Agreement for Performance of Work

Terms of Reference

Support services to enable country level collaboration for improved institutional frameworks in the area of health financing systems

Situation Analysis and Action Needed
for
NIGER

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by

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A. BACKGROUND DOCUMENTS (Original Language):

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- Stratégie nationale de la couverture sanitaire universelle au Niger (2021-2030), ministère de la Santé Publique, de la Population et des Affaires Sociales, juin 2021, 128 pages.

- Stratégie nationale de financement de la santé au Niger en vue de la Couverture Santé Universelle, ministère de la Santé Publique, juin 2012, 73 pages.

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- Présentation du Fonds commun d'appui à la mise en œuvre du plan de développement sanitaire, Fonds commun santé, janvier 2020, 9 pages.

- Projet de réforme de la gestion de la gratuité des soins au profit des femmes et des enfants de Zéro à cinq ans au Niger : définition du cadre institutionnel et fonctionnel de la structure nationale de gestion de la gratuité des soins, ministère de la santé publique, mars 2020, 43 pages.

- Refonte de la gratuité au Niger, Fonction d'achat de la cellule de gratuité et gouvernance, ministère de la santé publique, février 2020, 11 pages.

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- Rapport d'audit, Subventions du Fonds mondial à la République du Niger, Fonds mondial, Genève, Suisse, Septembre 2018, 22 pages.

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B. SITUATION ANALYSIS :

(i) Political/Governance Challenges :

Improving the infrastructure of the health care system throughout the country and strengthening the access of women and girls to health facilities, family planning, sexual health as well as reducing child mortality are today the priorities of the Government of Niger from a health perspective. The Government has continued in recent years its efforts to increase the rate of health coverage, relying in particular on its free health care (FHC) policy[1]. In view of the implementation of universal health

[1] Health services are currently provided in the public sector by a network of healthcare establishments at all levels, amounting in 2019 to 1,063 Integrated Health Centers, 2,401 health huts, 38 district hospitals, 7 regional hospitals, 7 health centers. of Mother and Child, 5 Regional Blood Transfusion Centers, 5 national hospitals, 1 central referral maternity unit, 10 national referral centers. There are 348 private establishments, including 52 clinics and polyclinics, 71 treatment offices, 41 medical offices and 179 treatment rooms and 2 private non-profit hospitals, 2 private centers specializing in

coverage (UHC), the Government wishes to build a universal health risk coverage mechanism (CMU) based not only on the achievements of its free healthcare policy, but also by capitalizing on good practices on other insurance mechanisms (public, private or community) in progress in the country[2].

The services provided according to the free health care policy cover all children aged 0 to 5 (nearly 4.5 million children in 2019), women in antenatal consultation (ANC), emergency obstetric and neonatal care (mainly C-sections), vaccinations, malaria, long-acting insecticide-treated bed nets, intermittent preventive treatment (IPT), tuberculosis, HIV/AIDS[3], neglected tropical diseases (NTDs), malnutrition, and female cancers[4].

These free health care services cover a wide range of health services and the maximum of the population, without direct payment for the patients. In the private sector, there are other patient care mechanisms through private insurances and community-based or professional health mutuals. However, these mechanisms cover very little the population.

The major difficulties in health financing are the following : insufficient budgetary resources allocated to health by the State (the percentage of the State budget allocated to health is around 6% in 2020, remaining largely below the 15% recommended by the Abuja Declaration in 2001) ; insufficient funding from communities for health ; low mobilization of internal and external resources ; the delay in the disbursement of financial resources ; the low predictability of State and

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ophthalmology and orthopedic trauma and one private confessional hospital. This increase in health infrastructures had an impact on health coverage, which rose from 48.33% in 2016 to 50% in 2018 according to the results of the annual sector review.

[2] The proportion of the population benefiting from a formal health risk protection system is estimated at 5.10% of the population in 2019. Health risk coverage is insufficient among workers in the formal sector and almost non-existent in the sector informal. The payment exemption mechanisms for care make it possible to remove financial barriers in access to care for a population estimated at 27.69% 18 of the population.

[3] Free care for people living with HIV (PLHIV) is governed by Law n° 2015-30 of May 2015 (as well as by its implementing decree n° 2017-014 / PRN / MSP of 06 January 2017) repealing Law 2007-08 of April 30, 2007. The Law stipulates in its Article 10 that “Any person living with HIV must benefit from the services of medical and psychosocial assistance. Support is free and comprehensive”.

[4] Free services related to female cancer provided by public health establishments are governed by Decree n° 2007-261 / PRN of July 19, 2007. The implementation of this Decree is the responsibility of the MSP/P/AS through its structures of specialized care: the national hospital of Niamey (HNN), the Issaka Gazobi maternity unit (MIG), the national health and reproduction center and the National Center for the Fight against Cancer. Free coverage covers all services related to breast cancer and cancer of the uterus and its appendages.

Partners' funding; the low purchasing power of the populations (59.5% live on less than a dollar a day) ; the large part of direct payments supported by households ; the lack of adequate assistance mechanisms for the poor and vulnerable people ; the insufficient quality of care and services offered ; the very high illiteracy rate among the population ; the delay in the reimbursement of free healthcare bills ; the weak adhesion of the population to mutuals and health insurance ; the weak development of mutual health insurance ; the low financial capacity of mutual health organizations to cover a high level of care ; and the delay in setting up a social health fund.

