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FINANCING OF UNIVERSAL HEALTH COVERAGE AND FAMILY PLANNING

Financing of Universal Health Coverage and Family Planning

A Multi-Regional Landscape Study and Analysis of Select West African Countries: Niger

January 2017

This publication was produced for review by the United States Agency for International Development.
It was prepared by Jenna Wright, Karishmah Bhuwanee, Ffyona Patel, Jeanna Holtz, Thierry van Bastelaer, and Rena Eichler for the Health Finance and Governance Project.

The Health Finance and Governance Project
USAID's Health Finance and Governance (HFG) project helps to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team works with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. The five-year, $209 million global project is intended to increase the use of both primary and priority health services, including HIV/AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG supports countries as they navigate the economic transitions needed to achieve universal health care.

January 2017

Cooperative Agreement No: AID-OAA-A-12-00080

Submitted to: Scott Stewart, AOR
Office of Health Systems
Bureau for Global Health

Eleonore Rabelahasa,
Senior Health Systems Strengthening and Policy Advisor
USAID West Africa Regional Health Bureau

Recommended Citation: Wright, Jenna, Karishmah Bhuwanee, Ffyona Patel, Jeanna Holtz, Thierry van Bastelaer, and Rena Eichler. 2016. *Financing of Universal Health Coverage and Family Planning: A Multi-Regional Landscape Study and Analysis of Select West African Countries*. Report prepared by the Health Finance & Governance Project. Washington, DC: United States Agency for International Development.

Abt Associates | 4550 Montgomery Avenue, Suite 800 North | Bethesda, Maryland 20814
T: 301.347.5000 | F: 301.652.3916 | www.abtassociates.com

Avenir Health | Broad Branch Associates | Development Alternatives Inc. (DAI) |
| Johns Hopkins Bloomberg School of Public Health (JHSPH) | Results for Development Institute (R4D)
| RTI International | Training Resources Group, Inc. (TRG)

FINANCING OF UNIVERSAL HEALTH COVERAGE AND FAMILY PLANNING

A MULTI-REGIONAL LANDSCAPE STUDY AND ANALYSIS OF SELECT WEST AFRICAN COUNTRIES

NIGER

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ACRONYMS

ANAM	*Agence Nationale d'Assistance Médicale* / National Agency for Medical Assistance (Mali)
ANAM	*L'Agence Nationale de l'Assurance Maladie* / National Health Insurance Agency (Benin)
APSAB	*Association Professionnelle des Societés d'Assurances du Burkina Faso* / Professional Association of Insurance Companies of Burkina Faso (Burkina Faso)
CAMNAFAW	Cameroon National Association for Family Welfare (Cameroon)
CAMS	*Cellule d'Appui aux Mutuelles de Santé* / CBHI Technical Support Cell (Cameroon)
CANAM	*Caisse Nationale d'Assurance Maladie* / National Health Insurance Fund (Mali)
CBHI	community-based health insurance
CNPS	*Caisse National de Prévoyance Sociale* / Social Security (Cameroon)
CNSS	*Caisse Nationale de Sécurité Sociale* / National Social Security Fund (Burkina Faso, Guinea)
CONSAMAS	*Concertation Nationale des Structures d'Appui aux Mutuelles et Assurances de Santé* / National Coordination of CBHI Schemes and Health Insurances (Benin)
CPS	*Cellule de Planification et de Statistique* / Planning and Statistics Unit (Mali)
DHS	Demographic and Health Survey
FCFA	West African CFA franc (Burkina Faso)
FP	family planning
GIZ	*Deutsche Gesellschaft für Internationale Zusammenarbeit* / German Corporation for International Cooperation (Cameroon)
HFG	Health Finance and Governance Project
HIV/AIDS	human immunodeficiency virus / acquired immunodeficiency syndrome
HSDP	Health and Social Development Plan (Mali)
INAM	*L'Institut National d'Assurance Maladie* / National Agency for Medical Assistance (Togo)
INSD	*Institut National de la Statistique et de la Démographie* / National Institute of Statistics and Demography (Burkina Faso)
IPM	*Institution de Prévoyance Maladie* / Sickness Insurance Institution (Senegal)
IPRES	*Institut de Prévoyance Retraite et Sociale* / Institute of Social Welfare and Retirement (Senegal)
IUD	intrauterine device

