THE IMPORTANCE OF PRACTICAL NORMS IN GOVERNMENT HEALTH AND EDUCATION SERVICES IN NIGER

January 2018

by
Jean-Pierre Olivier de Sardan,
Mahaman Tahirou Ali Bako and Abdoutan Harouna

Part of the research findings of the project
'Accountability through Practical Norms:
Civil Service Reform in Africa from Below' (2016-17)
funded by the British Academy/DfID
Anti-Corruption Evidence Programme

Introduction: Practical Norms in Niger's Public Service[1]

Like all Nigerien public servants, healthcare staff and teachers are generally familiar with the official norms of their professions, which they learn about during their initial training at the faculty of health sciences, various paramedical institutions and teacher training colleges. A wide range of additional training courses, provided and funded by aid donors and international NGOs, is also available.

However, countless instances of behaviour that deviates from the official norms are observed in health centres and schools on a daily basis. Four common examples of these behaviours include:

1. What is sometimes referred to as 'petty corruption':

   > It is common practice for a teacher to give one or several months salary or a lump-sum to the inspector of the departmental directorate of primary education to secure a post in an urban school rather than a remote village.

2. Practices that are considered legitimate but deviate from official norms and compromise the effective delivery of services:

   > Absences among midwives due to attendance at the baptisms, weddings and funerals of a large circle of relatives, friends and acquaintances cumulate from week to week; these absences far exceed the maximum legal period of annual leave.

3. Practices that flout the law and regulations but may be necessary in the interest of providing services:

   > When a particular medication is not available in health centres (due to delays in state reimbursements for services to payment-exempted categories), many nurses issue patients with 'informal' prescriptions on 'bits of paper' that enable them to buy the medication in private pharmacies – a practice prohibited by the Ministry of Health.

4. Practices that are widely condemned but persist with no real attempt being made to eliminate them:

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[1] M.T. Ali Bako and A. Harouna carried out fieldwork in 2017 in Ouallam and Niamey and worked with masters students in 2016 to conduct a collective study on education in Kollo. JP. Olivier de Sardan coordinated an education working group consisting of education professionals (schoolteachers, professors, trade unionists, ministry officials) and HCME (*Haut-Commissariat à la modernisation de l'Etat*) and HALCIA (*Haute Autorité de lutte contre la corruption et infractions associées*) officials, which has met several times in Niamey to discuss LASDEL's initial findings and present proposals. A two-day workshop was held for mayors and health professionals, education professionals and HCME and HALCIA officials, at which the presentation of our findings and of the mayors' viewpoints was followed by a discussion of the powers available to the communes in relation to education and health and a presentation of proposals. The second training session of LASDEL's centre for maternal health workers (Niamey, 26 September to 4 October 2017) provided an opportunity for debating the LASDEL team's verdict on maternal health, to approve the list of practical norms and to present new proposals.

> Inspectors, educational consultants and school principals complain about the lack of disciplinary sanctions for incompetent, corrupt and habitually absent teachers, however almost all of them back down when faced with the scale of the problems arising from their attempts to discipline their poorly performing subordinates.

These deviations from the official norms cannot be blamed on ignorance of these norms. All teachers know that it is illegal and immoral to buy a convenient posting, midwives know that taking leave for social reasons violates the labour code, nurses are fully aware that they should not issue prescriptions for the private sector and school inspectors are fully aware of the range of disciplinary measures at their disposal.

Nevertheless, certain individuals from all these groups routinely behave in this way. It is considered normal to violate the official rules sometimes, and these deviations have become 'habits'. *These are not marginal, pathological or criminal behaviours. 'Noncompliant behaviours' that is behaviours that do not conform with official and professional rules are commonplace and although they are criticized, they are still tolerated*. We define as 'noncompliant behaviour' the everyday practices of teachers and healthcare workers that do not fully adhere to the official standards of the public service or their profession (sanitation procedures, educational rules, ethics etc.).[2] Such practices may arise from corruption, clientelism, interventionism or a lack of professional ethics, however they may also serve the purpose of 'plugging a gap' or 'making do' when official standards cannot be applied, as is all too often the case in the real context of Nigerien schools and healthcare facilities. It is clear that noncompliant behaviours are widespread; they are a reflection of a serious crisis in the Nigerien education and health systems and they contribute to the exacerbation of this crisis. These behaviours testify to the fact that the quality of public education and health services leaves much to be desired, and has even declined considerably in spite of a nationwide increase in the number of schools, colleges, health centres and hospitals in recent decades.

These noncompliant behaviours are usually the cause of failures in public services, and particularly social services; *generally speaking, the significant growth in these services contrasts with their poor quality*. A consensus emerged from the many interviews we conducted with the users of these services (parents of school pupils and patients): they are critical of the poor quality of the services provided and attribute it to the behaviour of teachers and health workers. This is also acknowledged by many members of these professions.

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[2] Compliance', a concept borrowed from public health (compliance with prescribed medication) is referred to as "dependability" by Britan & Cohen (1980: 20): "the degree to which an official satisfies the rules and regulations governing his office".

A major characteristic of noncompliant behaviours should be highlighted: they are convergent, routine and predictable. Hence, to a certain extent, they are *regulated but in a completely informal way*. They follow a set of *de facto* rules rather than the official, public rules. We refer to these 'invisible' norms that regulate the habitual gaps between actual behaviour and the official norms as 'practical norms'.

Unlike official (and social) norms, which are explicit, practical norms are implicit. They do not exist in writing. They are not expressed verbally, and are not even always deliberate; they are latent, underground and habitual. Practical norms have only been distinguished from similar behaviours and described as such by researchers; they are not identified as such by the social actors. However, when challenged by researchers to describe these shared practical norms, the latter basically accept that "everything happens as though" these norms actually do exist.[3] In effect, they enable the identification of the convergence of non-compliant behaviours and it is this convergence in the gaps between actual behaviour and the official norms that is the focus of this report.

By way of example, the four following practical norms illustrate the gaps between actual behaviour and the official norms:

> Giving money to a school inspector to obtain a desired posting.
>
> Giving priority to social obligations over professional ones.
>
> Providing an informal prescription which is helpful to patiensts.
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> Disciplining a subordinate leads to disapproval and problems that it would be better to avoid.

Needless to say, practical norms are not always respected. Some public servants refuse to offer bribes to inspectors and some inspectors refuse to accept them; some nurses refuse to issue informal prescriptions; midwives exist who will give priority to a professional emergency over a family event; and inspectors do take action against incompetent teachers.

This means that public servants do not always follow practical norms; they sometimes comply with the official norms. *Their behaviour falls somewhere between the official and practical norms; sometimes they are compliant and at other times they are not*.

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[3] We held a number of discussion sessions on the 'practical norms' we identified in our studies with professionals from the fields of education and health: on all occasions, there was agreement on the fact that "everything happens as though" these practical norms actually do exist.

As is the case elsewhere, practical norms are at the heart of everyday life and operation in Niger's public authorities.[4] *The assume specific forms according to the context in which they are implemented. They are not necessarily negative*. A state where all public servants fully comply with regulations at all times is unthinkable (and would probably be unbearable!).

Some practical norms (which we refer to as 'adaptive' norms) can make abstract, impersonal official norms appear more compatible with particular contexts and specific situations; they can also 'humanize' official procedures.

> In Niger, for example, where user-fee exemptions apply to children up to the age of five, children who are clearly older than five are treated for free and recorded as being five years old.

However, others can seriously damage the quality of public services and the efficient operation of public authorities. We refer to these practical norms as 'transgressive'.

> The production and presentation of fake qualifications (BEPC, the junior secondary education certificate) has resulted in the recruitment of people with no command of written French (and even spoken French) as contract teachers.

Lastly, some practical norms have an ambivalent effect; the public service operates in a 'patchwork' fashion and tolerates 'informal privatization'. These norms, which we refer to as 'palliative' flout the rules but ensure the service is provided.

> In order to enable free evacuations, many health centres have introduced an 'extra centime' payment (XOF 100) for all patients, including those who are officially entitled to free healthcare (children under the age of five, pregnant women); this practice is prohibited by the Ministry of Health.
>
> Teachers asks parents for contributions to buy chalk and sponges for cleaning the blackboard.

Before any reform of non-compliant behaviour can be carried out, is essential that the practical norms are known. To create effective reform, it is necessary to identify the behaviours that must be changed (partially or completely) and the behaviours that should be accepted or tolerated (occasionally or frequently, temporarily or in the long term). *Improving the quality of service provision must start with the everyday, real experiences of public servants*. This is not a typical basis for public policy-making: *successive reforms of public services and the state, carried out largely on the initiative of aid donors, do not tend to*

[4] The existence of practical norms is not restricted to Niger, or even Africa. In all countries, including Europe and North America, practical norms regulate the gaps between actual behaviour and official norms. However, they vary according to the historical, political, economic and social context.

consider the current practical norms; the standard approach is to superimpose new official norms on existing ones (which were not generally complied with).

Each state profession obviously has its own practical norms: those of healthcare workers differ from those deployed by teachers.

> While illicit earnings gained from labouring women and their attendant family members are sometimes shared by the midwives of an on-call team in Niamey's central maternity unit, this never occurs among teachers. Any teacher who is given money by a parent for 'favouring' their child keeps it for him- or herself.

Nonetheless, many practical norms are found throughout the various state professions and within all public authorities. They exist in both healthcare and education, and are *shared bureaucratic practical norms*.

We begin our report by examining the shared bureaucratic practical norms in the education and health sectors in Niger and highlight the variations between them. We then describe the practical norms particular to healthcare staff[5] and to teachers. This is followed by an attempt to elucidate the place of corruption within these practical norms. Finally, we conclude this report by considering what can be done to improve public service provision based on an analysis of the challenges and obstacles involved in any attempt to modify these practical norms and a presentation of innovative potential approaches to reform in this area.

Our findings and reasoning are based on a fundamental observation in relation to the battle against corruption: *it is impossible to draw a clear line between corrupt and all other noncompliant practices. Practical norms due to corruption are embedded in a much larger set of practical norms, all of which must be considered in the scope of public service reform.*

[5] In addition to the studies carried out for this research programme, we refer to the many studies carried out by LASDEL on the health sector in Niger over the last 15 years. See, in particular, the issues of *Etudes et Travaux du LASDEL* on this topic (open access online at *www.lasdel.net*): Souley 2001; Hahonou 2002; Moumouni et Souley 2004; Moussa 2004; Olivier de Sardan, Bako Arifari et Moumouni 2005; Olivier de Sardan, Diarra et Moumouni 2006; Diarra et Moumouni 2007a; Diarra et A. Moumouni 2007b; Diarra et Moumouni 2008; Olivier de Sardan et Ridde 2011; Ousseini 2011a; Ousseini 2011b; Diarra 2011; Kafando, Mazou, Kouanda & Ridde 2011; Diarra 2012. The occasional reference to older studies is justified by the fact that the vast majority of the practical norms analyzed by LASDEL in Niger in the past are still deployed today.

Practical Norms in Health and Education: Shared and Specific Norms

> Contractor teachers (who account for 70-80 percent of primary school teaching staff) are well known for their high level of absenteeism: not only are most of them absent for the last week in every month so that they can collect their wages from the regional administrative centre (or the following week, if the money has not arrived), but many of them leave for the weekend a day early or return a day later.
>
> Absenteeism is equally common among healthcare staff but takes different forms: starting work one to two hours late, leaving early at the end of the day, regular half-days of absence (especially for women) to attend social ceremonies (baptisms, marriages, deaths) held within a vast 'PAC'[6] network.

Just as absenteeism assumes many forms, numerous 'families' of practical norms exist in the different areas of Niger's public service and specific forms can be found within each state profession. We focus here on general issues relating to staff management under the headings of intervention, inconsistency, impunity, absenteeism and 'brain drain'. We conclude with a list of the practical norms in relation to the management of staff.

Constant intervention in appointments and postings

> "The Ministry of Health is responsible for all of this. I can tell you, we were assigned a new ophthalmologist, an assistant surgeon, an assistant anaesthetist, a sonographer and a radiologist at the beginning of the year, even though the x-ray equipment is not working. Within two months, they had all found jobs elsewhere! One of them never even turned up! We have the equipment, but the sonography and ophthalmology services have been shut down. This is serious! And the ministry's to blame because that's where they change postings." (Communications officer in a district hospital, interview notes A.H.)[7]

Political and clientelist considerations are always at play when it comes to appointments, promotions and the assigning of posts, including in primary schools and health centres. However there is not complete disregard for the appropriate skills and interests of the services, and these aspects are also considered within allocation policy, along with issues such as disciplinary posting and 'social' posting (cf. Blundo 2011b).

But multiple, long-established interventions can clash or be combined in the effort to place a 'protégé' in a post with the result that recruitment criteria are not always respected.

> "When the ministry allocates staff, I don't think they care at all about what the service needs. It comes down to who you know or political pressure." (Graduate in obstetrical surgery, district hospital, interview notes A.H.)

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[66] The acronym PAC ('*parents, amis connaissances*'), meaning 'relatives, friends, acquaintances' is widely used in urban areas, particularly to describe all forms of favouritism, and even corruption, associated with the vast networks of people known to every public servant. Accountability to a worker's PAC is one aspect of the 'multiple-accountability' of the public service of Niger (and other African nations).

[7] The interview notes are credited to Abdoutan Harouna Abdoutan Harouna (A.H), Ali Bako (A.B.), Olivier de Sardan (JPOS) Sani Bizo (S.B.), Abdou Dangali (A.D.)

> "A new head of the Division for Health Information and Education (*Division de l'information et de l'éducation pour la santé*, DIEPS) was needed. The undisputed favourite was the deputy head, who was extremely experienced and had just completed a specialisation qualification in Belgium. He got on well with the three main divisional officers (all postgraduates). To everyone's surprise, the job went to a young social worker with no experience (with junior secondary certificate and vocational training)." (Elhadji Dagobi, 2010: 76).

Intervention comes into play at different levels in the appointment of health and education staff:

- recruitment of sometimes incompetent protégés;
- assigning of protégés to sought-after posts or not assigning them to unpopular posts;
- enabling of incompetent protégés to keep their jobs, making them 'untouchable' (widely-used expression), in spite of calls for their dismissal by their superiors or service users.

The two paths of interventions are political and PAC-related and they sometimes intersect. The result is informal accountability, which is often more compelling than formal accountability: a teacher appointed to a favourably-located post (on a major road with access to frequent public transport services) will be more accountable to the person who 'intervened' in his appointment than to their school principal.

Political intervention: the politicization of the administration

This is a major element of human resources management in the public sector and was viewed negatively by all of our informants. Very often, membership of the right political party is what is needed to obtain a particular post.

> "Appointments to the most senior positions (directors of National Hospital of Niamey, senior posts within the Ministry of Health etc.) are not based on merit but on the political hue of candidates climbing the social ladder." (Hahonou, 2002).
>
> "Job allocation is purely political now. Every minister wants to set up his campaigners; the party wants him to do this or that." (Technical consultant, Ministry of Health, interview notes A.H.)

The absence of a stable single-party majority since the end of military rule has produced a shaky system of political alliances and the formation of a presidential movement between several parties under constant threat of collapse. This extends the scope for political appointments and postings, as one of the obligations of the alliance in power is to satisfy the claims of all of its participants. In other words, the politicians and leading campaigners of all

of the parties involved in the presidential movement have to be 'accommodated' in the administration, a process that involves complex calculations which take factors of personal influence within each party and issues of regional balance into account. A common approach involves the reservation of a particular ministry (or board) for a particular party, which then fills it with its own people in accordance with its own criteria. However, the allocation of posts can also be carried out by service or public institution.

> "Sometimes people who don't match the job profile are made managers. These appointments don't make sense! And it's all politicization because we know that in the Ministry of Health, one board is linked to a particular party and another is linked to a different party, they don't even try to hide it. It's the same for hospitals; it's well known that a particular hospital is run by a particular party and so on." (Technical consultant, Ministry of Health, interview notes A.H.)

Health is seen as a lucrative (or 'juicy') ministry because of the scale of the external funding and equipment contracts it controls.

> The recent turmoil around the formation of a national unity government combined with certain politicians' statements have highlighted the notion of 'good' ministries (like health, hydro-electric power, mining, public works), which the rumour mill immediately translates into 'juicy' ministries – rich opportunities for commissions, misappropriation of funds and lucrative appointments for friends – and 'bad ministries' (tourism and craft industries, or higher education and research), known as 'empty shells' with nothing to offer.

The party system operating in Niger, which has been in place since the National Conference of 1991, works on this job allocation-reward system: all of the executives in a party associated with the government feel they deserve profitable positions within the state as compensation for their devotion to the party, and they exert pressure to acquire them.[8] This system also gives excessive powers of intervention to party donors (in particular large retailers), who provide substantial sums to create a good impression in the elections, and expect a 'return on their investment'.

The politicized allocation of posts reflect negatively on the state, which is perceived as an arena of rent, privilege and opportunities for personal opportunity.

> "When an administration is politicized, there is no fear of consequences. People tend to see through the public officials in political parties, who answer only to their parties." (Head of anti-corruption organization)

Politicized post allocations have two disastrous impacts on public opinion.

[8] The 'winner-take-all' or 'spoils' system also exists in Western democracies but tends to be reserved for senior administrative roles. The extent to which this system is found in state services is specific to Niger (as is its association with prospects for rapid personal gain).

1. They reinforce the feeling that those in power and their many protégés in the administration make personal gain with impunity at the expense of the state, which is viewed as a 'cash cow'.

2. They damage the reputation and authority of those in charge at every level, as it is thought (sometimes unjustly, but often with good reason) that their jobs are acquired through political 'leverage' rather than on merit or based on qualifications.

> "Ultimately the hierarchy is meaningless: people do not view their superiors as superior as they are accountable to a party, they feel that their post depends on a party, and they cannot be moved from their position without the party's agreement." (Head of anti-corruption organization)

The politicized allocation of posts combined with strong political instability also result in a dual inverse effect: extreme mobility and immobility.

> "People move too much or they are irremovable, particularly at central management level because of the politicization of posts." (Inspector of services, Ministry of Health, interview notes A.H.)

1. Constant ministerial reshuffles, whether due to regime changes or a reorganisation of the alliances of the governing coalition, create equally rapid mobility among senior ministerial staff and the permanent reorganization of services: sustainable reform cannot be assured under these conditions.

> "The mobility of ministers is the reason why reforms don't get put in place or operate very slowly now. We thought we'd calculate how long ministers stay in the Ministry of Health since the National Conference, and the average is 11 months." (Technical consultant, Ministry of Health, interview notes A.H.)
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> "The first thing that shows that reforms have not been introduced or that they've stalled is the instability of directors at the Ministry of Public Health. In six years, for example, there have been four or five different ministers in charge of this ministry. And when a minister changes, lots of things change; when a minister leaves, his managers leave too." (Director of Human Resources, Ministry of Health, interview notes A.H.).
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> "All these changes within the ministry, creating departments and changing management all the time. Not only does it cost the state a lot, it's very unsettling for us out here in the bush when we go to the ministry for our papers. You turn up and they tell you that the office isn't part of that department any more, it's another department, etc." (Communications officer, district hospital interview notes A.H.)

2. Middle managers can remain in their post almost indefinitely, however, as long as they change party with each new minister. These public servants tend to be opportunistic; they show little concern for improving public service and do not embrace a new minister's reforms.

> "Managers in the ministry now know that when there's a new minister, they say they're from the same party." (Technical consultant, Ministry of Health, interview notes A.H.)

> "One of the problems with reforms is that the people who are supposed to be implementing them are not on the same side." (Division Head, Ministry of Health, interview notes A.H.)

