge of the follow-up of the implementation of free health care.

It should be noted that a National Conference for the reinforcement of free health care in Niger was held from 13 to 15 March 2012. This conference resulted in strong recommendations. Thus, the MSP has set up a committee to follow up on the implementation of the recommendations of the conference on free health care.

2.4. Organisation of the care delivery system

The health system in Niger is organised as follows:



If a level is limited to cover the health benefit, it is referenced to the higher level.

2.5. Informing stakeholders about the measure

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

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

- A note on the management modalities (management tools) of free health care was elaborated and transmitted to the different actors concerned;

- A communication plan has been elaborated by the MSP to inform and sensitize the population and all actors involved in the effective implementation of free health care;

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

- The "word of mouth" system.

2.6. The implementation of the free health care package

The implementation was as follows :

2.7. The financing of the free-of-charge package measure

The measure is financed by the following third-party donors:

- The State: Following the 2006 budget discussions, the MSP obtained the creation of a "free care" budget line in its favour. In 2007, the Finance Law provided for a budget of 3 billion for free health care through the "free" budget line;
- 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.

2.8. The free package

The package concerns curative and preventive care for pregnant women, children from zero (0) to five (05), family planning, female cancers and caesarean sections. The State, as guarantor of the health of the population, has substituted third-party payment for the payment of these services provided free of charge. The care package is provided according to the level of coverage.

2.9. How the free-of-charge package is paid for

Before any treatment can be paid for, it is first checked whether the patient is not covered by a company, an organisation or a health insurance. If they do, the costs to be reimbursed are only for that part of the cost of care borne by the patient (e.g. 10%, 20%). A procedure manual is developed to describe the process of free care. It presents the control tools of the free care package, the mechanism of control and processing of files, the internal control, the external audit, as well as the monitoring and evaluation mechanism.

2.10. The theory of change of the free measure

The theory of change of the free-of-charge measure 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 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 taking into account the alarming level of poverty indicators, the government of the Republic of Niger undertook the implementation of the free health care measure. To do so, it mobilised adequate human, financial, organisational and informational resources to conceptualise and implement this major reform. It has been implemented through a package of actions including the elaboration of the free health care procedure, the setting up of a free health care unit, the training of actors concerned by the implementation of the measure, the mobilisation of the State and partners and the organisation of information campaigns for the benefit of the population.

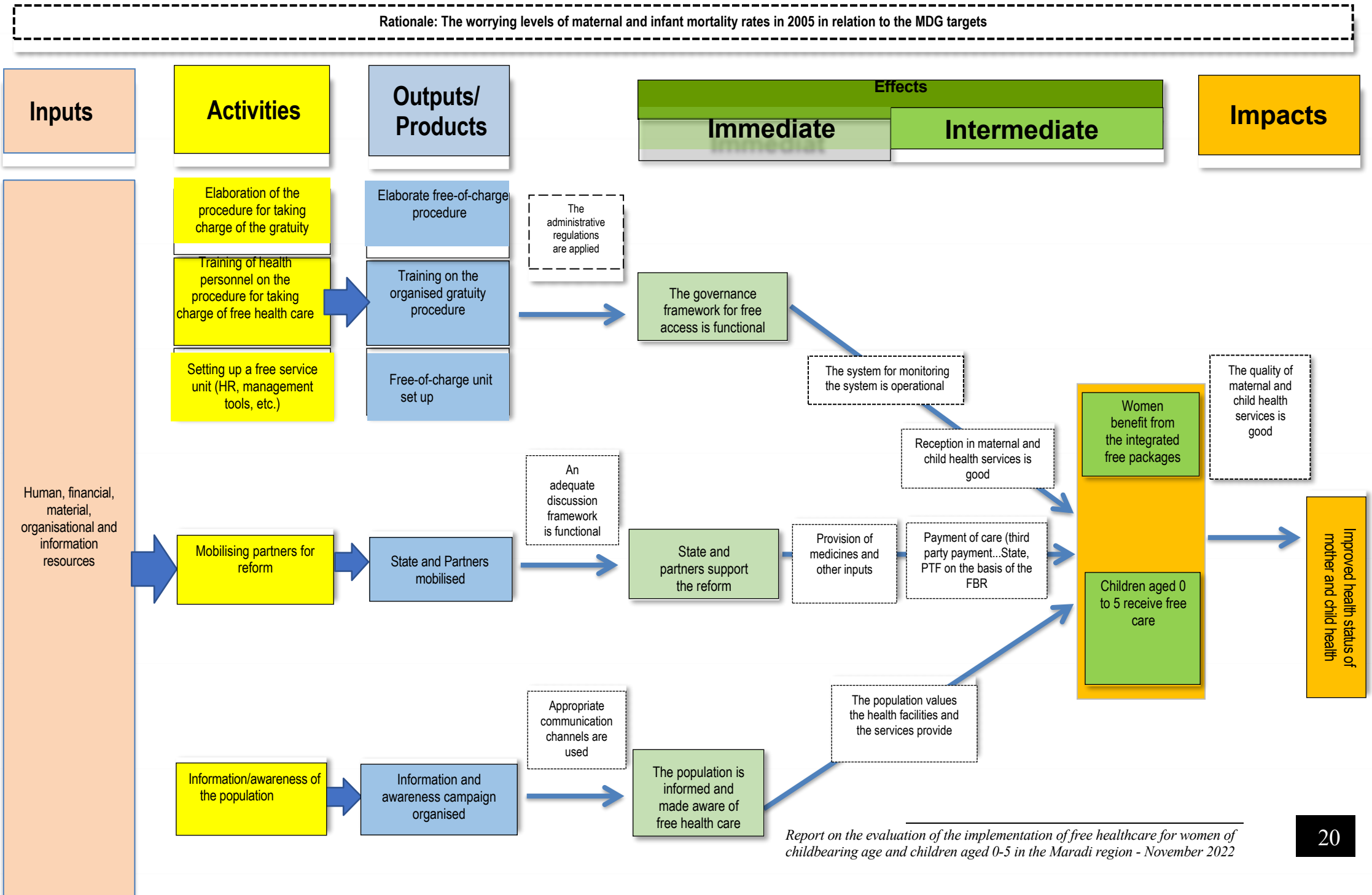
This should lead to a functional governance framework for free health care, the state and partners mobilised to support the reform so that the population is informed and made aware of free health care.

Thus, women of childbearing age and children from zero (0) to five (5) years old will benefit from the measure and will ultimately see their health status improved. However, it should be noted that the materialisation of the virtues of free health care depends on a set of critical conditions or hypotheses which condition the realisation of the successive changes envisaged by the reform. These include

- the regularity of the reimbursement of benefits by the State and other third-party payers
- the availability of medicines and other inputs
- the quality of reception and care in maternal and child health services
- the valuation of health services by the population.

The logic model that embodies 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



3. MEASUREMENT EVALUATION

3.1. Objectives of the evaluation

The objective of this 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 care measure in the Maradi region.

Specifically, the aim is to :

- to make a summary of the implementation of free health care in the different public health establishments of the Maradi region;
- analyse - Analyse the level of effectiveness of free health care at the level of the target groups;
- Analyse the real costs of free health care;
- Identify the contribution of the State and the Technical and Financial Partners;
- Analyse the preparation and management mechanisms of free health care;
- Study the adequacy of this measure with the health care needs of the populations in the Maradi region;
- Examine the results of the free health care measure;
- Assess the means deployed for the reform in relation to the results obtained;
- identify the shortcomings and difficulties inherent in the implementation of the free access measure;
- Analyse the effects of the implementation of the free access measure;
- Propose mechanisms for the sustainability of the achievements;
- formulate operational recommendations for the improvement of the implementation of this measure.

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

3.2. Methodological approach

The methodological approach adopted in the framework of this mission is structured in six (06) steps: (i) technical and operational planning of the evaluation, (ii) design of collection tools, (iii) data collection and processing, (iv) evaluation specifications, (v) evaluation strategy, and (vi) preparation and validation of the report

3.2.1. Technical and operational planning of the evaluation

The first phase of the mission provided the evaluation framework. This is a technical document that guides the evaluation team and all stakeholders in making methodological choices, taking into account the perspectives and context of the evaluation of the measure. It includes: theory of change, evaluation questions, indicators and evaluation strategy.

The design of the evaluation framework mobilised documentary resources related to the free-of-charge measure and the organisation of a technical workshop on methodological design. The workshop, which took place on 27 and 28 October 2022 in Maradi, allowed the technical committee, under the direction of the facilitating consultants, to refine the theory of change of the free-of-charge measure, to refine the evaluation questions, to elaborate the evaluation matrix and to design the data collection tools.

3.2.2. Design of data collection tools

For the purposes of the evaluation and in accordance with the 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 the IHCs, District Hospitals and Regional Hospitals, as well as those in charge of the health centres (managers, collectors, etc.). The other is designed for community actors (COGES, NGOs, traditional authorities) and TFPs.

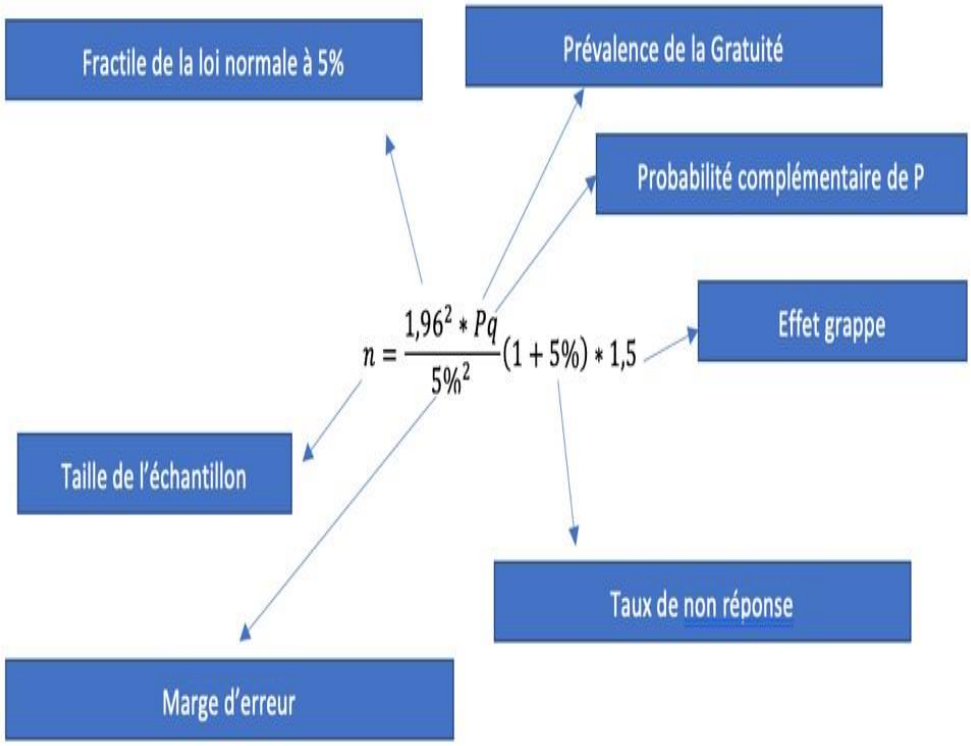
The household questionnaire is intended for women of childbearing age who will be interviewed in the households to be visited.

All the tools designed have been digitised on kobotoolbox.

3.2.3. Data collection and processing

- *Sampling procedure*

The sample size at household level is determined on the basis of the following formula:



It should be noted that four (4) prevalences were taken into consideration. These prevalences constitute the free care package, namely

- Family planning;
- Caesarean section;
- Prenatal consultation
- Care of children under 5 years old.

The optimal sample size is one that allows us to reproduce at the sample level the statistics obtained at the population level.

As the different components of the free-of-charge package give rise to different sample sizes, the statistical law instructs us to take the sample with the highest number of members among the samples calculated according to the prevalences of the different centres of interest of the free-of-charge package.

The application of this formula and according to the law of sample statistics allows us to retain the sample size 579, as shown in the following table:

Table 1 : Sample size estimates

Free of charge package	Prevalence (%)	Sample size
PF	40	579
Caesarean section	2	40
Pre-natal consultation 1	82	361
Pre-natal consultation 4	37	564
0 to 5 years	8	180

***Source**: Study data, based on statistical yearbooks*

The IHCs were considered as sample areas in each Health District (HD). In fact, we listed the number of IHCs per HD. This allowed us to distribute the sample according to the weight of the districts in IHCs, as these are the point of delivery of the free package.

The number of IHCs to be sampled per Health District is determined according to the weight of the District in IHCs. All the health districts were systematically taken into account. The IHCs sampled are chosen randomly within the districts. The number of sample observation units to be considered per IHC is determined by the method developed by the Afrobarometer network. This method consists of taking an average of eight (8) respondents per IHC. This led us to distribute the sample as follows:

- Households were drawn from within the city/village district where the IHC is located.
- The method of drawing households within the villages/towns is the systematic method.
- A sampling step is defined in each village/township 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). Information on the sampling steps is provided to the interviewers.

More specifically, the sample consists of the following MICs:

Table 2 : Distribution of the sample

Integrated Health Centre Sample					Household Load	Focus Load	Health Load	COGES Load	Manager Load	NGO/FTP Load	Total Form
Axis 1											
Guidan Roumdji	CHADAKORI	EL KOLTA	KARAZOME		24	24	2	2	2	2	56
	DAN TOURKE	G/ROUMDJI	N'WALA		24	24	2	2	2	2	56
	DARGUE	HALBAOUA	TIADI		24	24	2	2	2	2	56
	Tibiri				8	8	0	0	0	0	16
Dakoro	ALFORMA	INTOUILA	SABON MACHI		24	24	2	2	2	2	56
	BIRNI LALLE	ISKITA	ALI GARI		24	24	1	1	1	1	52
	BADER GOULA	KORNAKA	DAN MALAM TANOUDE		24	24	1	1	1	1	52
	GUIDAN MAYAKI	MAIYARA			16	16	1	1	1	1	36
Madarounf a	N'Yelwa	Tokarawa	Kandamaou		24	24	2	2	2	2	56
	Guidan Basso	Safo	Keguel		24	24	2	2	2	2	56
	Elkokiya	Madarounfa	Soumarana		24	24	1	1	1	1	52
	Tchizo Kourégué	Tchidafawa	Mai-Gamji		24	24	0	0	0	0	48
		Dama			8	8	1	1	1	1	20
Bermo	AKADANE				8	8	0	0	0	0	16
	BERMO				8	8	1	1	1	1	20
	WURSENA				8	8	0	0	0	0	16
Axis 2											
Tessaoua	Romaza	Guindawa	Kafin Gatari		24	24	2	2	2	2	56
	Korgom	Agama	Gararé		24	24	1	1	1	1	52
	H,Dawaki	Toki	Kirin		24	24	1	1	1	1	52

Integrated Health Sector Samples					Household Load	Focus Load	Health Load	COGES Load	Manager Load	NGO/FTP Load	Total Form
Aguié	Aguié				8	8	1	1	1	1	20
	Dan Bouzou				8	8	0	0	0	0	16
	Maiguizaoua				8	8	0	0	0	0	16
Mayahi	Amani Aréwa	Allassan Maireyreye	Koren Habjia	Zongon Oumara	32	32	1	1	1	1	68
	Baja Kouykouyo	Zaroumey	Maché Jambowchi	Guidan Gagéré	32	32	2	2	2	2	72
	Dan Mallam Mairak	Issawane	Dan Mairo	N'Yelwa	32	32	3	3	3	3	76
	SAIDOU GOULA	Kalgo	Mekesso	Guidan Amoumoune	32	32	2	2	2	2	72
Maradi	17 Portes				8	8	1	1	1	1	20
	Ali Saibou				8	8	1	1	1	1	20
	Andoumé				8	8	0	0	0	0	16
	Zaria II				8	8	0	0	0	0	16
Gazaoua	Aïkawa				8	8	1	1	1	1	20
	Mallam Daweye				8	8	1	1	1	1	20
	Madobi				8	8	0	0	0	0	16
	Makada				8	8	0	0	0	0	16
TOTAL					584	584	35	35	35	35	1 308

Source : *Study data, 2022*

NB :

- Household surveys were conducted in all villages with IHCs in this sample..
- The health worker, village focus group and SMC questionnaires were administered in the IHCs that are coloured red in the sample..

