Case 16

From Unintended to Undesirable Effects of Health Intervention

The Case of User Fees Abolition in Niger, West Africa

Valéry Ridde and Aissa Diarra

This case study of an evaluation carried out in Niger describes a situation in which the evaluators uncovered effects that the client had not anticipated in the evaluation design, but which helped the client improve the intervention. The methodology employed was qualitative, with data analyzed from an anthropological perspective. All data collection took place while the innovative program was in operation. Sources of data included the NGO staff, service providers, service recipients, decision makers, and local authorities.

DESCRIPTION OF THE CASE

In many countries in Africa, access to heath care is very much constrained because patients must pay for services (Ridde, 2008), whereas the abolition of user fees has the potential to save around 230,000 children under age 5 each year in 20 African countries (James, Morris, Keith,

& Taylor, 2005). This case study was carried out in Niger, where only 4% of mothers in the poorest quintile used skilled care at delivery and 63% in the richest quintile. In 2006 an international NGO decided to start an intervention in two districts. Each of these districts has approximately 500,000 inhabitants, a district hospital, and slightly more than 20 health centers (CSI) where women (rarely) come to consult and to give birth. The health centers are managed by a nurse and overseen by a community-based management committee. The intervention consisted of abolishing user fees for deliveries and prenatal consultations in order to increase the financial accessibility to health care. Before the intervention was inaugurated, a community awareness and information campaign was undertaken in the villages with the help of administrative and traditional authorities and local leaders. All required drugs and medical supplies were provided by the NGO. To compensate for financial losses to the cost recovery system related to the abolition of user fees, operating grants were given to all health centers in the two districts. The nurses received a monthly bonus in addition to their salary to cover any extra clinical and administrative workloads. Refresher courses were provided to them on site.

Early in 2007 the director of the NGO contacted us to find out whether we were interested in carrying out this evaluation. In line with our usual approach to evaluation (Ridde & Shakir, 2005; Ridde, 2006, 2007), and after several conversations to understand how the NGO intended to use the results, we set up a multidisciplinary team of three evaluators (one researcher in public health from Canada and two physician–anthropologists from Niger) to respond to the call for tenders. Our proposal was selected and the evaluation took place in April 2007 over 22 workdays, of which 14 were in the field. Ten evaluation questions were retained, having to do with the attainment of the intervention's targets and the implementation processes. Data sources were the registers of the 43 health centers, eight focus group discussions, 85 in-depth interviews, participant observation in 12 health centers, and self-administered structured questionnaires (n = 57, health staff).

UNEXPECTED EVENTS

The introduction of an innovation such as abolishing user fees in Niger's health system provoked some unexpected reactions from health care workers and the population. Analysis of these unanticipated effects was not envisioned in the evaluation design requested by the client.

From the Population's Perspective: Medicines Associated with the Distribution of Food Aid

Two years before this health intervention, the NGO had begun its action in Niger by distributing food supplies during the food crisis in 2005. Thus the abolition of user fees, and the abundance of new consultants and drugs to cope with it, was sometimes interpreted by the population as a distribution of medicine. As with food aid, where the organizers are very aware of pilferage, "there was lots of wastage" in the first weeks of the intervention, one nurse told us. Thus, not knowing whether this windfall would continue, or to make sure they would have medicine for when their children actually became sick, some patients apparently came to the centers to build up a reserve of medications: "There's a big rush on, because it won't last," said a nurse. Thus, according to the nurses, there was a phenomenon of stockpiling.