To conclude on this issue, we note that any change in the country's leadership sees the opposition – regardless of political party involved – claiming that any steps taken to depoliticize state systems to-date are pushed aside once they are in power.

Interventions by PAC

Networks of influence extend in all directions; they are not confined to political parties but also, and primarily, include extended family. They also incorporate other types of social relationship, such as people from the same region, former fellow students, economic or social dependents of a benefactor, and so on. Placing someone in a post or finding employment for a dependent are commonplace activities for 'big men', who see the effects of their influence and their prestige grow as a result.

Intervention also works in the opposite direction when officials are struggling to keep their jobs under pressure of criticism from the community or their superiors.

> In a health district of the city of Maradi: "These 'untouchables', to quote one of the people we interviewed, always stay in their jobs, even though many of the nurses and their own superiors see them as the cause of failings in the organisation. For example, the director of a rural CSI (integrated health centre) has been challenged by people in the community, especially since one of our interviewees said that an external audit showed that he provided inaccurate figures about the activities of his CSI. (Diarra, 2012: 14).

When multiple interventions come into play in allocating a post, it is possible that an entire public policy can be threatened or blocked, even in a high-priority area such as maternal health.

> The vast majority of midwives are based in Niamey.[9] They are often married to civil servants, some at a senior level, and invoke their 'protection' to avoid being sent to isolated areas. (cf. Jaffré & Prual, 1993).

One key explanation of the power of intervention is that it is considered lawful by all those who benefit from it – yet anyone can benefit from it, if the occasion presents itself. The interventions of PAC in obtaining posts are one element of a much larger system of favours that operates in society as a whole and can be analyzed as an 'extensive exchange of favours', in which "the service rendered may not be repaid with an equivalent favour from the 'debtor', but with other services rendered by other acquaintances." (Olivier de Sardan 2004).

[9] According to Ministry of Health figures, 90 percent of midwives (500 out of 543) were based in Niamey in 2010, cf. CREDES, 2010: 7.

Intervention and the extensive exchange of favours are justified by personal and social obligations.

> "Personal reasons always win over professional reasons when it comes to allocating posts because arguments such as illness, being with the spouse or personal disputes are always put forward." (General secretary of SYNACEB teachers' union, interview notes A.D.)

In many respects, it is an issue of basic human decency; it is normal to help others, so the person who refuses to intervene or enable the intervention is the one who is viewed negatively and stigmatized by other members of their circle, who describing them as 'bad' and 'unsympathetic'.

However, interventionism can also be directly linked to corruption (see below).

'Interesting' posts – for whom?

The central criterion of a posting policy must be to benefit the service; in other words, job allocations must be optimized to satisfy the national coverage of the services delivered, and to ensure quality.

Two practical norms exist, however, that are central to posting policies (and thereby to the interventions partially directing them) and are based on completely different criteria: the quest for urban and lucrative postings.

In areas like health and education, the quest for jobs in urban areas has become systematic; people are looking for ways out of rural areas or to remain in rural areas for the minimum possible period. The result is a high concentration of qualified staff in urban centres (particularly in Niamey) and very few elsewhere.[10]

The general rule now is that people do anything to avoid posts in outlying regions.

> " Rural areas are deprived so most workers are situated in urban areas, mainly Niamey and the major regional towns. There is an abundance of staff there, but 30km or 50km out, there are few or no midwives, nurses and lab technicians." (Director of Human Resources, Ministry of Health, interview notes A.H.).

Hence, posts in towns and near main roads (or with a phone network, at the very least) are routinely sought after.

The only cases where posts in outlying regions are sought or tolerated is when they are lucrative, for example at border crossings (opportunity for business, sometimes on the black market, outside or even during working hours) or for a 'project' funded by an international

[10] On this issue, see also Cummings & Ali Bako 2016 for education and Caremel 2016 for health.

NGO (e.g. MSF) that offers certain advantages. Otherwise, being posted to a village without the prospect of personal gain is very negative and seen as bullying.

The rationale for avoiding rural postings

Three actor strategies converge in the rejection of serious professional posts in rural areas: (a) the recourse to intervention to avoid the post at all costs; (b) the refusal to take up the post; (c) absenteeism once in situ. These three strategies are at the basis of the *rationale for avoiding rural postings*

In the case healthcare staff for example, the absence of decent residential and professional infrastructure in rural areas and the Ministry of Health's obvious lack of interest in this problem are clearly an important factor in the rationale for avoiding rural postings, however this is not the only one. Other major problems relate to the fact that that most health workers are accustomed to an urban lifestyle (proximity to personal and family networks and availability of infrastructure) and considerations relating to schools: the failure of the public school system has led to nearly all healthcare workers moving their children to private education, thus if you work in a rural area, you condemn your children to a public school education. Finally, working in urban areas also provides healthcare workers with additional opportunities not found in the villages: second or even third jobs in private clinics, with NGOs and pharmaceutical companies, further training in medical schools, opportunities for exchanging favours, illicit income etc. If they go to the country, they give all this up.

The feminization of health and education

Women are not only in the majority in the nursing and teaching professions but also in the institutes that train them.

In Niger's administrative culture, preserving the family unit is a priority: a women must have a posting near her husband's place of work.

> "Marriage is a woman's biggest goal, no matter what anyone says, and women would rather be in town than in the country. A nurse's or midwife's aim is not to be working in the country, but in the town." (Technical assistant, Ministry of Health, interview notes A.H.)
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> "Our problem is the feminization of the health sector; in a class of 40 healthcare students, only three or four will be boys. If the woman is married, she has to stay with her husband; if she is single and we give her a posting, after six months, say, or a year or two, she gets married and then follows her husband, who is in the town, so she leaves her job. It's our culture that the woman follows her husband, she has to be near him. This is a particular problem for us because 68 percent of our healthcare workers are women." (Director of Human Resources, Ministry of Health, interview notes A.H.).

The result is that a very small proportion of women are found in outlying areas: only men (and very occasionally single women) accept posts in isolated villages.

> "Right now, once a woman is married, she does not want to go to the bush." (Nurse, CSI director, interview notes A.H.)
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> "Even if I got a post in the bush, I wouldn't go. I can't go there; life is hard, especially for a married woman. And I don't think my husband would accept it if it happened. Living conditions are poor, and I'm afraid of the bush, there are witch doctors there." (Contracted midwife, interview notes de A.H.)
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> The regional education authority in Kollo requested male primary teachers in the Tillabery region, but out of 200 teachers, only two are men!

When the new Minister for Health tried to end the routine practice of keeping couples together, he faced the opposition of the healthcare workers' union (Syndicat Unique de la Santé et de l'Action Sociale SUSAS):

> "Family is sacred, the union said 'no', and the first demand he met was to give married women posts near their husbands." (Head of SUSAS, interview notes A.H.)

Inconsistency in human resources management

Aside from improper interventions, it is unusual to find an actual human resources management policy – one which is well-thought-out and consistent – at any level, be it ministerial or for decentralized services.[11]

In all state sectors, the approach to staffing tends to be improvised, arbitrary and planned on a day-to-day basis only. Human resources management, and management generally, is appalling.

> "I have four midwives in the maternity service, only one is a public servant and she is older. I have done everything I can to put her in charge of the maternity service, but they refuse to do it, they've given the job to a contractor. She does not respect me. She has a problem filling out reports, she never does it even when I tell her. She knows nothing, but I can't change the situation; she has connections, she's married to the son of the canton chief." (Nurse, CSI director, field notes A.H.)
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> "Implementing reforms is a problem, because the people who are supposed to be doing it are not up to the job. You can't ask someone who isn't even capable of writing a permission request to follow up on a reform that was created and introduced by a panel of experts. So the people who are meant to be monitoring implementation are incompetent; they are young doctors who either have no experience or who've spent all their time in NGOs or clinics. They are sent to the regional health authorities (Direction Régionale de Santé Publique, DRSP) to implement reform, or they have a central role in their supervision. So when they finally get a local posting, it's a disaster, anything can happen - hospital cleaners and attendants doing nursing duties! Where will it all end? I was in Loga once for work and there were staffing problems; the person doing antenatal checks was a hygiene and sanitation technician!! And the other problem at the Ministry for Public Health is that they only run things from day-to-day, there's no planning; there's no management

[11] For other examples, cf. Diarra, 2012: 18.

> chart – if it did exist, no one would follow it. Another problem is the people they have in the district supervisory teams (*Equipes cadres du district*, ECD): you can't send a communications specialist or manager to supervise a midwife." (Senior ministerial official, interview notes A.H.)
>
> The law for the reform of the education system (*Loi d'Orientation du Système Educatif*, LOSEN) of 1998, which is still meant to regulate Niger's education system (along with the sectoral programme for education and training 2014-2024), is still not respected!! The recommendations of the higher education council are not monitored. The education system is split between five ministries, mainly for political reasons (to provide posts).

Measures tend to be adopted in response to external requests (from the United Nations, aid donors or NGOs) and do not address real domestic needs (see below).

> "All these modifications in the Annual Activity Plans (*plans annuels d'activité*, PAA). We base our AAP on the Health Development Plan (*plan de développement sanitaire*, PDS), but things are added while it is being implemented which totally disrupt our planning. There is no evaluation, changes are made and by the end of it, we don't even know what needs to be evaluated. It feels like we do things just to satisfy the people who thought of them. There are some reforms but we have no idea how people agreed to them." (Communications officer, district hospital, interview notes A.H.)

Another consequence of the endless barrage of reforms, projects and vertical programmes is the excessive and uncontrolled growth in bureaucracy, at the expense of clinical or teaching activities, and without any clear indication of the purpose of many of the reports produced. This is an even greater problem for workers with poor writing skills.

> "When you look at reforms and all the documents to be produced for the dispensary, for an integrated health centre (*Centre de santé integré*, CSI), there's so much paperwork. There are at least two to three reports to do in a dispensary every month. The CSI has more than ten reports at the end of every month to send to the district hospital – it's too much! There are people in offices in Niamey, but only the senior medical officer can do these reports, on top of his other duties." (District hospital nurse, A.H.)

The broad aims declared by the state, with pressure from the international community – to achieve Millennium Development Goals, send all Nigeriens to school and introduce universal health cover – are far beyond the reach of the country's actual capacity. Nevertheless, they form the basis of improvised public policies, which do more to disrupt public services than improve them. In both health and education, the international indicators used for comparison focus on maximizing the quantity of those receiving these services, but make no consideration of quality.

> Combined with a huge increase in the number of classes with a view to meeting the school enrolment targets quickly, structural adjustment measures implemented in education in the late 1980s (early retirement of qualified teachers with 30 years' service, recruitment of under-trained contractors) and the absence of both a school strategy and political will produced a disaster in education (massive fall in the quality of teachers and students, worthless qualifications).
>
> The introduction of a series of user-fee exemption measures in the early 2000s, which lacked the necessary national or international funding, pushed health centres to the brink of collapse; they are often unable to provide the free medication required.

Over- and under-staffing

There is a paradox within the administration; sectors with an overmanned and inefficient workforce exist alongside sectors where one or two agents are permanently overworked. Some rural integrated health centres (*Centre de santé integré*, CSI) only have one employee, who is completely overworked and dealing with huge numbers of patients, whilst others have several employees who are often idle.

This phenomenon exists in all areas; inflexibility in the administrative systems is a barrier to rational human resources management, including at the local level where staffing discrepancies are all too evident.

> In all towns in Niger, it is very common to find two (and sometimes three) teachers for one class, meanwhile there is a dramatic shortage of teachers in rural areas. We even have a case with seven teachers for a single class." (Senior executive of the anti-corruption authority HALCIA, interview notes JPOS)
>
> "I enjoy working with a second teacher, it's someone to talk to; last year, my assistant only gave the class once in three months. She does nothing and gets paid for it." (Teacher at lower secondary school, *Collège d'Enseignement Général*, CEG)

Lack of preparation

Another inconsistency within human resources management is the inadequate preparation for new measures, which often seem improvised or implemented hurriedly in response to a ministerial or presidential order.

The 'Special Presidential Programme' launched by President Tandja is a clear example of this.

> For example, "dispensaries have been built too quickly and without a plan. This frenzied construction of dispensaries is backed by the highly political slogan, 'Operation; 1000 dispensaries!' Construction was carried out with no regard for the criteria governing the establishment of dispensaries up to that point and sometimes without the knowledge of local health centre managers (heads of CSIs and ECDs). The CSI heads complain that these dispensaries impact on their area of health without their being informed. One CSI head told us: 'I usually hear about them from patients. The other day, a patient told me 'So there's a new *likita* (nurse) in our village now'. Do you understand? Is that any way to carry on?" [manager of rural CSI]. Note that, added to the fact that this programme does not comply with the official criteria for establishing dispensaries, it also contravenes the Ministry of Health's strategic plan." (Diarra, 2012: 13).

The same applied to the fee-exemption policy.

> "There were no preliminary studies, or even debate within the ministry; it was just dropped on the minister's head!" (Technical consultant, Ministry of Public Health, quoted in Ousséini, 2011: 24)
>
> "The decisions about fee exemption (…) were also made hurriedly and without preparation (…), announced suddenly and publicly, surprising not only those working on the ground

> but even the technical staff at the ministries (…);the extent of the practical problems they raised was completely under-estimated (…).The vote on fee exemption for pregnant women and children under five in the 2007 budget was rushed through: it turned out to have been drastically under-estimated (3 billion, with 1billion eventually coming from budget support, instead of the 7 billion needed), and totally unrealistic (only 70 million, just 4 percent, was paid in the end) (…).Healthcare workers were suddenly presented with a *fait accompli*, without preliminary discussions or preparation." (Olivier de Sardan & Ridde, 2011: 20-22).

The rushed posting of doctors to the integrated health centres (CSI) is another recent example of this lack of preparation (see below).

Extreme deprivation: posts but no resources

This is one of the most depressing situations encountered by Nigerien civil servants: many have experienced being sent to do a job with no means to perform it. It is a kind of forced idleness, a total waste of human and financial resources: the state pays someone a wage to do nothing. The most alarming aspect is that this is hardly ever reported in the state information system (thereby demonstrating the limitations of the system), therefore it does not officially exist.

In reality, of course, it does exist, at many levels of the administration and very often in decentralized services.

> The state education inspectors cannot inspect the village schools because they do not have any means of transport.
>
> The laboratory technicians in Dosso Regional Hospital spend their days doing nothing because they do not have the necessary reagents. (Cf. documentary film by Malam Saguirou *La gratuité des soins au Niger*)
>
> "The typical 'we don't have it' logic has become the norm in the healthcare facilities." (Diarra, 2012: 64).

It is, of course, possible to take the view that the deprivation is not due to poor human resources management but to the general poverty of the state and country. This is true in part but only in part as demonstrated by the two following objections:

- Placing someone in a post without providing them with the means to do their job is a human resources issue: those responsible for assigning these posts should be able to refuse to do so. Giving political priority to the principle of 'no post without the necessary resources' should make it possible to find the necessary funds in the national budget or through development aid.

- The lack of resources is partly due to the scale of corruption within the administration (vast misappropriation of office supplies, medical supplies and medication, fuel vouchers or the funds allocated to them).

The 'social' management of staff

The criterion of 'age' (or birth right, or priority), having a large family to support, length of service, preserving the family unit or approaching retirement are some of the arguments used by colleagues and superiors to justify the *laissez-faire* attitude towards public servants who are incompetent, ineffective or even dishonest.

Misuse of skills: over- and under-qualification

> "A teacher who spends her time maintaining the mail log for the one piece of correspondence produced by the departmental directorate of education and a teacher employed for years as a storekeeper (over-qualification) contrast with a hospital attendant assisting with deliveries in the maternity ward (under-qualification)." (Lasdel 2003).

Some public servants have much higher qualifications than necessary to perform the task assigned to them.

> "The secretary whose main task is to deliver the occasional mail of the department's primary education inspectors is actually a teacher nearing retirement who is being paid XOF 120,000 – that is, three to four times the rate of an actual secretary. This situation also arises in many services using seconded teachers (DREBA, DRESS, directorates of youth services, or social development, etc.)." (Lasdel, 2003).
>
> "District medical officers, especially any with a surgical specialization, should spend some of their time on clinical activities. But at G.R., just like everywhere else, this is not the case: 'He is not the only district medical officer DMO to take little interest in the medical aspect of his job, one of our interviewees tells us in confidence because most of the district medical officers he has seen coming through this district hospital are the same. They say they are too busy to do anything other than administrative tasks, and the rare occasions when they show an interest in the medical side is when there are visitors to the hospital who they want to impress (…).' The nurse could only remember one district medical officer at her district hospital who had not followed this pattern." (Diarra, 2012: 17).

But the opposite also occurs, with under-qualified staff being called on to perform delicate tasks.

> "The assistant surgeon does everything. When the deputy chief medical officer [who is trained in obstetrical surgery] is attending a caesarean, the assistant is in the frontline. We are the only ones who know what really goes on in the operating theatre." (Nurse, district hospital, quoted in Diarra, 2011a: 17).
>
> "Matrons also attend deliveries in healthcare facilities but they don't admit to it. It's the same thing for nurses when they're asked whether matrons do deliveries in maternity hospitals; they usually say 'it's forbidden', but the facts tell us otherwise." (Diarra, 2012: 57).

More generally, the entire primary education policy of the last 20 years has been built on an under-qualified workforce, with large-scale recruitment of young contractor teachers who left school early and have no training (see below).

Impunity

> "It has reached the point where politicians don't have anybody disciplined; no one is scared, not even me!" (Head nurse, district hospital, interview notes A.H.)

Almost without exception, impunity takes precedence over professional failings in all state services, from hospitals to the water and forestry service and from the town halls to the regional teaching inspection authorities. Although the labour code contains specific provisions, ranging from verbal warnings to dismissal or appearance before a disciplinary board, whether the issue is a professional failing, the refusal to take up a post or blatant theft, they are almost never applied. The only 'punishment' imposed is the transfer the employee to another service or location.

> "Management is acutely aware of the corruption and racketeering involving patients but the anonymous notes left lying around are completely ignored. No effective steps are taken to discipline offenders." (Hahonou, 2002)

Nevertheless, department heads all complain and agree that the departments run less well without effective discipline.

> "What use are all these heads of staff and HR directors? What good are they? In reality, they have no use because they can't punish anyone. Managers who can't discipline their staff are useless. We should get rid of the heads of staff and HR." (Head of an anti-corruption organization, interview notes AB).

A range of arguments is presented to explain or justify impunity within the services:

- the local social pressure which advocates leniency
- Intervention (see above), whether by politicians or PAC, which results in further interventions by the offenders 'protectors':

  > Inspectors told us about the case of the daughter of a 'regime kingpin' who was caught cheating with her mobile in the teacher training college exam (she had the official answers): after a few phone calls, she was left alone.

- the risk of being disciplined for disciplining an 'untouchable';

  > "An inspector in Tahoua was given another job because he had disciplined a contractor for incompetence." (Primary school inspector, interview notes MY)

  > "The other problem of feminization is that the women here are married to the bosses working in nearby centres, but they don't work and won't take orders. You're helpless in that situation because if you're not careful, you'll make problems for no reason; if you try to do anything about a politician's wife or anyone powerful, you'll be the one leaving." (Head nurse CSI, interview notes A.H.)

- The principle of charity and pity (forgiveness)
- The principle of shame (it is important not to be seen as a 'bad' person)
- rules of decency and deference (towards elders or 'respectable' people):

> "Most [public service midwives] are respected (even feared) and given titles which reflect a level of deference: junior staff, trainees, volunteers and young people generally call them 'Mum' or 'Tanti' (aunt), or address them formally; doctors and other senior technicians call them 'big sister', *uwar gida* (madam) or *hajiya* (reference to the pilgrimage to Mecca). These marks of respect and distinction show that they are not addressed simply as colleagues. They have the [social] status of elders who are above blame (not openly), and who are not given orders. Their generous collaboration is requested as politely as possible. It's understood that they can't be disturbed when they're asleep or praying, during meals, or even during conversations." (Moumouni & Souley, 204: 20).