- *Processing and analysis*

Once the data had been collected and compiled, it was processed and analysed in order to produce results that could be used to answer the evaluative questions. The data processing tools used for this purpose were Stata and Excel.

3.2.4. Evaluation estimate

The evaluation design refers to the protocol, approach or strategy adopted to measure and assess the results of the implementation of the free-of-charge measure in accordance with the evaluation questions. It is an analytical framework developed to measure the results that can be attributed to the measure. For this purpose, an evaluation model has been adopted per evaluation criterion.

- *Model for assessing the relevance and coherence of the project*

The evaluation of relevance and coherence makes it possible to assess the reform in its intentions, objectives, functioning and the assumptions on which its implementation is based. The evaluation model consisted of the analysis of the theory of change of the measure..

- *Model for assessing effectiveness and impact*

The assessment of the reform's effectiveness made it possible to draw up a coherent and structured overview of all the results obtained from its implementation and to identify the effects recorded in terms of improving the health status of women and children aged 0-5 years.

As the reform is applied to all these targets in a systematic way, the evaluation model adopted is the implicit model, as there is no reference group other than the beneficiaries.

This model is chosen because it makes a direct estimate of the difference between the situation with the reform and that without the reform. It has real limitations but is the only model that can be used in the context of this free-of-charge measure. The experimental group is made up of the beneficiaries of the measure who themselves report the transformations observed as a result of the free-of-charge measure. This analysis is completed by a meta-analysis of the statistical yearbooks, especially concerning the evolution of the indicators related to the free-of-charge measure.

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- *Sustainability measurement model*

In order to account for the sustainability of the achievements of the implementation of the free health care package, a sustainability analysis was carried out. This analysis consisted in identifying the positive effects of the measure and assessing the factors of the health system affected by the free health care measure in the light of the evaluative questions on sustainability.

3.2.5. Evaluation strategy

The evaluation design, data collection and analysis methods in relation to the evaluation questions reflect the overall evaluation strategy, which is summarised in the evaluation matrix (see Annex 1). It provides a synoptic view of the technical and operational planning of the evaluation.

3.2.6. Preparation of the evaluation report

The draft report was prepared during a workshop held from 24 to 26 November 2022. The workshop involved the processing and analysis of primary data from household surveys and interviews as well as secondary data from statistical yearbooks. This led to the proposal of answers to the evaluative questions and the drafting of the evaluation report. The report was edited and finalised by the team of facilitating consultants.

3.2.7. Limitations of the study

The methodological choices used in this evaluation assignment have some limitations that should be noted. The analysis of the induced effects as presented could lead to the assumption of a causality analysis. However, it is basically a contribution analysis, as the free health care measure cannot be fully responsible for the changes observed in the health indicators.

The nature of the secondary data resulting from the exploitation of the statistical yearbooks, notably their mode of calculation as well as the number of missing data, do not allow for an adequate trend analysis over the period of implementation of the reform. This has somewhat diluted the informational potential of the secondary data.

4. RESULTATS DE L'EVALUATION

4.1. The relevance and coherence of the measure

i. Relevance analysis

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

A preliminary question to this investigation is to know if the reform is known by the population.

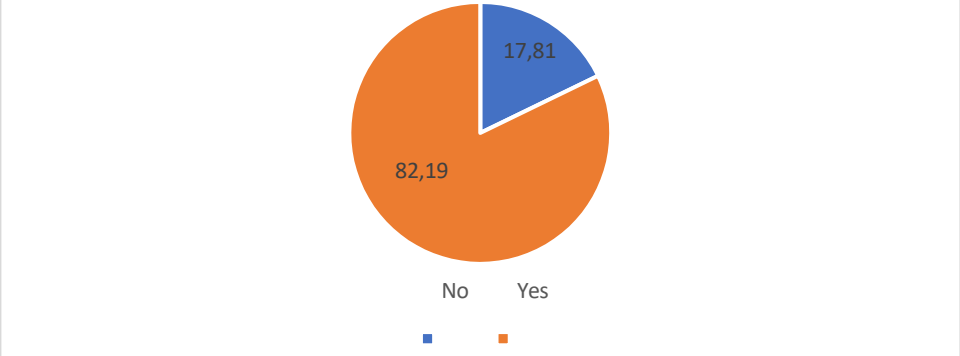
- ***The population's knowledge of the existence of the reform***

The results of the analysis of the data collected show that the entire population surveyed is aware of the free health care measure. For the COGES stakeholders, all the localities concerned declared to have been aware of the free health care reform. As for the households interviewed, 97.24% said they were aware of the free health care package in the health facilities.

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

Regarding the adequacy of the free health care package with the real needs of the population, the data reveal that 82.19% of the surveyed population assert that the free health care package meets their real needs against 17.81% who claim the opposite.

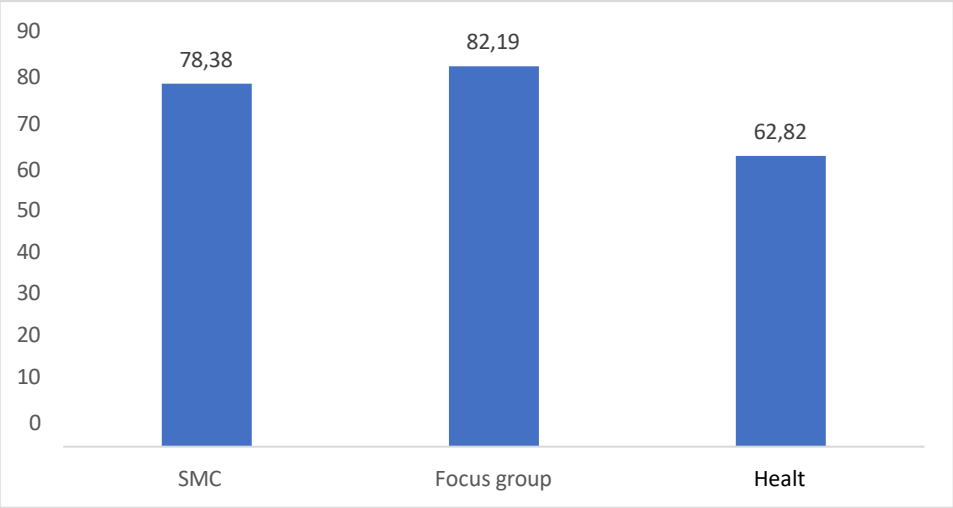
Figure 1: Distribution of the surveyed population according to their point of view on the adequacy of the free package with their needs.



Source : *Study data, 2022*

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

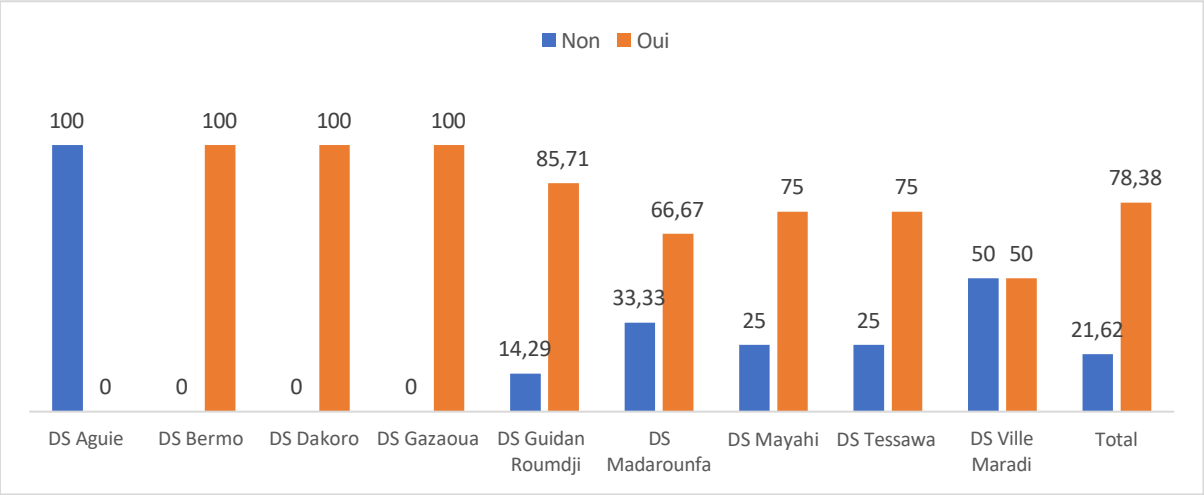
Figure 2 : *Distribution of the surveyed population by group of actors according to their point of view on the adequacy of the free health care package with the needs of the populations*



Source : *Study Data, 2022*

At the COGES, 78.38% of these actors recognise the adequacy of the free health care packages with the real needs of the population. However, disparities between the districts of the Maradi region should be highlighted. Indeed, AGUIE affirms a total inadequacy between the offer of free health care and the real needs of the population. This is also the case in the city of Maradi with a proportion of 50% inadequacy. As for Madarounfa, Mayayi and Tessaoua, they represent respectively 33.33%, 25% and 25% who think that there is an inadequacy.

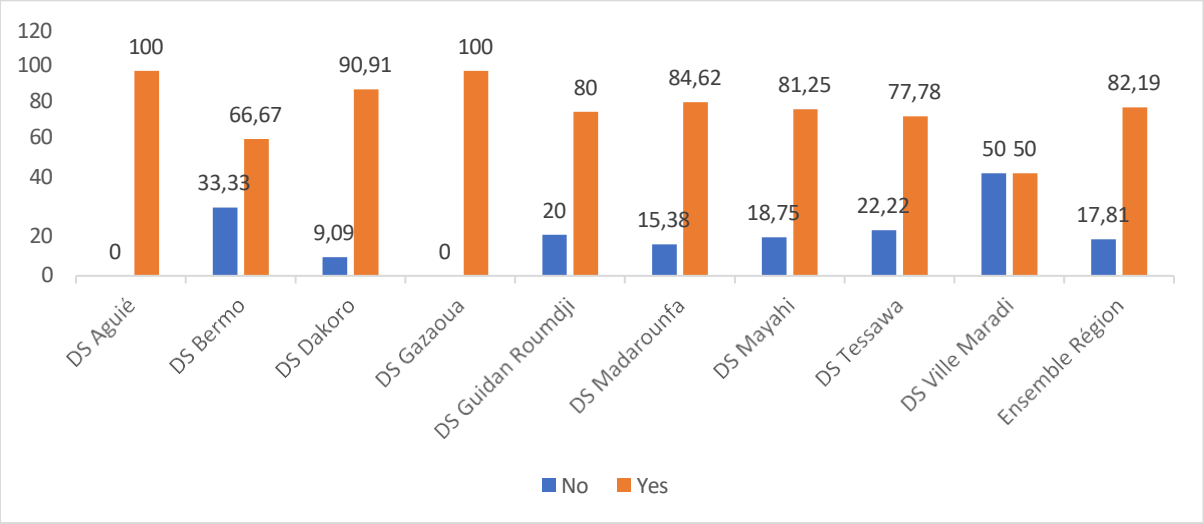
Figure 3 : Distribution of COGES by District according to their point of view on the adequacy of the free health care package with the needs of the populations



Source : *Study Data, 2022*

At the community level, 82.19% answered that the free health care packages are adapted to the population's health needs. If we look at the districts, we notice that more than 70% of the actors affirm that the free health care package is adapted to the needs of the population, except for the city of Maradi (50%) and Bermo (66.67%).

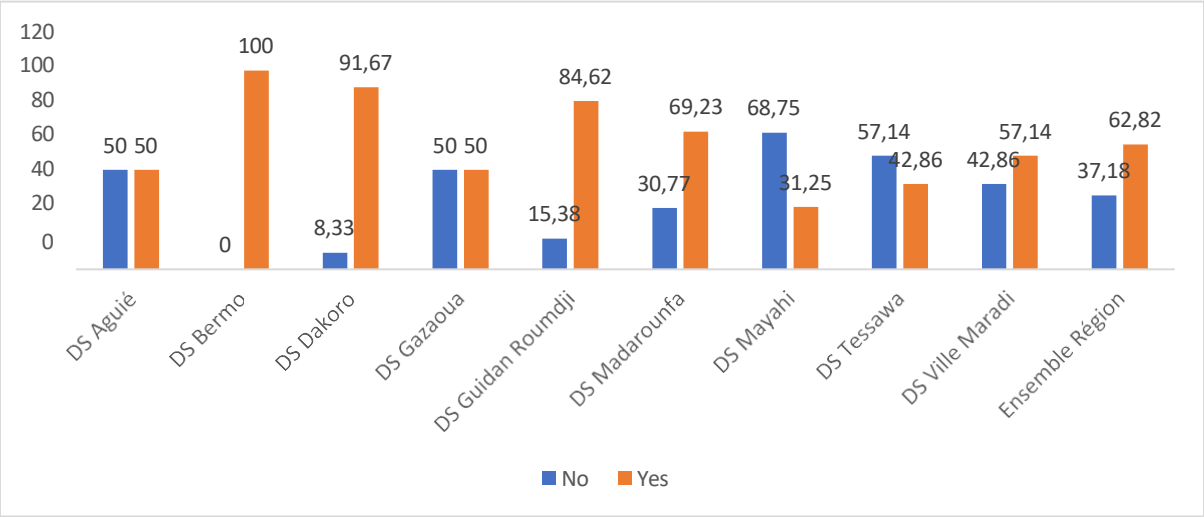
Figure 4 : Distribution of communities by District according to their point of view on the adequacy of the free health care package with the needs of the populations.



Source : *Study Data, 2022*

As for the health workers, 62.82% of them think that the free health care packages perfectly meet the needs of the population. Opinions are divided at the district level. They vary from 100% of the actors who affirm the adequacy, in Bermo to 31.25% in Mayayi.

Figure 5 : Distribution of health workers by District according to their point of view on the adequacy of the free health care package with the needs of the populations



Source : *Study Data, 2022*

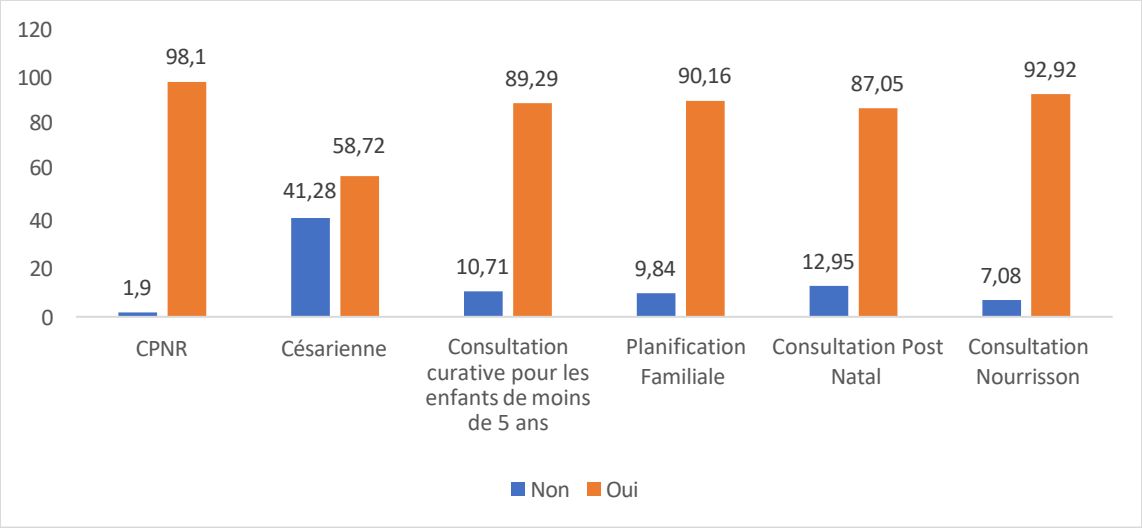
Furthermore, if we look at the nature of the free service, from the households' perspective, the following can be seen:

- For NRPC, 98.1% said that the offer is adapted to their needs.
- As for the free caesarean section, 41.28% of households said that this package does not meet their expectations.
- Regarding curative consultation for children under 5 years of age, 89.29% of households said that their expectations were met.