MPHH	Ministry of Public Health and Hygiene (Mali)
MPSWSS	Ministry of Public Service Work and Social Security (Burkina Faso)
MS	*Ministère de la Santé* / Ministry of Health (Togo)
MSHA	Ministry of Solidarity and Humanitarian Action (Mali)
MWCFP	Ministry of Women, Child and Family Promotion (Mali)
NGO	non-governmental organization
NHA	National Health Accounts
NHFS for UHC	National Health Financing Strategy toward Universal Health Coverage / *Stratégie nationale de financement de la santé vers la CSU* (Guinea)
PDS	*Plan de Développement Sanitaire* / Health Development Plan (Niger)
PMAS	*Le pool micro-assurance santé* / The micro health insurance pool (Senegal)
PNDS	*Plan National de Développement Sanitaire* / National Health Development Plan (Benin, Guinea, Togo)
PRODESS	Programme for Social and Health Development (Mali)
PROMUSCAM	*Plateforme des Promoteurs des Mutuelles de Santé au Cameroun* / Platform for the Promotion of CBHI (Cameroon)
RAMED	*Régime d'Assistance Médicale* / Medical Assistance Mechanism (Mali)
RAMU	*Régime d'Assurance Maladie Universelle* / Universal Health Insurance Plan (Benin)
RH	reproductive health
ST-AMU	*Secrétariat technique de l'assurance maladie universelle* / universal health insurance technical secretariat (Burkina Faso)
STI	sexually transmitted infection
TB	tuberculosis
UEMOA	*L'Union Economique et Monétaire Ouest Africaine* / West African Economic and Monetary Union (Niger)
UHC	universal health coverage
UN	United Nations
USAID	United States Agency for International Development
UTM	*Union Technique de la Mutualité Malienne* / CBHI Technical Unit (Mali)
WARHO	West Africa Regional Health Office
WHO	World Health Organization

ACKNOWLEDGEMENTS

This study was funded by the United States Agency for International Development (USAID), and implemented by the Health Finance and Governance Project.

Mr. Abdoulaye Ba, Senior Health Financing Consultant, supported data collection and key informant interviews in Cameroon, Guinea, Mali, and Senegal. Dr. Birahime Diongue, Senior Health Financing Consultant, supported data collection and key informant interviews in Benin, Niger, and Togo. Dr. André Zida, Senior Health Financing Specialist, supported data collection and key informant interviews in Burkina Faso.

The leadership, support, collaboration, and input of USAID/West Africa Regional Health Office (WARHO) colleagues were critical in completing this landscape study and analysis. The authors are grateful for the support provided by Dr. Eleonore Rabelahasa, Senior Health Systems Strengthening and Policy Advisor (WARHO), and Ms. Rachel Cintron, Health Office Director (WARHO). The authors recognize the active participation and collaboration of USAID Missions and multiple implementing partners and non-governmental institutions in Benin, Burkina Faso, Cameroon, Guinea, Mali, Niger, Senegal, and Togo. The authors are also grateful for the input and collaboration provided by Ministries of Health and other government agencies in these countries. The authors are grateful to all the key informants, who shared their time and wisdom (see Annex C for the list).

Finally, the authors are thankful to Bry Pollack (Abt Associates) for editing, Alain Schuster and Julie Verbert (ASJV Associates) for translating, and Erin Miles and Audrey Hanbury (Abt Associates) for designing the report.

EXECUTIVE SUMMARY

Recognizing that a healthy population promotes economic development, resilience, and strength, many governments have started pursuing a universal health coverage (UHC) agenda. The international community, national governments, and private organizations and individuals are converging on the principle that universal access to family planning is a goal worthy of increased financial investment. Improved access to family planning is also important for a country's economic development, and it helps countries improve key population health outcomes for mothers, newborns, and children.

The reality of limited resources for health care has brought increased scrutiny of how health care is financed. To reach UHC, governments are looking to pursue more and better spending mechanisms for health care and to promote financial protection for households. While there is no single or perfect model for financing health care, the health policy community can draw on international experience to identify best practices.