- Absence of a management culture (no knowledge of the basic principles of managing a team)
- Common knowledge, where the offender knows too much about the person who may be disciplining them, etc.

> "Discrepancies arise when senior people in the hierarchy call on junior staff to reserve a hospital room for a sexual indiscretion, deliver meat from the kitchens or make personal use of hospital equipment: these discrepancies prevent the senior staff from exercising their full authority when the same junior staff are found to be bending the rules themselves." (Hahonou 2002).

The trade unions are powerful obstacles to the imposition of discipline.

> "As soon as I am told, I go and see the medical officer or the director to try to calm things down so the worker is pardoned, not disciplined." (Hospital staff union representative, Moumouni & Souley, 2004: 69)

> When a number of health workers were imprisoned following major misappropriation of funds in the GAVI vaccinations affair, the main health sector unions, among them SYMPHAMED and SUSAS, initiated protest movements to get their colleagues freed.

Sometimes the lack of staff leads to discipline not being carried through due to the lack of replacements.

> " Even if we have to dismiss a teacher for serious misconduct, we don't know whether we'll get a substitute." (School principal)

> "If you say that you're going to discipline a worker for misconduct, it will be your lookout or the worker will find a reason to quit. As soon as you threaten someone, he goes to Niamey and, if he's a public servant, he comes back with a post. If he's a contractor, he leaves the post and is gone. He just stops working and you can't do anything. He'll just go and find a new contract in another district." (Communications officer, district hospital, interview notes A.H.)

One of the most damaging consequences of impunity is that it negates the commitment to achieving results and hinders attempts to improve the service.

> When professional failings or incompetence are identified during supervision by education consultants and no discipline is forthcoming, the teachers' behaviour does not change.

> "I wanted to set up an on-call system, but there was one nurse at the integrated health centre (CSI) who refused to participate and who is untouchable. She's the daughter of a canton chief and she refused to work out of hours. I told her that she had to do it, because if she

> didn't, the others wouldn't do it. But they got rid of me! The rules don't mean anything in Niger; if you want to do something for the good of the community, you're the one in the wrong!" (Head nurse CSI, field notes A.H.)

Absenteeism

Absenteeism is universally condemned by the heads of public services, but they are unable to put an end to it. One of the problems is that there are many reasons behind it; social and economic absenteeism are the most widely known, but there are three other forms: institutional absenteeism, absenteeism for reasons of personal convenience and religious absenteeism.[12]

It should be noted that all of these forms of absenteeism ultimately affect the service users who are left with no service. In nearly all cases, absent healthcare workers and teachers are not replaced.

It should also be noted that this is an area in which nostalgia for the 'Kountché years' (military dictatorship) is often observed. Collective memory credits him with paying close attention to working hourse and professional morals (and there are many famous anecdotes to back this up). Conversely, 'democracy' is blamed for the relaxed attitude and resulting impunity that has grown steadily since the 1990s.

Social absenteeism

This problem was already referred to above. All family ceremonies (e.g. baptisms, marriages, funerals) involving not only an individual's extended family but their large network of acquaintances are considered unavoidable social obligations and as justification for leaving work early or turning up several hours late.

This form of absenteeism appears to impact more on women, who tend to be more involved in baptisms and marriages, than men. The shift to female dominance in some areas (such as health and education) is often perceived as having a detrimental effect on the needs of the public service.

[12] We are indebted to Mahaman Moha for this category of religious absenteeism.

Economic absenteeism

> "It is very common to find female staff selling *pagnes* (fabric), jewellery and perfume in the department. They [female public servants] spend more time selling than working." (Official at the Directorate of Primary Education, quoted in Lasdel 2003).
>
> "In B., there's a network between the nurses and midwives and a printer. The health staff get batches of notebooks which they sell at consultations. This activity is not permitted." (Souley, 2002).

Sometimes posts are simply abandoned when higher stakes and more senior jobs are involved.

> "The most flagrant violation is the case of the doctor in a medical unit whose colleagues and patients accused him of abandoning his job. He was known to not turn up to work for several days at a time, leaving patients and staff in difficulty: 'The patients or their family members often harass us because they never see the doctor. Some give up waiting and just put their faith in God. I think this behaviour is unacceptable in a referral hospital like ours.' (nurse) (…) It appears that the person in question has a private practice, hence his absence." (Moumouni & Souley, 2004: 66).

Institutional absenteeism

To a certain extent, the state and its institutions set a bad example, as paradoxically they are the cause of some forms of absenteeism.

One cause is the ever-increasing number of meetings, seminars, assignments and courses that staff are required to attend.

> Hahonou (2002) refers to "various assignments which make some departments ineffective for long periods: 'one Nigerien doctor is on a course in France… on thoracic surgery, but by the time he gets back, the patient will be long since dead.'" (Intern on a patient requiring treatment)
>
> National Immunization Days are known to cause major disruption each year to the provision of primary level health services.

The payment of salaries is another area of concern. Contractor teachers (and healthcare workers) leave their jobs at the end of every month as their wages can only be collected in the region's main town – in reality, due to delays in the payment of salaries, this could happen during any week when the rumour spreads that the payments are on their way. Hence they do not know the exact payment day and may have to wait several days, and sometimes they are not paid at all.

> "If you get there at the wrong time, the end of the month, everyone has gone to get their wages" (Department of secondary education, Kollo)

Frequent health workers' and teachers' strikes are another reason for institutional absenteeism. Strikes by contractors due to the non-payment of salaries are particularly common and punctuate the school year.

> There were no more than four months of teaching out of the nine months scheduled in 2016. (Educational consultant, interview notes AB)

Absenteeism for reasons of personal convenience

We use this expression to describe the behaviour of many workers who deliberately trim back their working hours or days, either by routinely arriving late for work or leaving early, take undue leave or refuse to be on call.

In the urban integrated health centres (CSI), this is a routine occurrence.

> "The midwives arrange between themselves to finish their antenatal consultations at 10 a.m., having only started at 9 a.m. This could even happen in the middle of a strike which has gone on for at least two days so patient numbers have built up. In this case, the midwives feel obliged to extend their work time to 11 a.m. Any patients unfortunate enough to arrive after then are usually turned away. If they do get to see a midwife, they only get a 'high-speed' consultation which is far from relaxed for the patient." (Moussa, 2003: 374)

> "Except for people on call or on shifts, work everywhere around 9 a.m. at the earliest and around 4 p.m. in the afternoon. It finishes around 11 a.m. in the morning and 5.30 p.m. at the latest in the afternoon. This gives a maximum of four hours of work per day or 20 per week rather than the 40 hours legally required." (Souley 2003: 131)

However, it also occurs in rural areas.

> "In the maternity unit [of a rural district hospital], midwives do not work out of hours. It seems that an attempt by the head of the CSI [integrated health centre] to get them to do so failed. The first midwife refused to be on call because she is on her own and her children are too young to be left alone at night (her husband is a contract teacher in Niamey). The second also refused for the same reason, although she lives in grounds of the CSI. Nurses and matrons ended up working out of hours in the maternity unit. " (Diarra, 2012: 18).

The situation prevails in the referral centres.

> " When there are students, the other workers take off, leaving us with the work." (Student working as intern, central maternity hospital, quoted in Moumouni & Souley, 2004)

In education, many contractors are registered at the university in Niamey for graduate studies.

> People posted to remote villages take up their jobs and then disappear or are absent for several weeks every term.

Many heads of the village schools also complain about the excessive absences of contractor teachers (see below).

> In the village of N.: "The teachers have very little interest in village life. (…) They stick together after work, leave for Niamey as soon as possible (high level of 'informal' absenteeism, particularly among 'volunteer teachers')." (Olivier de Sardan, 2005)

The same situation arises with many community health workers.

> "It's not uncommon to see the highest level of absenteeism among community health workers trained through the 'special programme' and 'parachuted' into the villages. Some of them blatantly abandon their jobs. In cases like these, the shortage of human resources presents as absenteeism or the abandonment of jobs." (Diarra, 2011 : 19).

It would be interesting to conduct rigorous quantitative study on the large numbers of workers who do not return to their jobs (but are still paid) or allow themselves generous leave.

Religious absenteeism

Niger is 95 percent Muslim and the once dominant Sufi brotherhoods are facing growing competition from Salafi Muslims and various other rival Islamist groups. Hence, absences from work for religious reasons are becoming more acceptable. This applies to the daily afternoon prayers which take place during working hours (*zuhur* around 2 p.m. and *asr* around 4 p.m.;[13] these are sometimes supplemented by additional morning prayers by the very pious. There is also the pilgrimage to Mecca, which is widely accepted as part of Nigerien society and is not deducted from a worker's holiday allowance but from working time. During fasting periods (Ramadan), all public services operate more slowly from midday onwards, and may even stop altogether.

Concurrent posts

Many healthcare workers and secondary school teachers hold their public posts concurrently with various private-sector jobs. This is officially prohibited (unless permission is obtained from management, but it is never requested) and inevitably has a detrimental effect on the public post, to which less time and/or personal commitment are given, often because of the lack of career prospects.

Many teachers work in the fields, drive motorcycle-taxis (*kabu-kabu*), give home tuition (often to their own students) or teach in private institutes. They are more motivated to work privately because they get regular wages and even advance payments.

> "It's not difficult to hire contractors privately, they've worked for three months without wages, they're cheap." (in Abdoutan)

[13] Under President Kountché's military regime, it was prohibited to leave work for prayer; people had to catch up during their free time.

Many healthcare staff based in towns also work in nursing practices and private clinics, sometimes doing double shifts.

Brain drain

This arises at many levels, in both health and education. Both sectors are increasingly seen as offering fewer career prospects; people are less likely to join them because of a vocation or to work in public service and more because the jobs they offer serve as a stop-gap or something to fall back on until better employment can be found.

A distinction can be made between an external brain drain, i.e. a movement to areas the education and health sectors, and an internal one, e.g. remaining in education but working outside the classroom or within health but away from clinical duties.

External 'drain'

The destinations of people leaving the professions differ according to the level of the workers involved. The preferred targets of senior managers include international organizations, cooperation agencies, NGOs and consultancy firms, hence the public service is permanently deprived of its best staff, i.e. those headhunted by the aid donors. The pursuit of a career in politics is another popular option among senior staff.

For frontline workers, the situation varies depending on the sector. In education, people tend look for positions in other public services that pay regular and better salaries, in particular the police force, or national guard. The preferred target areas in health are the private sector and medical NGOs.

Internal 'drain'

The main movement here is into the ministries.

> "If you're looking for quality, all the good teachers I've seen are at the ministry." (Driver, quoted by Issoufou)

Another way to get away from the frontline is to accept a trade union post. This enables workers to be released from their public service role – officially only on a partial basis, however in reality they are released from all obligations.

Finally, there is also the option of being assigned to purely administrative roles.

> Towards the end of their careers, teachers can be given one of various unproductive (almost bogus) jobs outside the classroom, such as computer specialists, statisticians, equipment managers and librarians; they often take up these posts without training and without the necessary resources (libraries with no books, computer service with no computers etc.).
>
> "I have not really carried out any real duties since I started on 3 March 2014, I just sit at my desk. I only have a job here because of my master's thesis." (Deputy director of further education at the Departmental division for primary education, field notes Alassane Sani Bizo)

List of practical norms related to human resources management

Based this analysis, we can draw up a list summarizing the implicit, *de facto* practical norms being implemented, under the heading 'it is as though …'. Unlike official norms (explicit in rules, procedures and training programmes) and social norms (explicit in family or religious education and public social interactions), these practical norms are never publicly declared or described as such. Note that these only relate to human resources management and are similar in the areas of education and health.

- The most loyal supporters and most prominent party members must be rewarded with appointments to posts throughout the administration
- Political affiliation is a major factor in the assigning of posts
- The ability to obtain posts for protégés is a sign of social success
- You cannot refuse a favour to a relative or a powerful individual
- It is normal to present gifts to superiors with whom you wish to curry favour
- The rejection of an intervention is a sign of malice
- Posts are assessed in terms of the (legal or illegal) financial (collateral) benefits to which they provide access, or the resulting benefits for the employee's family
- Any intervention to obtain a desired post is considered normal
- The allocation of posts does not take the actual resources assigned to the post in question into account
- Measures announced by a President are formulated in writing after they are announced and not before
- A key objective for public servants is to be offered a job on a project, with an NGO or an international organization
- Becoming a minister or member of a ministerial or presidential cabinet is an ambition that exceeds all other professional aims
- It is normal for many tasks to be carried out by volunteers, trainees and persons enrolled for civic service (known as *civicarts*)

- It is normal to pay volunteer staff members with small gifts
- It is normal to show leniency towards elders
- The main reason to attend training is to receive expenses
- Nomination for a political post is more important than the professional requirements of the nominee's job
- Disciplining a subordinate leads to unwanted disapproval and problems
- Fulfilling social obligations takes precedence over professional ones
- Deputies or subordinates who are too busy and involved in their work should not be trusted
- Delegating tasks can cause problems
- Working in a team involves too many risks and limitations
- It is important to avoid conflict and not become involved in other people's business
- A good manager shares and redistributes resources
- Being at work does not necessarily mean respecting official working hours
- There is no reason to find a replacement in the case of absence
- It is normal to have two jobs (including for people who are not officially allowed to)
- Any administrative job is a promotion and preferable to operational tasks
- Recruitment by a United Nations Organization, cooperation agency, a 'project' or an international NGO is the ambition of all managers
- It is necessary to accept the assignment of a post to a subordinate in accordance with the recommendation of an important person to keep one's own job

Practical Norms and Critical Nodes Specific to the Health Sector

Some practical norms have an integral connection with their respective professional settings and cannot be separated from them.

> For a number of reasons, some drugs are in short supply and unavailable in health centres, so health personnel offer to sell them to patients privately. They are obtained either by misappropriating drugs from the pharmacy in the health centre or by buying them from informal networks known as 'roadside pharmacies', which obtain their supplies from informal wholesalers at the big market in Niamey.

In other words, these practical norms are embedded in the working cultures of the various state professions. Health is particularly specialized and regulated by numerous norms, procedures and technical limitations and, as a result, has a particularly extensive and diverse range of specific practical norms that diverge from these official ones. We will focus here on the practical norms that have particularly significant impacts on the delivery of healthcare to users, in other words the practical norms that concern 'critical nodes'.

Critical nodes specific to each profession

Of the many practical norms inherent to each state profession, some relate to the key stages in professional processes and public service delivery. The existence of practical norms creates fundamental problems, as they compromise the effectiveness of these processes and can lead to major operational failings.

We use the term 'critical nodes' to describe these key problems. They are found within all state authorities and services in which the professional behaviour of public servants and the constraints of their working environments are so intertwined that they create bottlenecks in the delivery of the public service.[14]

> Due to the 'medical desert' in the interior of Niger, the allocation of doctors to the communes' main towns is an inconsistent and largely ineffective response to this critical node. Widespread interventionism, a scarcity of rural infrastructures and the absence of incentives or constraints to work in remote rural areas all come together (see below).

Each critical node reveals the countless misguided decisions, contradictions and inconsistencies in the way the state's public policies and human resources are run. It also reveals the extent to which the various bodies involved (state, NGOs, aid donors, international organisations) are unaware of the reality and the practical norms in operation.

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[14] Nassirou Bako Arifari (2007) used this 'node' concept in a similar way to describe the crystallization of problems within a public service suited to the intervention of a mediator.

We will now present a series of case studies to illustrate how various practical norms are implicated in critical nodes, starting with maternity hospitals to provide an overview of the professional culture of midwives and the practical norms they follow. Another rather different case study focuses on the Ministry of Health's move to create and fill doctors' posts in all of the country's rural communes and reveals inconsistencies in the health policies of Niger (among other countries) and their ignorance of the pragmatic contexts in which they are supposed to be implemented.

Maternity hospitals: practical norms, critical nodes and professional culture

Niger has one of the world's highest maternal mortality rates. Despite considerable improvements over the last 20 years or so, there is still a very long way to go to meet the Millennium Development Goals in this area.

Maternal mortality is not confined to women who are unable to access maternity hospitals, i.e. in isolated rural areas, it also affects women attending health centres for antenatal consultations and delivery. *In other words, a substantial proportion of maternal deaths can be attributed to failings in the healthcare system and to the critical nodes within it. The reforms which aim to eliminate these failings are not adapted to real-life situations, and are 'circumvented' by the practical norms routinely followed by the healthcare workers.*

We will now examine four critical nodes which are typical of Nigerien maternity facilities: (a) antenatal care, which should identify at-risk pregnancies and prevent them, or direct them to a referral centre (if necessary); (b) the monitoring of deliveries in primary level maternity facilities which, in the event of a dystocic delivery, should result in emergency evacuation to a referral centre with surgical capacity; (c) the removal of cost barriers so that patients can avail of evacuations and access caesarean sections; (d) the use of oxytocic drugs.

Monitoring the birthing process: partograms

The partogram is a simple, standardised tool that is presented as a fundamental tool in the fight against maternal mortality in Africa. All schools of health in African countries introduce their students to the partogram, and numerous training courses are provided for practising midwives in its use.

However, in most cases in Niger (and also in neighbouring countries), the partogram is not completed during labour, but afterwards, often at the end of the shift, and using standard data. When a midwife decides to make a referral, it is generally based on her judgement alone and not on a partogram. She then fills it out before the evacuation, as it must be attached to the file, taking care to enter the 'right data' (false, but standardized) to justify the referral.

Of course, there are midwives who fill in partograms during labour and use them as a guide. However, according to many interviews with midwives conducted by LASDEL researchers, they are in a very small minority.[15] The 'practical norm' followed by most midwives is to complete the partogram after the delivery.

Although all frontline health workers (and many officials or experts) are aware of this situation, no mention is made in public settings (conferences and seminars, official publications and reports from international organisations or NGOs) about the actual use of partograms in primary level health centres and maternity hospitals. In other words, everyone speaks and acts as though partograms are used reliably and routinely, as though there are no problems surrounding their use, and as though the 'model' of the partogram is an effective one.

The question arises, therefore, as to why Nigerien midwives do not complete the partograms during labour. Various explanations were obtained from the midwives themselves during our research. An excessive workload – "with several simultaneous deliveries, there is not enough time to fill out the partogram" – is the justification commonly provided by the parties involved. However, this situation is only a frequent occurrence in very few maternity units, hence the argument contestable in the vast majority of cases. The primacy granted to experience (and the resulting 'flair' for the job) is another, more credible, explanatory factor. Other reasons include a weak culture of writing among midwives, a profound reluctance in relation to 'bureaucratic' tasks, an often poor professional ethic, the subcontracting of births to matrons, trainees or attendants, and the absence or non-functionality of the instruments (blood pressure monitors, thermometers) needed to measure the data in question.[16] Finally, the fact that partograms are an evaluation tool used during supervisions has a perverse effect[17]

[15] Other researchers working with qualitative methods in West Africa have also observed a failure to complete partograms during labour: cf. Jaffré 2009, 2012.
[16] Souley 2001, 2003; Moussa 2003, 2004.
[17] Olivier de Sardan & Bako Arifari 2011.

which encourages the recording of the 'right data' or standard data rather than the actual data, which could indicate incompetence or failures on the part of the midwife.

All of these reasons and justification reflect local professional contexts that 'circumvent' the proposed official model in one way or another.