With regard to free family planning, 90.16% of households stated that their needs are met by the service offer.

Finally, for postnatal consultation and infant consultation, households gave their satisfaction levels as 87.05% and 92.92% respectively.

Figure 6: The degree of adaptability of free health care packages in relation to the expectations of the households surveyed



Source : *Study Data, 2022*

ii. Analysis of the consistency of the measure

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

The process of evaluating the coherence of free health care is based on two types of analysis: the analysis of external coherence and the analysis of internal coherence, which respectively highlighted the extent to which free health care responds to national health priorities and the way in which its technical implementation elements are articulated in order to achieve the set objectives.

- ***External consistency***

At the international level, the measurement of free education is in line with international commitments, notably the United Nations 2030 Agenda's MDG 3, the African Union's 2063 Agenda's objective 3 and the ECOWAS 2020 Vision's Pillar 1, etc.

At the national level, all the multi-sectoral strategic documents have always put the reform of free education at the centre of their priorities. There is perfect alignment between the reform and the Poverty Reduction Strategy (PRS-PRDS) as well as the Sustainable Development and Inclusive Growth Strategy (SDDCI) Niger 2035, which is implemented through five-year Economic and Social Development Plans (PDES), the first version of which is the PDES 2017-2021. In this regard, strategic axis 2 of the PDES 2017-2021 is devoted to the development of human capital and demographic transition.

Also, the PDES 2022-2026 devotes its first axis to the "Development of human capital, social inclusion and solidarity" through which the measure of free health care is taken into account in programme 2 "Improvement of the health and nutritional status of the population and demographic determinants". Similarly, the measure of free health care is contained in the different SDPs (2011-2015, 2017-2022) and is taken into account in the Regional Development Plans (RDP) and the Communal Development Plans (CDP).

- ***Internal consistency***

As part of the preparation for the implementation of free health care, a manual for the management of the reform was developed in 2007. Several texts, notably decrees and orders, were issued to reinforce the legal framework. These texts include: (i) decree 2005-316/PR/MSP of 11 November 2005 granting free services related to caesarean sections provided by public health establishments, (ii) decree n°2007- 261/PRN/MSP of 19 July 2007 instituting free services related to female cancers provided by public health establishments, (iii) decree n°0015/MSP/LCE/DGSP of 27 January 2006 on the modalities of application of the caesarean section decree. Similarly, the channels for financing the reform have been identified, notably a "free" budget line and contributions from technical and financial partners (AFD, UNFPA, UNICEF, Global Fund and NGOs).

In addition, a coordination and monitoring-evaluation mechanism has been set up with an institutional anchor at the level of the Ministry of Public Health, Population and Social Affairs. The latter includes the heads of health structures at all levels. External evaluations are planned every three (3) years to assess the effects of this measure.

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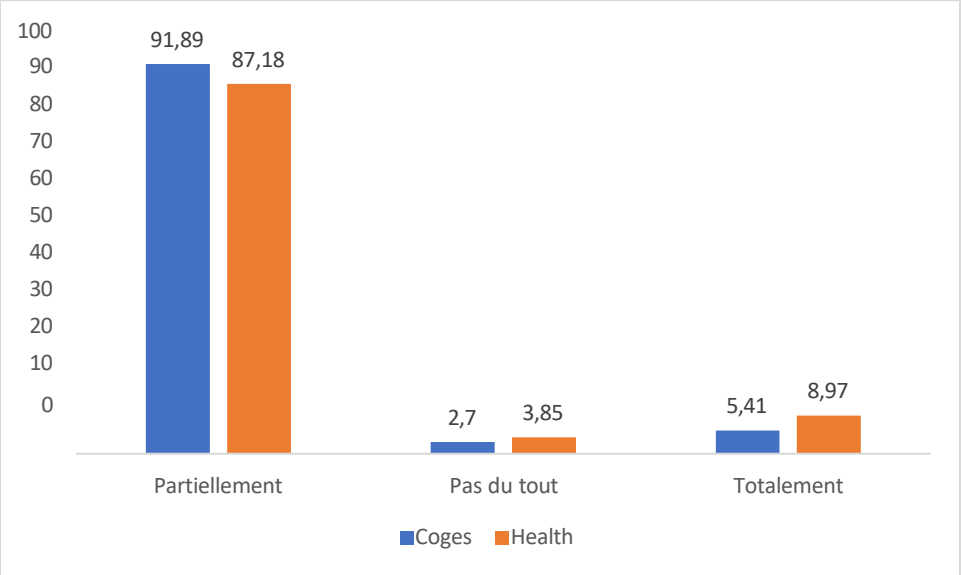
- ***Coherence of resources with the actions envisaged by the measure***

***Adequacy between resources allocated to the free-of-charge reform and the services offered**

The majority of the actors (SMCs and health workers) interviewed declared that the adequacy between the resources allocated to free health care and the services offered is partial.

These proportions vary according to the actors: 91.89% for the SMCs and 87.18% for the health agents. On the other hand, a small percentage of these actors affirmed a perfect adequacy between the resources allocated and the services provided. These proportions are 5.41% for the SMCs and 8.97% for the health workers.

Figure 4: Match between resources allocated and delivery

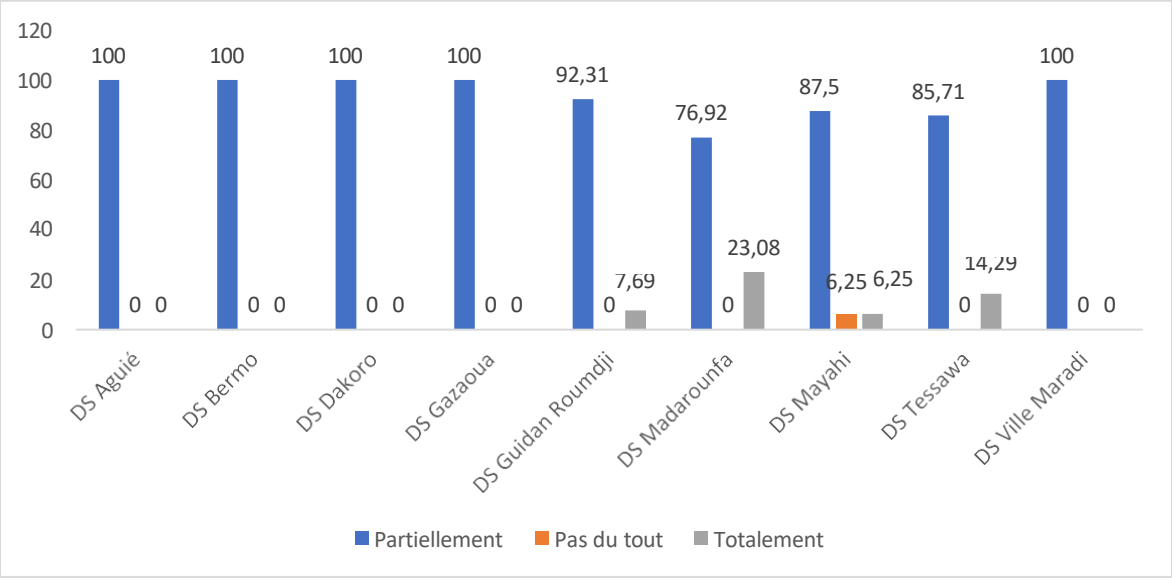


Source : *Study Data, 2022*

***Adequacy between the means and the demand for the service**

On the whole, all the health workers interviewed judged the adequacy between the means and the demand for services to be partial, with proportions varying between 76.92% and 100% between health districts. However, we note that in Madarounfa, Tessaoua and Guidan Roumdji, the assessment of the adequacy between the means and the demand for services is judged to be total with 23.08%, 14.29% and 7.69% respectively.

Figure 5 : Match between resources and demand for services



Source : *Study Data, 2022*

Box 1: Analysis of relevance and consistency

The free health care measure is relevant given its role in facilitating access to health services for vulnerable populations. The latter generally consider that its content meets their needs. It is among the national priorities and can be found in the main national and sectoral policy documents and is also in line with the African Union's Agenda 2063 and the United Nations' Agenda 2030. By its design and implementation framework, it is expected to improve maternal, child and newborn health indicators. However, the allocation of resources and the provision of means (health inputs and medicines) have not been commensurate with the demand of the population and the health services envisaged. Therefore, the state would benefit from strengthening its coordination and monitoring-evaluation mechanism for this free service.

4.2. The effectiveness of the free-of-charge measure

In this section, we present some stylised facts on the use of free health services by the population, the evolution of some indicators reflecting the health status of the population in the Maradi region and the analysis by stakeholders of the effectiveness of the implementation of the free health services measure.

4.2.1. Use of free services in the Maradi region

3.2.2.1. Family planning

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

The table below shows that the Dakoro Health District recorded the lowest average proportion against that of Bermo which recorded the highest. These proportions are respectively 24.67% and 60.54%. In addition, Tessaoua District recorded the lowest standard deviation (2.73%) against Bermo (60.8%). This explains why Tessaoua District has less disparity of observations than Bermo District. The upward trend over the last 5 years is observed in the Districts of Aguié, Dakoro, Guidan Roumdji, Madarounfa, Mayahi and Tessaoua. On the other hand, the downward trend is observed in the Health Districts of Bermo, Gazaoua and Maradi town. But overall the trend is upwards in the Maradi region.

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

Districts	Aguié	Bermo	Dakoro	Gazaoua	Guidan Roumdji	Madarounfa	Maradi Ville	Mayahi	Tessaoua	Région
2017	35,2	19,87	16,93	37,27	29,89	27,68	29,97	32,48	42,81	30,16
2018	1,5	168,24	10,54	67,24	16,15	37,15	44,93	19,63	38,46	11,43
2019	36,66	34,21	27,65	39,51	36,19	25,71	28,28	35,91	45,03	34,14
2020	39,35	37,54	33,84	34,81	41,61	32,6	29,29	36,39	45,24	39,61
2021	45,34	42,87	34,41	37,31	53,02	37,77	25,87	34,38	42,72	37,33
Average	31,61	60,546	24,674	43,228	35,372	32,182	31,668	31,758	42,852	39,61
Standard Deviation	17,27	60,8	10,58	13,53	13,7	5,44	7,57	6,95	2,73	11,25
Minimum	1,5	19,87	10,54	34,81	16,15	25,71	25,87	19,63	38,46	11,43
Maximum	45,34	168,24	34,41	67,24	53,02	37,77	44,93	36,39	45,24	39,61
Trend	Increase	Decrease	Increase	Decrease	Increase	Increase	Decrease	Increase	Increase	Increase

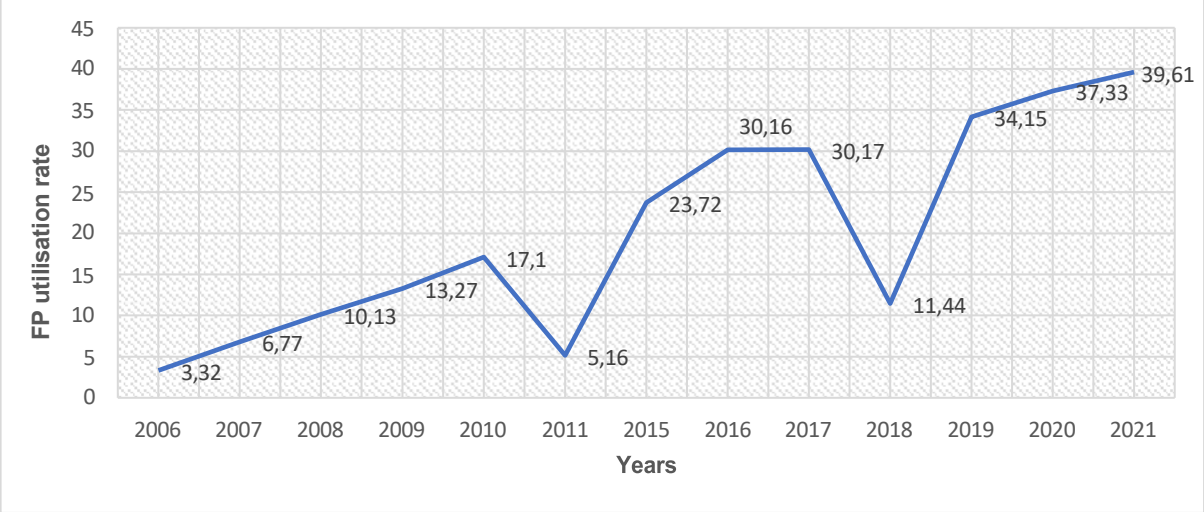
Source : *Statistical directories, DS*

The following graph shows that the family planning use rate has an upward trend from 2006 to 2021. However, there is a downward trend over the same period, with falls in 2011 to 2018.

These results can be explained by a generalized 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 the use of contraceptive products. In addition, the communication strategy put in place has contributed to the acceptance of the system and the improvement of women's and children's health. Finally, we can state that the family planning policy is a success in the Maradi region, as it shows an overall upward trend, despite some decreases in certain years.

Figure 6: Overall FP utilisation rate in Maradi region



Source : *Statistical directories, DS*

En In terms of year of protection pairings, as shown in the table below, Dakoro Health District recorded the lowest proportion (10.9%) against Madarounfa which recorded the highest (40.59%). Furthermore, the District of Aguié recorded the lowest standard deviation (2.84%) against that of Guidan-roumdji recording the highest standard deviation (14.87%). This explains why the Aguié District shows less disparity in observations than the Guidan-roumdji District.

The upward trend over the last 5 years is observed in the Maradi City Health District. In addition, the downward trend is observed in the Districts of Mayahi and Tessaoua.