Niger has made significant efforts to improve governance in the health sector. In this regard, a General Inspection of Services (GIS) has been set up. In order to strengthen governance, an institutional audit was commissioned by the Ministry of Public Health, Population and Social Action (MSP/P/AS) in 2015. This audit identified a number of shortcomings which relate to the following aspects: sector planning, decentralization, political dialogue and sector coordination, inspection, control and admissibility, implementation of reforms and partnership.

Improving governance and leadership in the health sector is a major challenge today. The main expected results are as follows : the health structures are staffed in accordance with the needs identified ; the transfer of skills and resources to the communities is effective ; coordination and planning meetings are held regularly ; the bodies ensuring community participation are well functional ; a sectoral policy dialogue is established ; the GIS recommendations are implemented by the different levels (intensifying the inspection and control missions of health structures at all levels is a priority) ; the GIS is reinforced in material and qualified human resources ; quality health products are available (fight against illicit drug trafficking and strengthening the financial, material and human capacities of the National Office of Pharmaceutical and Chemical Products - ONPPC).

The Citizen's Observatory of Access to Health Services Care (OCASS) which is a platform for civil society in Niger is a gateway to ensure that the governance of health facilities is in place and constitutes a force for critical analysis and proposal. Also, the "social accountability" carried out by civil society focuses on two fields of action: the quality of care and the use of public and private funds.

Efficiency in the allocation of resources is also a priority action in strengthening health governance. It should materialize in particular through the financing of high-impact interventions in provider and management services, the implementation of the Health Development Plan (HDP) and the search for transparent and participatory management. At this level, strategies are developed, but adequate implementation is

still required (joint review mechanisms; quality management; audits focusing on partner funds and free healthcare delivery, etc.).

(ii) Socio-Economic Challenges:

Niger has already reached major achievements in favor of the implementation of UHC. These achievements are mainly related to the free health care mechanisms and the insurance mechanisms already implemented in the country. However, the difficulties are still great from a socioeconomic point of view: health coverage is less than 50%; poverty continues to grow and take root (poverty rates are higher in rural areas than in urban areas). Moreover, in terms of access to health services, more than half of the population must travel more than 5 kilometers before accessing basic health services.

The policy of free health care (FHC), implemented from 2006, has significantly improved the access of vulnerable populations to health care and services. Free access mainly concerns healthcare for children under 5, female cancers, HIV, tuberculosis, vaccination, antenatal consultations (ANC), cesarean sections, contraceptive products, malnutrition. However, most of the total or partial exemptions granted under the free health care policy concern practically only health supplies (few services) and are linked to supply circuits that escape to providers.

The National Social Security Fund (CNSS) offers health insurance to all workers as well as dependents and members of their families, but its scope remains limited to 2% of the population. In the private and informal sectors, there are other patient care mechanisms through private insurance and community-based or professional mutuals. However, these mechanisms cover very little the population and the extinction of community-based mutuals has further weakened the situation[5].

(iii) Financial Challenges:

- Revenue raising:

The health sector, like all others, suffers from the weakness of mobilization of internal resources. The credits allocated to the sector are insufficient in front of the

[5] The national social security fund (CNSS) was established by the Law No. 65-004 of February 8, 1965, repealed, and replaced by the Law No. 2003-34 of August 5, 2003, establishing a public establishment of a social nature called CNSS. Its statutes were adopted by the Decree n° 2005-64/ PRN/MFPP/T of March 11, 2005.

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increasingly growing needs. Improving the mobilization of domestic (internal) resources is fundamental because the health sector does not yet receive the necessary support from the State. Households are the primary source of financing for health spending. Indeed, their contribution to the national health expenditure since 2005 represents on average 40%. This situation deserves special attention from the authorities in charge of health, given the high level of poverty of the population (59.5%).

The mobilization of internal resources requires the strengthening of awareness-raising and advocacy actions with central administration authorities and local communities. Developing arguments for budget discussions and creating an MSP/P/AS - Ministry of Finance consultation framework is more necessary than ever.

- Pooling:

The use of funds pooled or managed individually by programs to support health care and service delivery has covered 51% of the Nigerien population in terms of physical access to health services. Health care mobile strategies are also organized in all health districts to compensate for this insufficiency.

A Social Fund should be set up by the Government to provide care for the indigent and the most vulnerable people. If authorities have already agreed upon the principle and efforts are already underway, so far, they have not materialized yet.

Niger has developed a sectoral approach for the pooling of resources in order to finance the CMU. The Sector Wide Approach Program (SWAP) is a program-based approach. It aims to formulate, program, execute and monitor a sector development plan encompassing all aspects of the sector and all sources of financing. It is generally characterized as a framework for relations between donors and beneficiaries based on: a coherent, realistic and comprehensive sector policy; a sector budget based on medium-term financial programming encompassing all the financial resources available to the sector; a comprehensive and consistent business and investment planning; clear, measurable and realistic indicators and targets to assess the progress of sector policy implementation; a monitoring and evaluation system covering all activities in the sector; an institutional mechanism to coordinate and harmonize approaches and activities in the sector, in which all stakeholders participate under the responsibility of national authorities.

