Management of Health Areas in the Context of Integral Communalization: Case of Health Huts of the Urban Municipality of Tibiri, Doutchi in the Niger Republic

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Abstract: Niger Republic has been implementing a decentralization process for several years to create the conditions for better sharing and more organized implementation of administrative reform, to contribute to the entrenchment of democracy and to empower grassroots communities in the management of their development.

This decentralization has been adopted also by the government of Niger to strengthen national systems, particularly the health system management.

But this process of decentralization has produced very young municipalities with a low level of experience of the actors in terms of administrative management. Among the constraints mentioned in the functioning of these municipalities, we can mention, among others, the politicization of administration, the difficulties of collecting taxes (market and municipal) and of coordinating interventions, especially external ones (INS: 2013).

The relationship between local authorities and health facilities is characterized by collaboration weak due to the lack of rigid establish official strategies and plans and therefore several difficulties arise about the management of health facilities, especially between the municipalities.

The Urban Municipality of Tibiri is one that has the lowest coverage rate of health facilities in the region of Doutchi and these shortcomings and difficulties constitute a barrier for its development. That is why this study aims to understand the degree of collaboration between health facilities and local authorities, particularly health areas. It is a question of knowing how the urban commune of Tibiri participates in the management of its health huts attached to the health facilities of the communes of Koré-Mairoua and Douméga.

Accordingly, interviews and observations were conducted to understand the difficulties linked to the functioning of the municipal health facilities of Tibiri (the results showed that very often the patients relied on itinerant medicine products coming from Nigeria which qualities as they are generally expired, exposed to the sun and therefore their consumption arise various health concerns for the population. The study ends up with some key recommendations for a better the management of health services in the municipality of Tibiri and to preserve the exposition of the population of this to health concerns.

Keywords: Health facilities management, Integral Communalization, Health Huts, Municipality, Tibiri, Doutchi, Niger Republic.

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Introduction

A Sahelo-Saharan country, Niger Republic is a landlocked country covering an area of 1,267,000 km2 of which three quarters (3/4) are desert. Niger is located in the heart of West Africa between 11°37 and 23° north latitude and between the meridian of Greenwich and 16° east longitude.

On the socio-economic level, Niger is a country characterized by deep, continuous and generalized economic gloom in all sectors. This poverty affects approximately 60% of the total population (extreme poverty), who live below the poverty line of one (1) $ USD. If we consider a threshold of $2 USD per day, approximately 85% of the population is poor. The most vulnerable segments of the population are women and children, especially living in rural areas (UNDP: 2013).

In the health field, despite the efforts made by the various successive governments in collaboration with the technical and financial partners (TFP), the situation leaves something to be desired. Indeed, according to the Ministry of Public Health (MSP: 2012), the health coverage rate is low, it is only 47.53%. The ratio of health personnel to population is an important target that is far from being achieved. The standards of the World Health Organization (WHO) provide for one (1) doctor for ten thousand (10,000) inhabitants, one (1) nurse for five thousand (5,000) inhabitants and one (1) midwife for five thousand (5,000) women of childbearing age. In Niger, this ratio is one (1) doctor for forty-one thousand two hundred (41,200) inhabitants, one (1) nurse for five thousand six hundred and sixty 5,660 inhabitants and one (1) midwife for five thousand four hundred (5,400) women of childbearing age (PDS: 2011-2015).

In its drive to find permanent solutions to the problems to which the populations are exposed, the Government of Niger has been implementing administrative reforms for several years. One of the reforms is to create the conditions for a better distribution of resources, to contribute to the entrenchment of democracy and the rule of law, to empower grassroots communities in the management of their development through a decentralization process.

However, after several years of implementation, the reform has produced municipalities that are still poor with a low level of experience of the actors in terms of administrative management.

In form and substance, the relationship between local authorities and health facilities is characterized by weak collaboration on the various aspects provided for by the text. The municipalities are supposed to create health facilities, participate in their management and their supply of drugs. However, real difficulties arise in the management of health facilities, especially those attached to other municipalities. The local authorities, due to a lack of transfer of powers from the central level, are still unable to participate actively in the management of the health of their populations.