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

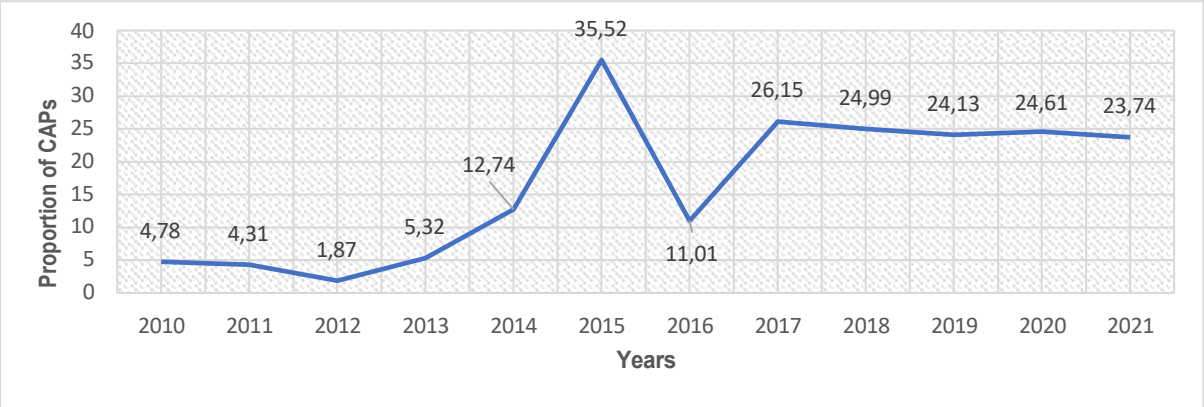
District/Région	Aguié	Bermo	Dakoro	Gazaoua	Guidan Roumdji	Madarounfa	Maradi Ville	Mayahi	Tessaoua	Région Maradi
2017	15,38	6,61	3,63	38,19	32,16	29,31	16,45	30,01	40,52	26,15
2018	20,22	24,19	18,01	22,05	15,83	34,05	21,05	24,71	39,94	24,99
2019	19,15	24,29	12,87	19,31	13,32	52,25	20,45	24,38	28,25	24,13
2020	13,98	24,51	10,76	22,85	20,17	47,58	30,46	27,11	24,93	24,61
2021	19,85	10,13	9,24	21,75	49,43	39,79	30,81	14,85	11,19	23,74
Average	17,716	17,946	10,902	24,83	26,182	40,596	23,844	24,212	28,966	39,61
Standard Deviation	2,84	8,83	5,25	7,58	14,87	9,43	6,45	5,7	12,11	0,93
Minimum	13,98	6,61	3,63	19,31	13,32	29,31	16,45	14,85	11,19	23,74
Maximum	20,22	24,51	18,01	38,19	49,43	52,25	30,81	30,01	40,52	26,15
Trend	Increase	Increase	Increase	Increase	Increase	Increase	Decrease	Decrease	Decrease	Decrease

Source : *Statistical directories, DS*

The availability of data allowed us to consider the series from 2010 to 2021 from the statistical yearbooks of the MSP/P/AS. The results show that, overall, the trend in year-of-protection couples is upwards from 2010 to 2021, despite the jagged evolution of the curve with a peak in 2015 (35.52%) and a break in 2016 (11.01%).

But the amplitude of variability is more observed from 2010 to 2017. In contrast, the evolution is more stable from 2017 to 2021.

Figure 7: Percentage of couple year protection in the Maradi region



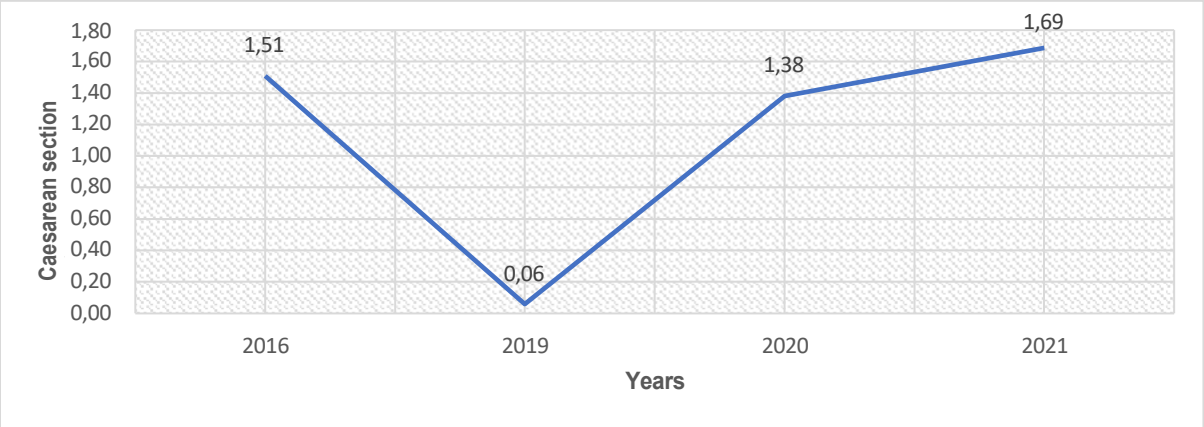
Source : *Statistical directories, DS*

3.2.2.2. Caesarean section

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

The graph below shows that in 2019, the caesarean section rate dropped drastically compared to 2016 before rising again in 2020 and 2021. This can be explained by the advent of the COVID-19 pandemic, which negatively influenced the attendance of IHCs. However, we note that despite the non-effectiveness of the caesarean kit, free access has increased the attendance of health facilities, which allows health workers to identify the need for caesarean sections.

Figure 8: Caesarean section rates in the Maradi region



Source : *Statistical directories, DS*

3.2.1.1. Childbirth

As shown in the table below, the Bermo Health District has the lowest average rate (8.01%) of births attended by skilled personnel, while the city of Maradi has the highest rate (53.57%). The highest standard deviation (11.2%) is in Tessaoua against Dakoro with the lowest standard deviation (4.98%). Only Tessaoua district showed a downward trend in the increase in the rate of births attended by skilled personnel. However, this decline does not explain the drop in care, but rather the increase in the health coverage base, which has developed disproportionately.

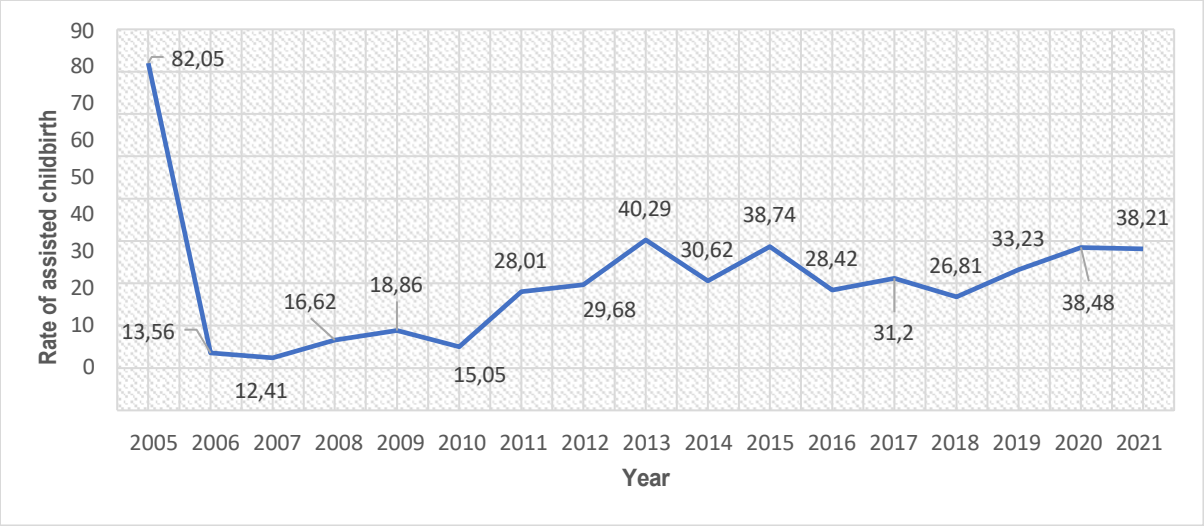
Table 5: Rate of births attended by skilled personnel over the last 5 years

District-Region	Aguié	Bermo	Dakoro	Gazaoua	Guidan Roumdji	Madarounfa	Maradi Ville	Mayahi	Tessaoua	Région Maradi
2017	32,42	10,22	19,77	25,28	17,4	23,87	35,8	24,91	59,7	31,2
2018	23,04	12,72	17,68	23,59	20,97	23,71	55,85	23,31	30,85	26,81
2019	38,09	10,84	23,6	30,13	27,98	33,81	52,52	30,03	34,26	33,23
2020	38,91	24,47	28,17	33,21	29,79	43,56	62,54	32,95	41,1	38,48
2021	39,57	31,81	28,94	35,75	33,61	46,02	61,16	31,29	43,74	38,21
Average	34,406	18,012	23,632	29,592	25,95	34,194	53,574	28,498	41,93	39,61
Standard Deviation	6,96	9,65	4,98	5,15	6,62	10,54	10,73	4,18	11,2	4,93
Minimum	23,04	10,22	17,68	23,59	17,4	23,71	35,8	23,31	30,85	26,81
Maximum	39,57	31,81	28,94	35,75	33,61	46,02	62,54	32,95	59,7	38,48
Trend	Increase	Increase	Increase	Increase	Increase	Increase	Increase	Increase	Decrease	Increase

Source : *Statistical directories, DS*

The rate of skilled birth attendance dropped from 2005 to 2006. However, since 2006, with the implementation of free health care, the rate of births attended by quality personnel has increased. This shows the undeniable contribution of free care in the increase of births assisted by qualified personnel.

Figure 9 : Rate of assisted deliveries per skilled person



Source : *Statistical directories, DS*

3.2.1.2. Services for children aged 0-5 years

Table 6 presents the evolution of the coverage rate for infant consultations over the period 2017-2021. It shows the following: Bermo Health District records the lowest average (100.448%) against Aguié Health District recording an average of (53.37%). For the whole region except for the Aguié District where the trend is constant, only the Guidan Roumdji and Madarounfa Districts recorded a downward trend in infant consultations.

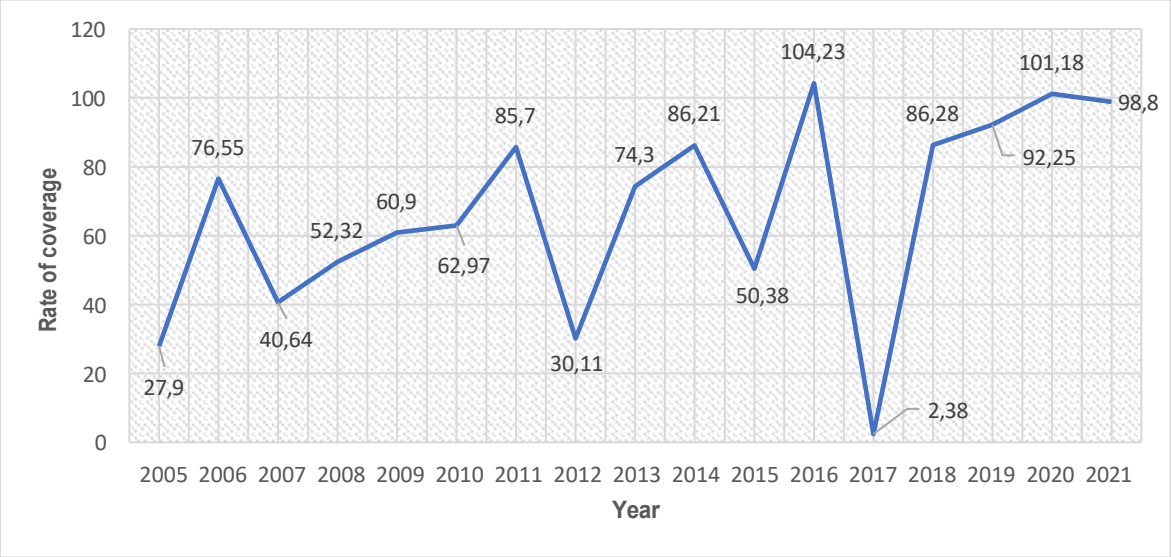
Table 6 : Infant consultation coverage over the last 5 years

DISTRICTS / REGIONS	Aguié	Bermo	Dakoro	Gazaoua	Guidan Roumdji	Madarounfa	Maradi Ville	Mayahi	Tessaoua	Région Maradi
2017	93,97	13,96	27,86	12,82	22,21	16,15	4,38	3,05	5,54	2,38
2018	102,51	76,71	87,42	124,39	62,43	74,87	83,44	86,44	101,73	86,28
2019	109,39	54,2	83,62	107,17	85,67	76,61	82,93	90,76	120,53	92,25
2020	103,14	64,65	87	116,29	99,11	87,99	92,38	110,8	124,3	101,18
2021	93,4	57,33	97,61	115,48	94,39	89,73	88,91	98,97	119,16	98,8
Average	100,482	53,37	76,702	95,23	72,762	69,07	70,408	78,004	94,252	39,61
Standard Deviation	6,77	23,67	27,8	46,47	31,59	30,31	37,12	42,92	50,35	41,66
Minimum	93,4	13,96	27,86	12,82	22,21	16,15	4,38	3,05	5,54	2,38
Maximum	109,39	76,71	97,61	124,39	99,11	89,73	92,38	110,8	124,3	101,18
Trend	Constant	Increase	Increase	Increase	Decrease	Decrease	Increase	Increase	Increase	Increase

Source : *Statistical directories, DS*

As shown in the figure 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 that year. However, there was a drop in 2007, followed by a progressive increase in the consultation rate from 2007 to 2011 and a drop in 2012 and 2017. The overall trend in infant consultation rates is upwards from 2006 to 2021. This explains the contribution of free care to infant consultations. Free health care has increased women's attendance at health facilities.

Figure 10: Infant consultation coverage rate



Source : *Statistical directories, DS*

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

Maradi region is presented in the table below.

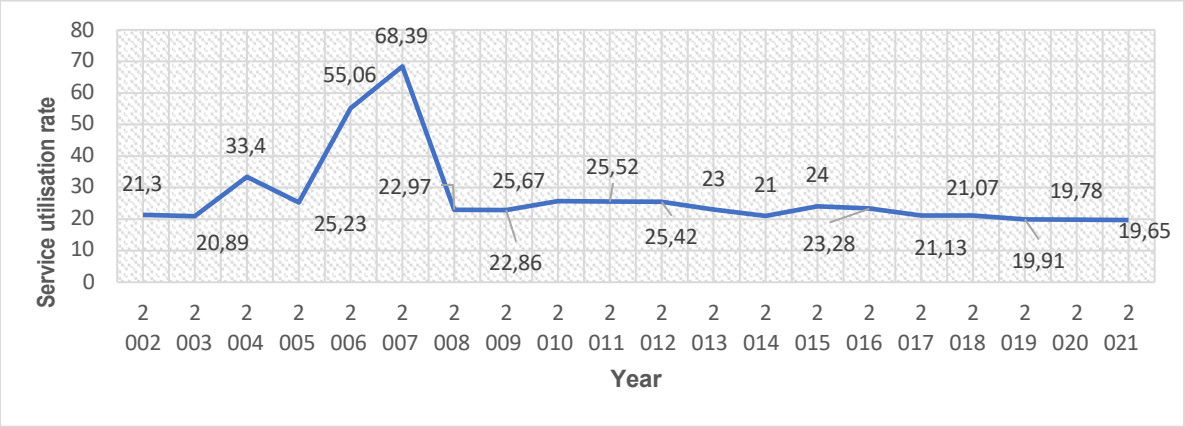
It should be noted that all the characteristics of central tendency and dispersion are almost identical (average (20.314%), standard deviation (0.73%), maximum (21.14) and minimum (19.66) for all the Districts of the Maradi Region. The overall trend in the Maradi Region in the use of health services for children under 5 years of age over the last 5 years has increased. However, this decrease is not due to user attendance but is linked to the increase in the number of people requesting the service.