From this point of view, the establishment of the Common Fund to support the implementation of the HDP materializes the transition from a "project" approach to a "program" approach in the health sector. As a multi-donor mechanism, the Common Fund centralizes and ensures the fiduciary management of all contributions intended to support the implementation of the HDP. The mission of the Common Fund is to guarantee greater coherence in health interventions together with an equitable distribution of resources for health financing. The Common Fund should also ensure a greater accountability of the national administration, the establishment of an efficient and effective results-based management and the use of standard operating procedures (SOPs) to simplify and clarify the management of health financing.

Mutual health organizations are also supposed to play a key role in the implementation of the CMU, by pooling the financial resources of their members in order to increase their financial protection for health. The development of social mutuals in Niger is part of the reflection carried out on the alternative ways of financing health (e.g., through the development of mutuals and insurance) and concretizes the political will of the Government to strengthen the existing partnerships between the populations, the local territorial collectivities, civil society organizations (CSOs), and development partners.

Health mutuals were introduced by the Law 2008-10 of April 30, 2008, instituting the general scheme for all health mutuals in Niger. As civil societies with variable capital and personnel, their very purpose is to guarantee access to health care for their members and their dependents. Article 3 of the Law clearly states that every citizen in Niger must have a health insurance, whatever the modality.

Subsequently, other formal provisions came to complement the mutual health insurance scheme. In 2009, WAEMU adopted the Regulation 07/CM/2009 regulating health mutuals within WAEMU. And by the Decree 2015/474/PRN/MET/SS of September 2015, the Government of Niger sets up a structure called the Nigerian Agency for Mutual Health (ANMS). This institution was supposed to respond, on the one hand, to the political will expressed by WAEMU to strengthen the role of mutual health organizations in all Member Countries, and, on the other hand, to the desire of the Nigerien State to nationalize the health mutuals sector together with the social protection sector. But the results have been disappointing: only six health mutuals are registered with the ANMS in 2020, and there is no constraint obliging the different health mutuals to join. Moreover, the ANMS does not have the means for its policy. State subsidies represent 42% of its budget, which remains very insufficient.

The financial resources of health mutuals come mainly from internal funding through membership fees. External support is rare. It comes on an *ad hoc* basis, and sometimes emanate from town halls or certain NGOs (AFUA – health management through local initiatives, PSI – Public Services International, Mercy corps). Health mutuals still cover too few people today and are repeatedly faced with financial problems that jeopardize their viability. Many have disappeared or are on the verge of extinction.

Developing the creation and professionalization of municipal, departmental, and regional health mutuals is now a priority action for the Government.

- Purchasing:

The MSP/F/AS must rely on the normative framework regulating public finance management in Niger to set up strategic purchasing and define payment mechanisms for healthcare providers and other providers of health goods and services. It must also establish a harmonized and unified reporting system as part of the strategic purchase.

The rate of use of the health services offered is only 40%. This low rate is mainly explained by the low quality of care and services offered (40% of beneficiaries of health services give a negative judgment on the quality of services) and the financial difficulties of the populations.

To improve this situation, the MSP/P/AS, with the support of its partners, has put in place health support mechanisms relating to: priority allocation of funds to healthcare provider services and management services; encouraging demand for care based preferentially on the purchase of services from existing health mutuals (community-based, professional, or in place for certain public services such as customs); reimbursement of care provided to private insurance subscribers; purchase of curative and preventive care services for vulnerable populations; signing of service contracts with civil society, in particular national NGOs; and initiatives to incentivize the performance of health care and services through experiments in remuneration for quality improvement (in particular with GAVI) and the start of Performance Based Financing (PBF).

The main features of the PBF approach are the following: segregation of duties, which means that the responsibility for regulating the health sector, the provision of health services, and the financing of services are entrusted to independent organizations; the conclusion of clear and transparent contracts between purchaser

and service provider; greater autonomy for health facilities to decide how best to use their available resources; allocation of a part of the subsidies to staff providing health services as a "incentive bonus"; establishment of affordable pricing, in consultation with the community; providing additional funding to ensure access to the most vulnerable; and the strict verification of usage data before payment of subsidies, to prevent fraud. It has been shown in several African countries with comparable incomes that this approach can lead to relatively rapid improvements in the use and quality of health service delivery.

- Financial Rules and Regulation/Budget

Public finance management in Niger is fundamentally based on the Organic Budget Law related to the Finance Laws (LOLF). Several specific texts (decrees, orders, and instructions) provide a framework for budget management[6].

The reform of the budget structure in Niger, moving from the budget “by inputs” to the budget “by programs”, establishes the legal framework for expenditure by priority programs and puts in place the rules for contracting. It sets up a reporting system by results. It is now opportune for the MSP/P/AS to connect this reform to the strategic purchasing of health care and services. This should improve access to health care and services for Nigeriens.

The optimal functioning of the payment exemption policy for children under 5 and pregnant women is a major strategic axis. The policy relating to this exemption is the “flagship” national policy for Niger in terms of health risk coverage. It aims to offer significant financial coverage to around a quarter of the population. Its operationalization under optimal conditions must constitute a gigantic step towards

[6] The Organic Budget Law No. 2012-09 of March 26, 2012 relating to Finance laws; Community Directive N° 007/2009/CM/UEMOA being the Organic Law for the General Regulations of Public Accounting within the WAEMU countries; Decree No. 2013-083 of March 1, 2013, laying down general regulations for public accounting; Decree No. 2016-641/PRN/PM of December 1, 2016, on the Code of public contracts and public service delegation; Order No. 0351/ME/F September 2015, on the National Budget Management System; Order No. 0352 of September 23, 2015, fixing the terms and conditions for the execution of State expenditure; Order No. 0353/ME/F of 23 September 2015, regulating the Revenue and Advance Departments of the State budget; Order No. 0334/MF/DGB of July 26, 2018 fixing the nomenclature of supporting documents for the expenditure of the State, Territorial Communities and their Public Administrative Establishments; Instruction No. 2064/ME/F/ DGB of 23 December 2015, relating to the modalities for the execution of State budget expenditure; Instruction No. 2065/ME/F/DGB of 23 December 2015, relating to the procedures for the execution of expenditure on delegated credits.