From the Perspective of the Health Care Workers: Strategies for Recouping the Shortfall

Health care workers have always organized parallel systems to boost their incomes. These parallel practices were integrated into a system where people paid for everything. Thus the act of abolishing some fees and informing the population of that fact made these strategies more complicated (but not impossible) to carry out. Nevertheless, the health care workers managed to adapt perfectly well to the new situation. All of them insisted that the abolition of fees greatly increased their workload "to the point of irritation" and reduced the time available for each patient—a claim that was not borne out by our observations. These statements are somewhat exaggerated; the most motivated workers managed to better organize the distribution of tasks and the roles of the health personnel. Actually, the strategy behind these statements is to pressure the NGO to recognize that they are "overwhelmed" and consequently to increase the bonuses they receive for working in the free system. Some nurses redirect the free drugs from the NGO into the fee-for-service system that continues for other categories of the population who are not beneficiaries of the project. Creating artificial stock shortages of goods supplied for free by the NGO is another way of getting around the NGO's rules. By forgetting to replenish the stocks of health booklets, nurses will create a shortage that will allow them to purchase the same booklets manufactured in neighboring Nigeria, which they then resell to patients privately at a profit. Others are even more creative. On the pretext that the women do not take proper care of the health booklets, some nurses

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have "required that the booklets be laminated," said one manager, for the same price at which they used to be sold. Other nurses write their prescriptions on a piece of paper that they staple to the booklet, then charge 25F ($0.05) for the staple. We were thus not surprised to see a nurse open, inadvertently, a drawer filled with coins in his office. The other solution is simply to charge for certain services that are free. One woman told us, "I paid 1,000F ($2) for a delivery a few days ago." Another woman recounted that she paid for her first prenatal consultation; but the health workers had chided her for coming in, because they took advantage of the rural inhabitants' lack of information to charge them when they came into town for services, so they said to her, "Hey, city-dweller, why did you come today? Today is for the peasants, they pay cash, so you'll have to pay, too." Some CSIs continue to charge each patient 50F or 25F to pay, we were told, the salary of a guard. Thus one woman reported having been charged several fees: "I didn't have to pay for the *awo* [prenatal care], but I had to pay for the booklet. So, I paid 100 francs for the booklet, 100 francs to have it plastified, and 25 francs for the guard." When we asked women who were waiting in line in front of a CSI why the services had become free, the response suggested to us that it was not always so: "It's because you are here today." We were also told that the abolition of fees "created problems of misunderstanding between the health workers and the population."

The Provider–Patient Relationship: Lack of Understanding

The abolition of user fees had several impacts on medical practice and particularly on the interaction between provider and patient. Many patients consider that the medicines supplied in the free system are, in effect, owed to them by the NGO and made available through the CSIs, and that health workers are only intermediaries whose role is to distribute them. This lack of understanding about the abolition of user fees has led users to develop strategies for hoarding medicines. Thus the majority of nurses (63%) completely agreed with the statement that abolition required them to deal with patients who were not sick and wanted to abuse the free system. According to the nurses, patients have adapted their strategies for acquiring medicines. Some pretend to be sick, and others, who arrive with a healthy child, listen to the description of the symptoms of the mother ahead of them in line and say the same things that will help them get the medicines they want. Since many nurses do not systematically take vital signs (none that we observed did so) and provide care based only on reported symptoms, the likelihood that mothers will be given medicines is quite strong. Some people go from one CSI to another. The massive arrival of cough syrup

was perceived by mothers as a great opportunity because they associate it with vitamins. Thus, as one nurse reported, "We were obligated to give the cough syrups to the mothers." Moreover, health workers say patients have become more demanding and insist on receiving the treatment of their choice. They arrive late at night, even for a mild cold. We did not observe any such behaviors during our observations and can only repeat here what was reported by the nurses.

However, patients are not happy, either, with how they are treated. Complaints about health workers are frequent. They complain that workers ration the medicines: "At first, when they arrived, you would be given a tube of ointment, but now you have to bring your child morning and evening for them to put the medication in his eyes." In addition, they find that the workers are scornful toward them, treating them as though they are pretending to be sick and only come to the CSI to get medicines.