The purpose of this report is to present findings of a landscape study of observed trends and lessons learned from fifteen countries across multiple regions. We conducted detailed analyses of eight countries in West Africa: Benin, Burkina Faso, Cameroon, Guinea, Mali, Niger, Senegal, and Togo ("core countries"). We reviewed the health financing landscapes of seven additional countries at various stages of achieving UHC to draw lessons learned and inform potential strategies: Ethiopia, Ghana, Indonesia, Kenya, Malaysia, Nigeria, and South Africa ("reference countries").

Parties interested in the report may include Ministries of Health or national UHC agencies, regional governments, UHC stakeholders in the West Africa region, the United States Agency for International Development / West Africa Regional Health Office and country Missions, and the private sector.

Chapter 1 of the report discusses the landscape study findings from an analysis across the fifteen countries. Chapters 2–9 of the report present in-depth findings from the eight core countries, including descriptions of each country's health financing landscape and its government's strategies for UHC and family planning, a discussion of the country's health financing challenges and strengths, and potential opportunities for high-impact interventions that could improve the country's health financing landscape for UHC and family planning.

Government Strategies to Pursue Universal Health Coverage and Universal Access to Family Planning

All fifteen governments mentioned UHC or a similar concept in major government health sector strategies, although most countries do not intend to reach universal coverage during their strategy's timeframe. Instead, governments generally plan to implement measures to increase population coverage under existing or new initiatives with a gradual scale-up. In general, countries' UHC strategy documents embrace the concept of progressive universalism, as described by Gwatkin and Ergo (2011) and adopted by the 2013 Lancet Commission on Investing in Health (Jamison et al. 2013). That is, they include multiple strategies to improve coverage for the poor, the informal sector, and the formal sector (and imply this will happen simultaneously). Most countries had specific strategies for engaging the private sector under their umbrella UHC strategy. Family planning, however, was often absent from the main policy documents and was often addressed in separate family planning or reproductive health strategy documents. Governments with separate strategy documents for family planning appear to have more concrete and specific action plans for family planning, whereas governments that mention family planning in a broader health system strategic plan demonstrate less detailed plans.

Although the fifteen countries vary in terms of coverage and use of family planning, many of the strategies for improving access to family planning are common to all of them, such as increasing awareness and demand through social marketing, task shifting to allow for community-based distribution, and increasing the number of distribution points for family planning services.

Health Financing Mechanisms in Core and Reference Countries, and Private Sector Engagement

Even in the least fragmented health care systems, health services are financed through a plurality of mechanisms. Most or all of the health financing mechanisms described below are included in the health financing landscape of all fifteen countries. Levels of service coverage, population coverage, and financial protection varied.

These coverage levels are a key way to measure a country's progress toward UHC and universal access to family planning. To assess the latter, one can evaluate the degree to which health financing mechanisms cover family planning services (i.e., seek to ensure their delivery), the percentage of the population who can and do access those services under each mechanism, and what degree of financial protection is provided for family planning.

Chapters 2–9 of this report elaborate on each of these mechanisms in the eight core countries; lessons from the seven reference countries are woven into the multi-regional analysis of Chapter 1.

Government-financed provision of health services exists in all study countries. Government funding to facilities allows them to operate without charging patients the full cost of providing services. The government often does the purchasing; in some countries, community committees are established to have a say in how facilities spend available funds. In many low- and middle-income countries, the purchasing mechanism employed by government purchasers is *input-based financing* (e.g., paying for health worker salaries, commodities, and infrastructure). Governments often pair such direct financing for health services with *demand-side financing* (e.g., paying for services on behalf of patients to reduce financial barriers to accessing care) to improve equity of access to health services.

User fee waivers or vouchers are two examples of pro-poor financing mechanisms, reducing cost sharing by poor and vulnerable households. Malaysia's experience as an upper middle income country with near-universal health coverage through the public health delivery system provides valuable lessons for West African countries as economies grow, health systems mature, and governments face new challenges arising from an epidemiological transition and an aging population. Governments can implement legal frameworks now to enable health system reforms to address changing needs.

In general, at least some family planning commodities are provided free in facilities and by community health workers who receive public financing, but these distribution systems can be improved. A voucher scheme in Kenya provides targeted subsidies for safe motherhood, long-term family planning methods, and gender-based violence recovery services. These subsidies benefit households as well as public and private providers. They may be applicable in the West African context, where governments are seeking to reduce financial barriers to priority services such as family planning, and to encourage demand and quality improvements among public and private providers.