CMU. To do this, an overhaul of the system is necessary, which must guarantee funders the effectiveness of the care for which reimbursement is requested and the optimal use of this funding. This will be done with the transfer of management to a professional management Unit. The system will be effective and sustainable provided that the funding is effective and corresponds at least to the costs of support not covered by salaries and subsidies for the service offer. This funding, which comes from the State and financial partners, must be made available under conditions of “fluidity”. It should also ensure guarantee of regular disbursement, demonstrating the Government commitment at the highest level.

As community-based health mutuals have shown their limits, the Government is currently studying the possibility of imposing a special tax at the level of local authorities to provide CMU for the majority of Nigeriens. The State will decide on the value of this tax according to social categories as well as on the methods of collection at the level of the communities. The communities will constitute themselves as third-party payers because they will be in charge of the management of “territorial health insurance”.

(iv) Collaborative Challenges :

The challenges of coordinating Technical and Financial Partners (TFPs) and the question of their alignment with the strategies and priorities of the MSP/P/AS in Niger are part of a complex system. To understand it, considering the great diversity of TFPs (bilateral, multilateral cooperation, agencies, investment banks, NGOs, etc.) and their specific approaches is not sufficient. The field is characterized by a multiplicity of configurations and health financing circuits which attempt to influence public policies through a superposition of initiatives (Common Fund, Global Financing Facility - GFF, thematic groups, etc.) and a multiplication of intermediaries.

The multiplication of initiatives and discussion frameworks maintains the logic of multi-positioning of TFPs and cross-participation in funding (WB-GFF, EU and bilateral cooperation, etc.). This fractionation disperses energies and leads to a disinvestment in solutions which had yet provided interesting answers (Common Fund). It makes the issues of coordination more necessary than ever, but also complex, and requires an evolution of their modalities.

The alignment of TFPs for health financing is essential and a priority. Bringing this issue onto the political agenda is fundamental. To do this and with a view to proposing common solutions, anchored in reality, and involving the various stakeholders (ownership), an intervention-research approach has been initiated. This

approach is based on a series of case studies identified and prioritized in a collegial manner. Each of them constitutes an axis of analysis which aims to illuminate, symmetrically (MSP/P/AS - TFPs), or in a multi-scalar mode (operational/national/global) the challenges of coordination and alignment.

(v) Human Resources Challenges:

Human resources in the health sector in Niger is characterized by an insufficiency (quantitative and qualitative), an inequitable distribution of personnel between urban and rural areas, insufficient control of the workforce, non-rational use of personnel and career profiles, unsatisfactory promotion systems, and ineffective continuing training. Those problems have persisted for decades. Indeed, they had already been identified as such in the previous National Health Plan (PNS) (2002-2015). In March 2014, the MSP/P/AS had a total staff of 7,647 agents, far below the minimum requirements to ensure decent territorial coverage. The women constitute an overall proportion of 59%. In 2015, 30% of CSI had staff according to the norms and standards defined by the MSP/P/AS. District Hospitals with qualified staff did not exceed 10% (17% for CHRs at regional level).

Motivating health agents in their work so that they produce more (quantity) and better (quality) for the benefit of the entire population is now part of the scaling up of the PBF that the Government is trying to put in place at all levels for health financing. The aim is to increase the motivation of health workers to perform their duties in an effective and efficient manner, with fair and transparent behaviors. Promoting good practices and reducing corruption is another crucial objective to increase trust from the population.

Financial rewards are core components of this new policy. Since they are not the only valid incentives, they create undoubtedly a powerful motivating force. Actually, when salaries are too low, they do not consent health agents to have a decent living. As a result, absenteeism is growing and employees try to find jobs in the private sector where incomes are higher, which further empties the public sector of its resources. It is thus of the utmost importance that the “staff bonus” included in most PBF programs is high enough to provide an incentive to work harder and perform better. For employees who already have high salaries, “staff bonus” are not real incentives. In this case, the PBF program needs to rely on other incentives to increase motivation, such as promoting a better work environment and providing for a greater autonomy to make decisions.

C. WHAT IS NEEDED ?

(i) Strengthening policy frameworks by:

- Adopting conducive policies.

"Professionalizing" the third-party payment applied to the free health care policy for children under 5 and for maternal health, in particular cesarean sections, is an innovative solution that should be implemented in the short term to accelerate progress towards the CMU. Women in antenatal care (ANC) and partial payment exemptions are examples of services that could be integrated into a professionalized third-party payment system.