Like many of the components of national and international health policy, the partogram is, in fact, an instrument of social engineering and not biomedical engineering, such as a drug or vaccine. In other words, its use and effectiveness essentially depend on whether and how it is implemented by a healthcare system and by frontline workers. Everything depends, ultimately, on the behaviour of midwives, their motivation, their competence, their professional culture and their 'practical norms'. Furthermore, there are several other actors involved in the dissemination and the implementation of the partogram, for example the directors of maternity units and hospitals and the type of leadership they practise, district health management teams and their mode of supervision, the trainers in the use of partograms, the hierarchy of the national health system, and international organisations and NGOs working in the field of maternal health. Even if midwives are the first involved, the non-use of the partogram during the delivery is the result of the behaviours of all these categories of actors.

For the international (and national) experts who developed and disseminated it throughout the world, the partogram is nevertheless a very simple tool that is accessible to any healthcare worker and usable in poorly-resourced contexts. This is what makes it valuable for the fragile health systems found in LMICs in contrast to the sophisticated computerized monitoring of delivery rooms in the countries of the North. Its simplicity enables the performance of several functions, such as following-up on deliveries, decision support (referral), the sharing of information between health professionals, the evaluation of personnel and even providing a medico-legal document in the event of maternal deaths. In a way, it has everything a 'miracle mechanism' needs, from an armchair perspective at least. A new partogram recently became available, which is more comprehensive, and therefore complex, than the older version – however it is no more widely used than its predecessor.

The partogram's standardization (health workers receive ad-hoc training and receive pre-printed forms from their Ministry, UNICEF or international NGOs) and internationalisation (these trainings and forms are roughly identical throughout the world)

make it a typical travelling model, among many others. Maternal health has not lacked travelling models; indeed, in the last ten years, Niger has seen the arrival of the prevention of the mother-to-child transmission of HIV (PMTCT), emergency obstetric and neonatal care, essential obstetric and neonatal care, the active management of the third phase of labour (AMTSL), user-fee exemptions for caesarean sections, focused antenatal care (FANC), the integrated management of childhood illness (IMCI), and performance-based financing (PBF). Seen from the ground, in Niger at least, some of these models like the PMTCT and FANC tend to have failed. Others, for example the AMTSL have achieved mixed results but there is still work to be done.

Health is a field where the standardization and the internationalization of interventions, policies and procedures are very well developed. While this international standardization has economic or managerial justifications, it is also based on a belief in the intrinsic effectiveness of travelling models in the fight against disease – indeed, one of the origins of this approach can be found in the fight against major endemic diseases and on the increasing 'protocolization' of care.[18] This is largely due to the importance and influence of the major international organisations that finance and disseminate these travelling models (see below),[19] although national health authorities and medical NGOs also contribute to the trend.

Antenatal care

Let us take another example. Antenatal care (ANC), which is carried out in primary level health centres by midwives in West African countries and inspired by an old European model from the early 20th century, is considered a key element in the fight against maternal mortality.[20] Nevertheless, the classical model as it has long been implemented in Niger and neighbouring countries suffers from various shortcomings. As revealed by our studies, most of the time, fast and sloppy ANC does not fulfil its primary function, which is to detecting risk pregnancies with a view to avoiding the risks in question or planning a delivery in a health facility equipped for difficult deliveries (Prual, Toure, Huguet & Laurent 2000). Hence a new travelling model for ANC known as focused antenatal care (FANC) was developed and

[18] Protocolization is inseparable from the bureaucratization of health (and all public services: Hibou (2012). For an analysis of standardization processes in health and their limits, see Timmermans & Berg 1997.
[19] WHO, UNICEF, Global Fund, Gates Foundation etc.
[20] We refer here to work carried out by LASDEL as part of the IDRC-funded programme "*Les problèmes négligés des systèmes de santé en Afrique*" ("Neglected issues related to African health systems"), specifically the research on midwives in Niger (led by Aïssa Diarra) and research on supervision (led by Mahaman Moha).

adopted by the WHO in the early 2000s (WHO 2002) and widely disseminated in Africa. FANC is based on a pre-printed form that includes a series of items to be scrupulously investigated and checked off, thus enabling a midwife, following the print-out to the letter, to perform the battery of operations required for an effective and personalized FANC (observations, examinations, questions, explanations). Based on the answers to a first set of questions and observations, the files are divided into two categories, one for pregnancies without specific risks (basic components) that will be followed per a standard protocol and another for at-risk pregnancies (specialised components) that will receive a specific follow-up. The principle of this mechanism is the same as that of the partogram (self-monitoring guided by tools to be filled out in writing) but it is based on the use of more complex devices (many more items, biological examinations, sustained dialogue with the parturient, two types of files etc.). The argument used to promote the FANC is similar to that used for the partogram – it is a simple tool adapted to the deprived conditions of LMICs.[21] However, once again, the implementation contexts fail to line up with the expert-generated scenario.

The problem of time management arose very quickly on the arrival of the FANC in Niger and other African countries (von Both & al. 2006; Conrad & al. 2012). In fact, according to the WHO, a minimum of 40 minutes is required to complete all the items on the form during the first prenatal consultation. Antenatal care appointments (ANC), which previously took less than 15 minutes on average, were already widely attended by pregnant women, hence the waiting times became much longer. This was made worse by the fact that, in most Nigerien health facilities, only two mornings per week (from 9 a.m. to 12 p.m.) are devoted to this, often with only one midwife staffing the activity. This obviously poses a problem in relation to the routine organization of activities in integrated health centres (CSI) and the limited working hours of many healthcare workers. Added to this is the strong reluctance and unease of midwives with regard to the bureaucratic tasks and writing involved. Under such conditions, the transition from around ten minutes for ANC to 45 minutes for FANC is an impossible task. Hence, most midwives do not perform a real FANC, except when a supervisory team is in attendance. They do not document many items and/or complete the forms in a standardized way. Some obs are rarely taken (such as blood pressure and

[21] "FANC is the best approach for resource-limited countries where health professionals are few and health infrastructures are limited." (Health Education and Training Team for Africa 2011).

ventricular tachycardia) and the speculum is not used as they are generally unavailable in maternity units. Birth plans and potential complications are also not discussed.

Ignorance of the problem posed by the length of the FANC session, ignorance of how work is organized in health centres and ignorance of the professional culture of midwives are direct causes of the failure (or partial failure) of FANC. Information on the actual non-delivery of FANC rarely gets back through the monitoring and reporting systems of the Ministry of Health and the vertical programmes set up by international institutions, therefore no rectifications are made. Even if the problem is well known in private, nobody in the health hierarchy refers to it in public. Faults in the health system must not be revealed; any 'bad management' behaviour must not be apparent to the international organizations that fund FANC activities like supervision and training. The laudatory statistics circulating on FANC mainly involve training (number of training sessions, number of health workers trained, number of post-training follow-ups), FANC activities reported (number of FANC performed, coverage rates), and logistical and financial aspects (number of forms disseminated, rate of budget execution). They do not concern the quality of the FANC supposed to have been performed and sometimes even conceal the reality.

The real cost of deliveries

The introduction of fee-exemption for caesarean sections in Niger in 2006, an initiative led by President Tandja with pressure from the World Bank, was unanimously welcomed as a positive step for women and a way of improving Niger's very poor maternal mortality rate by removing the financial barrier to caesareans.

In financial terms, this measure is very expensive. The free healthcare policy now in place means that these sums are not taken from patients but paid directly by the state to healthcare facilities.

Nevertheless, the cost of caesareans is not the only barrier preventing access to surgery for dystocic deliveries. Other causes of maternal mortality due to delays in providing the necessary treatment include the availability of ambulances for referrals, the availability of qualified staff (anaesthetists and surgeons), the availability of blood and the cost of evacuating the patient. Some of these challenges have been addressed (distribution of ambulances through the President's special programme, training of district surgeons). Blood shortage remains a problem and no measures have been taken regarding the cost of

evacuations (fuel, expenses for the drivers and members of the national guard who must escort the patient); the patients' families are still liable for these costs.

Hence, the cost of transfers can be as much or even more than the cost of the caesarean itself, especially in the most remote areas, and it is particularly difficult for people in villages to find the money required in such emergency cases.

A reserve fund was created to pay for patient evacuations by levying a small fee (XOF 100, referred to popularly as the 'extra centime') on all consultations. The system started off well, but the Ministry stepped in and banned it saying these payments contravened the free healthcare policy for children and pregnant women, who account for around half of all consultations in the integrated health centres (CSI).

The use of oxytocic drugs

The use of oxytocic drugs (uterotonic drugs which accelerate contractions) during labour is usually limited to very specific indications, as it carries the risk of uterine rupture and foetal distress. In reality, however, midwives use them freely, selling them to women to make their labour 'easier' and accelerate delivery.

> It is often a 'cocktail' (e.g. a vial of Spasfon, half a vial of Syntocinon and a vial of Butyl), for which the parturient must pay XOF 4,000.
>
> Extract from notes of a student trainee midwife during the night of 2 May in a maternity facility in Niamey: "At 5.30am, Mrs A gave birth to a female child, born alive at full-term. Five minutes later, we observed the midwife selling Syntocinon [product used to accelerate contractions] to a woman in labour. It was the remainder of the Syntocinon bought by another patient. Once she had been paid for the product, she set up the drip for the woman. It should be noted that the midwife only woke up because she wanted to sell Syntocinon." (Report by A. Souley, Niamey, quotedin Jaffré & Olivier de Sardan, 2003: 63).

Nowadays oxytocic drugs are routinely recommended by the WHO to aid the afterbirth process (AMTSL). This advice is widely respected, a sure indicator of the success of AMTSL, however cold chain compliance is not always maintained, and midwives often administer higher doses of the drug compensate for any possible deterioriation in its effectiveness.

The professional culture of midwives in Niger

A list of practical norms that characterize the exercise of the midwifery profession in Niger is presented below (in no particular order).[22] We are responsible for the formulations used to describe them, as they are never discussed in public and remain implicit in most cases. Nonetheless we encountered each of them repeatedly in the course of multiple observations, case studies and private interviews carried out at our research locations in Niger over a period of 15 years.

- Midwives are more competent at assisting deliveries than public health doctors and are more aware of what needs to be done
- The management of a delivery is a matter of experience and 'flair'
- The maternity hospital or unit is a space that 'belongs' to midwives and not to parturients
- Responsibility for eutocic deliveries (without problems) may be delegated to matrons, trainees, assistant midwives or ward attendants
- Rural women and young parturients are ignorant and impatient
- Women in 'false labour' (insufficient dilation) disrupt the department and must be sent home if possible
- When a woman in labour does not 'push' enough, she must be compelled to do so by any means; insults, harsh treatment and threats of referral are seen as legitimate and in her interest
- A 'recommended' parturient deserves a level of attention and consideration that does not have to be provided for anonymous parturients
- Bureaucratic tasks are unnecessary time-consuming chores
- Disciplining a midwife is not proper and would be wicked
- It is normal to arrive to work around 9 a.m. and to leave around 1 p.m.
- It is legitimate to skip work for a social ceremony (baptism, marriage or death of a relative or even a mere acquaintance)
- Seeking 'informal' earnings at the expense of parturients (sales of products, charging for free services etc.) is normal
- It is necessary to go to attend further training courses regardless of the content (to receive expenses and improve the CV)
- The intervention of highly-placed acquaintances is needed to access interesting positions and postings
- The completion of any supplementary tasks deserves a monetary bonus

[22] These norms were confirmed inter alia by the participants at the two sessions of the LASDEL Ecole professionnelle for healthcare professionals working in maternal health, which were held in Niamey in October 2015 and October 2017.

- All funding from the aid donors represents an opportunity to 'take one's share'
- Everyone must manage their own activities without interfering with those of others
- Forms must be completed with standard data, regardless of the actual data
- Staff meetings are a waste of time
- Individual failings should not be pointed out at these meetings
- If small items of equipment are missing, you wait for more senior members of the hierarchy to replace them
- When faced with recurrent shortages of certain products, you have to 'make do' and use a substitute if possible[23]
- Women giving birth in a rural maternity unit must provide soap for the midwife
- Women giving birth in urban maternity units must also provide bleach or the corresponding sum of money

It should be noted, again, that, unlike the official norms, these practical norms remain tacit, latent and are never publicly stated. However, they are at the heart of the routine care provided in maternity units in Niger. They constitute the more-or-less hidden basis of the professional culture of midwives and obstetrical workers. They regulate the response of midwives to a travelling model and most often explain its failure, partial or total.

The case of the communal doctors (the medicalization of the integrated health centres)

> "It should be acknowledged that medicalization, which should be reviewed, has not been investigated in detail. There are doctors that have been posted to CSIs [integrated health centres] where they are useless, less effective than an experienced nurse. A doctor without a laboratory for carrying out tests is worth less than an experienced nurse." (Former Minister of Health, interview notes A.H.)

A recent health policy that is without precedence in Niger consisted in the recruitment and deployment of around 300 doctors in the interior of the country.[24] It should be noted that, previously, the majority of the medical tasks carried out at the integrated health centres (CSI)

[23] For example, midwives use saline in place of the solvent to perform the PMTCT test or make an eye wash for newborns using a mixture of Betadine and saline (50% of each solution).

[24] These comments are based on the findings of the research study on supervision led by Mahaman Moha as part of the IDRC-funded programme "*Les problèmes négligés des systèmes de santé en Afrique*" ("The neglected problems of health systems in Africa".

were implemented by other healthcare professionals, e.g. nurses and midwives, who also make diagnoses and prescribe medicines. The only doctors in rural areas were the district chief medical officers, whose time was mainly taken up with bureaucratic tasks (and the majority of whom had abandoned any regular clinical work), and their deputies, who did clinical work as head doctors of the district hospitals.

The majority of the members of the district and regional health management teams and some of the ministerial officials are also qualified medical professionals and paramedics – in addition to the nurses and midwives, there are statisticians, hygiene and sanitation officers, and communications staff. They can find themselves in the position of having to supervise doctors or act as their superiors, something that is not unproblematic given the strong professional loyalties and rivalries between doctors and the other medical staff.

Like the sectoral policy for fee exemption (for children under five, pregnant women and caesarian sections), the posting of doctors to rural areas is a policy that was considered necessary in principle and on which unanimity prevailed in respect of its objectives. However, like the sectoral fee-exemption policy, it was designed and implemented in such an incoherent, contradictory, and hasty way and in a manner that was unsuited to the concrete contexts in which it would be implemented that it gave rise to numerous adverse ancillary effects and frequently failed in practice. This 'critical node' proves unforgiving when it comes to revealing the deplorable human resources management in the health sector and the unprepared nature of its policies.

A committee at the Ministry of Health worked quite logically on the development of a series of measures to be implemented with a view to gradually placing doctors in the CSIs. They cooperated with district health management teams and with the NGO Santé Sud which had extensive experience in relation to the deployment of 'country doctors' in Africa, for example in Mali.

However, following an abrupt decision by the President of Niger to recruit unemployed doctors to the public service with a view to deploying them across the country, the Ministry of Health, which was responsible for the design and implementation of this decision, decided to systematically assign a doctor to the CSI in the main town of every commune with immediate effect and without paying any heed to the preparatory work that had already been carried out in this area. This was a standardized and centralized

administrative measure that was taken without any reference to the local situations and without consulting either the regional boards or district health management teams about their human resources requirements and the locations where a doctor would be of greatest use to them or the healthcare committees and communal authorities about the modalities of the doctors' local integration. No preparation was planned or carried out in terms of ensuring the availability of the infrastructure and equipment necessary for hosting a doctor in a rural village.

There is nothing exceptional about this deliberate 'short-circuiting' of the district health management committees, which constituted the operational level of the health system and the only body in constant contact with the reality of the situation on the ground. This is a habitual practice of the ministry of Health, in particular in the highly sensitive and strategic area of postings. The latter are theoretically decentralized: the Minister deploys personnel in a particular health region and it is up to the regional board to assign them to posts on the basis of its requirements. The regional board, in turn, allocates them to each district so that the management team can appoint the nurses, for example, to a particular CSI of its choice. The constant interventions within the Nigerien administration is particularly evident in the area of health, and orders relating to postings can be observed emanating directly from the ministry.

The policy for the posting of rural doctors pushed this habit of short-circuiting the local administration to the extreme. This was also demonstrated by a complete lack of consultation of the communes and health management committees (*comité de gestion*, COGES) in contravention of the decentralization policy implemented since 2004, which allocated certain powers in relation to health to the mayors and management committees (see below).

Lack of preparation and chaos

The lack of preparation that characterized these purely bureaucratic assignment of postings had many adverse impacts.

<u>No preparation for the doctors</u>

Immediately after their recruitment to the public service on the basis of a contract that required them to remain at their allocated posting for a minimum period of three years, the doctors were deployed at the CSIs in the main communal towns. The majority of them were recent graduates who had completed their studies in the city and their training in hospitals and

found themselves being 'parachuted' without training or information into market towns and remote villages in an environment that was completely unfamiliar to them. The majority thought that they would be working in the district hospitals and found themselves, instead, stationed as isolated doctors in village CSIs.

Their precise status, their job brief and the conditions of their collaboration with the nursing staff already in place were not defined in any way: were they supervisors, should they adopt the role of medical officer (*major*), were they supposed to develop new activities? The minimum package of activities and the list of drugs that could be prescribed at CSI level (intended for prescription by the nurses) were not updated.

Lack of housing

No provision was made for the accommodation of the communal doctors and they had to make their own arrangements in situations in which good quality housing is very scarce and mains electricity and running water are not always available. In many cases, it was necessary to evict the CSI's medical officer, as basic accommodation is often provided for them in their location of work, to provide lodgings for the doctor.

Lack of infrastructure

The CSIs, which were built on the basis of standard plans, did not have an office available for the doctor. They had no inpatient wards or laboratories for carrying out basic medical tests, which are essential to the work of doctors.

Failure to take local staffing requirements into account

Various cases involving particularly absurd posting of communal doctors were observed in the course of our research. In some cases they involve CSIs that were merely health centre that had recently been transformed into 'limited CSIs' (*CSI réduit*) or they involved a Type 1 CSI which does not have a maternity unit. In other cases, the CSIs already had sufficient staff and were led by a very competent medical officer while a CSI located in another village in the commune that was more densely populated the main town lacked personnel.

The result: defections and absenteeism

Two years after the introduction of the policy, the outcome can be assessed as quite negative, although some successful exceptions can be observed. Needless to say, the ministry

does not comment on this and it is impossible to find reliable data on the number of doctors who abandoned their posts, especially as it is rare for such defections to be officially declared.

> By way of indication, the Moha survey showed that of the 11 doctors posted to the district of Dosso, only three are still there.

The same survey enabled the identification of three categories of doctors: those who 'defected', those who remained officially in their posts but are characterized by their absenteeism and those who are integrated into the service – the smallest of the three groups.

The 'defectors'

Some of the doctors refused to take up their posts once they learned that they had been posted to a particular remote village and breached their contracts as a result. Others travelled to the villages to which they had been assigned but left again quickly having been demoralized by the working and living conditions they found there.

The 'occasionals'

This group play the attendance game but disappear as often as possible. In the most extreme cases, which are far from rare, the doctor lives far away in the town and only attends the CSI on one or two days per week. This "residential absenteeism" (Moha) is based on 'self-managed' working hours and a distance between the place of work and residence, which prompts the doctors to dispense with duty and on-call rotas on their own initiative (for example, one communal doctor in the district of Boboye lives 100 kilometres away in Niamey).

The communal doctors are not the first group to adopt this kind of strategy: it has already long been practised by midwives whose husbands live in towns and who either live there too or return there as often as is can be accommodated by their work schedules. The well known problem of midwives who refuse to live in rural areas, because their partners are (often high-ranking) urban public servants[25] and they are thus accustomed to an urban way of life, was extended to the doctors when they were posted 'to the bush'.