Social health insurance is often part of a government strategy to purchase health services for members by mobilizing and pooling funds from public and private sources and based on members' ability to pay. Many governments plan to implement or scale up social health insurance schemes and have passed laws to this effect. However, mobilizing the required resources to adequately subsidize even basic benefits for citizens with limited or no ability to contribute can be a challenging and much longer process.

The rollout of Indonesia's ambitious single-payer system starting in 2014 is partly a result of a legal action brought by citizens to hold the government accountable for the 2004 law on the National Social Security System. Nigeria's Basic Health Care Provision Fund needs to receive annual budget appropriations to ensure it gets implemented. In 2012, legislation addressing Ghana's National Health Insurance Scheme reform required inclusion of family planning to be determined by the Minister of Health, but three years later, the government had yet to provide the policy directive and implementation guidelines necessary to make family planning methods part of the scheme. South Africa's government is in advanced preparations to scale up National Health Insurance in a multi-phased approach that is expected to span more than a decade.

Governments need to allocate significant funding to scale up social health insurance, so many countries focus social health insurance programs on employees in the formal sector, where administration is most feasible. However, unequal financial protection between the formal sector (often the wealthier households) and the rest of the population can create a cycle of inequity and higher levels of fragmentation in the health system.

Community-based health insurance (CBHI) is often included the UHC strategies of low- and middle-income countries because of its perceived comparative advantage in targeting and enrolling underserved, uninsured, and largely informal-sector populations into risk-pooling schemes. While increasing the number of CBHI schemes may seem feasible for governments in the short term, the model often leads to government-sponsored health financing mechanisms. For example, in Ghana, community members initially volunteered to manage the schemes; however, eventually they migrated into a more professional management arrangement, and the scheme managers became salaried government staff.

Enrollment in CBHI schemes is often voluntary or not enforced, so schemes are often vulnerable to *adverse selection*, where disproportionate enrollment by high-risk individuals accompanies non-participation by low-risk individuals. CBHI initiatives such as Ethiopia's may eventually evolve into larger risk pools once that transition is operationally feasible for the government. That transition could be beneficial for ensuring CBHI scheme members get financial protection for health services provided by regional or national hospitals.

Private health insurance is a health financing mechanism present in the fifteen study countries, although its role varies from country to country. Private health insurance tends to target wealthier households and workers in the formal sector. There are, however, a few rare examples of private health insurers and private CBHI schemes targeting lower-income households or workers in the informal sector. Some private companies voluntarily offer employees premium subsidies or other health benefits for private health insurance in order to attract and retain skilled people, in Kenya and Nigeria, for example. In general, this model does not contribute significantly to population coverage in countries with small formal sectors.

Household out-of-pocket spending means households pay providers directly for health goods and services at the time of service. This is the dominant financing mechanism in most of the fifteen study countries. Households in all countries invariably pay out of pocket for some health services or commodities, as seen even in Malaysia, where most services are provided free or at very low cost through a strong network of public health facilities. In countries with low levels of other health care financing and risk-pooling mechanisms, out-of-pocket spending on health care accounts for the majority of household spending, and household spending as a proportion of total health expenditure is generally quite high.

There is growing interest in mobilizing private financing. Because household spending is already a large proportion of total health spending and core countries have relatively small formal sectors, this study did not identify many examples of how to engage the private sector in health financing. However,

governments can improve equity and increase efficiency by implementing health financing mechanisms that spread risk among a large pool and protect households from catastrophic costs. Governments must continually reform the health system to pursue better and more-equitable coverage for the population, and the path to UHC needs to evolve over time as population needs and demands change.

Government-subsidized programs that lack the resources to cover all citizens will by necessity or design cover a subset of the population. This can undermine social solidarity and equity, however, and potentially derail the goal of *progressive universalism*. Smaller-scale or more-targeted health financing mechanisms can promote more-equitable access to essential services. Additionally, ensuring universal access to family planning through UHC initiatives is critical.