Another priority action consists in reaffirming the political will of the Government to effectively implement the measures relating to the partial cost recovery policy. This is necessary to achieve the objectives set up in the new HDP. Niger introduced the system of partial recovery of the costs for primary health care in the non-hospital sector by the Law 95-014 of July 3, 1995, complemented by its implementing decree No. 96-224 of June 29, 1996. This legislative and regulatory framework was supplemented by decrees N° 0024/MSP/MF/RE/P and N° 0026/MSP/MF/RE/P of 04 February 1999 creating a single fund for the recovery of primary health care costs respectively at the level of Integrated Health Centers (IHCs) and at the health district level. As a result, the health structures opened dedicated bank accounts to receive the revenue generated. While the MSP/P/AS provides administrative supervision of the cost recovery system, day-to-day management is entrusted to the health committees of the health area concerned (IHCs, District Hospitals). These committees are structures made up of people elected by the population.

The system of partial cost recovery is now facing several weaknesses, the first of which are: non-compliance with existing texts on cost recovery; frequent shortages of drug stocks and non-compliance with the authorized list of drugs defined according to administrative and geographic levels; deficiencies in management as a result of insufficient training, supervision and control; insufficient control of the management of health services and cost recovery, due to lack of audits; weak involvement and participation of community structures (ownership is insufficient); lack of normative texts and institutional frameworks governing collaboration or partnership between public health facilities and private health facilities; difficulties in recovering medical costs at the level of local authorities and at the central level.

A fair, updated, and relevant human resources policy is a key component of health financing and a core element to progress towards CMU. The Government is committed to: providing 80% of health structures with personnel in accordance with identified needs; plan initial and continuing training in accordance with the needs identified with all the health structures within the territory; manage the careers of all health workers in the best possible way within the different categories of public service employment; set up a certification and accreditation system for health training schools; develop forward planning of posts at the central level, at the level of the General Public Health Directorates and health districts; implement motivational measures in all health facilities as part of results-based management; strengthen HRM capacity at all levels of the health pyramid; and implement actions to promote the installation of doctors in rural areas.

- Elaborating costing frameworks.

Priority expenditure assessment should be carried out with a view to accelerating the release and disbursement of credits. Developing a Medium-Term Sector Expenditure Framework (MTSE) and a budget that consider the real needs of the sector are priority actions.

- Improving data availability to inform policy and decision making.

A number of reforms are planned or already underway, in particular to make the health information system functional. Revising the national health information system - NHIS (developing a single platform?) should facilitate the implementation of the HDP and allow for better measuring the performance of the overall health system. Monitoring and Evaluation (M&E) of health interventions at all levels is now considered a core instrument to improve performance.

The Government is also studying, more specifically, the feasibility of setting up an information system dedicated solely to the management of free healthcare schemes. In addition to formulating recommendations on the various possible technological options, such a reflection also requires analyzing the precise needs of a data system focused exclusively on free healthcare as well as the functionalities of such a system and the possible interactions with other data systems.

(ii) Strengthening legal and regulatory frameworks by:

- Adopting robust legislation:

The MSP/P/AS prepared in February 2021 the draft Bill on CMU. If the Law has not yet been adopted by Parliament, it should create, on the one hand, a health assistance scheme (RAMED) with its management body called the National Institute of Health Assistance (INAM), and, on the other hand, a health insurance scheme (RAM) with a management body called the National Health Insurance Fund (CNAM). Two schemes are therefore put in place to achieve CMU in Niger and progress towards UHC. RAM (health insurance scheme) is based on the contributory principle and should guarantee the coverage of curative, preventive, promotional and re-adaptive costs for its members. RAMED (health assistance scheme) is based on the principle of national solidarity and is established for the benefit of the vulnerable population.

People benefiting from RAMED under the conditions set by regulation are the following: people who do not contribute to any health insurance scheme and do not have sufficient resources to meet the expenses for basic health care, together with their spouses and dependent children aged 21 or over and not covered by any health insurance[7]; disabled children regardless of their age, who are totally and permanently unable to engage in remunerated activity due to physical or mental incapacity; and anyone else in a vulnerable situation who is not a beneficiary of any other health insurance plan[8]. Proof of vulnerability is established by the competent authority. The health assistance plan covers the same basket of care as that of the health insurance plan.

The RAMED is financed mainly by the State and the local authorities and by the participation of the TFPs, the financial products, the donations and bequests, the penalties related to the non-application of the provisions in favor of the access to employment of the persons with disabilities as well as any other resources allocated to this scheme by virtue of specific legislation and regulations. The State contribution intended to finance the health assistance scheme is entered annually in the Finance Law. The contributions of local authorities intended to finance the said scheme

[7] This age limit can be extended up to 26 years in case of duly justified continuation of studies.

[8] Children who live under the same roof, as the beneficiaries mentioned above, and who are in their effective, total, and permanent charge, are, on condition of providing proof, eligible for the benefits guaranteed under the health assistance scheme. The following people are entitled to full health care assistance: residents of charitable establishments, orphanages, hospices, or rehabilitation establishments; abandoned children or adults without families of any public or private non-profit establishment; residents of penitentiary establishments; homeless people; the elderly as defined by the texts in force.

constitute compulsory expenditure in accordance with the legislation in force. These contributions are entered annually in the budgets of the said communities.

The two management bodies of CMU schemes referred to by law, CNAM and INAM, are created by decrees issued by the Council of Ministers. INAM has a dual mission: a general mission of implementing all strategies and reforms of free healthcare as part of the UHC implementation process; and a specific mission of delegated management of the progressive management of free healthcare for vulnerable people, as they are defined and targeted by the implementing texts of the 2018 Social Protection Law.