I. Problem

From the Alma-Ata declaration to the exemption from direct payment for care and the Bamako initiative, health issues continue to be a concern. If through the various health policies, the African States and their partners have tried to find a solution to the problems which plague the health systems, it is to be noted that after all these years, each solution constitutes in itself a problem, the insufficiencies remain and remain a reality, the time of the uncertainty occupies more place.

Thus, in Niger, this health issue has had a particular history. Since its independence, the country has embarked on several sectoral health policies depending on the context. From 1960 to 1974, the health sector in Niger was characterized by the development of curative medicine with the payment of health care costs by the State. It was therefore a time marked by the free services delivered to the population. The participation of the population was weak and the infrastructures were only in the big cities. From 1974 to 1978 was the development of mass, preventive, mobile and free medicine. Then comes the period of implementation of several vertical programs from 1978 to 1987, including the ASVs, the subscription to the Lusaka declaration on the health districts and the adoption of the Bamako initiative. It is from this date that the constraints of structural adjustment are announced and the State found itself unable to assume these services, hence its more marked retreat in the basic social sectors. (INS, 2012:3)

A reform of the health sector was born through pilot tests, the Bamako initiative, the first health development plan (PDS 1995 - 2000), the declaration of sectoral health policies. From 1995 to 2000, Niger adopted a health district development policy, the generalization of cost recovery and the establishment of community participation structures. From 2000 to 2005, Niger was interested in the new declaration of health policies, the definition of strategic orientations for the first decade of the 21st century and the development of the health development plan (PDS 2005-2010). Finally, since 2010 we have been talking about the fight against poverty, respect for equity and gender, the millennium development goals (MDGs) and management access to results (GAR), (PDS, 2011-2015).

It was in order to meet current expectations that Niger embarked on a reform of territorial administration by adopting decentralization in the early 2000s. According to (DGDD, 2011), decentralization has always been a concern for public authorities since the colonial period. The history of decentralization in Niger is divided into four (4) periods. The postcolonial period which goes from 1960 to 1974. It is characterized by some attempts of the installation of the system of decentralization. Then the period of exception and the "standby" of decentralization (1974-1983), the period of the development society (1983-1989) and finally the post-sovereign national conference period (1991 to today) which reaffirms the need to be able to continue the process. This is how the first municipal elections were held in July 2004, after the overthrow of the regime of the fifth republic, elections were organized in 2011, they devote the new municipal councilors in office. Therefore, local populations are empowered through their representatives, and decentralization must be accompanied by the transfer of resources and areas of expertise.

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The health sector in Niger, despite the efforts made over the years, remains worrying with a predominance of many communicable, endemic and endemo-epidemic diseases (malaria, cholera, meningitis, HIV AIDS, tuberculosis, etc.) and the emergence of non-communicable diseases such as high blood pressure, diabetes, cancer, sickle cell disease and mental illness, MSP (2011).

In 2002, Niger opted for the continuation of primary health care and the development of health districts, which had already been in force in the country since the 1990s under the term "health self-management". This system includes three types of actors (public, private actors and traditional medicine) and three administrative and care levels: the peripheral level with operational support structures (health huts, integrated health centers and health districts). The intermediate level with technical support structures and including the care structures which are the regional hospital centers: CHR and finally, the central level with strategic support structures whose care structures are the referral maternity wards and the hospitals nationals. Despite this organization, the Nigerien health system still has shortcomings, resulting in a weakness in its ability to meet the challenges.

But this system is becoming familiar with decentralization depending on the context, despite the difficulties. The superimposition of the health division on the administrative division has given districts of very large demographic sizes (exceeding the standard which is 150,000 to 200,000 inhabitants) and many integrated health centers (5,000 to 10,000 type I and 10,000 to 15,000 type II).

In the texts of decentralization, the municipalities participate in the management of health services. Law No. 2002-013 of June 11, 2002 on the transfer of powers to the regions, departments and municipalities stipulates that the municipality participates in the definition and development of departmental plans and programs in terms of health development in accordance with departmental guidelines. Article 81 of the same law gives municipalities the management of integrated health centers and health huts. They are officially in charge of the creation, equipment and maintenance of the infrastructures of the integrated health centers and health huts established in their area, as well as their supply of drugs in compliance with the standards established in this area. But this provision is far from being applied in Niger.