The 'integrated' communal doctors

The doctors in this group are in the minority. Like they others, they were left to their own devices in rural areas but they decided to play the game and deal with their posting.

[25] Cf. Jaffré & Prual 1993.

Having been deprived of any support from the ministry, they often attempted to obtain support at local level from the mayors, chiefs or prominent members of local society.

Although they are by no means all reformers, reformers can be found in this group, that is doctors on whom the reform of the public service should rely. We shall see later on the ways in which these doctors innovate and how the hierarchy sometimes places obstacles in their paths rather than providing them with the support they need.

Practical Norms and Critical Nodes Specific to the Education Sector

> "It is not a question of a lowering of the level but more one of the loss of any level such is the extent that everything is at rock bottom." (Primary school teacher, interview notes A.D.)

The very poor quality of the teaching provided is the main problem. This was concealed for too long by the essentially quantitative considerations (number of schools built, number of children enrolled etc.) and, indeed, exclusively quantitative indicators applied at international level.

> "Niger opted for quantity over quality." (Secondary school teacher of French, interview notes Alassane)

This poor quality of teaching is a reflection of both the behaviour of teachers and education policy and practical norms play a central role in both cases. We will focus here on four critical nodes that relate directly or indirectly to the quality of teaching: the teacher training colleges (*Ecole normale d'instituteur*, ENI); the multiple scams, cheats and arrangements (*adyara*); the problem of contractors; and the failure of supervision, evaluation and routine reporting.

Of course, other critical nodes exist which we do not explore here: for example, the division of responsibility for education between four ministries[26] for reasons of political clientelism (distribution of ministerial posts among political friends and allies) and the failure to implement the LOSEN education act (*Loi d'orientation du système éducatif nigérien*) and, in particular, quality control mechanisms.

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[26] *Ministère de l'enseignement primaire, de l'alphabétisation, de la promotion des langues nationales er de l'éducation civique* (Ministery of Primary Education, Literacy, Promotion of National Languages and of Civic Education); *Ministère de l'enseignement secondaire* (Ministry of Secondary Education); *Ministère des enseignements professionnels et techniques* (Ministry of Professional and Technical Training); *Ministére de l'enseignement supérieur, de la recherche et de l'innovation* (Ministry of Higher Education, Research and Innovation).

Teacher training and the teacher training colleges (ENI)

The ENIs constitute the essential strategic element in the training of teachers and they are supposed to ensure a high quality of teaching. However, between 2006 and 2008, the duration of training at the ENIs for future public sector teachers, which had been three years, was reduced to one year with a view to meeting a target defined by the World Bank's Education III project which aimed to train between 450 and 750 teachers per year – an objective that was obviously implemented at the expense of the quality of the training. The students are recruited by means of a competition held at BEPC (junior secondary certificate) level for assistant teachers and the *bac* (senior secondary certificate) level for teachers. The duration of training was increased again to two years in 2008.

From 2008, the ENIs became public bodies of an administrative nature, which granted them autonomy of management among other reasons to enable them to generate additional resources to meet the operating responsibilities which the state is increasingly unable to fulfil. Since then access to the colleges is no longer limited to candidates who have passed the entrance examination and is opened to all holders of the BEPC or *bac* who are able to pay the enrolment fee privately. This has resulted in the admission of poor quality trainee teachers.

> Candidates that had failed the entrance examination succeeded in being enrolled in the ENI on a private basis.

In terms of the entrance competition, the state also requires that a certain number of candidates be admitted regardless of their level of attainment.

> "For example, if we need to train 5,000 teachers this year, to attain this number it is necessary to even let candidates through who score 3/20. The result is that the trainee teachers will not have the qualifications necessary to be able to learn and teach." (Former ENI lecturer, interview notes A.H. and S.B.)

And when it comes to the final examinations, all of the candidates pass.

> "In 2012, 60 percent of the candidates passed our exams. The ministry reacted by saying that these results did not meet expectations. The following year, the success rate was almost 100 percent, but just to please the ministry by showing that this pass rate had been achieved." (Former ENI lecturer, interview notes A.H. and S.B.)

Another bad decision involved the end of the ten-year obligation for all ENI trainees to remain in the public service for ten years after their training. This rule enabled the posting of teachers to the interior of the country. Since its removal, any teacher who is unhappy with their posting can leave the public service from one day to the next.

Poor training at the ENIs

The general view is that, for various reasons, the quality of the training provided at the ENIs is poor. The ENI lecturers themselves lack qualifications and skills and only become familiar with the content of the programmes at the same time as their students.

Placements pose another problem. The placement of teacher trainees in classrooms with experienced teachers was always a key element of their training. However, the originally three-month placement was reduced to 45 days at the end of the year, something that clearly indicates the lack of interest on the part of the ministry involved at the time in the quality of teaching. Various strategies involving favours and corruption are also deployed in association with placements.

> Some people do not do the placement if they have 'good relationships' but are nonetheless given good grades.

Permanently neglected training course

Similar to the situation with regard to their initial training, the further education provision for teachers reflects the state's lack of interest in their professional competence and quality.

The CAPED (*cellules d'animation pédagogique*) educational organization units were incorporated into the ten-year programme for the development of education (*Programme décennal de développement de l'éducation*, PDDE) in Niger from 1992 to 2012 and benefited from state support to enable their organization and funding on the level of the schools and education sectors (reorganization of groups of schools under the responsiblity of an educational consultant). However, state funding was eventually withdrawn from this strategic further training instrument and it became incapable of fulfilling its commitments in relation to the CAPEDs as a result.

Some positive reactions (palliative strategies) to the disappearance of the CAPEDs at local level are worthy of note. They include the organization of 'mini-CAPEDs' on the initiative of teachers, school principals and educational consultants, in other words educational meetings at institute or communal level, which are financed on a shoestring using any available resources (generated, for example, from fees or contributions from the communes, see below).

Multiple scams, deceits and 'arrangements'

Another critical node concerns the multiple informal negotiations that constantly arise in contravention of the law and ethics governing national education and essentially involve what is usually referred to as 'corruption', a concept that is often euphemized in the Haoussa language using the term *adyara*, i.e. 'arrangements'. The list of such practices is long. Despite being widely known, in most cases they are not reported and eventual (and vary rare) investigations into them are suppressed.

Reintegration into the public school system

Pupils who have been excluded from school or have to repeat years are enrolled in a different public or private institute so that they can be reintegrated into the public system at a later point in time. This practice is known as 'transferring'.

> "Transfers from the private to public system have become widespread in recent years. There two types: 'negotiated' transfers in which money is given to the person who will do it and another type, in which the order for the transfer is issued by a public authority and if the official does not carry it out, they can lose their job." (Private secondary school principal, interview notes A.H.)

These improper transfers are carried out in three ways that can be cumulative to varying degrees: through the intervention of senior education officials, through corruption or through the falsification of documents.

> "Massive fraud exists in relation to pupil transfers. In 2016, there were 56 cases involving transfers from Kollo to Niamey." (Private secondary school principal)

An even more extensive transaction of the same nature which was made public arose in Tchadoua:

> According to the Mayor's report, the principal of the secondary school in his commune, who was also the former mayor, organized with the complicity of the deputy principle and some teachers a lucrative system for the large-scale reintroduction of pupils into the public school (almost 500 cases) who had been previously excluded and to whom he provided a guarantee that they would not have to repeat and would pass their exams. Teachers who denounced this practice were isolated from the supervision and correction of the *bac* exams: "Because it involved recruitments with the promise of success, those who were not part of the system would never accept allowing the pupils to cheat and thus the teachers who opposed the system were isolated." (Mayor, field notes A.H et A.B.).

Falsification of reports

This is widely practised by different actors:

- By pupils so that they can show their reports to their parents:

> "The average grade on the report is not a sign that the pupil is working well because the children cheat before they take the reports, they doctor the reports." (Private secondary school principal, interview notes A.H.)

- By families and pupils to gain enrolment to a new school or to obtain scholarships or referrals.
- By teachers who have been bribed by parents:

> So many reports with blank spaces!!! "During my time in Gaya, a teacher altered a report himself, the pupil had scored 4/20 and he changed the grade to give him 14/20. It was noticed, however, in the space reserved for the teacher's assessment: he had scored 14/20 but the assessment was 'mediocre'. There was a contradiction there. The teacher was questioned by everyone but the case was not pursued. It is common to see a pupil negotiating with their form teacher about grades." (Teacher at a college of general education (*Collège d'Enseignement Général*, CEG), interview notes S.B.)

Payments for retention and progression

In this – very common – case, parents pay a teacher or principal to ensure that their child is allowed to stay at the school when they should have been excluded or is admitting to a higher class when they should have repeated the year.

Relationships with the private education sector

The private education section (*Direction de l'enseignement privé*, DEPRI) at the ministry is known as a place where things are 'managed', that a place of corruption. For example, some private school operators 'purchase' authorizations for schools.

Many teachers from the public system also work in the more lucrative private schools.

> "The teachers we recruit mostly hold permanent posts in the public system, mainly as contractors; two out of 29 teachers are permanent. It is not difficult to recruit full-time teachers from the public sector. They have worked for three months without being paid, they are good value." (Private secondary school principal, interview notes A.H.)

Cheating during exams and purchasing of certificates

> "There is fraud at all exams in Niger, the exams are rigged." (Secondary school teacher of French, interview notes S.B.)

Some supervisors, whether out of 'goodness', laxity or indulgence, do not report candidates who cheat and others accept money for turning a blind eye. The use of telephones for cheating is becoming increasingly common.

> "At the ENI, there are lecturers who are called *yan Aljanna* ('children of paradise') because they allow the pupils to do what they want [i.e. cheat] during exams. One day, when I was supervising an exam, the pupils said to me: 'The person supervising yesterday was good, you should be good too.'" (Former ENI lecturer, interview notes A.H. and S.B.)

The purchasing of certificates from the teachers who correct the exams and from the administrative workers who review the grades also arises:

> According to one principal and deputy principal, the junior secondary school certificate (*brevet d'études du premier cycle*, BEPC) was traded for XOF 50,000 and the senior secondary school certificate (*baccalauréat*) for XOF 150,000.
>
> "Corruption is rooted in our way of life at all levels. It is typical behaviour for Nigeriens. Corruption has poisoned the education system with fake certificates." (Official at the Ministery of Agriculture, interview notes A.H.)
>
> "It is customary to see mango-sellers with the BEPC! These are the cases we are aware of." (Secondary school principal, interview notes A.D.)

In 2010, a survey carried out by Niger's anti-corruption body HALCIA (*Haute Autorité de Lutte contre la Corruption et les Infractions Assimilées*) enabled the identification of 20 teachers who had sold certificates in the Kollo exam centre alone. In March 2017 the Minister of Education announced to Parliament that over 300 teachers holding false certificates (*baccalauréat* and teaching diploma) had been identified.

> The businessman Zakey, who is renowned in Niger for his corruption, is said to have initiated the mass circulation of false certificates in the Ouallam area by distributing false BEPC certificates to his supporters so that they could put themselves forward as candidates at the local elections (possession of a BEPC has been a requirement for candidature for local elections). After that, those who were not elected used these false certificates to be recruited as contractor teachers and their example was soon followed by others (Senior official from the anti-corruption body HALCIA, interview notes JPOS)

Appointment of fictitious teachers or teachers without qualifications

This practice mainly involves the contractors employed in education, who are recruited by the regional boards. The latter sometimes ask their inspectors to find replacement for contractors who have resigned themselves. Some of these inspectors appointed relatives who had no qualifications or presented someone else's qualifications.

The problem of contractors

> The Department of Kollo has 974 contractors and 272 publicly employed teachers.
>
> "All day from the first day after the holidays, the contractors are under the trees, they do not teach." (Primary school caretaker, interview notes A.H.)

On the suggestion of the World Bank, the state of Niger created a system of volunteerism in education in September 1998. The recruitment of volunteers who work in primary education is carried out thorugh an open test of young, unemployed Nigeriens between 18 and 35 years who hold one of the following certificates: *brevet d'études du premier cycle*, BEPC (junior secondary school certificate), *certificat de fin d' études de l'école normale*, CFEEN (Certificate of Completion of School Studies) or the *baccalauréat* (senior secondary school certificate).

Under pressure from the trade union, the volunteers working in education requested integration into the Nigerien public service. The volunteer system was abandoned and replaced by the contract system in 2003. The mode of recruitment to the new system remained the same but the former payments became official salaries and increased from XOF 35,000 to XOF 40,000. The contractors are not integrated into the public service, however they are registered with the national social security fund (*Caisse nationale de sécurité sociale*, CNSS) and a retirement pension. Contractors are assigned by the regional boards and are subject to educational assessments.

They teach directly without attending the teacher training colleges but receive 45 days of training, for which a certificate is awarded, after four years of service.

Around 80 percent of the entire primary teaching staff are contractors and not public servants.[27] This long-term consequence of the structural adjustment measures of the late 1980s, which was further exacerbated by the policy of successive Nigerien governments, has led to primary school contractors costing the state a total of XOF 5 billion every month.

Disastrous level

> "A class is entrusted to a teacher who as no basic knowledge and no motivation." (Primary school teacher, trade unionist, interview notes S.B.)

The contractor teachers generally have poor or very poor teaching skills. They are recruited locally and their qualifications, the BEPC certificate, which is very basic and often purchased, are not verified. Sometimes they have no qualifications at all or provide false ones (see below). They are not given any training before being deployed in the schools.

The survey revealed that 11.5 percent of teachers had 'very poor' skills and that 50 percent of preparatory course pupils had difficulty reading a single letter of the alphabet.

According to the evaluation of contractor teachers in French and mathematics carried out in July 2017 at the request of the ministry, over 19 percent of teachers scored less than 5 out of 20 in the tests. Only 33.5 percent achieved an average score.

Nonetheless, better-performing exceptions exist:

> "The advent of the contractors is not behind the decline in the level of education on the ground. Many contractors perform better than the permanent public servants, as some of

[27] 59,000 out of 73,000 teachers are contractors. Their salaries start from XOF 75,000 per month, half of the salary paid to a novice permanent teacher.

> them have university qualifications and others underwent teacher training at the ENI teacher training college." (Educational consultant, interview notes A.D.)

Strikes and absences

As already mentioned, contractors leave their schools in the last week of every month to go and collect their salaries in the regional capital and sometimes their journey is made in vain. Delays in the payment of contractual staff are recurrent and arrears often extend to two or three months. As a result numerous strikes have been held.

There were more than four strikes by contractors in 2016 alone.

Apart from striking, many contractors do not hold classes if their salaries are too far in arrears. They stay 'under the trees' and do not go to their classrooms. The 'rule of the eighth' is also invoked: if the contractors are not paid by the eighth of the month, they refuse to teach, a circumstance that frequently arises.

> "With three months' salary unpaid, the contractors simply come to school to sit around and pass a lot of time without doing anything." (Primary school teacher, trade unionist, interview notes S.B.)

Contractors also tend to be less reliable than permanent staff and can disappear from one day to the next.

> "When contractors are posted to remote villages, they either don't go or they leave to take up their posts and disappear." (Head of human resources, Departmental board of secondary education, interview notes A.H.)

Duplicate and fictitious teachers

When the contractors leave the education sector, for example to join the army or police, their names sometimes remain on the payroll of the regional capital where they were recruited and they continue to draw their teaching salary or someone else draws it without their knowledge.

The same situation can arise when a contractor is transferred to a different region: sometimes they are also paid by their old region.

The anti-corruption body HALCIA has had all 'duplicate' teachers suspended, however this measure is contested by the trade unions in that the teachers involved are sometimes (possibly often) unaware of the situation and do not draw their old salaries themselves, as they are pocketed by administrators or inspectors.

The practice of duplication often involves complicity along the payment chain and forged signatures and may even go back to higher levels in the hierarchy. This duplication of teaching posts is undoubtedly one of the factors that can explain the 3,000 fictitious teachers identified by an in-depth survey carried out by HALCIA in 2016. As revealed by the Ministry of Education itself in Marched 2017, these fictitious teachers cost the state XOF 4,789,000 annually.

Supervision, reporting and evaluation: a failure

Supervision

The ten-year programme for the development of education in Niger (PDDE), contains provision for 72 classroom visits per year per sector of education, irrespective of the number of schools involved (nine classroom visits per month). The reality on the ground is very different and sometimes only two such visits take place.

The schools and classes to be inspected are notified in advance of visits by the management team.

Reporting

The annual reports compiled by the educational institutes should be submitted at the end of the school year to enable the identification of requirements in terms of teaching staff and infrastructure for the following year. However, they are often submitted at the beginning of the following year and do not therefore enable any advance provision to be made.

Evaluation

The various educational reforms that have been introduced have never been evaluated.

Corruption within the Practical Norms

We have not focused on corruption in the presentation of our analysis up to now. Nevertheless, many of the behaviours we have described clearly involve what is usually referred to as 'corruption', for example those outlined in the above-presented section on 'multiple scams, deceits and 'arrangements'' within the state education system. A very similar list could be provided for the health sector, and various examples have indeed been cited in relation to maternal healthcare.

Corruption (in the broadest sense) has become systematic in Niger in that it is now practised widely – from the lowest to the highest levels of the state and by the public servants, citizens and public service users – and trivialized: it has become part of the country's everyday routines.[28] Paying a representative of the state to provide a service they are legally obliged to provide free of charge, to provide an illegal service or to provide false orders or invoices; the payment of 'commission' to public servants by businesses for giving them orders; accepting one or two month's salary from a person who has been 'helped' to attain an appointment or favourable posting: although such behaviours are deplored by many, their practice comes as no surprise to anyone.[29]

Blurred boundaries

In reality, as demonstrated by research previously carried out in Niger and also in Benin and Senegal (see Blundo & Olivier de Sardan 2006), the boundaries between corruption and other types of non-compliant behaviour, for example intervention, favouritism, nepotism, clientelism, or the concurrent holding of two roles in the public and private sectors are extremely porous or blurred and particularly difficult to delineate from an empirical perspective.

Here are four of the many such examples of blurred boundaries:

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[28] An in-depth social-anthropological study on 'petty corruption' was carried out in Niger, Benin and Senegal from 1998 to 2000. It was funded by the European Commission and the Swiss Agency for Development and Cooperation and involved the active participation of LASDEL researchers (cf. Tidjani Alou, 2001, 2002, 2007; Bako Arifari, 2007; Olivier de Sardan, Bako Arifari & Moumouni, 2007; Blundo & Olivier de Sardan, eds., 2007).

[29] For a comparative analysis of the forms of 'petty corruption' in Benin, Niger and Senegal and the differentiation between "seven basic forms of corruption", cf. Blundo & Olivier de Sardan, 2006.

Sale of medication

The trade in medication and other products required by the health system by healthcare workers and ancillary staff has been widespread for a long time:

> "[In] the medical officer's 'fetish' office, he stored among other things medications that were left over from previous deliveries and which he manages as he sees fit. In effect, this medication is sold to anonymous patients or supplied free of charge to PAC (relatives, friends and acquaintances). The strategy adopted with the former initially consists in systematically issuing them with a prescription on the completion of a consultation and then offering the prescribed products to them while telling them that they can avoid the long trip to the local pharmacy in this way (…). He is assisted in this illicit business by the centre's caretaker." (Moussa, 2003 : 369)

These sales involve a behaviour that is clearly noncompliant and gives the healthcare workers access to illicit payments. But is it 'corruption'? Of course, they should not sell medication themselves but who are they harming? These transactions do not pose any real threat to the very lucrative pharmacy business which will never complain about them. Moreover, the healthcare workers legitimize the practice by the fact that they are providing a service to the patients who would otherwise have to travel a considerable distance to find an open pharmacy. Regarding the ways in which the healthcare workers obtain this medication, five very different sources can be identified:[30] donations by medical sales representatives or doctors, direct purchases from the pharmacy, purchasing through an informal network (wholesalers), recovery of leftover products administered to clients and the misappropriation of medication belonging to the health centre. It is difficult to qualify the three first of these as crimes (even less as corruption), the fourth borders on illegal and only the fifth involves a clear case of larceny.