Many governments of the core countries in this study envision simultaneous interventions to improve financial protection for health care and pursue UHC: finance health facilities with public funds, scale up social health insurance, and encourage the establishment of CBHI schemes to contribute to population coverage of hard-to-reach populations. With relatively small formal sectors, core countries will need to dramatically grow the number of CBHI schemes in order to reach near-universal enrollment among their populations. Population coverage of CBHI and other forms of insurance is low in most of them.

This study's review of health financing landscapes in all core countries reveals several opportunities for each to expand on, or introduce, new health care financing mechanisms that can increase coverage for health care and family planning.

7. NIGER

7.1 Country Snapshot

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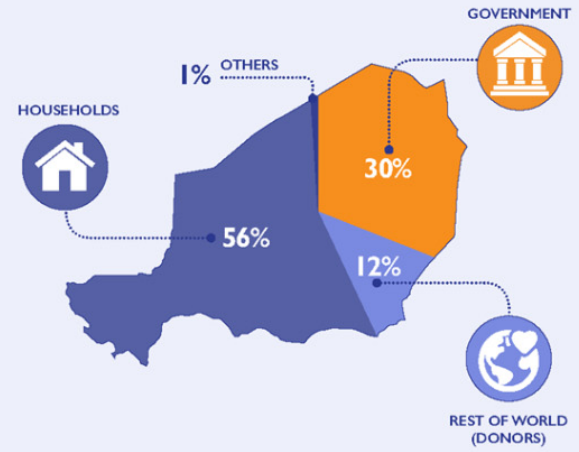
FINANCING STRATEGIES FOR ACHIEVING UNIVERSAL HEALTH COVERAGE AND ACCESS TO FAMILY PLANNING

Niger

Niger's Strategies for Improving Coverage of Health Services

TOTAL HEALTH SPENDING BY SOURCE



FAMILY PLANNING

UNMET NEED FOR FAMILY PLANNING IN NIGER REMAINED STABLE

16%
2006-2012

PRIMARILY DELIVERED THROUGH PUBLIC SECTOR FACILITIES

MAINLY FINANCED BY INTERNATIONAL DONORS

KEY INDICATORS

Indicator	Value (Year)
Population	19,899,100 (2015)*
General government expenditure on health as a percentage of total government expenditure	10% (2013)**
Total health spending per capita	US$26 (2013)**
Government spending for family planning as % of total family planning spending	1%**
Private prepaid plans as a percentage of total expenditure on health	0.3%**
Unmet need for family planning	16% (2012)***
Married women currently using any modern method of contraception	12.2% (2012)***
Married women currently using long acting reversible contraceptives (IUD, injections or implants)	2.5% (2012)***
Sexually active unmarried women currently using any modern method of contraception	39.9% (2012)***

* World Health Organization. Global Health Observatory. http://www.who.int/gho/en/ Accessed July 2016.
** Niger National Health Accounts. 2013.
*** ICF International. 2012. The DHS Program STATcompiler. http://www.statcompiler.com/. Accessed July 2016.

Niger's universal health coverage (UHC) strategy is described in its *Plan de Développement Sanitaire 2011-2015* (PDS)[1] and its 2012 National Health Financing Strategy for UHC.[2] The PDS includes strategies for expanding access to health services while the government's health financing strategy prioritizes establishing mechanisms to advance toward UHC through supporting community-based health insurance schemes *(mutuelles)*, promoting uptake of health insurance to reduce exposure to catastrophic health care costs, and establishing a fund for health. Currently, less than 3% of the Nigerien population is enrolled in any type of health insurance; private health insurers cover less than 1% of the population. Consequently, the government aims to engage the private sector to expand health care service delivery and to establish private health professionals in areas with insufficient coverage. Public-private partnerships are also seen as mechanisms to strengthen information and communication systems as well as pharmaceutical regulation. Currently, 56% of total spending for health is private, mostly out-of-pocket household spending on health services and pharmaceuticals.[3]

Niger's second strategic health priority is improving reproductive health services including family planning.[1] The PDS aims to promote large-scale and community based distribution of contraceptives across public and private facilities by integrating family planning into the national package of essential health services. Unmet need for family planning in Niger has remained stable at about 16% from 2006 to 2012. At present, family planning commodities are financed primarily by international donors.