According to Marté (2012), municipalities are supposed to contribute annually to the financing of health-related expenditure up to 8% of their budgets, but this has not always been the case. Many integrated health centers face problems in recovering the share that the municipality must allocate to them.

The subject on which this work relates is of particular interest. It deals with the management of health areas in the municipality of Tibiri. This commune has only one type II Integrated Health Center (CSI) and sixteen (16) health huts. Twelve (12) of these health huts (Afolé, Bangarassa, Bankoula, Bechémi, Bingel, Goboro, Kadidi, Koren Marina, Madé, Nassaraoua, Salkam and Tounga Ibrahim) are attached to this type II Integrated Health Center (CSI). The four (4) other health huts (Jikata, Gobawa-karé, Tombo-Bouya and Toullou-Madi) which constitute the study area are located in the commune of Tibiri but attached to the Integrated Health Center (CSI) of Maikalgo (commune of Koré Mai-Roua) and Birnin N'Falla (Commune of Douméga).

II. Methods

A qualitative method approach was used to examine the management of health areas in the context of decentralization in the urban municipality of Tibiri, through semi-structured interview. This method is used because of the combination of two analytical models.

Strategic analysis, which is a theory of the sociology of organizations developed by Crosier and Friedberg in a book entitled "The actor and the system: The constraints of collective action", 1977 and essay on the perspective of local governance in West Africa proposed by Olivier de Sardan 2009.

According to Crosier and Friedberg, in an organization, the actor has a margin of freedom even if it is in a given context. He has above all, "a head, that is to say, a freedom". He is therefore engaged in a system of concrete action and must "discover, with the margin of freedom at his disposal, his true responsibility" (1977: 38).

The perspective of local governance examined by Olivier de Sardan is an approach that has made it possible to analyze the functioning of the different modes of governance distinguished and public services, including health.

The author shows us through this perspective how local actors manage to implement the different governance strategies that drive them.

Through this approach, notions of "practical standards" developed by the author which are in reality "gaps and discrepancies" between the official delivery standards and concrete practices, which the author subsequently called "implementation gap have been introduced.

The combination of these two models of analysis in the context of this research results from the fact that the organization of the management of health areas can be considered as a system but also a mode of governance characterized by rules and bringing together several types of actors.

Thus, there is an interdependence in the interaction between the different actors involved in the management of health areas. This combination also allows us to understand the degree of collaboration and coordination or not of the various actors in health management.

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III. Background

The issue of local authorities and health has been addressed by several social science researchers. A large literature of the socio-anthropological type devoted to this theme is available and has therefore enabled us to make an inventory of scientific productions. The superimposition of the administrative division on the health division has given, in several localities, what are called health areas. Indeed, it is the management of these health areas in the context of integral communalization constitutes our article subject.

a. Question of Decentralisation and Local Governance: A Controversial Subject

✓ ***Socio-Political Context of the Advent of Decentralization***

Several social science researchers have developed the factors that explain the context in which decentralization emerged. Among these factors, we can note the democratization of our States, pressure from donors, protest movements etc.

In Niger, according to Marté (2012) the idea of decentralization is old as indicated by its constitutionalization by the fundamental law of March 02, 1959 in its article 59. But this policy did not know a significant evolution until the advent of democracy. This same democracy was born following the protest movements of the living forces of the nation after the killing of the students on February 9, 1990. According to the author, despite the age of the idea, it is necessary to wait for pressure from donors who impose the structural adjustment program (SAP) on the poor countries and especially the Tuareg rebellions of the North, who have made this policy one of the conditions for the laying down of arms to lay the groundwork for this political will enshrined in principle of governance, where its constitutionalization again on August 9, 1999 through article 18. To definitively lay, according to Marté, the bases of the great administrative reform in Niger, this courageous process largely supported by the international community, the first municipal elections took place in 2004.