Unnecessary episiotomies

One 'hidden' form of extortion involves the performance of unnecessary episiotomies in the maternity units. These are very difficult to detect and differentiate from episiotomies that are carried out for other, legitimate reasons. Episiotomies, which are sometimes necessary in cases of difficult vaginal delivery, are often practised excessively for two particular reasons: convenience and greed. In the first case, convenience, it reduces working time and enables the midwife to avoid having to resort to more demanding techniques.[31] In the second case, greed, a source of revenue is sought through the 'informal' sale of suture thread to the

[30] Cf. Souley 2002

[31] This is the motive behind identical practices (excessive use of episiotomies) recently uncovered in France and criticized as abuse. However, unlike in Niger and its neighbouring countries, there was no quest for any gain or advantage in this case.

parturients. The two motivations overlap and combine, moreover, in cases in which episiotomies are actually necessary.

Private tutoring

It is common for teachers to work as tutors outside their hours of work in the public education system. Private tutoring is very common and represents an important supplementary source of income for a large number of teachers. When these lessons are given to children who are in the teacher's own class, it is understood implicitly that the child in question will benefit from particular leniency when it comes to grading or that the teacher will have the child work in advance on material that will later be used for tests to be completed at school.

The question of 'gifts'

The presentation of gifts by service users is considered a legitimate act emanating from 'traditional culture', particularly by the public servants who receive them.

> "I don't think that a gift given to a nurse by a patient who leaves a medical service satisfied should be called corruption." (Nurse, Niamey hospital, quoted in Jaffré & Lasdel 2003: 61).

However, from the perspective of the service users in many cases the presentation of such gifts is very often obligatory or enforced.

> "My son has been wearing a dressing for four days now and it should be replaced every two days, but there is nothing to be done about this as we do not have anything to give the nurses (*lokotoro izey)* who expect a gift. In addition, I can see giving our roommate the appropriate treatment. His son is a trader and gives them small gifts. This is why they take good care of his father." (Patient's companion, quoted in Tidjani Alou, 2002).

Between these two extremes, there is an intermediary form of gift-giving whereby the gift is presented to reward a 'favour' that involves a deviation from the official procedure.

> "The three companions get out of the vehicle and head to the office of the chief medical officer of B4. They move hesitantly, with a slightly lost air and inscrutable facial expressions. Just as they arrive at the entrance to the office and are about to cross the threshold, they are intercepted by the orderly. After a customary greeting implying that he has known them for a long time, he takes their referral form and asks them to wait a few metres away. He then finds the on-call nurse and gives her the document. The latter, who is staring at a register which she seems to be completing with meticulous care, shoves the piece of paper away with a furtive gesture, saying that there is no bed available on the ward. The orderly does not give up. He moves on to B1. After some jokes and an exchange of words with a nurse there, his efforts are rewarded. He rushes into a corridor and grabs a trolley which he wheels to the vehicle in which the old man is lying. He is assisted by the three companions whose satisfaction is visible. The four of them convey the patient to his bed. As they leave the ward, the orderly is called over by one of the companions who hands him some notes and coins. His immediate reaction is to return to his accomplice to whom he presents his profit." (Moumouni & Souley)

It was with a view to taking this blurring of boundaries and overlaps between illicit and admissible behaviours that constantly arise in the empirical material that we consciously opted to include practices in our analysis that are habitually defined as corrupt within a broader group of non-observant behaviours.[32] In previous analyses, the various "elementary forms of corruption" (Blundo & Olivier de Sardan 2006) were embedded in a much wider range of practical norms that are sometimes transgressive (like the majority of the practices habitually defined as corrupt, but not all of them), sometimes quasi-tolerated, sometimes adaptive and sometimes 'palliative'.

Nonetheless, to conclude, we will now describe three groups of practices which are very generally defined as corrupt, arise on a significant scale in the areas of health and education, and have not been mentioned up to now: the rigging of public procurement processes, bogus missions and the purchasing of posts.

Public procurement processes

In both education and health, the 'arrangement' of public procurement processes despite the regulations imposed by the aid donors, the passing on of orders and issuing of retrospective orders, and the provision of non-compliant, incomplete or fictitious services all involve major instances of corruption. The 'orders' in question involve the construction and renovation of classrooms and educational institutes, the supply of furniture and school equipment and, in the case of health, the construction and supplying of health centres, CSIs, hospitals, medical equipment, and other inputs.

> Many commissions for the construction of classrooms were awarded to friends who were incapable of fulfilling them; numerous classrooms do not comply with the technical standards were signed off on and collapse at the first shower of rain; desks and benches that have been invoiced never arrive in the institutes; a lot of equipment is moved from site to site for receptions and inaugurations. (Senior official from the anti-corruption body HALCIA, interview notes JPOS)

The above-highlighted intervention arises on a permanent basis in the context of procurement and involves the favouring of traders who are friends or protégées with a view to

[32] This choice also enables us to avoid adopting the severe normative connotations conveyed by the term 'corruption', which are used to condemn and stigmatize practices of which people consider themselves victims while they are happy to legitimize the same practices when they benefit from them.

rewarding them for services rendered or to benefit from their share of an illicit commission or various other favours.

In the majority of cases, the public servant responsible for the placing of procurement orders will favour a supplier whom they know will give them 'their share' ('kickback').

> "When they want to award a commission to someone, they will only inform him and he will be responsible for finding the three token bidders. He will come to an arrangement with his brothers and friends who will act as false competing bidders." (Mohamadou 2003: 270).

The 'lowest bidder' requirement is used to benefit traders who are friends. However, it results in the considerable downgrading of the goods or services provided.[33]

> "In the case of the submission of bids by several non-complicit traders, those responsible for the procurement process will communicate the prices proposed by the competing bidders to their favourite bidder. All he has to do is to submit a lower bid to be selected. The principle of the 'lowest bidder' (even if they are the least suitable or qualified) explains why the material provided for the researchers is of very poor quality." (Mohamadou 2003: 270).

The 'minor commissions' which are not subject to public procurement processes,[34] are a source of quite widespread 'petty corruption' that can become significant over time: service providers who give an 'envelope' to an official who gives them an order, and/or to their boss (office supplies, materials, inputs, organization of seminars), consultants who repay a commission to the (national but sometimes also international) official who issued an order etc.

> This is the reason why the Ministry of Education continues to centralize the procurement of school supplies as decentralization would require that orders are issued at regional or even local level: "They say that education has been decentralized yet they continue to buy the books, notebooks and pens in Niamey to distribute them in the regions! The central authority is dragging its heels because there are lots of problems and this does not fix them! There are problems that are even beyond the ministers themselves!" (Education administrator, Ministry of Primary Education, interview notes A.H.)

The issuing of procurement orders gives rise to the concentration and combination of an entire series of illicit practices: unjustified splitting of orders, false invitations to tender, bribes and kickbacks, agreements between suppliers, token nominees, false invoicing and over-invoicing etc.

Two of the most important corruption scandals that arose in Niger in recent years involved education and health and, specifically, the issuing of procurement orders: the MEBA

[33] The poor quality of schools and health centres built under the former special President's programme is a well known example of this.
[34] The splitting of orders to remain below the threshold necessitating the implementation of official procurement procedures is common practice.

(*Ministère de l'éducation de base*) affair and the Gavi affair (involving vaccination campaigns funded by Gavi, the Vaccine Alliance).

The MEBA affair

Between 2002 and 2005, XOF 4 billion of the funds provided for the ten-year education and development programme (PPDE) were misappropriated by two successive ministers of education. The scandal was uncovered in the context of an evaluation of the PDDE programme carried out by technical and financial partners, who had to threaten the suspension of their funding to ensure the pursuit of those responsible.

The Gavi affair

An international audit carried out in relation to the use of funds provided by Gavi, the Vaccine Alliance in Niger uncovered wide-ranging rigging and misappropriation in association with the issuing of orders in the health sector.

> "Public procurement practices reveal abnormal cases involving the splitting of orders, manifest over-invoicing and the use of suppliers whose physical domiciliation is difficult to establish." (Gavi audit, Mission d'investigation Gavi, 2012: 6)
>
> "The deployment of repair sheets at the administrative garage of the Ministry of Public Health (SERPA garage), which is supposed to produce quotes and carry out repairs, reveals that repairs that were supposed to have been carried out during the audited period for the sum of XOF 85,330,680 were not, in fact, carried out." (ibid: 16)
>
> "The investigation enabled the discovery that instead of YAMAHA DT 125 motorbikes from Japan, lower-end Chinese motorbikes were supplied at an average unit cost of XOF 2, 100,000 while their market price as obtained by us and indicated by the official register of prices ranges between XOF 350,000 and 400,000. The average rate of over-invoicing in this case is 517 percent. Moreover, our examination of the delivery records of three of the suppliers revealed that the delivery notes provided by each of them were similar and characteristic (content, character, font, text, size), and this clearly indicated that the tendering process had been fraudulently simulated and the order had been given to a single individual acting behind by fictitious names." (ibid: 16)
>
> "Anti-competition practice: this practice consists in the participation in anti-competition agreements between suppliers and has the purpose or effect of limiting the scope of the competition and/or its distortion. Two of the suppliers who frequently benefitted from orders or commissions from the DI, and whom we met separately and then jointly, confirmed to us that they had engaged in such practices." (ibid: 17)

False missions and salaries

The less publicized corruption associated with false mission orders is considerable and enables managers with strategic responsibility for signing off on such orders (for example

regional directors) to gain rapid access to large sums. Expenses are an important issue and it is tempting for people to avail of them, even without travelling.

> A regional health director built more than a dozen villas in two years. One of his sources of money was mission orders: none of his officials could go on a mission in the health region if they did not put the director's name on the order as also being on the mission: of course the director remained in his office and obtained expenses. (Enquiry carried out for Belgian Development Cooperation (BTC) by LASDEL, interview notes O.S.)

Travel in the field always involves expenses for fuel and, possibly also, vehicle repairs. This is another important source of fraud and misappropriation, as it is tempting for officials to use the petrol vouchers for personal use. This is a widespread practice and many small, everyday 'gifts' take the form of petrol vouchers.

> The Gavi report describes "systematic fraud involving these so-called purchases of motor fuel."

Another category of fraudulent payments is based on the salaries paid by the state to people who do not have any right to them: former state employees who have left the public service or are resident abroad, dead officials, officials who no longer carry out their jobs, for example, some university teachers and hospital doctors, etc. To this may be added the payment of exorbitant salaries in some cases, which are entirely unjustified and completely out of line with the public sector framework.

> A senior official from the Ministry of Public Health estimates that 45 percent of the salaries paid every month by the state are unjustified; according to him, the situation is even worse in the state education sector. It would appear that some senior officials and finance officers 'play their part' in this system. (Interview notes O.S.).

The purchasing of posts

Along with appointments and promotions, interesting postings are also purchased:

> "When I was the chief district doctor and then regional director I saw and heard things that I would have found difficult to believe if I had not experienced them myself. To be appointed to a post, chief district doctor for example, you have to give one salary or one out of two salary payments or half of your salary, not to speak of motor fuel. And even to be head of a CSI. Corruption and kickbacks play an important role in assignments." (Technical assistant at the Ministry of Health, interview notes A.H.)
>
> The general director of resources told us how "a few years ago" her promotion to chief district doctor, which was passed by the regional board, was not confirmed by the ministry because she did not know that she should have given "an envelope" to a ministerial official. (Interview notes A.H.).

A related corrupt practice involves the participation in training courses. These are very sought after due to the expenses involved.

> "To participate in training, there are districts where it is said that you have to give one or two days of expenses. That's a lot of money for a healthcare worker." (Graduate in obstetrical surgery working in a district hospital, interview notes A.H.)

The competitions for entry into the public service, which are supposed to facilitate recruitment on the basis of merit rather than corruption and nepotism, have also become areas for corruption. Several competitions (finance officials, customs officers, healthcare workers) have had to be cancelled due to the extent of the fraud involved which was condemned by the press and the trade unions and highlighted by an enquiry carried out by HALCIA (cf. above).

Reform: Challenges and Approaches

> The great problem currently being experienced is that there is no reform leading to a desired change, none! There is no policy, there is no consideration of where we would like to go, where we are, where we will go. The problem is that there is no roadmap, even for the old PDS [health development plan], there is no guide no follow-up framework that works, there is no reflection on this. (Director of a development agency, interview notes A.H.)

This stark assessment, including the information about the failure of reforms, which is based on incontestable data like those we present here, represents an essential first stage towards realistic reform and the effective improvement of the quality of the services provided to service users and citizens. This makes it possible to avoid the trap of meaningless cant and to start from the basis of real contexts.

Based on this assessment, our aim is to contribute to a debate within the Nigerien professional circles affect, that is among both front-line actors (nurses, midwives, hospital doctors in health; teachers and lecturers in education) and managers at all levels, to the indispensable reforms for improving the quality of the education and health systems and to changing the behaviour of teachers and healthcare workers. This debate was initiated in Niger by LASDEL several years ago and has already achieved a degree of success.

We believe that these reforms cannot come from outside the country (international institutions, education and medical NGOs, bilateral cooperation, decentralized cooperation, experts from the North[35]) and must instead emanate from the Nigerian teachers and healthcare workers who are most aware of the problems and are motivated to improve the system on the basis of the reality of life in the country's classrooms and healthcare facilities without ignoring the gravity of the situation.

We shall attempt here to present the issue of reform by identifying three major challenges facing all reforms: the ambiguous role of the trade unions; the ambiguous role of public service users; the ambiguous role of the development partners (the limitations of the 'travelling models'). We conclude by examining three interesting approaches to reform, all of which originate from national actors and are not associated with the import of 'travelling models': the reformatory activity that sometimes comes from the top of the state, the potential

[35] These institutions should support reforms originating from within the country while, today, they propose reforms originating from outside the country to the Nigerien state.

reformatory role of the communes and, finally, the 'invisible' reformatory activity originating from frontline staff.

Three challenges

It is generally considered that there are three types of institutions beyond the state that have the capacity to promote reforms aimed at improving the quality of healthcare provision and teaching: the trade unions, the service users and the development partners (international institutions and NGOs). However, this is not a simple matter; their role is ambiguous and, indeed, sometimes negative.

1. The ambiguous role of the trade unions

The trade unions are mainly known in Niger for organizing many strikes, which reflect their influence, particularly among teachers and healthcare workers. They are also known for their systematic defence of workers who have been accused of wrong-doing, be it by the hierarchy, service users or the justice system. Finally, they are also known to be strongly politicized and for being disposed to playing a role in the political machinations of the parties in power or opposition.

Hence their role is a particularly ambiguous one. On the one hand, their involvement appears essential to the success of reform, as their capacity for mobilizing people and blocking initiatives is strong. Thus it is regrettable that they are rarely, if at all, consulted about any reforms and that the ministries have little regard for the social dialogue. At the same time, however, they appear to be rather conservative and corporatist forces and more interested in the blanket defence of workers than in improving the quality of public service provision.

The strikes they lead are often 'hard' in terms of their modalities (strikes without even minimum service provision in the health sector, strikes by doctors and specialists), duration and frequency (school strikes). Hence the strikes severely penalize service users and the quality of service provision deteriorates even further.

For many teaches and healthcare workers, the trade unions present as much of a problem as a solution. It should be acknowledged that the various education trade unions are considerably more discredited than the main health sector trade union (*Syndicat Unique de la*

Santé et de l'Action Sociale, SUSAS), which is subject to far fewer accusations in relation to corruption and the pursuit of privileges.

> "They are established like the political parties. People establish the trade unions to be in the urban centres, to levy contributions and collect their payments." (Secondary school teacher, interview notes S.B.)

Far from upholding competence and skills-based recruitment, the teaching trade unions have themselves have become an important lever of intervention for the benefit of their managers, their militantes and their relatives. They are criticized for their politicization, for their systematic defence of poorly-performing members, for obliging education workers to strike, for the way that their leaders seek privileges, for establishing a bureaucratic career pathway, for having too much power and using it for their own benefit.

> "They sometimes chose their teachers, their suppliers." (Teacher, interview notes AB)
>
> "Unions were often reported to accept bribes from political parties to call off a strike." (Cummings & Ali Bako 2016: 6)
>
> "It is not possible to post a trade unionist, they choose where they want to go. If you lay a finger on one, there's a strike. And they arrange things so that they can be in Niamey." (Former Minister of Health, interview notes A.H.)
>
> "The inspectors are afraid of posting contractors who are girlfriends of trade unionists." (Primary school principal, interview notes Boubacar Amadou)

The issue of the trade union levy on the earnings of contractors working in education also merits a mention. The (low) salaries paid to contractors are known as *pécules* (lit. 'nest egg'). The trade unions obtained the authorization of the ministry to deduct trade union contributions 'at source' for all members, a practice is known as *coupure des pécules*, hence they are taken from the salaries and paid directly to the unions. This process is not without benefits for certain individuals.

> "Many people in the chain 'eat'." (Secretary of the *Syndicat Autonome des Enseignants du Supérieur* (SYNAES), interview notes A.H.)

In relation to this deduction, the trade unions opposed a 'stopgap' initiative intended to reduce absenteeism among contractors.

> Some inspectors took the initiative to go and collect the salaries of rural teachers employed in their districts and to take them do the villages (with each deducing XOF 500 for 'transport costs') to prevent the teachers from being absent for several days when they go to collect their salaries themselves at the administrative centre. But this practice was halted by the trade unions so that they could continue to take their 'cut'! (Senior ministry official, interview notes A.H.)

The ambiguous role of families

The exertion of pressure by service users, for example through the mobilization of 'civil society', is often put forward as an important factor for inciting reform. Unfortunately, the situation in Niger does not give much cause for optimism in this regard.

According to many teachers and parents, a lot of families no longer fulfil their role of providing support in the area of education. On the contrary, they are often sources for the extension of corruption, for example by being willing to ensure that their children progress through the system and pass their exams at any price. The following statement was frequently repeated to us: "educational failure is no longer accepted and work is no longer valued."

In the health context, staff report that the users themselves are the vectors of corruption, as it is they who offer money in exchange for favours.

The parents' and patients' associations only act for their minority group interest and in a corporatist manner to an extent: for example, the patients' associations are limited to a particular disease or condition and only want to gain advantages for their own category of patients (sickle-cell anaemia, HIV-AIDS). Regarding the management committees (CGDES for primary education; COGES for secondary education; COGES and COSA for healthcare), the majority engage in few or no activities and show little interest in the quality of teaching or healthcare.

The ambiguous role of the aid partners: travelling models and constant reforms

> "All of the reforms are designed by people who do not know the situation on the ground." (Principle of private boarding school, interview notes A.H.)
>
> "The problem with health policies in Niger is that there is a lot of imitation of things that have been done elsewhere even if it will not lead to anything. The Ministry of Health introduced many reforms merely to comply with the international rules and not because they were things that were needed by the Nigerien health system. Above all these reforms were not adapted to the Nigerien health system." (Director of a cooperation agency, interview notes A.H.)