Table 7: Rate of use of services (0-5 years)

Districts/Regions	Aguié	Bermo	Dakoro	Gazaoua	Guidan Roumdji	Madarounfa	Maradi Ville	Mayahi	Tessaoua	**Région Maradi**
2021	19,66	19,66	19,66	19,66	19,66	19,66	19,66	19,66	19,66	19,66
2020	19,78	19,78	19,78	19,78	19,78	19,78	19,78	19,78	19,78	19,78
2019	19,91	19,91	19,91	19,91	19,91	19,91	19,91	19,91	19,91	19,91
2018	21,08	21,08	21,08	21,08	21,08	21,08	21,08	21,08	21,08	21,08
2017	21,14	21,14	21,14	21,14	21,14	21,14	21,14	21,14	21,14	21,14
Average	20,314	20,314	20,314	20,314	20,314	20,314	20,31	20,31	20,31	20,31
Standard Deviation	0,73	0,73	0,73	0,73	0,73	0,73	0,73	0,73	0,73	0,73
Minimum	19,66	19,66	19,66	19,66	19,66	19,66	19,66	19,66	19,66	19,66
Maximum	21,14	21,14	21,14	21,14	21,14	21,14	21,14	21,14	21,14	21,14
Trend	Increase	Increase	Increase	Increase	Increase	Increase	Increase	Increase	Increase	Increase

Source : *Statistical directories, DS*

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



Source : *Statistical directories, DS*

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

3.2.1.3. Overall situation of the use of services

Health service utilisation over the last five years in the Maradi region has increased significantly. Looking at the situations of the Health Districts, we note that the Dakoro Health District recorded the lowest average (36.7%) in the region compared to the Maradi City District which recorded the highest average (99.91%) with the lowest standard deviation of 0.2%. An upward trend has been observed over the last five (5) years in all the Health Districts except for the Maradi City District where the trend is constant.

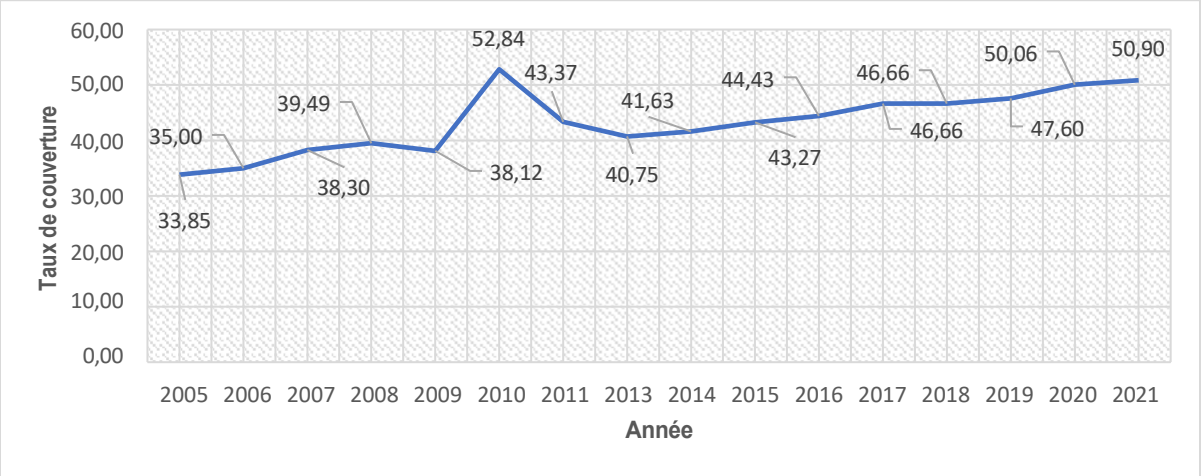
Table 8: Overall rate of use of services

District / Région	Aguié	Bermo	Dakoro	Gazaoua	Guidan Roumdji	Madarounfa	Maradi Ville	Tessaoua	Région Maradi
2017	48,54	28,74	35,73	50,16	36,98	54,51	100	46,99	46,66
2018	48,54	28,74	35,73	50,16	36,98	54,51	100	46,99	46,66
2019	51,23	28,61	35,58	53,35	36,82	56,6	99,56	46,79	47,60
2020	51,46	57,07	37,36	55,06	38,37	61,8	100	47,3	**50,06**
2021	51,47	57,07	37,47	55,06	38,5	61,79	100	48,02	50,90
Average	50,24	40,04	36,37	52,75	37,53	57,84	99,91	47,22	48,38
Standard Deviation	1,56	15,54	0,95	2,47	0,83	3,71	0,2	0,48	1,98
Minimum	48,54	28,61	35,58	50,16	36,82	54,51	99,56	46,79	46,66
Maximum	51,47	57,07	37,47	55,06	38,5	61,8	100	48,02	50,90
Trend	Increase	Increase	Increase	Increase	Increase	Increase	Constant	Increase	Increase

Source : *Statistical directories, DS*

The analysis of the use of health services since the introduction of the free health care measure shows a progressive evolution over the whole period 2005-2021, except for a slight decrease in 2011.

Figure 12: Overall health service utilisation rate



Source : *Statistical directories, DS*

3.2.3. Evolution of some health indicators

3.2.3.1. Death at birth rate

Death at birth is experienced differently in all districts of the Maradi Region. The highest mean and standard deviation are observed at the Mother and Child Health Centre (CSME). On the other hand, the Bermo district records the lowest rates in the region. These results for the CSME are due to the fact that this health facility receives complicated cases referred by the CSI. The majority of the cases referred are in a critical situation. This explains the high infant mortality rate observed at the CSME. The results also show an upward trend over the last five years at the level of the CSMEs, the Health Districts of Bermo, Madarounfa and the town of Maradi, in contrast to the Health Districts of Aguié, Gazaoua and Guidan Roumdji, which show a downward trend in infant mortality at birth. This can be explained by the occasional shortage of medicines in these health facilities, which makes it impossible to provide effective care for patients from vulnerable families.

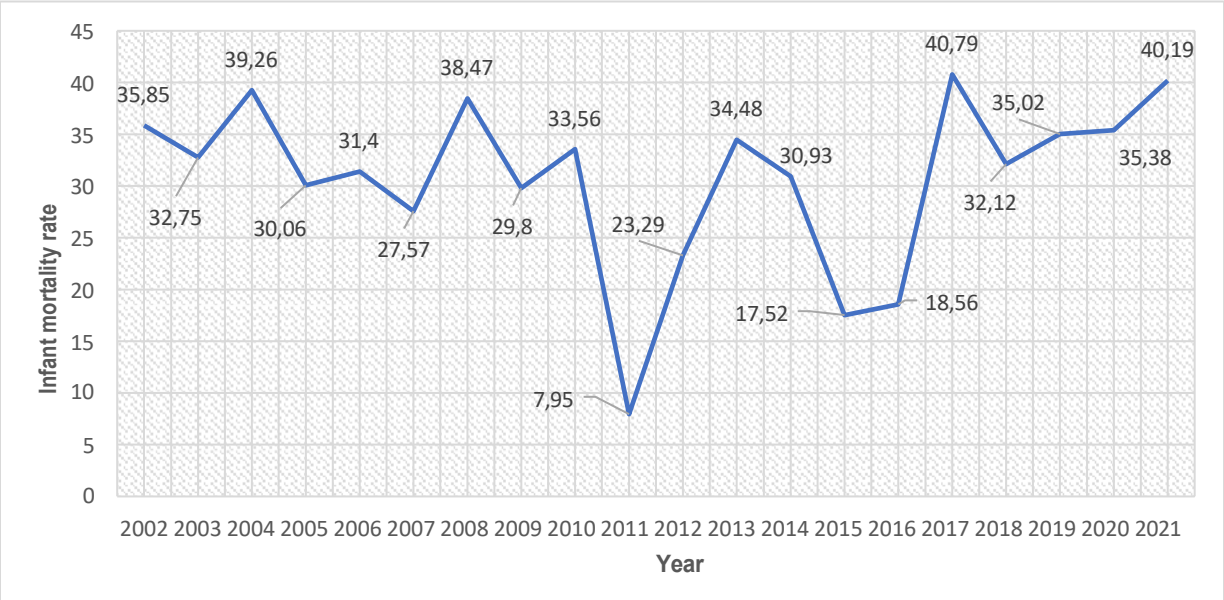
Table 9 : **Death rate at birth over the last five years (‰)**

District-Region	CSME Maradi	Aguié	Bermo	Dakoro	Gazaoua	Guidan Roumdji	Madarounfa	Maradi Ville	Mayahi	Tessaoua	Maradi
2017	160,48	53,31	14,18	21,52	26,64	48,16	29,91	20,81	30,74	35,34	40,79
2018	111,25	36,37	3,25	21,36	27,57	30,03	36,38	23,11	37,32	25,34	32,12
2019	105,94	35,82	7,86	26,71	28,85	37,92	25,76	25,96	28,82	36,42	35,02
2020	114,71	56,46	34,48	29,53	23,39	38,65	29,93	19,9	30,89	31,04	35,38
2021	170,42	39,9	22,06	52,81	32,74	34,02	32,67	24,36	30,51	32,55	40,19
Average	132,56	44,372	16,366	30,386	27,838	37,756	30,93	22,828	31,656	39,61	39,61
Standard Deviation	30,39	9,79	12,35	13,01	3,4	6,76	3,92	2,49	3,27	4,36	3,69
Minimum	105,94	35,82	3,25	21,36	23,39	30,03	25,76	19,9	28,82	25,34	32,12
Maximum	170,42	56,46	34,48	52,81	32,74	48,16	36,38	25,96	37,32	36,42	40,79
Trend	Increase	Decrease	Increase	Increase	Decrease	Decrease	Increase	Increase	Decrease	Constant	Increase

Source : *Statistical directories, DS*

The graph below shows the evolution of the death rate at birth since 2002. Overall, it can be seen that birth mortality has decreased from 2002 to 2004. An increase was observed in 2005. However, with the implementation of free health care in 2006, we saw a gradual decline in infant deaths at birth until 2008. On the other hand, from 2008 to 2021, the results show an up and down evolution of the infant mortality rate at birth. This can be explained by the shortage of medicines in the districts, which weakens the effectiveness of free care. These shortages are due in the majority of cases to the non-reimbursement of the costs generated by free care, which have led to the over-indebtedness of health facilities.

Figure 13 : **Death at birth rate (‰)**



Source : *Statistical directories, DS*

3.2.3.2. Maternal mortality rate

The analysis of the maternal mortality rate over the last five (5) years shows that this indicator is on the rise in the Maradi Region. The Maradi City Health District has the lowest average maternal mortality rate compared to the Mayahi District which has the highest rate. The disparity in maternal death rates is much greater in the Dakoro Health District

Table 10 : Maternal mortality rate (‰)

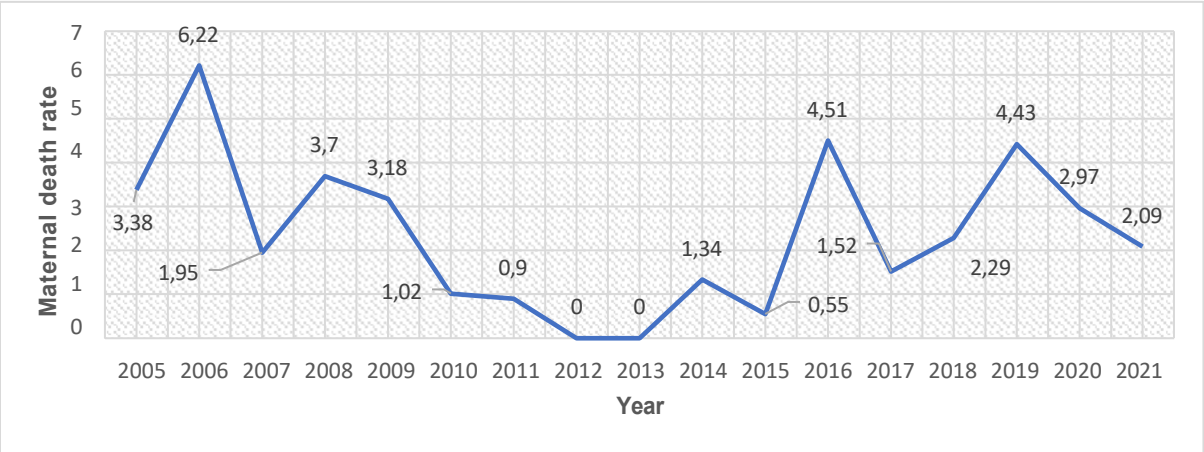
District-Région	Aguié	Bermo	Dakoro	Gazaoua	Guidan Roumdji	Madarounfa	Maradi Ville	Mayahi	Tessaoua	Région Maradi
2017	0,21	3,05	0	1,11	3,47	0,38	0,12	3,02	1,01	1,52
2018	4,02	0	0,15	2,15	2,23	2,45	0,33	4,77	3,69	2,29
2019	5,29	0	7,93	0,9	1,69	1,44	0,1	2,79	4,95	4,43
2020	1,92	1,11	3,27	0,53	2	1,37	0,17	3,24	2,4	2,97
2021	2,96	0	2,94	3,11	1,64	1,73	0,08	3,39	2,07	2,09
Average	2,88	0,832	2,858	1,56	2,206	1,474	0,16	3,442	2,824	39,61
Standard Deviation	1,95	1,33	3,22	1,05	0,75	0,75	0,1	0,78	1,53	1,12
Minimum	0,21	0	0	0,53	1,64	0,38	0,08	2,79	1,01	1,52
Maximum	5,29	3,05	7,93	3,11	3,47	2,45	0,33	4,77	4,95	4,43
Trend	Increase	Decrease	Increase	Increase	Decrease	Decrease	Decrease	Decrease	Increase	Increase

Source : *Statistical directories, DS*

The analysis of this indicator over the period 2005-2021 reveals that the maternal mortality rate was high in 2006, the year in which free health care was implemented.

As a result of the reform, a drastic decrease in this rate was observed in 2007. However, despite some increases observed from 2006 to 2021, the maternal mortality rate remains lower compared to the rate before free health care.

Figure 14: Maternal mortality rate (‰)



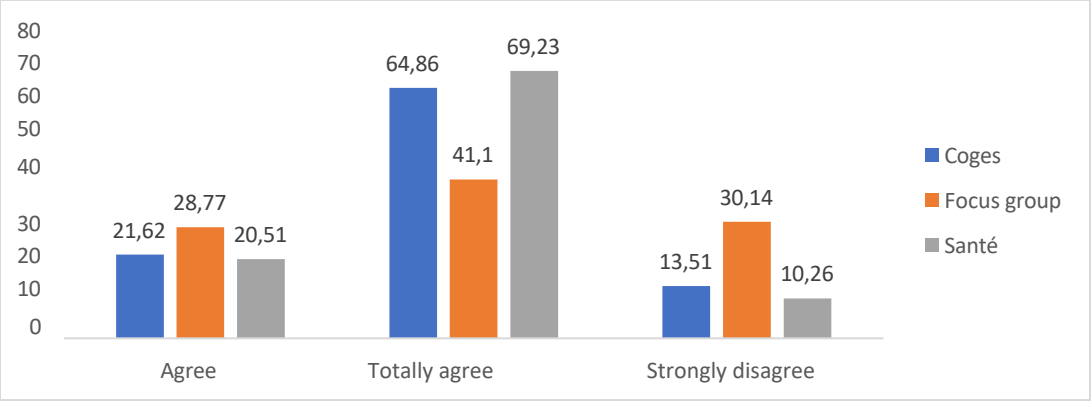
Source : *Statistical directories, DS*

3.2.3. Assessment of the effectiveness of the free care measure

3.2.3.3. Assessment of the effectiveness of free health care

The effectiveness of the free health care measure is recognised by all stakeholders in the Maradi region, whether they are health agents, the community or the COGES actors, the majority agree that the services are free. However, signals of disapproval are noted to the tune of 30.14%, 13.51% and 10.26% respectively for the community, the COGES and the health agents.

Figure 15 : Effectiveness of free health care



Source : *Study data, 2022*

3.2.3.4. Assessment of the actions implemented in the framework of the reform

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

3.2.3.4.1. Raising awareness about free access

About 86.53% of the population in Maradi region say they are aware of free health care against 13.47% who say no.

