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Providing public goods:

Local responses to policy incoherence and state failure in Niger

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In Niger, as in most African countries, the implementation of public policies poses enormous challenges: there is no guarantee that the state will deliver public goods and services of reasonable quality. Local measures to plug the gaps are usually informal, with all the strengths and weaknesses that informality implies. Some are more institutionalised. However, these can face opposition from the state, which may block local solutions without providing effective alternatives.

Introduction

Development agencies working in Africa today are committed to strengthening, or helping to reform, the public policies implemented by states. While in practice donor thinking often substitutes itself for government thinking, the principle of supporting country processes is clear. A good understanding of how policies are made, and above all how they are implemented, is therefore essential. And it is at the local level that we can best appreciate the reality of policies on the ground – their limitations, incoherence and contradictions, and how well they succeed in delivering basic services to the population. It is also at the local level that we appreciate the important role played by a multiplicity of organisations and individuals in the delivery of public services, whether alongside or in interaction with agencies of the state.

The research

The *Laboratoire d'études et de recherches sur les dynamiques sociales et le développement local* (LASDEL) has been undertaking research in three municipalities (*communes*) in Niger since 2009 within the framework of the Local Governance work stream of Africa Power and Politics (APPP). The focus is on four areas of 'public goods' provision: drinking water and sanitation, security, markets and maternal health. The primary data collection has been qualitative, involving residence in the field, observation, open-ended interviewing and case studies.

Health Centre of Kaita, Niger: Women collecting food supply for their children
Photo: by permission, LASDEL

Four major conclusions have emerged:

- Front-line state services are incapable of delivering the expected goods.
- Local improvisation and palliative measures are the norm, with a variety of local actors involved and users often co-financing the costs. The state ignores such measures, which usually remain informal.
- When local measures become more formally institutionalised, if they are seen as contrary to official policy they may be blocked by the state, even if its own policy is not working.
- In such contexts, development agencies contribute only marginally to improving provision through direct intervention, but they can play a useful indirect role by supporting local initiatives.

Incoherent public policies

In every area covered by our research, the state lacks credibility with other players because of its inability to undertake effective measures in a sustained way, the sharp contrasts between intentions and the reality on the ground, and a string of broken promises. Decentralisation, for example, and the 2004 creation of elected municipal authorities throughout Niger were carried out without real political backing. Rather than supporting the new municipalities, central government put barriers in their way, and the funds that the state committed to return to city councils were never disbursed.

Health policy is a prime example of the incoherence and poor design of public policies. In response to the crisis of health-care financing in the 1980s, cost recovery was adopted as the national strategy. In 2006, however, President Tandja Mamadou suddenly decided to introduce a policy to exempt children under five and caesarean sections from user fees. This policy was unplanned and the government had not set aside the necessary resources.

In principle, the state must reimburse maternity units for the cost of caesareans and health units throughout the country for the cost of health care for under-fives. In practice, these reimbursements are subject to serious delays. After six years, the state now owes its own health units 14 billion CFA francs (€ 21m).

In reality, children under five account for most consultations carried out by primary care units, and under the former policy were their main source of income. So reimbursement delays threaten the equilibrium of the whole health system. Deprived of cash, many health units are heavily indebted to drug wholesalers, and this has led to a shortage of medicines.

Another striking example of policy incoherence is found in the system for transferring the sick and women with difficult pregnancies to higher-level health facilities. Health districts were provided with ambulances for this purpose before the exemptions policy was introduced. But nothing was done to provide fuel or to cover drivers' expenses, which had to be covered by the users. The sums that families were required to contribute for transport could easily exceed the cost of a caesarean, resulting in delays that threatened lives.

> ***"the practice of collecting extra pennies spread like wildfire across Niger.***

Examples of local measures

Our research has found a wide variety of solutions to these challenges, often in the form of 'do it yourself' initiatives. Some mayor's offices, for example, advance part of the cost of the fuel for ambulance journeys. Sub-chiefs may decide to pay the transport costs for a very poor family. A sponsor (often a local 'big man') or the Prefect may repair a broken-down ambulance at their own expense.

Sometimes, however, more durable and formally institutionalised solutions emerge. For example, in 2003 the regional health management team of Dosso agreed with the management committee representing the users to undertake an experiment in one district under which all health centre users (including under-fives) were required to pay an 'extra penny'. This 'extra penny', amounting to 100 CFA francs (€ 0.15), served to create a fund to finance ambulance journeys. This was supported by local personnel of Belgian Technical Cooperation (BTC), though the agency did not intervene directly and provided funding only for an evaluation study.

The measure was quickly found to be effective; more than enough money was collected and placed in a specific bank account. It was then widened to cover the whole Dosso region. The practice of collecting extra pennies subsequently spread like wildfire to all health districts across Niger. It was, in effect, a modest tax on all health centre users, but one that would help those who needed ambulance transport.