To oversee the operation and viability of the two management bodies, the law also provides for the creation, by decree of the Council of Ministers, of the Nigerian Agency for Universal Health Coverage (ANiCMU) to regulate universal health coverage. ANiCMU will be a public institution with legal personality and financial autonomy. The management bodies will be required to communicate, annually, to the administrations concerned and to the ANiCMU, the statistical documents and information relating to the health care products and services used by insured persons. Establishing effectively and efficiently the ANiCMU is fundamental for the operationalization of the normative framework of CMU.

Management bodies are authorized to set up financial reserves for their functioning. The nature and the methods of constitution of these reserves are fixed by decree taken in the Council of Ministers. A decree taken in the Council of Ministers fixes the rate and the terms of the resources allocated to actions of health promotion and disease prevention as well as actions aiming at increasing quantitively and qualitatively the offer of health care products and services. CMU schemes established by law are managed according to the principle of financial balance between their resources and their expenditure. An external actuarial study is carried out at least every five years in order to assess the sustainability of the financial balance of the management bodies.

Management bodies are also subject to controls by State bodies as well as by those of the Inter-African Conference on Social Welfare. The controls carried out extend to delegated management bodies with regard to financial and accounting operations. A technical control is also put in place by the Government, the purpose of which is to ensure that management bodies fully comply with the provisions of the law and the texts adopted for its application. This technical control is carried out on documents and on site. To this end, the management bodies are required to produce to the administration any relevant statements, reports, tables, or documents. In addition to

controlling the financial situation of the management bodies, the technical control aims at verifying the issuance and collection of contributions, the settlement of files, the constitution and representation of reserves and the effective application of agreements concluded with care providers.

The relationships between the management bodies and pharmacies or public or private health care providers, in particular with regard to the reference tariffs for reimbursement or direct coverage, are defined. within the framework of national or individual agreements, on the initiative and under the guidance of the management bodies concerned. National agreements are concluded between all health insurance management organizations, the professional health orders represented at the national level and the administration where applicable. A standard conventional framework for each national agreement is established by regulation on a proposal from the management bodies of both schemes, after consultation with representatives of professional organizations providing health care and approved by regulation.

In recent years, the adoption by the Government of several texts (decrees and interministerial orders) transferring powers and resources from the State to local authorities (municipalities and regions) in the fields of health should allow significant progress to CMU in increasing regional health insurance coverage. Niger has decided to invest in the creation of "territorial health insurances" and is committed to providing substantial start-up funds at local and regional levels.

The Government of Niger revised in 2007 the Norms and Standards of the Health System for all types of health functions as well as for all Regional Public Health Directorates and District Executive Teams. The very purpose was to support the preparation of district and regional health development plans through the adaptation of standards adapted to the socioeconomic context of Niger. This decentralization policy with a particular focus on the territories and the district level, mainly aimed at: rationalizing human resources management within all the territory; improving the management of infrastructure and equipment; increasing the accessibility of health services; offering relevant quality care to patients after their admission or hospitalization, in particular by creating and strengthening working relationships with private care structures and traditional medicine providers[9]; guaranteeing the continuity of care by developing a referral and counter-referral system for patients;

[9] Public healthcare services may enter into partnership agreements with parastatal and private healthcare services for one or more objectives allowing them to improve the quality of their services and health information.

ensuring the permanence of health services, e.g. the availability of care, taking into account the workload of health staff; and promoting the rational and transparent use of resources at the health district level.

In addition, it is necessary to adopt texts for existing free health care policies without legal bases such as tuberculosis, epidemics and neglected tropical diseases (NTDs). For the latter, for example, Niger has introduced free mass treatment (MT) but there is no legal framework governing this policy so far. The normative framework of the national neglected tropical disease control program (NTDCP) therefore needs to be changed.

As part of the overhaul of the free health care management system[10], the study carried out in 2018 by the WHO and entitled "Exemption from payment for care provided to children under 5 years of age and reproductive health services in Niger: Analysis and proposal for an overhaul of the system with a view to universal health coverage", proposed the creation of a Free Health Care Management Technical Unit (UTGG) including risk management within the framework of the Common Health Fund.

It is now necessary to define the legal and institutional status of the UTGG, as well as the modalities relating to its governance and its mode of management. The missions of the UTGG include the management of strategic purchasing for health services. From this point of view, the establishment of a procurement fund should aim, on the one hand, at implementing the policy of free care for children under 5 years old and for pregnant women and, on the other hand, at implementing Results-Based Financing. This requires the setting up of a management structure of third-party payer with separation of decision-making, execution and control functions, the latter being outsourced. Another mission consists in ensuring the piloting of the various mechanisms put in place for total or partial free health care services, with a view to integrating them progressively into the national CMU system. In addition, the

[10] Several studies and proposals for reforming the free health care management system and improving its tools and procedures have recently emerged. The proposed institutional arrangements include: the creation of a Social Health Fund; the creation of a State Public Establishment (EPE) (2011); the creation of a mission structure attached to the General Secretariat of the MSP (2011); the creation of an autonomous management structure with decentralized bodies and a monitoring system by the central level (2015); and the creation of an Autonomous National Agency for Free Healthcare Management (ANAGS) with a Board of Directors and attached to the MSP/P/AS (validation by the steering committee on August 31, 2017).