RESPONSE TO UNEXPECTED EVENTS

Xu et al. (2006), evaluating the Uganda experience, stated that abolition can have "unintended consequence." In South Africa, nurses already reported that some patients abused the new system after abolition (Walker & Gilson, 2004). In Niger, an analysis of food distributions during the 2005 crisis (Olivier de Sardan, 2007) revealed that malnourished children in the villages were considered "lucky babies" because they gave mothers the right to multiple forms of aid, and some women therefore "borrowed" such children. Other women tried to "cause diarrhea in children so that they would lose weight," to receive aid. The problems associated with the distribution of a per diem in development projects are also well known to field workers and well documented (Smith, 2003; Ridde, 2008). Thus the term "unexpected" is not the most apt, since the workers had to some extent anticipated the behaviors we have just described. For example, knowing that the nurses were going to lose a part of their income, the NGO had decided to pay them a monthly bonus. The pretext was that the intervention would increase their workload (clinical and administrative), but it was also a way (discreet and unacknowledged) of ensuring their participation in the project. The NGO had also decided to change the color of the health booklets (from blue for the government to yellow for the NGO) to prevent the workers' selling those that were supplied free. In summary, the problems encountered could have been known had the program designers had the inclination to check the literature, knowledge of where and how to access that literature, and the background needed to understand it. This,

however, constitutes specialized knowledge and skills that the program designers, who in any case were operating under extreme pressure (a few days to write a $2 million proposal), did not have.

Thus what we uncovered in this evaluation may be effects that were not only unexpected but also undesirable, and which the client had not wanted to have exposed by the evaluators. What was unanticipated was the actors' capacities for coping with the new situation and rules (creating shortages, selling the lamination of booklets, etc.). There is an adage that rules are made to be broken. Social anthropologists say that actors always retain some room to maneuver in a system to ensure the status quo. These phenomena are well documented in the literature on development aid (coping strategies) (Olivier de Sardan, 2005; Ridde, 2008) and on organization theory (margins of maneuver) (Crozier & Friedberg, 1977).

Thus the evaluation uncovered practices that the evaluators had not been asked to explore. However, faced with the ethical issues of ensuring that the action would actually benefit the worst off, it seemed to us essential that these practices should be revealed. Of course, they were not described in order to destroy the project or stigmatize the actors, but rather to make the project more effective. In the present case, these unanticipated effects can largely be explained by a lack of familiarity with the scientific literature, the limited experience of the NGO management in the field of intervention, and too little time invested in the project's planning phase. However, the stakeholders were very open-minded and sincerely wanted to improve their intervention. Thus, on the day when the results were presented and the content of the evaluation report was discussed, the participants mostly talked about these unanticipated effects. Only one person challenged them (for emotional reasons linked to his own investment in the project), but all the others agreed with the diagnosis. The two African members of the evaluation team had anticipated these reactions (being accustomed to these types of challenges) and had kept specific items as evidence of the events we described. The qualitative anthropological approach with tangible proof was another coping strategy on the part of the evaluators! Thus those responsible for the intervention largely accepted the operational recommendations coming out of the evaluation. Reducing illicit practices, for example, requires restoring administrative authority. Because the NGO had organized its project at some distance from the administration, the latter was not in a position to engage fully. Today, the NGO works to support the administration directly, rather than as an alternative to it. This obviously will not resolve all the problems, but there is no magic wand to fix corruption. This being said, these illicit practices, although significant, are nevertheless marginal, and this intervention

helped improve access to health care services for the local populations. We hope this will endure.

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NOTE

1. We wish to thank all the members of the NGO, the health workers, and members of the population who agreed to participate in this evaluation. The involvement of Mahaman Moha was essential to the success of the evaluation.

From unintended to undesirable effects of health intervention: the case of user fees abolition in Niger (West Africa)

Valéry Ridde[1,2], Aissa Diarra[3]

[1] PhD, Department of Preventive and Social Medicine, Faculty of Medicine, University of Montréal, QC, Canada

[2]Centre de recherche du Centre hospitalier de l'Université de Montréal, Montréal, QC, Canada

[3]MD, Laboratoire d'Études et de Recherches sur les Dynamiques Sociales et le Développement Local, Niger

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1. Description of the case

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2) Unexpected events

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i) From the population's perspective: medicines associated with the distribution of food aid

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3. Response to unexpected events.

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