The initiative was a form of user charging, but was located at the intersection of two logics: *the institutional logic of cost-recovery* in which all health providers were trained in the late 1980s; and *the logic of informal user contributions*, which has become the norm in recent times in response to the limitations of state provision.

The latter is seen in other areas. The police, whose fuel allowances are pitiful, do not go out on mission unless complainants pay the fuel and their 'expenses'. They only escort trucks into areas where there are risks of bandit attack when the truck owners pay them. It is the same for drinking water: tube-well water, once free, now has to be paid for because this is the only way to ensure maintenance and repair. This applies whether the well is managed by a local management committee, or contracted out to a private operator.

The 'extra pennies' scheme involved two major innovations. First, it was a palliative response to the incoherence of public policy and a 'bottom-up' initiative. But, unusually, it was not informal but fully embedded in the relevant formal organisations. It was validated throughout the country by the management teams of the health districts and the users' management committees, though without consulting the Ministry, without the Ministry's agreement or support, and without any 'project' or funding emanating from donors. Second, it was not the users of the ambulance who paid directly (that arrangement had been a cause of maternal mortality, with families often unable to raise such large sums in a hurry). Instead, the costs were spread over time and over the whole population of health-centre users, providing a mechanism akin to an insurance scheme.

Unfortunately, in late 2009 the Ministry of Health took steps that threw the scheme into crisis. It took the view that this form of user contribution was contrary to the official policy of user fees removal, given that officially exempted users were being charged the 'extra pennies'. It forbade health centres to take the 100 CFA francs from the parents of under-fives. At one blow, the funds dried up, and the situation has returned to reliance on the informal 'do it yourself' options that previously prevailed. The Ministry's ban was not accompanied by any alternative formal arrangement.

In other words, a decision taken in the name of official policy consistency put an end to an interesting and effective bottom-up initiative to alleviate the real-world incoherence of that same policy.

Informal adjustments and co-delivery

In all of the areas we have researched, development projects try, but often fail, to plug the gaps left by the state in meeting the basic needs of the population. Project interventions are partial, uncoordinated and relatively ephemeral, and they induce behaviour by service providers and users alike that is geared to tapping into donor funding (capturing the 'development rent') rather than solving problems in the delivery of public goods.

The only realistic solutions, therefore, are solutions with a local character. They are usually 'do it yourself' arrangements based on informal coordination among actors. So, to have drinking water, to be assured of a reasonable level of security in the face of land conflicts or banditry, or just to be able to hold a weekly market, there must be collaboration among members of several organisations: municipal authorities, traders, chiefs, technical services, home-area sponsors and local associations. However, these more or less improvised forms of 'co-delivery' have significant limitations:

> ***"the only realistic solutions are solutions with a local character.***

- They often depend on personal relationships or individuals in strategic positions and are, therefore, fragile.
- There is no legitimate body capable of providing the real coordination needed for sustainability, even if this is a function that the municipalities are best placed to perform in the medium term.
- Recourse to co-financing by users often excludes the poorest and most vulnerable.
- Public services that are not perceived as belonging to the top priority group, such as sanitation, are subject to complete neglect.

The example of the 'extra pennies' shows that some of these limitations can be surmounted. Here we have an institutionalised local solution, one that transcends personal relationships and provides a legitimate form of coordination (thanks to collaboration between health staff and health management committees). As for the problem of financial affordability, it is true that it imposes a tax on everyone, including the most vulnerable, but it also allows cost-free emergency ambulance journeys for everyone, including the most vulnerable.

Another, somewhat unexpected, finding from the research concerns the positive role that can be played by development projects. Their very presence or their support can provide 'windows of opportunity' for local actors, facilitating the adoption of initiatives that take an institutional rather than an informal shape and direction. This function of discreet and responsive support to local reformers and to institutionalisation 'from the bottom up' should become more central to the official strategies of development agencies.

Turn the page for further policy lessons.

Policy lessons

The following conclusions may be drawn from our research:

- The evaluation of public policies in Africa should not be based only on accountants' reports and official and technical documents, but should rely more on enquiries about implementation on the ground at the front line of service delivery.
- The principal objective should be to identify the bottlenecks and policy inconsistencies as they present themselves on the ground, to identify realistic and credible solutions.
- A focus on the various solutions arrived at locally in response to the limitations of official provision should be a top priority for decision-makers.
- Engaging with local informal initiatives and helping them to become institutionalised would be a better strategy than ignoring them.
- The municipal authorities should be supported to enable them to play a coordinating role, a role not currently included in their mandate or in the training offered to the elected officials.
- As a default position, it would seem desirable to support or at least tolerate local institutional initiatives even if they may appear to conflict with official policies – at least as long as it remains impossible to propose an alternative solution that is realistic and credible.

References

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