UTGG should ensure the generalization of RBF in a harmonized way for all existing funding mechanisms for free healthcare.

Last but not least, strengthening the legal framework for the pharmaceutical sector is a critical challenge. Pharmaceutical sector reform should focus on reorganizing the ONPPC, in particular by defining new service missions, opening its board of directors to new members such as TFPs and allocating a more substantial part of its capital to its functioning in order to allow it to fully play its role.

(iii) Strengthening institutional frameworks by:

- Creating supportive environments:

The institutional framework of coordination for the implementation of the national strategy relating to UHC was created by order n° 232/PM of December 5, 2014, and by order n° 309/MSP/SG/DEP/DF of August 2 amending and supplementing Order 292 /MSP/SG/DEP/DF of August 2, 2016. This framework is made up of two bodies: the National Working Group (GTN), responsible for leading the implementation process of UHC; and the Restricted Working Group (GTR) with a mandate to assist the GTN technically. The functioning of the GTN is structurally handicapped by the nature of its plethoric and heterogeneous composition, which justified the creation of the GTR. Composed of a team of ministerial executives and representatives of TFPs, the GTR is set to grow, with certain organizations not represented within the GTR (such as mutuals, for example) claiming their right to officially sit there.

Niger has changed its institutional framework for the implementation and the M&E of the UHC strategy. This institutional framework is currently made up of the following structures: the High-Level Steering Committee of the UHC; the UHC GTN; the Permanent Technical Secretariat; and Permanent Thematic Groups. Changes still need to be made, in particular to revise the regulatory texts governing the composition, organization and functioning of the GTN. Besides, a Permanent Multisectoral Technical Secretariat (PMTC) should be established to coordinate the implementation, monitoring and evaluation of the national strategy for UHC.

The objectives of the M&E framework of the UHC strategy are the following: to provide a solid mechanism for producing quality data to measure Niger's progress towards UHC; to facilitate political dialogue and support evidence-based decision-making; to share reliable information with the actors involved in the implementation of the UHC strategy with a view to obtain greater commitment on their part; and to

institute a permanent learning framework in order to improve performance, and adapt UHC implementation strategies according to the operational context.

The CMU system put in place, called to gradually provide the entire population with a unified basket of essential health care and services, is intended to be supplemented at the top by the establishment of the Nigerian Health Coverage Agency (ANiCMU)[11].

In addition to these structures, Niger has a strategic framework to help advance the UHC agenda. This strategic framework includes in particular the Economic and Social Development Plan, the National Social Protection Policy, the National Health Policy (adopted by the Government in 2017), the Health Development Plan 2017/2021, and the Law on Social Protection.

The Constitution of November 25, 2010, of Niger stipulates that “everyone has the right to life, to health, liberty, security, physical and mental integrity, education and instruction under the conditions defined by law". To translate this vision into reality, on April 27, 2018, the National Assembly passed Law No. 2018-22 of April 27, 2018, determining the fundamental principles of social protection. To complement the framework, Niger further adopted Law No. 2019-062 of 10 December 2019 determining the fundamental principles of the social integration of people with disabilities. The very purpose is to offer better living conditions to the population in an environment conducive to respect for human rights[12]. The law determining the fundamental principles of social protection defines the concept of "vulnerability" and lists the vulnerable categories among the population. It recognizes the rights of vulnerable people to free health care, specifying that the benefit of free health care gives rise to the granting of a "solidarity card".

In order to strengthen the regulatory framework dealing with free health care schemes and to equip it with new infrastructures, the Government of Niger has decided to institute a new, autonomous structure, endowed with reinforced governance mechanisms, and transparent principles: the INAM. Core objective is to manage free health care access according to the operating principles of third-party payment.

[11] The ANiCMU will have a mission of coordination, technical supervision, standardization, and regulation of the CMU schemes managed by the National Health Insurance Fund (CNAM) and the National Institute of Medical Assistance (INAM).

[12] Ordinance 93-012 of March 2, 1993, determined the minimum social protection rules for people with disabilities in Niger. It was amended and supplemented by ordinance 2010-028 of May 20, 2010.

Free healthcare for women and children aged 0 to 5 is indeed a priority and a flagship program of the national health strategy in Niger. The right to health and the State's commitment to facilitate financial access to health care for the entire population in case of need, are thus explicitly enshrined in the Country's Constitution of November 25, 2010. This free health care policy implemented in 2006, today affects a quarter of the population and all households through the coverage of health services for children under 5 and antenatal consultation - ANC (order n° 79 of 2006), cesarean section (decree n° 2005-316 and decree n° 015 of 2006), contraceptives and condoms (decree n° 065 of 2006), and services related to female cancers (Decree 2007-261). It constitutes a priority public policy and constitutes a first step towards UHC.

However, if this free health care program has contributed to improving maternal and child health in Niger, it still has many weaknesses. They are mainly due to an insufficient regulatory framework and a deficient institutional mechanism based on a complex bill payment mechanism and on a free management unit (CGG) with few resources and lacking an appropriate and operational tool to manage and control the billing system. The CGG is thus limited to an arithmetic verification of the invoices, without carrying out any real medical control and supervision in the “field” due to lack of resources. The CGG does not have neither a M&E framework nor a reporting mechanism, jeopardizing a better management and control of the reimbursement process for free care costs. This results in the impossibility of having a clear view of the status of invoices. As a consequence, the following risks have recently emerged: double payments; significant invoice discrepancies between the central level and the operational structures; impossibility of tracking the reimbursements received by health structures, and, consequently, impossibility of determining the exact cost of free care. At the end of 2019, the stock of invoices pending payment was in the order of FCFA 55 billion.