Challenges and Opportunities

Niger's challenges lie in low levels of public health spending (5.8% of total budget), weak infrastructure for social protection (public and private), and delays in implementing the health financing strategy established in 2012. *Mutuelles* are mainly organized by sector (e.g., energy, health care) while community-based health insurance schemes tend to be poorly managed, resulting in low enrollment. The development of social health insurance, regulation of existing *mutuelles*, and extension of *mutuelles* to the informal sector have potential to expand population health coverage and reduce the currently high out-of-pocket spending by households.

1 Niger Ministry of Public Health. January 2011. Plan National de Développement Sanitaire 2011-2015.
2 Niger Ministry of Public Health and WHO. June 2012. Stratégie Nationale de Financement de la Santé en vue de la Couverture Universelle en Santé au Niger.
3 Niger National Health Accounts. 2013.

Figure 1: Niger Country Snapshot

Public and Private Sector Roles in Health Financing

The public and private sectors contribute to three main health financing functions:

RESOURCE MOBILIZATION	RISK POOLING	PURCHASING
THE PUBLIC SECTOR'S ROLE IN HEALTH FINANCING		
• General tax revenue (30% of THE) • Grants or loans from development partners (12% of THE)	• The government pools risk at the national level through financing of public health facilities • Community-based insurance schemes pool risk at the community level	• The government purchases services delivered to the population at public health facilities through: » Fee-for-service payments to facilities based on the service provided, the facility's level in the health system (primary, secondary, or tertiary) and location (urban/rural), and client socioeconomic status » User fee exemptions for pregnant women and children under 5 for family planning, prenatal care, cesareans, antiretroviral therapy, malaria, tuberculosis, dialysis, and certain cancers » User fee reductions for: – Government officials and healthcare workers – Individuals with a certificate of indigence obtained through social worker evaluation » Subsidies for generic essential medicines » Results-based payments to health workers in the Dosso region
THE PRIVATE SECTOR'S ROLE IN HEALTH FINANCING		
• Household out-of-pocket payments (56% of THE)	• Private voluntary insurers pool risk at the scheme level, although penetration in Niger is extremely low. Private insurers only manage 0.3% of total expenditure on health.	• Households are the main private sector purchasers of health services in Niger • Households pay out-of-pocket for family planning services, typically provided at no- or low-cost by NGOs and development partners through public and private facilities

Health Financing Mechanisms by Population Segment

Health financing mechanisms available to population segments will vary:

PUBLIC SECTOR

	POPULATION SEGMENT: FORMAL SECTOR	INFORMAL SECTOR: NON-POOR	INFORMAL SECTOR: POOR/ VULNERABLE
Publicly-provided health services	✓	✓	✓ (including enhanced subsidies for the designated poor)
Voluntary community-based health insurance	✓	✓	✓

PRIVATE SECTOR

	POPULATION SEGMENT: FORMAL SECTOR	INFORMAL SECTOR: NON-POOR	INFORMAL SECTOR: POOR/ VULNERABLE
Voluntary private health insurance	✓	✓	
Out-of-pocket spending	✓	✓	✓

ABOUT THE SERIES

This country snapshot is one in a series of 15 produced by the Health Finance & Governance Project. The snapshots capture information on public and private financing programs for family planning and health services that support country plans to reach universal health coverage. View the series and a summary report at: www.hfgproject.org.

7.2 Background

Health financing is a core building block of a health system and a key enabler of progress toward universal health coverage and universal access to family planning. Governments often use a plurality of health financing mechanisms to advance toward universal health coverage. In Chapter 1, we presented trends across the health financing landscape across fifteen countries in multiple regions and drew lessons that may be applicable in Niger and other West African countries. This chapter describes the health financing landscape in Niger and identifies opportunities where the government and other stakeholders can develop, strengthen, and expand their health financing mechanisms to progress toward universal health coverage and access to family planning.

Health financing specialists from USAID's Health Finance & Governance project collected the information presented below. HFG performed desk research and in-country data collection (key stakeholder interviews, policy and planning document collection) to map public and private health financing mechanisms in the country and identify potential opportunities where the government might expand population, service, or financial coverage for health and family planning services.

7.3 Niger's Health Financing Landscape

Niger uses four major health financing mechanisms. Each major mechanism is described in more detail below.