The aid donors and international organizations strongly promote reform in response to this situation. However, in most cases, the reforms in question are designed by international experts and based on supposedly miraculous mechanisms, e.g. 'magic bullet' and 'one size fits all' solutions. These travelling models are based on the techniques created by new public management (NPM), which are now being exported to Niger and, indeed, all of Africa, and involve the social engineering of all aspects of human resources management: for example,

having introduced 'results-based management' (RBM), the World Bank, UNICEF and Belgian cooperation are currently promoting 'performance-based pay' (PBP or P4P). This comes on top of the 'rapid results initiative' which also originated in the USA. There has also been an avalanche of sectoral reforms, for example in the health sector: hospital reform, pharmaceutical reform, payment exemptions, and the above-described multiple reforms in the area of maternal health. All of these feature on the Ministry's agenda and in the health development plan (*plan de développement sanitaire*, PDS) but were introduced on the initiative of and with the support of international institutions. Finally, innumerable reforms of a more technical nature can also be observed which also incorporate major components of social engineering: in the case of health, these involve the protocols or programmes disseminated by the WHO (facility-based antenatal consultation, FANC) and UNICEF (essential family practices, EFP). In education, the reforms in question involve an entire succession of educational strategies and 'new education programmes" which are piled on the teachers who have no training in any of them: for example, education by objectives (*pédagogie par objectifs, PPO*); competence-based approach (*approche par les competence, APC*); situation-based approach (*approches par les situations, APS*) etc.

The Nigerian political leaders and senior national officials in the areas of health and education basically play the game of the international organizations and approve or endorse the travelling models, irrespective of their nature.[36] Each minister wants to introduce his own reform, most of which are based on imported expert systems. Hence, the travelling models are at the heart of the national health and education policies which, moreover, are frequently incoherent, indecisive, and lack the human and material resources necessary for their implementation.

> "All of the reforms implemented in Niger are policies that are based on things that were done elsewhere. It is never possible to carry a reform through to its conclusion and we go backwards and forwards, another reform is introduced that resembles it or has more funding." (Assistant surgeon, district hospital, field notes A.H.)
>
> Regarding literacy reform: "This new program which goes from the sentence to the letter is difficult and inaccessible to the children, the teachers and the parents who support their children at home and who are familiar with the progression from the letter to the syllable and then to the sentence." (Primary school secretary, interview notes A.H.)

[36] This criticism was frequently expressed by Nigerien officials in relation to political leaders. The proverb 'don't look a gift horse in the mouth' ('*à cheval donné on ne regarde pas les dents*') was frequently quoted in this context.

In addition, the partners that introduce these reforms at various levels and have their own individual agendas, protocols and requirements, disrupt the implementation of everyday activities.

> "We also have other problems with the partners, for example the UNFPA. They come when they want to and expect people to abandon what they are doing and what has been planned and make themselves available to them. When they arrive, we stop what we are doing because they come with senior people. There are other NGOs that come to monitor their activities and they want to be accompanied by a member of the district management team. They have to go to one CSI or another and all of this disrupts our activities. At CSI level, the problem this causes is that all of the partners want to intervene at the level of the CSIs and each one wants a report on its activities. This is a lot of work for the mangers because they also have to compile their quarterly reports for the district." (Communications officer, district hospital, interview notes A.H.)

However, the implementation of a travelling model in contexts that are very far removed from those of western countries proves to be a considerable challenge, and the extent to which it is underestimated comes as a surprise. Contrary to the received wisdom of the expert world for the development and diffusion of such models, the intrinsic effectiveness of a model is less important than the contexts in which it is implemented, in particular the routines and limitations of the healthcare and education staff who are in direct contact with the service users. It is these 'frontline workers' who will 'test' the proposed model, which is generally imposed by the health or education hierarchy, will adapt it to their working conditions and professional culture, and will 'accommodate' it in their own way, often by circumventing, rerouting it or dismantling it and sometimes even by ignoring it or boycotting it in reality.

Three approaches

The following three approaches all involve national actors and no international institutions. Hence they subscribe to the perspective of promoting 'reforms from within' which should be prioritized in our view. We will now examine some initiatives originating from the top of the state, various suggestions emanating from the communal administrations and, finally, the crucial question of reformers within the health and education systems.

1. The top-down reformers

Some reform practices, which are admittedly rare, can originate from the top of the state. Hence they are 'top-down' in nature, but unlike the reforms imported by the international organizations, they are carried out by a national actor from the top level of a public institution and reflect a real knowledge of the contexts in which they are implemented.

Their limits are twofold and raise the following questions: will the individual responsible for the reform remain in their position for long enough to manage its long-term implementation? Will the reform receive real political support? The answers to these questions are not yet available in the cases presented below.

Two cases currently arise in Niger. The first involves a new approach adopted by the ministries responsible for education and health and the second involves two ad-hoc institutions (*Haute autorité de Lutte contre la Corruption et les Infractions Assimilés,* HALCIA *and Haute Commissariat à la Modernisation de l'État,* HCME) which are developing reforms under the direct management of their director and the team formed by him.

Current reform activities of the ministries of primary education and health

A new phenomenon arose recently. For the first time a Nigerien minister (Minister of Primary Education, Daouda Marthé) publicly acknowledged the disastrous state of the sector for which he is responsible.

> "Action is urgently needed to save the Nigerien education system, the future of which is a matter of extreme concern. (…) Based on the results of several studies, the Minister noted that the main cause of this situation is the very poor quality of some teachers and their lack of qualifications. According to one conclusion based on international, national and local research carried out on the quality of teaching in Niger, the performance of approximately 11.5 percent of the 72,000 teachers who provide instruction at Niger's primary schools is very poor." (Press briefing by the minister responsible for primary education regarding the problem of the quality of teaching in Niger: "*M. Daouda Marthé tire la sonnette d'alarme et annonce des measures*", Souley Moutari, Office National d'Édition et de Press, ONEP, March 2017)

Previously, irrespective of which party was in power, the rhetoric of the politicians strove to deny all problems, particularly in the education and health sectors, to treat any criticism made in the press as an opposition plot, and to harshly dismiss all scientific analyses as a low blow aimed at the country, as they risked resulting in the withdrawal of external funding and 'development rent'.[37] Any mention of the poor quality of public services was prohibited and only positive quantitative indicators were mentioned, e.g. number of schools or health centres constructed.

[37] Accordingly, following a research study that demonstrated the negative consequences of the implementation of the targeted free healthcare policy, LASDEL was accused of inciting the aid donors to withdraw their support.

Of course, the existence of corruption in general was acknowledged and it was incorporated into certain public discourses at the highest level of the state. However some of the measures taken petered out or were not capable of meeting the challenge involved.[38]

In the case of the current Minister of Education, the rhetoric has begun to be followed up with action, something that has inevitably triggered the strong opposition of the trade unions. In effect, the Minister decided to go ahead with a knowledge test for all of the contractor teachers working in the country. The results were clear:

> 56,444 of the 61,747 registered teachers were assessed. 18.947, that is 33 per cent, achieved the average score; 26.676 or 47.3 percent achieved between 5/20 and 9.99/20; 11,466 or 20.3 percent scored between 1/20 and 5.99/20; and 567 teachers achieved a score of between 0.12/20 and 0.99/20. In addition, the Minister revealed that the teachers who had not trained at the teacher training colleges performed better than those who had.

From the perspective of SYNACEB (*Syndicat national des enseignants contractuels et de l'enseignement de base*), the trade union that represents almost 90 percent of contractors, the assessment was considered nothing more than a way of getting rid of contractors with a view to reducing the burden on the state, and the question of quality was merely a pretext.[39] Several trade unions (e.g. SYNACEB and CAUSE) told the contractors not to answer the questions on the basis that a teacher cannot be not assessed on the basis of an (exam-type) test of competence but on the basis of the way they perform in the classroom (cf. public service statute). However, the contractors who refused to do the test were dismissed immediately. Teachers who scored less than 3 out of 20 were obliged to leave their schools and are supposed to be re-assigned to training centres (*centres d'apprentissage*). Given the shortage of teachers, those who scored more than 3/20 were retained (and not as originally planned teachers with a score exceeding 8/20), however, if they achieved between 3/20 and 5/20 they are obliged to participate in training sessions. There is no information available about either the form or content of this training.

Given the number of contractors that were dismissed or relieved of their teaching duties (e.g. almost 40 percent in the Tillabéri region), a large number of new teachers needs to be appointed as a matter of urgency. Given the scale of over-staffing in urban areas, it would be possible to resolve this problem in theory through redeployment to rural schools. The

[38] Nevertheless, it may be considered that the work of HALCIA (*Haute autorité de lutte contre la corruption et les infractions associées*) was positive despite its lack of resources.
[39] "Niger. Mounkaïla Harouna : un syndicaliste dans le tempête", *Le Point Afrique*, 29 :03/2017

problem remains however as to how women whose husbands are resident in the towns can be sent to work in rural areas and how teachers who benefit from protection at a high level in the hierarchy can be made to move to the country.

It is obviously too early to draw any conclusions or learn any lessons from this 'top-down' reform. An optimistic perspective would lead to the hope that various new measures will combine to improve the quality of education in Niger considerably. A more pessimistic one would prompt the fear that the momentum will peter out and that the Minister will tire of the issue or be replaced.

Successive ministers of health have set about tackling the problem of the deployment of healthcare professionals in the interior of the country in recent years. We have already examined the inconclusive case of the communal doctors (see above). Another recent attempt involves the mandatory posting of specialists to rural areas. Unlike the communal doctors who were recruited specifically for posts in rural areas, these specialists had already been appointed to positions in the capital.

> Prior to his arrival, regions like Diffa, Agadez, Dosso and even Zinder only had a single gynaecologist or at most two. So you can see the need! Meanwhile in Niamey, there were 17 gynaecologists at the CHR Poudrière hospital. They only have two offices and some of them only work once a week and spend their times in the clinics.
>
> The first thing the Minister asked for was an assessment of the actual requirements in Niamey, MIG, CHR, HHN, CHU etc., and he said that the surplus would be redeployed to the interior. So all of Niamey's gynaecologists were convened at a meeting here and were told to agree among themselves on a proposal for solutions regarding their postings, as people would be assigned to new posts the following week and would be leaving the city. We asked them to agree on the postings themselves or else we would do it, and we gave them a week to do it. One week later, the measure was applied. It caused the uproar you know about in the media but it was done nonetheless.
>
> I'm not saying that he does not show *bara bara* (favouritism), however, he did try to resist pressure and implement the decisions taken. The same was done for the surgeons: five or six were sent to each regional centre to cover shifts." (Technical consultant, Ministry of Health, interview notes A.H.)

As in the case of education, this measure met with the opposition of the trade unions, specifically that representing consultants (*Syndicat des médecins spécialistes*, SMES). The question arises, however, whether this redeployment, which was necessary and indisputable in principle, was carried out under good conditions and will endure. Some of the problems already encountered in relation to the communal doctors also arise here: lack of preparation for accommodating the doctors at their new placements (in particular a lack of teams and functioning technical platforms which prevents the specialists from practising) and an worrying combination of resignations, returns to the city and absenteeism.

In addition, the Minister recently closed 14 private health clinics and some pharmacies that were selling illegally imported drugs. This marked an end to decades of impunity and acquiescence in this area.

It will, of course, be necessary to assess periodically whether these ministerial measures actually lead to new health and education policies in the long term or whether they are merely temporary attempts at reform like the many other ministerial reforms that preceded them.

The current reform activities of HALCIA and HCME

The extent of corrupt practice in teaching was officially revealed by the *Haute Autorité de Lutte contre la Corruption et les Infractions Assimilées* HALCIA (High Authority for Combating Corruption and Similar Infractions). The corrupt practices in question include: the rigging of public procurement procedures, the awarding of false qualifications, the inadmissible reintegration of pupils into the public system, payments for fictitious contractors and the purchasing of assignments. The joint evaluation carried out by the ministry and HALCIA in all regions of Niger with a view to 'cleaning up the education sector' uncovered over 300 teachers holding fake qualifications; 157 contractors with fake qualifications left the service to avoid being caught.

However, HALCIA never had the resources to develop its enquiries and even less to follow them up with judicial action, something that was not covered by its mandate. Nevertheless, its President, who was recently dismissed due to a rumour concerning his contact with members of the opposition, succeeded in having a law passed which requires that state prosecutors initiate a judicial investigation of all cases of infractions notified by HALCIA.

HALCIA was less active in the area of health, nonetheless succeeded in having a recruitment process halted in which various interventions on behalf of candidates who were protégés of senior political figures had given rise to multiple instances of fraud. It also succeeded in having some pharmacies closed following its enquiry into the sale of contraband drugs with false import licences.

Nevertheless, HALCIA does not have the resources necessary to carry out in-depth investigations. It is attached to the Presidency of the Republic and its budget has decreased

from XOF 1 billion when it was established to a current allocation of XOF 300 million; to put this in context, the sum allocated to the President's security is XOF 8 billion.

For its part, the *Haut Commissariat à La Modernisation de l'Etat* HCME (High Commission for the Modernization of the State), it has established 'circles of modernization' (inspired by the Japanese circles of quality) in the ministries of education and health. It supports the Ministry of Health in compiling job descriptions at all levels of the health pyramid and has organized a 'team-building' training course for senior managers. It established a 'best manager' competition for the teachers employed by the four ministries involved and the results were not contested – a surprising outcome in Niger. Finally, it also initiated a mobile public service for nomadic areas, which covers health and education and supports the appointment and monitoring of healthcare officials and teachers in these remote locations.

However, these innovations collide with the established and acquired habits, that is the practical norms in force, for example the pursuit of expenses.

> "All they do is chase the money." (HCME executive, interview notes JPOS)

The training courses and meetings intended to improve the operation of public services or put an end to illegal practices meet with the approval of the participants but there is no change to the routine of the services thereafter.

> "On the spot, the people are happy and committed. When you turn your back, they forget." (HCME executive, interview notes JPOS)

HALCIA and the HCME are manifestly reformatory institutions and clearly the only ones at the highest level of the administration. However, their capacities for intervention and their resources remain extremely limited and their activities face multiple resistance, both within the ministries and among the political class.

Overall, top-down reforms are exposed to two particular risks:

- Irrespective of the obvious excellence of the intentions and measures decided on, all of the difficulties arise at implementation level. The implementation of reforms is extremely ineffective in Niger.

- Political leaders and public sector managers are not truly motivated and committed to far-reaching reforms of the health and education systems: they never send their own children to public schools.

2. The potential role of the communes

In the context of decentralization, new powers were assigned to the communes in the area of health and education. In relation to health, the communes are now responsible for the construction, maintenance and management of health centres (*cases de santé*), integrated health centres (*centres de santé integers, CSI*) and district hospitals. In relation to education, they are responsible for the construction and maintenance of primary schools, the equipping and supplying of education infrastructure, the acquisition and management of school equipment and supplies, the development of school catchment areas, and the recruitment and management of contractor teachers.[40]

However these new powers, in particular the management of health centres and the recruitment and management of contractors, which are the main ones and constitute two critical nodes, are not truly implemented, because the health and education hierarchies are holding on to their prerogatives and because these powers are not well known and thus rarely appropriated by the actors involved (mayors and general secretaries of the communes in particular).

Nonetheless some support measures on the level of what could be described as secondary powers are being implemented almost everywhere, e.g. the construction classrooms or walls, the purchasing of school supplies, the equipping of the health centres and the payment of their caretakers.[41]

> The commune of Kollow provides various supports for education: petrol (for the sector chief), expenses for CGDES meetings, supply of teaching materials (tables, benches, blackboards and easels). However the sum of 50 million for education, which was earmarked in the commune's annual budget, was not made available.

However, for the most part, the communes still have little involvement in health and education. School supplies are mainly ordered by the regional boards, thereby generating opportunities for corruption, and not at communal level. The mayors do not sign off on the authorizations for work carried out in schools and health centres and they are not informed of

[40] Decrees of 26 January 2016.
[41] On the relationships between local authorities and health, cf. Oumarou 2015

education or health ‘projects’ carried out in their communes. Classrooms and health centres are built without their knowledge.

They mayors do not have the right to monitor postings. Irrespective of whether they involve contractors (who are recruited at departmental level) or public servants, their views are not solicited.

Some mayors are only interested in education or health if there is a ‘project’ offering an opportunity for something to ‘eat’. In contrast, others show considerable interest in these areas. One indicator of this interest is the case of training sessions for school teachers (known as ‘*mini CAPED*’). The CAPED (*cellules d’animation pédagogique*) education organization units were formerly financed by the state and provided teachers with regular opportunities to participate in further education and training. The state no longer funds them: this is a characteristic indication of the state’s lack of interest in the quality of education as the CAPEDs were one of the rare available and effective tools for improving the teachers’ competence and skills. A number teachers, educational consultants and inspectors have since taken the initiative to re-establish ‘mini-Capeds’ at local level with the support of understanding mayors, who provide funding for the travel involved.

During seminars organized by LASDEL in 2009, 2010 and 2011 and involving the participation of around 40 mayors of communes where we had carried out various studies over a period of 15 years, we were amazed at the interest expressed by the mayors in education and health. They all deplored the fact that they had been excluded by the services involved and that they did not have the resources to intervene more effectively in these sectors. During the debates, the mayors seemed very concerned about improving the quality of local education and health services and placed themselves clearly on the side of the service users when it came to encounters with health professionals and teachers.

Based on this and as part of the ‘practical norms’ programme we decided to organize a workshop on 9 and 10 May 2017 with mayors we believed to be open to reform. The workshop dealt specifically with health and education, with one day being dedicated to each topic, and enabled us to present our assessment (on which there was unanimous agreement) and, above all, to collect their suggestions for reform which are presented below.

It seems clear to us that the greater involvement of the communes in the education and health sectors represents a very serious avenue for the implementation of effective reforms.