All this explains the creation of the INAM. The INAM is a State Administrative Public Establishment (EPA), placed under the dual supervision of the MSP/P/AS (technical) and of the Ministry of Employment, Labor and Protection (general). The INAM is supposed to manage progressively the entire free healthcare policy (initially it will cover women and children from zero to five years old, and gradually, it will integrate other vulnerable categories, accordingly to the law). The INAM is also called upon to implement the reforms of the free healthcare programs decided by the State, as well as their gradual integration into the national system of CMU.

The INAM offers a governance mechanism that is both strategic and operational and which fully reflects its dual mission, both as manager of the future CMU’s health

assistance scheme and as operator of the State. The INAM is made up of the following four bodies: i) a supervisory board chaired by the Prime minister; ii) an auditor appointed by the supervisory board; iii) a board of directors on which the associated TFPs sit in an advisory capacity, and iv) a general management, recruited on the basis of competence and merit.

The relationship between the INAM and the supervisory authorities is framed by a Performance and Means Objective Contract (COPM). The COPM is a tool for managing relations between one or more supervisory bodies (MSP/P/AS and Ministry of Finances - MF) and a state operator (UTGG). It manages reciprocal obligations based on clear and simple indicators and favors participatory approach between all stakeholders.

- For revenue raising:

The lack of financial resources (mobilization) still prevents municipalities and other public authorities from fulfilling their obligations under the free health care policy, in particular for the indigent and most vulnerable people.

Decree 64-004 MS of January 28, 1964, made provisions establishing the free coverage of health care, hospitalizations, and medical evacuations by municipalities for indigent people, provided they are in possession of a certificate of indigence. Municipalities and public collectivities are required to cover all costs related to hospitalization and sanitary evacuation of people in need. Public health facilities must provide health services for people recognized as indigent. However, as no payment is made to public health facilities to cover their expenses, the operationalization of the system set up by the decree is deeply hampered.

To remedy this situation, the Government had planned, in September 2011, in its national social protection policy, “the creation of a Special Social Protection Fund (FSPS), instituted on the basis of a share of the national budget representing at minus 1% of GDP”. To set up this social fund, the MSP initiated Decree 00145/MSP/SG/DEP/DERP of April 16, 2012, establishing a technical committee responsible for considering the creation of a social health fund in Niger. The Social Health Fund should have the task of ensuring the financial support of free health care for the indigent and vulnerable. Its creation was to be in line with Law 2002-013 on decentralization, which gives municipalities the responsibility for social action. As of November 2021, however, the Social Fund is still to be established.

- For purchasing:

Two strategic objectives have emerged in recent years: on the one hand, to facilitate strategic dialogue on health financing in Niger between the relevant ministries and the TFPs, with a focus on the creation and financing of a procurement fund for the management of the free health care policy; and, on the other hand, to support the MSP/P/AS in setting up the procurement fund with a view to facilitating the institution of the CMU. The institutional and functional framework of the procurement fund will be further specified and validated by the Government.

Strengthening Public-Private Partnerships (PPPs) and the “contracting policy” is also a priority in Niger today. The integration of the private sector and CSOs in the national strategy for UHC implies to strengthen the regulation of the private sector and to open it up to other actors. It will be also necessary to establish a specific framework defining not only the relations between the MSP/P/AS and the private sector but also the nature and modalities of the public-private partnerships.

- Improving coordination:

The issue of harmonizing the various health financing mechanisms within the framework of a global UHC vision is a major issue in Niger. The main health financing mechanisms include free health care schemes, RBF, in particular the RBF Enabel (Belgian Federal Government Development Agency), the World Bank project to purchase health services for assisted delivery, the UNICEF “health inputs” program, and the KFW procurement fund.

The task is not easy because the mechanisms are complex and heterogeneous. The KFW procurement fund, for example, is a fund made available to the Tillabéri Region by the Reproductive Health Program (PSR), with funding from the German Financial Cooperation through the German public bank KFW. The fund must allow the payment of subsidies in cash for a whole set of care and services, the list of which is pre-established. Basically, the KFW procurement fund is a tool whose purpose is to improve the quality and quantity of health care and services. This approach is embodied in a performance contract signed between the Contracting, Verification and Payment Agency (ACVP) and the representatives of health facilities. The payment of subsidies is made on the basis of previously defined indicators and in compliance with norms and quality standards for health care in Niger. This approach is also characterized by the separation of the functions of regulation, delivery, contracting, verification, and payment of funds.

- Enhancing data collection:

Niger has decided to strengthen both its information system and its information collection mechanisms for the health care management bodies. Basically, the data collected by the different CMU management bodies should feed the M&E framework of the CMU strategy. It will be up to the regulatory body of the CMU to aggregate the various data.

The Government is currently working on establishing and operationalizing a mechanism whose very purpose is to inform stakeholders on the progress of UHC. A framework allowing for enhanced collaboration with academic institutions in also under study to promote research on UHC and identify best practices and lessons learnt at national and international levels.