7.3.1 Government financing for health services

Government financing for health services is an important health financing mechanism because it has the potential to provide some degree of financial protection from health costs for Nigerien citizens who access care at public health facilities. However, the government faces considerable health financing challenges because of the nation's economic state. According to the government of Niger's *Plan de Développement Sanitaire 2011–2015* (PDS; Health Development Plan), the high level of poverty limits access to and use of health services. Some 62% of the population lives below the poverty line, including 66% of the rural and 52% of the urban population.

Public health services currently employ user fees, exposing individuals to a high level of financial risk. Moreover, the government is exposed to poor cost recovery when individuals are unable to pay these user fees (MSP 2011). There are some user fee exemptions for treatment of specific priority diseases (e.g., HIV/AIDS), to support vulnerable population segments (e.g., indigent people accessing hospital care, rural poor), and to address priority health concerns (e.g., free family planning services). The government purchases services based on inputs as well as outputs, largely focused on infrastructure, direct financing for health services, and performance incentives. Health workers are salaried, and there are no results-based financing programs for providers.

7.3.2 Community-based health insurance

In Niger, most active CBHI schemes are organized by sector (e.g., *Société Nigérienne des Produits Pétroliers* (Nigerien Petroleum Products Company) for petroleum, *Société Nigérienne d'Electricité* (Nigerien Electricity Society) for electricity); there are also geographically based CBHI schemes, but HFG research found these to be low-functioning. As of 2015, the *Federation des mutuelles de santé* (Federation of CBHI Schemes) was established to improve coordination and penetration of CBHI schemes nationwide. CBHI schemes in Niger subscribe to regulations from the multinational government-affiliated entity *l'Union Economique et Monétaire Ouest Africaine* (UEMOA; West African Economic and Monetary Union).

Benefits and contributions vary across CBHI schemes. Subscribers present with identification at the point of service.

Family planning services in public health facilities are free of charge.

7.3.3 Private health insurance

Private health insurance penetration is well under 3% in Niger. Indeed, private health insurance accounts for just 0.3% of all health spending (Niger Health Accounts 2013). Participation in private health insurance is voluntary and is dominated by private sector, employer-based health coverage. Only a few private insurance companies exist; they are centrally operated and reimburse health services that may be accessed in public or private facilities as policy terms dictate.

7.3.4 Household out-of-pocket spending

Household out-of-pocket spending is high, at 56% of health expenditure, signaling that most Nigerien citizens have poor financial protection for health services. As more Nigerien citizens gain access to and enroll in financial protection mechanisms such as health insurance, some household spending will likely shift from out-of-pocket spending to regular premium payments to risk-pooling schemes offered by the government, employers, the community, or private insurers.

7.4 Progress Toward Universal Health Coverage and Universal Access to Family Planning

The government of Niger's *Plan de Développement Sanitaire 2011-2015* included several strategies to enhance the government's financial capacity to meet population health demands and reduce household out-of-pocket payments. Two notable financing strategies revolve around enhancing internal and external resource mobilization efforts and developing innovative risk-pooling mechanisms. Resource mobilization is a critical strategy for the Nigerien government because a large proportion of the population that lives below the poverty line can access only no- or low-cost health services. Resource mobilization strategies include enhancing intragovernmental advocacy efforts to reach the Abuja Declaration target of 15% of the state's budget allocation for health, as well as advocating for donor support for strategic plan development for UHC.

The PDS expected that supporting the development and expansion of risk-pooling mechanisms such as CBHI schemes would complement the government's efforts to provide free, or at least highly subsidized, services and expand financial risk protection to the population. HFG learned that the Ministry of Health is commissioning several department-level personnel to explore issues with and potential strategies for achieving UHC under the next PDS, for 2016-2020. These managers will advise the Prime Minister accordingly. This suggests high-level, intragovernmental interest in addressing population health needs through UHC.

Other strategies from the PDS 2011-2015 included determining how to more efficiently use existing resources and developing a social fund to cover health services for indigent people. The PDS also identified the development and adoption of a sector-wide CBHI strategic plan as a priority intervention. This plan would elaborate on the structure of CBHI schemes and how they would contract with facilities for health service provision, though details were not provided on when this plan would be developed.