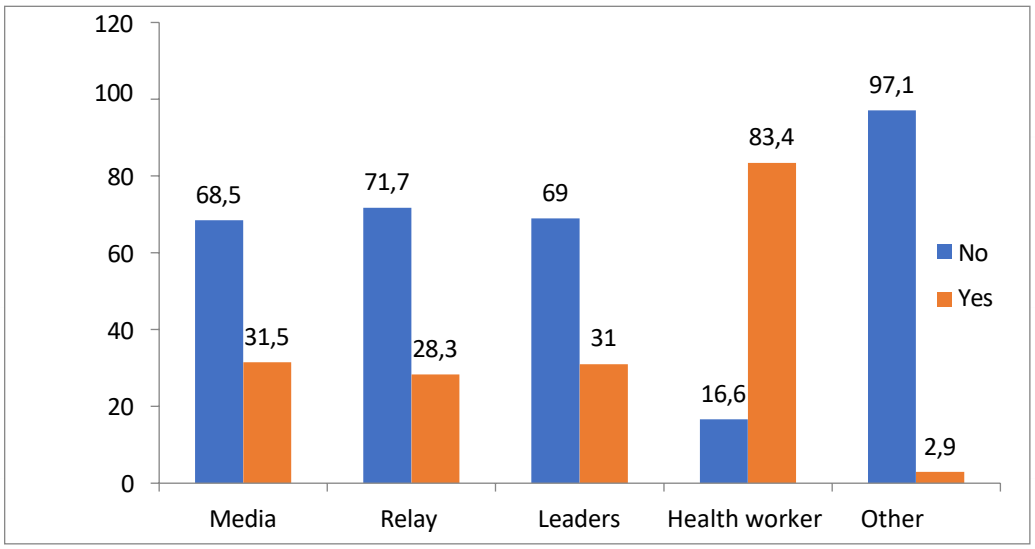
Figure 16 : Raising awareness on free health care

Source : *Study data, 2022*

For the population that has been sensitised, they claim to access information through several channels.

The graph below shows that the majority of the population (83.4%) was sensitised by health workers. However, the information also reached them through the media (31.5%), leaders (31%) and community relays (28.3%).

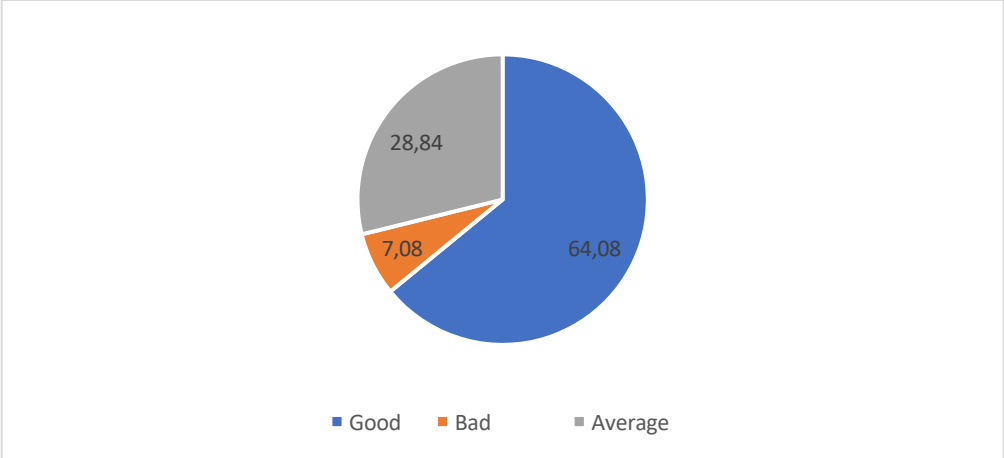
Figure 17 : Communication channels used



Source : *Study Data, 2022*

The graph below shows that 64.08% of households find the effectiveness of communication channels good, 28.84% find them average and 7.08% find the effectiveness of communication channels poor.

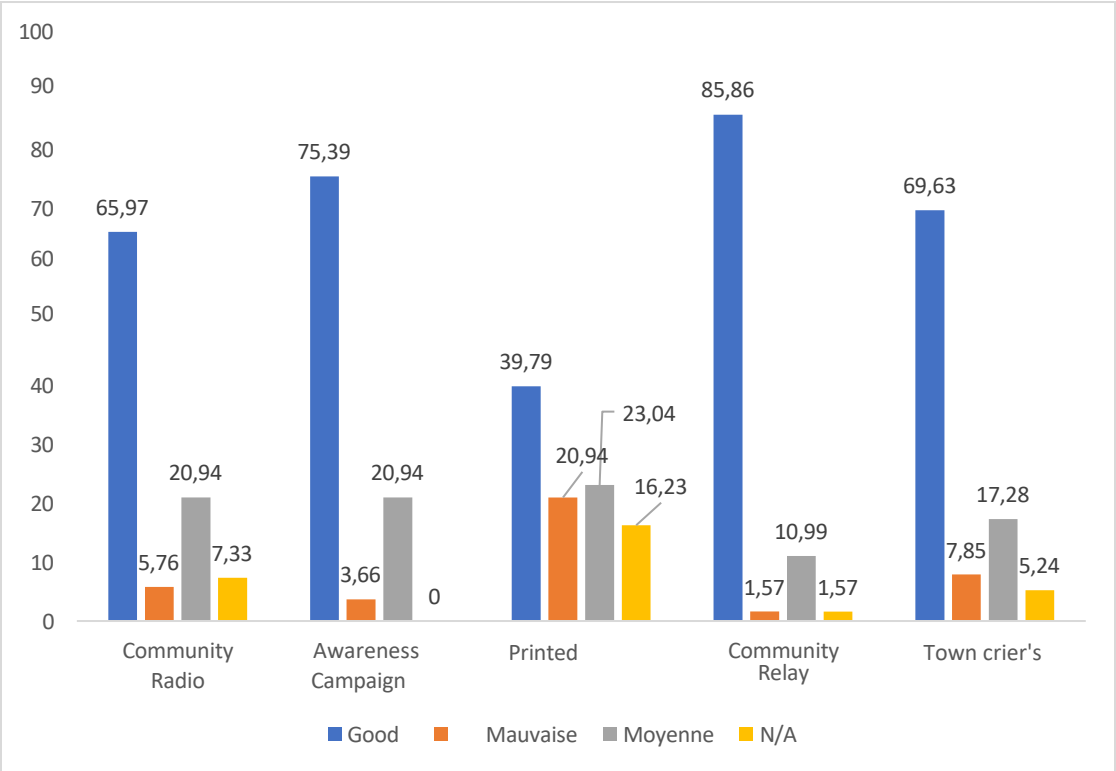
Figure 18 : Overall effectiveness of communication channels on free health care



Source : *Study Data, 2022*

When this assessment is made on a specific channel, it emerges that three channels are considered the most effective in facilitating information in the Maradi region. These are the community relays, the awareness campaign and the town criers. It should be noted that community relays are one of the best communication channels, but this requires the mobilisation of resources in the implementation in order to have a wide dissemination.

Figure 19 : Specific assessment of the communication channels used



Source : *Study Data, 2022*

3.2.3.4.2. Use of the free health care package

The graph below shows the households that benefited from the free health care package. Thus, the majority of the households surveyed stated that they benefited from free care such as: CPNR, curative consultation for children under 5, family planning, post-natal consultation and infant consultation for 96.89.2%, 87.39%, 76.68, 86.70%, 93.26 and 93.26% respectively.

Table 20 : Use of the free package

Free of charge package	NA	No	Yes
CPNR	0.17	2.94	96.89
Caesarean section	11.40	80.66	7.94
Curative consultation for children under 5 years of age	0.69	11.92	87.39
Family Planning	1.73	21.59	76.68
Post Natal Consultation	0.69	12.61	86.70
Infant consultation	0.52	6.22	93.26

Source : *Study Data, 2022*

3.2.3.4.3. Assessment 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 treated at the IHCs in the Maradi region. It emerges that 65.12% of the women surveyed stated that they were attended to in less than an hour, 29.02% were attended to between 1 and 3 hours and 5.87% were attended to for more than 3 hours.

Table 11 : Average time taken for users to be picked up for the service

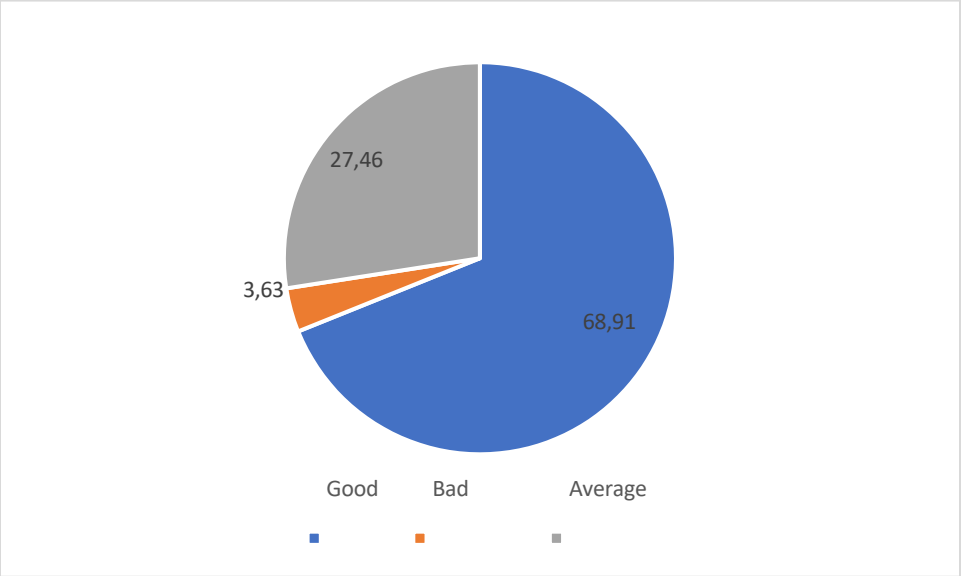
Department	Minus 1hour	Immediately	From 1h to 3h	More than 3h
DS Aguié	0.00	100.00	0.00	0.00
DS Bermo	4.17	58.33	37.50	0.00
DS Dakoro	27.27	28.41	42.05	2.27
DS Gazaoua	3.13	75.00	21.88	0.00
DS Guidan Roumdji	36.25	22.50	28.75	12.50
DS Madarounfa	11.54	48.08	40.38	0.00
DS Mayahi	10.57	69.11	12.20	8.13
DS Tessaoua	1.39	51.39	30.56	16.67
DS Ville Maradi	6.25	53.13	40.63	0.00
Overall Region	14.34	50.78	29.02	5.87

Source : *Study Data, 2022*

3.2.3.4.4. Assessment of the functioning of the implementing bodies of the free health care measure

As the primary beneficiaries of the free-of-charge measure, it is important to collect the views of households on the organisation put in place to conduct the reform. The graph below shows that 68.91% of households consider the organisation to be good, 27.46% consider it to be average and 3.63% consider it to be bad.

Figure 21 : Appreciation of the organisation of the assumption of responsibility for free accommodation by households



Source : *Study Data, 2022*

3.2.3.4.5. Assessment of the availability of funding and medicines

- **Regularity of reimbursement**

The primary data collected from the SMCs and health workers show that overall there is irregularity in reimbursements at 86.59% due to failure to collect the full amount in the appropriate time. In fact, a minority of the interviewees stated that there is a good regularity of reimbursements at the level of 3.39%.

Figure 22 : Assessment of the regularity of repayments

Department	Good	Bad	Average	NA
DS Aguié	0.00	100.00	0.00	0.00
DS Bermo	0.00	50.00	25.00	25.00
DS Dakoro	5.26	73.68	10.53	10.53
DS Gazaoua	0.00	100.00	0.00	0.00
DS Guidan Roumdji	9.52	80.95	9.52	0.00
DS Madarounfa	5.26	78.95	10.53	5.26
DS Mayahi	0.00	91.67	4.17	4.17
DS Tessaoua	0.00	100.00	0.00	0.00
DS Ville Maradi	0.00	100.00	0.00	0.00
Overall Region	3.39	85.59	6.78	4.24

Source : *Study Data, 2022*

- **Availability of medicines**

The table below shows that the majority of respondents report an average shortage of pharmaceutical products with 69.49%. This shortage is linked to poor distribution of drugs at the level of the IHCs according to their monthly coverage and also to a delay in the supply of the necessary drugs in real time from the districts to which they are attached. About 10.17% of the population rated the availability of medicines as poor and 19.49% rated it as good.

Figure 23 : Assessment of the non-availability of products

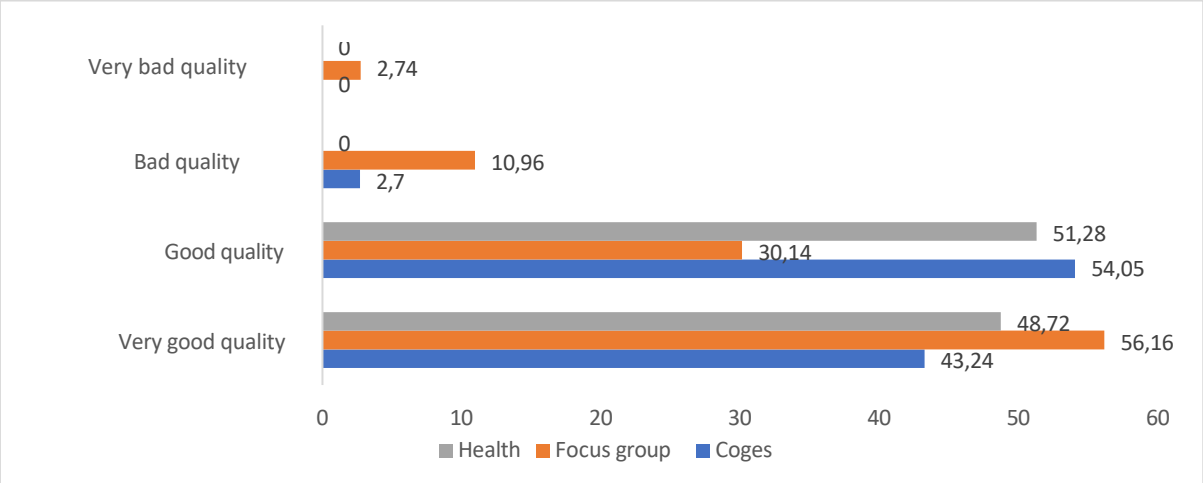
Department	Good	Bad	Average	NA
DS Aguié	0.00	33.33	66.67	0.00
DS Bermo	50.00	0.00	50.00	0.00
DS Dakoro	10.53	5.26	78.95	5.26
DS Gazaoua	0.00	25.00	75.00	0.00
DS Guidan Roumdji	33.33	4.76	61.90	0.00
DS Madarounfa	31.58	5.26	63.16	0.00
DS Mayahi	4.17	12.50	83.33	0.00
DS Tessaoua	27.27	9.09	63.64	0.00
DS Ville Maradi	22.22	22.22	55.56	0.00
Overall Region	19.49	10.17	69.49	0.85

Source : *Study Data, 2022*

3.2.3.4.6. Assessment of the reception in health services

The population surveyed and the SMC rate the quality of reception as very good at 56.16% and 48.72% respectively. On the other hand, a small minority (2.74%) rated the quality as very poor.