Proposals presented at the 'Mayors and Education' workshop

Local level

- Improved efforts in relation to the reception of teachers by the local population and communal authority (accommodation, working conditions, support)
- Annual excellence award for the commune's best teacher
- Strengthening of links between teachers and communes
- On-site training for teachers; funding of mini-CAPEDs, co-funding or pre-funding of CAPEDs; funding of class visits by consultants and inspectors with reporting to the communal authority
- Recruitment of contractor teachers from the communal budget
- Recruitment tests for contractors in communes with inspections
- Ceremonies for the validation of knowledge (pupils) and excellence awards
- Regular cooperation with management committees (CGDES and COGES)
- Revitalization of the communal federations of management committees (CGDES and COGES)
- Establishment of an annual or bi-annual communal consultation framework with the teachers and the management committees (CGDES and COGES)
- Interviewing of absentee teachers by the mayor (based on inspectors' reports or checks by the communal authority)
- Action in the context of 'general powers' to extend the scope of action available to mayors: for example, activation of Article 21 of the public service statute (*Statut de la fonction publique*)
- Rejection of over-staffing of inspectors
- Introduction of requirement for inspectors to provide reports on classroom visits
- Introduction of the right to dismiss a principal/head who is performing inadequately
- Improve equality between girls and boys
- Build classrooms on improved semi-dry clay (*banco*)
- Mobilize citizens in relation to education

Regional level

- Establishment of regional education forums (annual)
- Restoration and activation of the regional disciplinary committees (*comités régionaux de discipline*)
- Implementation of effective classroom visits with verification of preparatory notes

National level

- Updating of texts, strict application of texts
- Depoliticization of nominations and postings
- Improvement of teachers' skills and qualifications (*Ecoles normales d'instituteurs*, ENI), CAPEDs, other training)

- Restoration and respect of the school catchment areas
- Either return to directing the best pupils towards the ENIs (instead of holding competition for entry) or establish rigorous and monitored competitions
- Introduction of incentive-based payments for teachers in remote locations and in difficult areas
- Identification of a solution to the problem of the inability of numerous teachers to apply the new programmes which require skills that they do not possess (cf. literacy programmes)
- Allocation of powers to mayors in relation to the recruitment and evaluation of teachers and principals
- Reform of the training provided by the ENIs, attendance of which should be mandatory for all teachers: compliance with the six-months of training
- Simultaneous transfer of resources and competences to the communes
- Need for firm political will for reform at the top (and in the long term)
- Allocation of XOF 100 million in investment per commune for education on a case-by-case basis; eventual adoption of an equalization system
- Regular and punctual financing of CAPEDs by the state
- Monitoring of the implementation of the 'Minimum Package of Quality-Focused Activities' (*Paquet minimum d'activités centrées sur la qualité*) developed by the ministries

Proposals made to the mayors by the HCME

- "Do not wait to cook good food until your husband gives you more money for the seasoning!"
- Persuade the elected representatives of the need for reform
- Mobilize the citizens, for example in support of the CAPEDs

Proposals resulting from the 'Mayors and Health' workshop

Local level

- Create a list of requirements for the CSIs in relation to the treatment of service users
- Provide better nursing care in the commune
- Six-monthly survey of healthcare staff attendance involving elected representatives (to reveal failures to assume posts, lateness and absenteeism); this report would be sent to the district and ministry and could also be made publicly accessible
- Interviewing of problematic healthcare staff by the mayor (performance, absenteeism, lateness etc.)
- Improved efforts in relation to the reception of doctors by the population and communal authority (accommodation, working conditions, support)
- Increasing of budgetary allocations for health and provision of a line for 'response to epidemics' in the communal budget
- Nomination of vice-mayor with responsibility for health
- Ensure that communal authority is represented on the health management team (COGES)

- Effective presidency of the health committee (Comité de Sante, COSAN) by the mayors
- Make the management teams (COGES) functional, develop training for them (strengthening of capacities)
- Plan an annual or bi-annual consultation framework between the commune and healthcare staff, including the communal doctor
- Require 'projects' and NGOs active in the commune in the area of health to truly engage with the commune and to grant a right of review throughout the duration of the project; mandatory annual review between the communal council, the projects and NGOs
- Obligation to involve the communal authority in the reception and distribution of donations of material and inputs made by citizens, associations of NGOs and international organizations

Regional and national levels

- Doctors posted to a commune should combine specific consultation tasks (public duty) and tasks involving the supervision of the commune's healthcare staff
- Provide open access to documentation relating to the health districts and regions
- Establish regional health monitoring centres (involving elected representatives, members of the health committees (COSAN), healthcare staff and researchers)
- Establish a national federation of management committees (COGES and COSAN)
- Give mayors a right of review of the posting of healthcare staff in the commune
- Give mayors a role in the evaluation of healthcare staff in their communes
- Distribute texts relating to communal powers in the area of health to the local authorities
- Involve the communal authorities in the development of the health catchment areas and healthcare planning

3. The frontline reformers

The first example of frontline reformers concerns a referral facility – a regional hospital. We then explore the approach to reform involving practical norms (modification of some and introduction of others) based on the case of maternity units. Finally, we present the results of a seminar held with healthcare staff attending training organized by LASDEL.

An experience worth investigating: record-keeping at Tahoua regional hospital

A process for improving the quality of patient management was carried out at Tahoua regional hospital from 2013. A study carried out by LASDEL (Hamani 2016) drew attention to this interesting local initiative focused on the creation and maintenance of medical records. In effect, this regional hospital (*centre hospitalier regional*, CHR) where records within the

individual services had been previously more or less inexistent or extremely poorly maintained, improved its results significantly, for example by reducing patient mortality rate in the first 24 hours from 17 percent to 3.2 percent. The hospital's director instigated the creation of a unique medical record, which was not adopted from elsewhere but designed on-site by a team of nurses and doctors, involved monthly monitoring by the team and did not necessitate the use of any additional resources. In addition:

> "We compiled a document containing the latest management standards. These standards were contextualized and adopted on a consensual basis with the team." (Assoumana 2017)

This experience would clearly merit further in-depth investigations, however it already points us in the direction of an alternative approach to the important travelling models as, unlike these, it originated from a local context and was developed by frontline healthcare staff.

The case of a reformatory midwife: modifying practical norms

We sometimes encountered 'reformatory' midwives and gynaecologists who attempted to improve the quality of the healthcare services provided based on real contexts and problems that exist on the ground and without following the standardized interventions to the letter. Thus they applied a logic that was far removed from strict compliance with the travelling models. Their initiatives were unobtrusive, scattered and almost invisible for the most part, but we feel that they are worth acknowledging and documenting.

By way of example, we present a case study below involving a 'reformatory' director of a maternity unit in Niger.[42] She succeeded in modifying the practical norms implemented by the staff in her unit in three ways and without resorting to the official standards (while also maintaining a gap between the official and practical norms).

Late attendance

The official hours of work for healthcare staff are 7.30 a.m. to 4.30 p.m. with an hour for lunch. However, the midwives arrive around 9 a.m. and leave around 1 p.m. (except when they are on call). The Minister recently attempted to intervene with a view to improving compliance with the official working hours: health facilities are now obliged to keep attendance sheets with a red line indicating mandatory attendance from 8 a.m. It will come as

[42] See Maman Sani 2016. This study was carried out for a masters thesis in the anthropology of health at the University of Abdou Moumouni and the research programme on midwives funded by the IDRC and led by Aïssa Diarra.

no surprise to learn that staff continued to arrive as usual around 9 a.m. but note a fictitious starting time before 8 a.m. on the attendance sheet. The Director of Salam Maternity Unit[43] does not use the official sheet as she knows that it is useless. However, she arrives at the unit herself at 8 a.m. and does a tour of all of the departments to greet the staff who feel an obligation to be present as a result. By setting the example herself and using a 'soft' means of control, the director achieves better results than the bureaucratic measure officially imposed by the ministry. Nonetheless, she still does not respect the official norms: 7.30 a.m. starting time according to the attendance sheet.

Haemorrhages

In the majority of cases, post-partum haemorrhage is associated with an error by the midwife in charge of the birth. Nobody applies the legal disciplinary sanctions provided for professional errors in Niger. This impunity from sanction is a widespread practical norm applied throughout the public service. The director of Salam Maternity Unit does not avail of the legal disciplinary sanctions (official norms) in this case either. However, she has 'invented' a local sanction, a practical norm that she has imposed: in the event of a haemorrhage the midwife must accompany the patient to the referral centre herself. This will involve a loss of time (and money) for the midwife and, even worse, a loss of face: the personnel at the referral centre will know that an error has been made if a haemorrhaging patient is taken to them and they get to see the person responsible for the error.

Informal payments

The average sum earned by midwives (and other maternity service staff) through the 'informal' payments they request from patients (sale of oxytocin, serum, suture thread, surgical gloves etc.) is estimated at around USD 10 per birth. The Director of Salam Maternity Unit did not attempt to eliminate these 'contributions', which would be unrealistic, but to reduce them. She called a meeting of her staff and set a maximum limit of USD 5 on this income stream.

These three examples involve local reforms that are based on practical reforms but do not attempt to impose compliance with the official norms, which are not only ignored ('revenge of the contexts') but are clearly inapplicable in the absence of the radical reform of the public service and the state.

[43] The name has been changed.

It should be noted, however, that this director, who was initially supported by the local district management team (*équipe cadres du district*, ECD) on taking up her post, was later marginalized and abandoned by a new ECD. Nonetheless, following a period of despondency, she resumed her reforming activities by imposing the application of the rule on on-call service as a new disciplinary measure. In effect, the law allows for 24 hours rest for every 24 hours of on-call duty performed. It is common throughout Niger, however, to allow 48 hours rest for 24 hours on-call; this is a practical norm that has almost become official. The director now obliges the midwives to take only the legal rest period of 24 hours following an on-call stint of 24 hours.

Other reformatory midwives in addition to the Director of Salam Maternity Unit doubtlessly exist in Niger – as in all other countries. They represent an invisible minority, of course, but the question arises as to whether it would not be worth establishing a network of such reformers and relying on them as a basis for the definition of various approaches for improving maternity services. This is what a LASDEL research-action programme[44] is trying to do: the central focus of this programme is the research and documentation of local reforms and 'pockets of effectiveness'[45] within the maternity system, in other words formal and informal innovations that made it possible to change behaviour with a view to providing better quality of care. Based on the experience of 12 reformatory midwives in the 'real-world setting' and their knowledge of the practical norms in use, the programme will aim to define experimental actions that will be implemented by the midwives in some of the maternity units with the ultimate objective of providing points of support for local and regional 'reform coalitions' in the area of maternal health and of gradually improving the professional culture of Nigerien midwives (based on the practical norms they follow). This involves confronting some very concrete everyday realities: what should be done about the use of partograms if the reality on the ground is to be used as a basis for action? Should they be modified, abandoned or replaced – and with what? Relevant responses to these questions can only be found by experts in the field; in other words by the 'frontline' reformers and not experts in bureaucracy.

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[44] This programme, which is entitled "*Santé maternelle et adolescente en Afrique de l'Ouest. Pour des réformes à faible coûts enracinées dans la réalité*" ("Maternal and adolescent health in West Africa. For low-cost reforms rooted in reality") concerns Benin and Niger and is funded by the IDRC.

[45] Various interesting studies on 'pockets of effectiveness' exist in LMIC: cf. Crook 2010, Leonard 2010, Roll 2014.

Proposals for reform based on reality

During the second session of the LASDEL professional training aimed at healthcare staff and involving around 20 midwives, doctors, nurses, we held a two-day seminar (3-4 November 2017) on the topic of practical norms in the area of health, in particular maternal health. As part of this process we carried out group studies, which were instructed to start from local realities and critical nodes and conceive of realistic reforms suitable for Niger and capable of being implemented cheaply (without depending on external aid).

The critical nodes

Significant convergence was observed among the trainees in the identification of the critical nodes specific to the maternal health system which, in terms of the solutions to be applied, must be the focus of innovative thinking that is rooted in the field: their assessments of frontline practices highlights the difficulties of the 'real world' of healthcare in Niger and raise very different 'concrete problems' to the 'abstract' issues raised by epidemiology.

- *The long queues of women waiting at the doors of healthcare facilities:* how should everyday and weekly work be reorganized so that more time can be provided for consultations? How can waiting times be minimized – use of numbers or appointment system?
- *The very poor punctuality of healthcare staff:* how can the different forms of lateness and absenteeism be reduced?
- *Racketeering aimed at patients and informal payments:* how can the levying of undue payments by the staff on patients be reduced or eliminated?
- *Absences due to training, participation in seminars, meetings, assignments etc.*: how to ensure continuity of service and replacements when staff are away?
- *The loss of ethical reference points among staff and the demise of 'vocations'*: how to re-establish a public service morale?
- *The lack of hygiene in healthcare facilities*: how to establish compliance with minimum antisepsis rules?

- *The failure to complete records*: how to provide for simple monitoring and minimal traceability?
- *Nepotism, clientelism and selfishness in the selection of staff for training courses*: how to prevent senior members of staff from evading training and only allocating places on training courses to their favourites? How to make competence and the interest of the service the priority criteria?
- *The lack of follow-up of hospital patients*: how to ensure that all of the necessary care is provided when required?
- *The remuneration of numerous beneficiaries in health facilities*: how to provide a minimum of resources so that patients are not charged for them?
- *The disappearance and inadequate maintenance of minor equipment necessary for the recording of basic obs*: how to maintain or repair blood pressure monitors, thermometers and weighing scales?
- *Shortcomings in referrals (necessary information not provided) and absence of counter-referrals*: how to establish a relevant professional communication between staff who make referrals and those at the referral centres?
- *Absence of sanctions*: how to establish a system of realistic and effective sanctions?
- *The de facto prohibition of the traditional squatting birth position*: how to convince healthcare staff to accept this birthing position and under which conditions?
- *The failure to coordinate partners who intervene individually and carry out their own procedures*: how to initiate coordination and impose the respect of common rules?

All of these critical nodes raise problems for which local solutions can generally be found without any need for external input. It is important to draw attention one central problem, which was repeatedly referred to, for which only a national solution can be found, and which is at the heart of health policies and public policies in general: the question of

postings, which are completely contaminated by political intervention, clientelism and corruption.

Towards local solutions

From the perspective of local solutions, a number of approaches repeatedly featured among the participants' proposals:

- The need for consultation with healthcare staff within the services in advance of any reorganization, modification of procedures, introduction of new media, establishment of new rules (for example on the question of 'racketeering' or the selection of people for participation in training). This strategy contrasts with the habitual reality of the healthcare facilities (and also of the Ministry of Health and international organizations), where verticality, the imposition of changes decided on elsewhere and 'top-down' orders are very much the dominant mode of operation.
- The need for a dialogue with service users and the population: they should have their say and the healthcare staff should listen to them. The innovative channels through which this dialogue should take place remain to be found, as 'community participation' should not be limited to either the COGES management teams (which are very often reduced to a president and treasurer) or general meetings convened by aid donors, and even less to the production of bricks for the dispensary wall.
- The decisive role of a leadership based on example. The director of a maternity unit, chief medical officer of a CSI, director of a district hospital and director of a service should all act as both human resources managers and role models. The reality is very far from this in the majority of cases.
- On-site coaching and mentoring at the work place as opposed to the training courses that take place outside the workplace and with vertical supervision.

- Creation of sanctions that are tailored to concrete problems and take into account the practical norms applied by the staff, which are far removed from the ignored and inapplicable official regulations.
- The provision of symbolic rewards for staff who provide better quality care. As demonstrated by our research, unlike highly complex performance indicators and particularly demanding mechanisms for performance-related payments, the recognition of the competence and seriousness of a healthcare worker by the hierarchy and peers only requires modest local resources (public testimony, a weekly or monthly roll of honour, reception at the town hall, a traditional lamb barbecue or *méchoui* etc.) and constitutes an important resource for motivating staff.
- Holding staff responsible for cross-sectoral tasks. Many critical nodes in healthcare facilities can be resolved through simple on-site assessment and monitoring. This task should be delegated to staff members in addition to their habitual work: e.g. monitoring hygiene standards, completing records, ensuring the maintenance minor equipment, managing referrals and counter-referrals. The heads of services, who are often overburdened, do not have the capacity to assume responsibility for this task.
- Establishment of multi-tasking on the level of general first-line staff. This multitasking would enable the rotation of tasks, the avoidance of certain routines, the substitution of absentees and recognition of the work done with a view to providing a better service to users.

The most detailed proposal for reform that does not involve the use of external funding relates to minor equipment and resources. What is involved here are very simple measures which are suited to local contexts but are not currently being practised, for example the maintenance of a regular inventory of minor equipment and supplies to avoid misappropriation and ensure the repair of faults would be a first measure. Another measure would consist in the development of release records for loans between staff and services. Provisions should also be made for the employment of a general handyman in the supervisory teams so that repairs of defective equipment can be carried out on-site or in a workshop. A particularly innovative measure would involve the creation of a stock of replacement

equipment at district management level, which could be used to replace defective material immediately while repairs are being carried out.

Conclusion: Practical Norms as a Basis for Inciting Change
The Quest for Innovations and Internal Reformers

To conclude, we propose to increase our experimental activities in relation to 'internal reformers' based on an alternative strategy: starting from practical norms to bring about a gradual change in these norms rather than repeatedly importing new standardized official norms in the course of successive interventions that scarcely modify the routine behaviours and lack any credible prospects of appropriation and perpetuation.

Of the practical norms that regulate the everyday operation of schools and healthcare facilities, which ones can be amended, modified, improved or even enhanced? How can we introduce better practical norms and routinize or institutionalize them?

This perspective prioritizes a 'tailor-made' approach over an 'off-the-peg' one. Moreover, practical norms can be positive and innovative. They do not always involve opportunistic, conformist or selfish strategies. On the contrary, they can enable employees to 'get by' and 'cobble together' solutions, invent 'palliative' practices, develop coping strategies that serve the interests of the service users, manage staff shortages and the problem of demotivation, and try out adapted forms of leadership.

The research we have carried out over the last 20 years at the heart of the health and education systems in Niger have led us to encounter various reformatory professionals working on the frontline and providing services to users. These 'admirable exceptions' attempt to improve the everyday operation of schools and health centres without resources, publicity or support, and sometimes even against the wishes of their superiors. They invent local solutions. They establish new practical norms or adapt those already in place. They do not adhere rigorously to the wide range of official norms in force. Their 'good practice' is not the good practice of the 'best students' of the international organizations, instead it involves innovations and improvements that are primarily adapted to the real working contexts and remain invisible to the experts in most cases.

In our view, making them visible, documenting these multiple, unobtrusive reforms appears is a priority task for anthropological research and constitutes an initial step towards a

the development of new approach to the crucial question as to how we can improve the quality of education and healthcare in the public services aimed at the majority of the population (in particular its most vulnerable members) while the elites have long abandoned these same public services.

References

: n°2 « Interactions entre personnels de santé et usagers à Niamey », par A. Souley (2001) ; n°5 « *Le service des urgences à l'hôpital national* », par E. Hahonou (2002) ; n°19 « *La Maternité Issaka Gazobi et l'Hôpital National de Niamey* », par A. Moumouni et A. Souley (2004) ; n°23 « *La pratique de la planification familiale en milieu rural : cas du district de Kollo* », par H. Moussa (2004) ; n°40 « *La corruption dans la santé au Bénin et au Niger* », par JP. Olivier de Sardan, N. Bako Arifari et A. Moumouni (2005) ; n°45 « *La prise en charge des PvVIH et l'observance des ARV à Niamey (approche socio-anthropologique)* », par JP. Olivier de Sardan, A. Diarra, A. Moumouni (2006) ; n° 54 « *Les visites à domicile auprès des PvVIH à Niamey (approche socio-anthropologique)* », par A. Diarra et A. Moumouni (2007) ; n° 55 « *L'appui alimentaire aux PvVIH à Niamey (approche socio-anthropologique)* », par A. Diarra et A. Moumouni (2007) ; n° 62 « *Les personnels de santé face au SIDA et à la prise en charge des PvVIH à Niamey. Transformation ou reproduction des représentations et pratiques habituelles ?* » par A. Diarra et A. Moumouni (2008) ; n° 81 « *La délivrance des services de santé dans la commune urbaine de Say* » par A. Oumarou (2009) ; n°89 « *Une comparaison provisoire des politiques d'exemption de paiement dans trois pays sahéliens (Burkina Faso, Mali, Niger*) », par J.P. Olivier de Sardan et V. Ridde (2011) ; n°91 « *Une politique publique de santé au Niger. La mise en place d'exemptions de paiement des soins en faveur des femmes et des enfants* », par Abdoulaye Ousseini (2011) ; n°92 « *Exemptions de paiement des soins en faveur des femmes et des enfants de moins de 5 ans. Mise en œuvre dans la région sanitaire de Dosso* », par Abdoulaye Ousseini (2011) ; n°96 *« La mise en œuvre de la politique d'exemption de paiement dans les districts sanitaires de Gaweye et Say* », par Aïssa Diarra (2011) ; n° 99 « *Les retards de remboursements liés à la politique de gratuité des soins au Niger ont des effets néfastes sur la capacité financière des formations sanitaires* », par Y. Kafando, B. Mazou, Seyni Kouanda & Valéry Ridde (2011) ; n° 101 « *La prise en charge de l'accouchement dans trois communes au Niger : Say, Balleyara et Guidan Roumji* », par Aïssa Diarra (2012).

Assoumana H. « Mise en place d'un processus d'amélioration de la qualité de prise en charge des patients au Centre hospitalier régional de Tahoua, Niger », Health 4 Africa, July 20, 2017.