Aside from the PDS, the government worked with development partners to finalize its *Stratégie Nationale de Financement de la Santé en vue de la Couverture Universelle en Santé au Niger* (National Health Financing Strategy for Universal Health Coverage in Niger) in 2012. The strategy re-emphasizes the PDS

2011-2015 financing strategies of increasing resource mobilization and using resources more efficiently. The health financing strategy also explicitly lists universal health coverage as a strategic aim. At the time of this HFG study, implementation of this 2012 strategy had not yet begun.

Niger mobilized donor support through the International Health Partnership (IHP+) in 2009. It signed a country compact with eleven development partners plus civil society organizations in 2011 to support the development of the PDS 2011-2015, as well as a roadmap for strengthening monitoring and evaluating and a national health plan. Niger has remained engaged with IHP+ through participation in multiple rounds of IHP+ results monitoring. Niger has also mobilized resources through USAID's family planning access initiatives and with support from the Ouagadougou Partnership to advance family planning in francophone West Africa for the development of *Planification Familiale au Niger: Plan d'Action 2012-2020* (National Family Planning Action Plan) (USAID 2016).

The PDS includes explicit aims to integrate family planning services at large into Niger's package of essential services and to promote nationwide, community-level distribution of contraceptives at public and private health facilities. It outlines six priority strategies including community-based distribution of contraceptives, mobile and outreach strategies, and provision of contraceptives free of charge at all public services.

The PDS highlights several aims for private provider engagement through developing public-private partnerships, improving pharmaceutical regulation, and promoting private health insurance.

7.5 Opportunities in Health Financing

HFG's analysis of the health financial landscape in Niger revealed several areas where the government might focus efforts to develop, strengthen, and expand health financing mechanisms to progress toward UHC and access to family planning.

Overall, the government has the opportunity to improve efficiency of its financial risk protection efforts by expanding the availability of health insurance schemes. While existing health financing mechanisms provide some degree of protection from financial risk, their concentration among the formal sector subpopulation, combined with high (56%) out-of-pocket spending nationwide, suggests financial protection against health shocks is poor or absent for many. Niger is the lowest-ranking country on the 2013 Human Development Index. High poverty levels and high fertility rates contribute to a low-performing health system. Dependence on out-of-pocket spending negatively affects both access to and use of health services in Niger. Even the smallest user fees can be prohibitive, presenting an opportunity to expand coverage and efficiencies of existent health insurance schemes—CBHI and private health insurance.

The government has opportunities to shape its policy efforts around UHC. First, the new *PDS 2016-2020* has been developed, but the validation process began only in July 2016. With validation and subsequent implementation of that plan, Niger may choose to strategize on efficiently achieving its PDS priorities for UHC. Second, this could be an opportune time for Niger to re-energize health financing strategy efforts, given that only a relatively small share of Niger's budget (5.8%) is allocated to health and the implementation of its 2012 health financing strategy has been delayed for reasons unknown. Moreover, given limited social protection mechanisms Niger could use this time of PDS validation to determine how to develop and coordinate technical research, planning, strategy, and advocacy efforts dedicated to promoting UHC. This could include plans to include the private sector in health sector development, which was considered important in the PDS. The above-listed opportunities could be realized through the establishment of a concrete policy and strategy to progress toward UHC.

The government also has opportunity to increase financial protection for informal, rural, and indigent populations. HFG found evidence of wide variation in processes for identifying indigent people in

communities. This could be an important gap to understand and address given the significant implications for financial risk protection of individuals. Exploring this further could lead to reduced incidence of fraud at the point of care and more-efficient government financing of health services for indigent people. Moreover, the government may have the opportunity to address limitations to CBHI. Not only is enrollment in CBHI schemes very low (less than 3%), but it is often largely limited to the formal sector. Also, HFG analysis found that management and oversight of CBHI schemes is poor despite the 2015 creation of a national agency to regulate them. This suggests gaps in effective strategy, implementation planning, and capacity to reinforce and regulate CBHI schemes.

Last, the government has the opportunity to improve access to family planning across public and private sectors. Family planning commodities are free only in the public sector, with the exception of private providers that are part of a donor or NGO's procurement network. As the private health sector develops in Niger, the government can explore potential implications for how, where, and at what cost (if any) family planning commodities are provided across the health system.

7.6 Sources

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