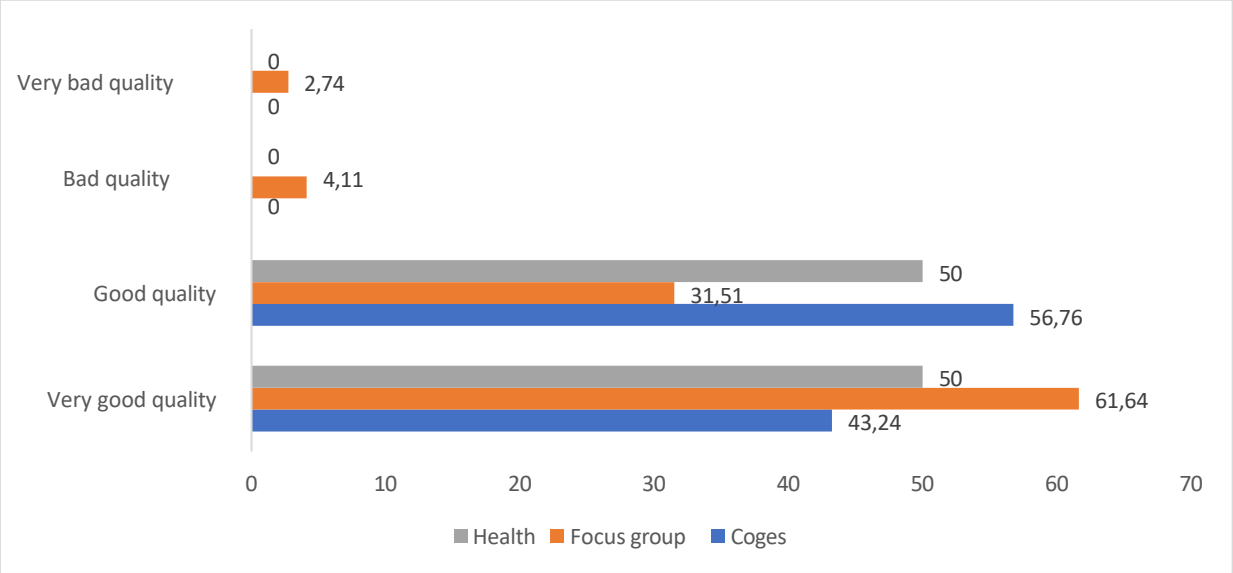
Figure 24 : Appreciation of the reception in the health services by the population



Source : Study Data, 2022

43.24% of SMC members and 61.64% of community members rated the quality of care as very good, but very few people rated the quality of care as very poor.

Figure 25 : Stakeholders' assessment of delivery in health services



Source : *Study Data, 2022*

3.2.3.4.7. Assessment of performance in health services

More than half (63.04%) of the population is very satisfied with the quality of care in the health facilities, and 34.54% is satisfied, although there are some pockets of low satisfaction or minor dissatisfaction in some departments. The provision of care is unsatisfactory in Mayayi and Madarounfa at 0.81% and 1.92% respectively.

Table 12 : Quality of health care provision in health facilities

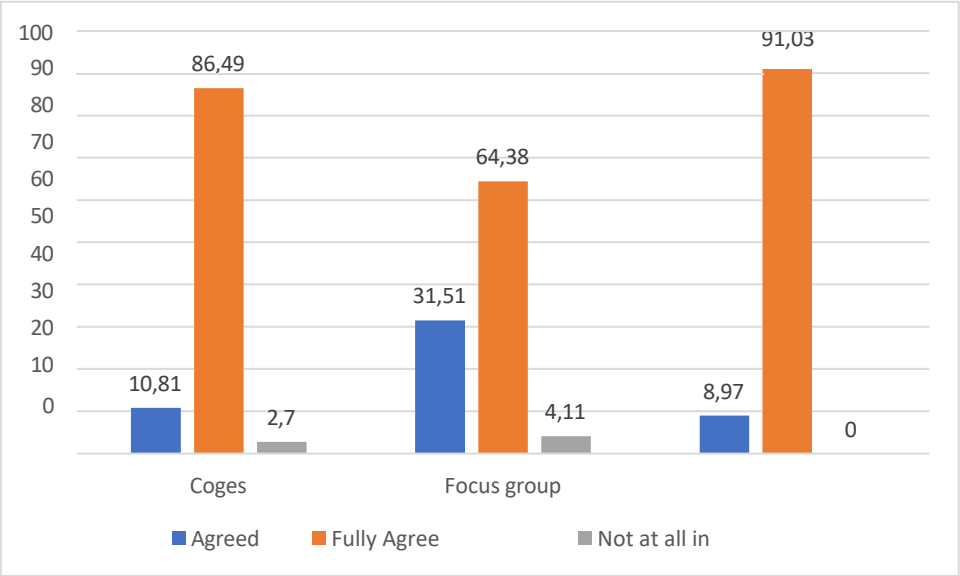
Department	Not satisfactory	Satisfactory	Very satisfactory
DS Aguié	0.00	33.33	66.67
DS Bermo	0.00	0.00	100.00
DS Dakoro	4.55	53.41	42.05
DS Gazaoua	0.00	3.13	96.88
DS Guidan Roumdji	2.50	22.50	75.00
DS Madarounfa	1.92	59.62	38.46
DS Mayahi	0.81	21.14	78.05
DS Tessaoua	1.39	33.33	65.28
DS Ville Maradi	12.50	43.75	43.75
Overall Region	2.42	34.54	63.04

Source : *Study Data, 2022*

3.2.3.4.8. *Assessment of attendance at health facilities for free prenatal consultations by pregnant women*

The actors interviewed fully agree that free access has increased the attendance of health facilities for antenatal consultations in the Maradi region. As shown in the graph below, 86.46% of the SMC members, 64.38% of the communities interviewed in focus and 91.03% of the health workers share this opinion.

Figure 26 : attendance at health facilities for prenatal consultations at regional level

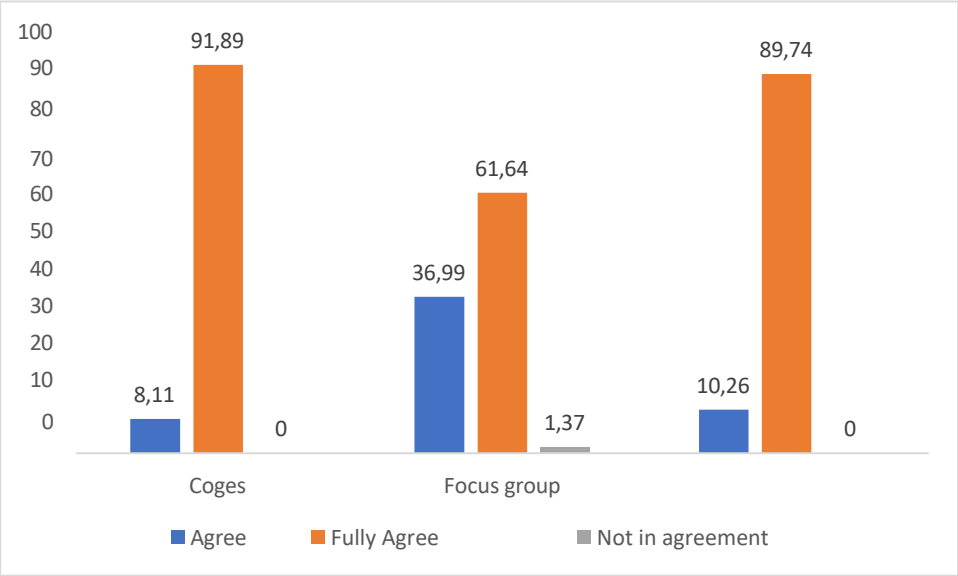


Source : Study Data, 2022

3.2.3.4.9. *Assessment of the attendance of health facilities for free care by children aged 0 to 5 years*

All the actors are in full agreement with the improvement in the use of health facilities by the population as part of the free health care measure. Indeed, the community questioned through the focus groups organised is unanimous on these observations with 61.64%. More than eight (08) health workers out of ten (89.74%) and 91.89% of SMC members also share this opinion.

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



Source : *Study Data, 2022*

3.2.3.4.10. Valuation of health facilities and the services they provide

The previous observation is corroborated by the beneficiaries of the free health care measure in health facilities, which are their first resort for the majority of the sick population. Indeed, 87.91% use health facilities in case of illness. However, in the city of Maradi 43.75% resort to self-medication and one individual out of four in Guidan Roumdji resorts to a traditional practitioner.

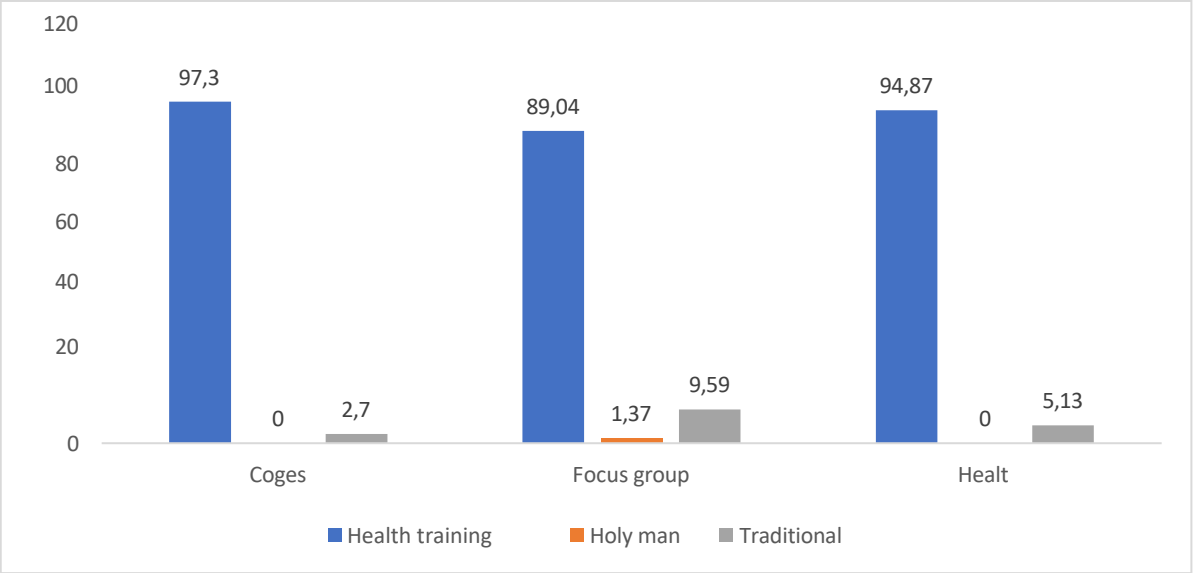
Table 13 : 1st recourse in health matters by the populations

Department	Self-medication	Health training	Traditional practitioner
DS Aguié	0.00	100.00	0.00
DS Bermo	0.00	100.00	0.00
DS Dakoro	11.36	88.64	0.00
DS Gazaoua	0.00	96.88	3.13
DS Guidan Roumdji	0.00	76.25	23.75
DS Madarounfa	0.96	99.04	0.00
DS Mayahi	1.63	88.62	9.76
DS Tessaoua	12.50	84.72	2.78
DS Ville Maradi	43.75	56.25	0.00
Overall Region	6.22	87.91	5.87

Source : Study Data, 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 case of health problems by stakeholders



Source : *Study Data, 2022*

Box 2: Analysis of effectiveness

The implementation of free health care has been effective, given the recognition by almost all the target populations of the free health care received. The populations have testified to the effectiveness and efficiency of the information campaigns in the framework of the reform and show a certain satisfaction with the services offered. However, this free health care service shows some shortcomings, especially in the supply of inputs due to the non-reimbursement of bills.

4.3. The efficiency of the free health care measure

In order to conduct an efficiency analysis in accordance with the rules of the art, we must have a costing of the measure to fully satisfy the population that should benefit from the reform at the level of the health facilities. We must then assess the financing mobilised a posteriori in relation to the free service offered with regard to this standard. In the absence of this standard, efficiency is assessed in terms of the adequacy of the resources allocated to the services actually offered, according to the modalities of free care.

Quelle est la situation du remboursement des factures des prestations de soins liées à la gratuité des soins ?

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

The table below presents the reimbursement situation from 2006 to 2021. It shows that the reimbursement rate of bills related to free health care in the Maradi region is 56%. However, there are disparities in reimbursement between health structures. Indeed, the majority of districts have a reimbursement rate of more than 50%, the highest reimbursement rate is observed in Gazaoua (73%) while the lowest is recorded in Bermo (11%).

Table 14 : Reimbursement status of the free of charge service from 2006 to December 2021 by structure

Health structures	Total amount of invoices sent	Total amount of reimbursed invoices	Amount to be recovered	Reimbursement rate
DS AGUIE	1 890 176 125	1 105 997 750	784 178 375	59%
DS DAKORO	2 069 144 619	850 237 850	1 218 906 769	41%
DS MARADI	861 229 376	570 801 376	290 428 000	66%
DS GUIDAN ROUMDJI	1 703 922 088	1 016 952 450	686 969 638	60%
DS MADAROUNFA	2 079 089 907	1 349 819 550	729 270 357	65%
Mayahi	2 441 860 957	1 410 219 770	1 031 641 187	58%
DS TESSAOUA	2 519 118 774	1 374 558 972	1 144 559 802	55%
CHR	3 047 360 439	1 937 005 925	1 110 354 514	64%
CSME /MARADI	983 997 066	215 326 550	768 670 516	22%
Bermo	71 372 644	7 962 305	63 410 339	11%
Gazaoua	185 754 660	135 089 700	50 664 960	73%
TOTAL	**17 853 026 655**	**9 917 418 598**	**7 935 608 057**	56%

Source : *free health care cell DF/DEP/MSP/P/AS*

When we put this reimbursement rate in relation with the stakeholders' appreciation of the effectiveness of the measure, we note a reimbursement rate of 56%. Overall, 57.45% of the stakeholders interviewed (SMC members, the community and health workers) fully agree on the effectiveness of the free health care measure. Moreover, despite the modest funding, the measure was offered to the population and they show a total satisfaction rate of 63.4%.

Box 3: Efficiency analysis

The low rate of reimbursement of free health care invoices leads to shortages of pharmaceutical products in health facilities, thus reducing their capacity to give full satisfaction to the population in terms of quality of care offered. Despite this handicap, the majority of the target populations recognise the effectiveness of the free health care measure and are satisfied with its implementation.

4.4. Effects induced by the implementation of the measure

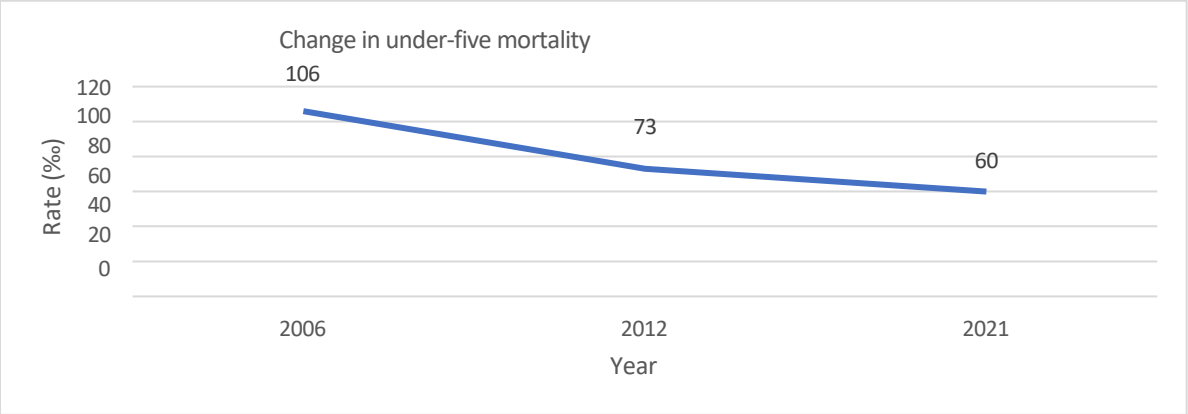
4.4.1. The effects of the implementation of the free access measure on the reduction of maternal and infant mortality

The analysis of the impact of free health care on the reduction of maternal and infant mortality will be based on survey data. As we did not have regionally disaggregated data for the maternal mortality rate in these survey data, the analysis focused on the infant mortality rate.

- **Changes in the infant mortality rate**

There is a significant decline in the level of under-five (05) mortality in Maradi region between 2006 and 2021. This mortality rate of children under five (05) years of age dropped from 106‰ in 2006 to 73‰ in 2012 and then to 60‰ in 2021, i.e. an absolute decrease of 46‰.

Figure 29 : Changes in rates for children under 5

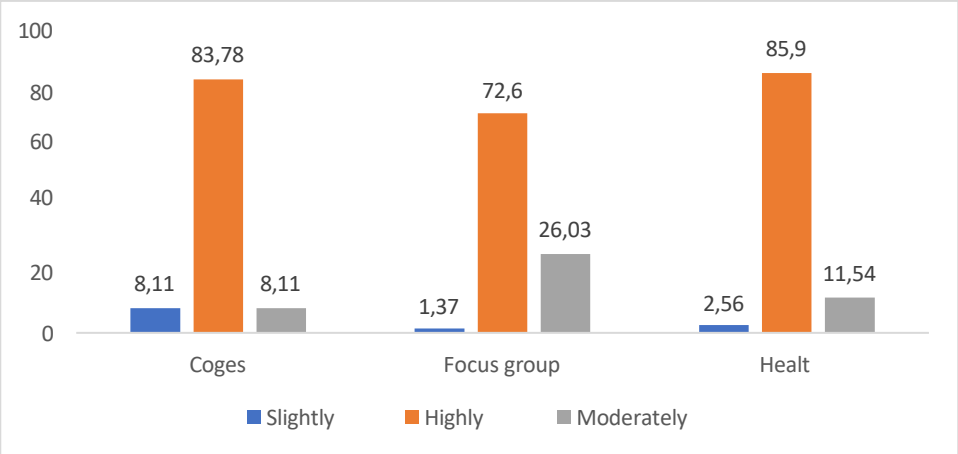


Source : EDSN 2006 and EDSN 2012 and ENAFEME 2021

- **Assessment of the induced effects of the implementation of the free-of-charge measure:**

The majority of SMC leaders (83.78%) felt that free health care has strongly contributed to the reduction of maternal and infant mortality in the Maradi region. Similarly, the results of the focus group (72.6%) showed that the reduction of maternal and infant mortality is linked to free health care. 85.9% of health centre managers think that free health care has a strong impact on the reduction of maternal and infant mortality.

Figure 30 : Assessment of the effects induced by the stakeholders



Source : *Study Data, 2022*

4.4.2. Effects on workload

The vast majority of health centre managers (96.15%) believe that the free health care measure has increased their workload. On the other hand, 3.85% of these managers continue with the same workloads despite the implementation of the free health care measure.

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

Department	No	Yes	Total
DS Aguié	0.00	100.00	100.00
DS Bermo	0.00	100.00	100.00
DS Dakoro	0.00	100.00	100.00
DS Gazaoua	0.00	100.00	100.00
DS Guidan Roumdji	15.38	84.62	100.00
DS Madarounfa	7.69	92.31	100.00
DS Mayahi	0.00	100.00	100.00

Department	No	Yes	Total
DS Tessaoua	0.00	100.00	100.00
DS Ville Maradi	0.00	100.00	100.00
Overall Region	3.85	96.15	100.00

Source : *Study Data, 2022*

Box 3: Induced effects of the implementation of the measure

The implementation of free health care is associated with a reduction in the maternal and under-five mortality rates. It also favours the attendance of health facilities by the target populations and the systematic use of health facilities in case of illness. However, the reform has a major impact on the workload of health workers.

4.5. On the sustainability of the achievements of free measurement

This exercise consists of assessing the overall viability of the measure of free care for children aged 0 to 5 and women's care, as well as the sustainability of the mechanisms put in place in order to identify good practices. It is about providing answers to a number of questions. These questions are necessary because the answers would allow us to know if the effects of the free health care measure could last.

4.5.1. Constraints on the implementation of the free-of-charge measure

They are potentially multiple and are analysed in terms of their occurrence from a list of constraints identified by previous studies. These constraints are assessed by health workers, SMC members and communities.

As shown in the table below, irregularity of reimbursements (74.87%), insufficient funding (61.26%), non-availability of pharmaceutical products (38.22%) are the major constraints to the implementation of free health care. The insufficient involvement of certain strategic actors (19.90%), the ineffectiveness of the monitoring system (17.80%), the inadequacy of communication (17.28%) and the lack of mastery of procedures (15.71%) by certain agents are also mentioned as constraints to a lesser extent.

Figure 32 : Constraints to the implementation of free access

Contraints	Weak	Strong	Acceptable
Insufficient funding	15,71	61,26	23,04
Lack of availability of pharmaceutical products	21,99	38,22	39,79
Insufficient communication	48,17	17,28	34,55
Lack of understanding of procedures by some staff	59,69	15,71	24,61
Irregularity of reimbursements	10,47	74,87	14,66
Inefficiency of the monitoring and evaluation system	40,31	17,80	41,88
Insufficient involvement of certain strategic actors	48,17	19,90	31,94

Source : *Study Data, 2022*

4.5.2. Incentives to encourage attendance at health facilities

This part allows us to assess the incentives put in place within the framework of free health care to encourage beneficiaries to attend health facilities. It is apprehended by the interviewed households.

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

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

- Good reception (90.85%);
- The quality of the service (89.98%);
- The availability of staff (85.84%);
- The existence of free care (84.80%);
- The geographical accessibility of health facilities (82.04%);
- Availability of medicines (81%);
- Continuity of service (78.58%);
- Other (1.73%).

Figure 33 : Incentives for free travel

Reason for attending health facilities	No	Yes	Total
Good reception	9.15	90.85	100.00
Availability of medicines	19.00	81.00	100.00
Geographical accessibility of health facilities	17.96	82.04	100.00
Quality of service delivery	10.02	89.98	100.00
Availability of health personnel	14.16	85.84	100.00
Existence of free health care	15.20	84.80	100.00
Continuity of services	21.42	78.58	100.00
Other	98.27	1.73	100.00

Source : *Study Data, 2022*

Box 4: Sustainability analysis

The implementation of the free health care measure increases the population's demand for health services. In this respect, the service offer must be adapted to meet this demand.

The regularity of reimbursements, sufficient financing, an adequate technical platform (infrastructure and health inputs) are levers for the success of the free health care measure. The sufficient involvement of certain strategic actors, the efficiency of the monitoring system, sufficient communication and the mastery of procedures by certain agents are also elements that will lead to the success of the measure.

5. RECOMMENDATIONS OF THE EVALUATION

In view of the findings of this study, in order to improve the implementation of the free health care policy in the Maradi Region and make it viable and sustainable for the well-being of the target beneficiary populations, it would be desirable to:

- ***The Government of:***
  - Take the necessary steps to clear the accumulated arrears of reimbursement to all health facilities and systematically pay current bills;
  - Reinvigorate the monitoring mechanism of the free health care policy by the central team in charge of free health care (provide more financial and human resources);
  - Reinvigorate the monitoring mechanism of the free health care policy by the central team in charge of free health care at the deconcentrated level (provide more financial and human resources);
  - Specify in the text that free health care for children aged 0 to 5 years is exclusively reserved for children of Nigerien nationality;
  - Capitalise on the reform of free health care through the INAM, which will develop strategic purchasing (quantity control, quality control and the voice of the community);
  - make the National Institute of Medical Assistance (INAM) operational with decentralised bodies.

- ***The Technical and Financial Partners of ::***
  - respect the alignment of their support with the objectives defined by the Ministry of Health in the framework of the free health care measure
  - support the pooling of resources in the health system for better care;

- ***The heads of the health structures of ::***
  - Respect the eligibility criteria for free health care;
  - Systematise quarterly accountability sessions.

6. GENERAL CONCLUSION

This policy of free care is part of the reduction of maternal and infant mortality. For women, the policy consists in having access to health services without payment (family planning, prenatal consultation, caesarean section/extra uterine pregnancy/uterine rupture, gynaecological cancer treatment) and for children under five (5) years old, free care concerns all preventive and curative care. This study allowed to evaluate the free health care policy in the region of Maradi on the one hand, and on the other hand, to identify the determinants of the adoption of the good practices of the measure by the populations.

The policy of free health care in the region of Maradi has made it possible to finance women's and children's health to the tune of 17,853,026,655 FCFA for eleven (11) health structures (09 health districts, 01 Regional Hospital Centre and 01 Mother and Child Health Centre). The investigation is based on data from a survey of a random sample of 579 households and 73 health structures and 35 NGOs/PTFs. The beneficiary perception method is used to estimate adoption rates and their determinants.

This shows that support for access to health services, timely reimbursement, information and sensitivity are means to facilitate the achievement of the "Sustainable Development Goals (SDGs)", relating to the reduction of maternal and child mortality. Finally, the study showed that policy adoption is influenced by a number of determinants such as age, level of education, function, speed of reimbursement, etc. This tells us that health actors must take these factors into account to ensure the success of the policy.

Cette This evaluation revealed some shortcomings in the implementation of this measure of the free health care package, namely

- the delay and/or non-reimbursement of a critical mass of bills to health facilities

- a lack of human resources and medicines

- a massive influx of patients to the health centres

- a reduction in the quality of services;

- a lack of sustainable sources of funding for the free health care policy;

- the existence of major problems regarding the reliability and sustainability of the free care system on the one hand, and the quality of care provided on the other;

- the impossibility of tracking the reimbursements received by health structures and of determining the exact share of free care in the functioning 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 use of health facilities by the population and is associated, among other things, with a reduction in the maternal and child mortality rates,

Taking into account the recommendations presented above will allow for better implementation of the reform with regard to the new institutional steering framework coordinated by the National Institute for Medical Assistance (INAM).

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APPENDICES

Appendix 1 :
Evaluation matrix

Evaluation matrix

Evaluation criteria	Evaluation questions	Indicators[7]	Data sources	Reference structure[8]	Evaluation model	Collection/analysis tools	Methods of analysis
Relevance and consistency	How do you assess the extent to which free healthcare meets the health needs of the population?		Reform implementation document. National and health sector policy documents			Guide/questionnaire	Meta analysis of documents + analysis of primary data
	What do you think of the mechanism for preparing for free access		Stakeholders at the origin of free access or involved in the measure			Guide	Meta analysis of documents + analysis of primary data primary
	How do you rate the free management mechanism		Practitioners + managers			Guide	Meta analysis of documents + analysis of primary data primary
	To what extent are the resources allocated to the measure consistent with the		Managers + TFP			Guide	Meta analysis of documents + analysis of primary data primary

7 Here, the indicator refers to the operational means by which the answers to the evaluation questions will be addressed.

8 These are the structures from which the information will be collected.

Evaluation criteria	Evaluation questions	Indicators[7]	Data sources	Reference structure[8]	Evaluation model	Collection/analysis tools	Methods of analysis
	actions planned?						primary
Efficiency	How would you rate the actions implemented as part of the reform in the Maradi region (training, development of procedures, establishment of an institutional framework, mobilisation of partners, information campaigns)?		Managers/health workers/NGOs/beneficiaries			Guide and questionnaire	Meta analysis of documents + analysis of primary data
	To what extent has the implementation of free care (prenatal consultation, care for children aged 0 to 5) been effective in the Maradi region? + planning + caesarean sections.		Managers/beneficiaries/health workers/NGOs/PTFs			Guide/questionnaires	Meta analysis of health training activity reports+, primary data analysis
	How do you assess the contribution of		Managers/Ministry/NGOs/health workers/local authorities and more			Guides	Meta analysis of health

Evaluation criteria	Evaluation questions	Indicators[7]	Data sources	Reference structure[8]	Evaluation model	Collection/analysis tools	Methods of analysis
	the TFPs in implementing the reform (AFD intervention by making medicines available, FBR, etc.)?						training activity reports+, primary data analysis
	How do you assess the operation of the bodies responsible for implementing the free-of-charge scheme?		Beneficiaries/NGOs/local authorities and+/PTFs/Health workers			Guides /questionnaires	Meta analysis of health training activity reports+, primary data analysis
	To what extent are administrative and regulatory texts applied?		NGO/TFP/health ministry			Guides	Meta analysis of health training activity reports+, primary data analysis
	How do you assess the framework for discussion between the State and the TFPs regarding the reform?		NGO/TFP/health ministry			Guides	Meta analysis of health training activity reports+

Evaluation criteria	Evaluation questions	Indicators[7]	Data sources	Reference structure[8]	Evaluation model	Collection/analysis tools	Methods of analysis
							primary data analysis
	How do you rate the communication channels used to inform people about the reform?		Beneficiaries/NGOs/TFPs/health authorities/local authorities			Guides /questionnaires	Meta analysis of health training activity reports+, primary data analysis
	To what extent is the system for monitoring free access operational?		TFPs/managers/health agents			Guides	Meta analysis of health training activity reports+, primary data analysis
	How do you rate the availability of medicines in health facilities + availability of FP inputs and caesarean sections?		Managers/health workers/beneficiaries/TFPs			Guides /questionnaires	Primary data analysis
	How do		Managers			Guides	Primary

Evaluation criteria	Evaluation questions	Indicators[7]	Data sources	Reference structure[8]	Evaluation model	Collection/analysis tools	Methods of analysis
	you assess the cost of drugs?		/ health officers/PTF				data analysis
	How do you rate the regularity with which the state pays for healthcare?		Managers/health officers/TFP			Guides	Primary data analysis
	To what extent do people value health facilities and the services they provide?		Beneficiaries/health workers/NGOs/local authorities			Guides /questionnaires	Primary data analysis
	What incentives are there to encourage people to attend health facilities?		All targets			Guides /questionnaires	Meta analysis of health training activity reports+, primary data analysis
	How good is the quality of services and reception in mother		Bénéficiaires/ONG/autorités locales			Guides /questionnaires	Meta analysis of health training activity reports+,

Evaluation criteria	Evaluation questions	Indicators[7]	Data sources	Reference structure[8]	Evaluation model	Collection/analysis tools	Methods of analysis
	and child health services?						primary data analysis
	How do you rate the attendance of pregnant women at health facilities for free prenatal consultations?		Community (COGES+ relays)			Guides	Meta analysis of health training activity reports+, primary data analysis
	How do you rate the use of health facilities for free care by children aged 0 to 5?		Community (COGES+ relay+ leader)			Guides	Meta analysis of health training activity reports+, primary data analysis
Efficience	To what extent do the resources allocated to the free-of-charge reform cover benefits?		Managers/reimbursement data			Guides	Meta analysis of health training activity reports+, primary data analysis

Evaluation criteria	Evaluation questions	Indicators[7]	Data sources	Reference structures[8]	Evaluation model	Collection/analysis tools	Methods of analysis
	How do you rate the adequacy of resources in relation to the services offered?		Managers/health officers/TFP			Guide	Meta analysis of health training activity reports+, primary data analysis
Sustainability of skills	What are the constraints involved in implementing the free-of-charge measure?		All targets			Guide/questionnaires	Meta analysis of health training activity reports+, primary data analysis
	What are the shortcomings inherent in the implementation of the free-of-charge measure?		All targets			Guide/questionnaires	Meta analysis of health training activity reports+, primary data analysis
	What are the best practices to capitalise on?		Managers/health officers/TFP			Guide	Meta analysis of health training

Evaluation criteria	Evaluation questions	Indicators[7]	Data sources	Reference structures[8]	Evaluation model	Collection/analysis tools	Methods of analysis
							activity reports+, primary data analysis
Effects of implementation	What are the effects of implementing free travel?		Managers/health workers/community			Guide	Meta analysis of health training activity reports+, primary data analysis

Appendix 2 :
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Editorial team

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