In the same vein, Brehima (1997: 69-70) takes stock of the decentralization process in Mali. According to the author, the violent political change that took place in 1991 caused the overthrow of the single-party regime of the second Republic and resulted in the establishment of what has come to be known as multi-party democracy. The author observes a double-speed development at this level, while exogenous forces linked to donors, who are the main development partners, condition economic, social and political constraints through structural adjustment programs (PAS) gradually strengthened, develop internally very large contradictions. The appearance of the Tuareg rebellions in the north of the country creating an imbalance in the socio-political stability of the country, corporatist disputes through numerous popular uprisings weakening the country, student slings, peasant claims... are the basis of this administrative reform.

It should be noted here that beyond these aspects listed above by the authors who explain the socio-political context of the advent of decentralization, there are others depending on the States and their realities. This is why, for some authors, this policy is the result of several years of reflection.

✓ ***Implications of Decentralisation for Better Democratic Governance***

It is a question of analyzing through the writings of the authors the different implications of decentralization for better democratic governance, namely the decentralization of power, the transfer of skills, community participation, etc.

Thus, for Etienne le Roy et al (1996), in French-speaking culture, to decentralize is to entrust public authorities, other than the State, with the responsibility of managing the common good. However, it can be argued that local public authorities (PLCs) are representational frameworks specific to a culture that believes in the existence of a specific "political body" to represent and manage society. Thus, during colonization, the rural world was entrusted to traditional or neo-traditional local authorities (the chiefs of cantons) who locked the existence of the populations by applying "customary" laws whereas in urban areas it was different. “Decentralized despotism” has accentuated the city/country divide by producing a rural world fragmented according to ethnic groups, Mamdani (1996).

Moreover, for Jacob, J.P (1999) this pattern was not changed by African countries after independence, when the city was organized on the basis of power delegated to civil society, the bush was subject to traditional authorities supported by the state in a vision of 'indirect rule'. According to the author, decentralization as a project aims first of all to break with the city/countryside dualism by constituting rural communes endowed with the same powers as urban ones and to end with multicentricity by creating territorial collectivities endowed with the moral personality and management autonomy to coordinate actions at the local level. He continues by showing that the examination of current or past decentralization policies in African countries (the dualism inherited from colonization) is not totally outdated on the one hand and on the other hand that multicentricity is not equally defeated by simple decree since, despite the States' desire to give priority to local authorities by transferring powers to them and putting pressure on donors to direct support towards local authorities, these States do not have the means to support the structures decentralized. This question has meant that decentralized structures do not always manage to monopolize the supply of this development.

However, for Ribot (2001:5 in Claude et al, 2006) one of the main objectives of decentralization is the transfer of competences, the point on which conflicts develop, "The security of the transfer of powers is also important, when powers can be given and taken back at any whim by the agents of the central power, the representatives remain subject to them and beholden to them”. For Coulibaly

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(1997:10), “the exercise of powers requires both the possession of technical and administrative skills by the new management teams and the availability of substantial financial and material resources to respond to the major questions (populations), conditions that few decentralized territorial entities would be able to carry out (….), a weak State by principle should not be decentralized”.

In the same direction, Ousmane (2005), underlines the administrative reform of 1996 in Burkina Faso, the State transferred nine (9) areas of competence to local communities to provide a more satisfactory response to the concerns of the populations. To the regions, municipalities and rural communities are transferred powers relating to the management and use of the private domain of the State, the public domain and the national domain, the environment and the management of natural resources, health, population and social action, youth, sport and leisure, culture, education, literacy, promotion of national languages and vocational training, planning, regional development, town planning and the habitat. These powers now devolved to local authorities contribute to the proper functioning of municipalities.

Thus, the success of decentralization is conditioned by the level of involvement of the population, collectively and individually, in developing the resources in a given territory. This vision is supported by "participatory" development institutions and projects imposing a logic of participation without the possibility of opposition. Indeed, during colonization in Africa, several operations were carried out with a view to “participating”, involving the populations (especially in the agricultural field). After the First World War, within the framework of the policy of "development" in the French colonies and of "indirect rule" in the English colonies, this participation was seen to increase to finally reach its peak after the war with this this time doctrines. In fact, there is a weak operation and a lack of knowledge of the participation mechanisms (DGDD, 2011). According to (CGD, 2011: 4), "the assessment of the decentralization process highlights on the one hand the weak capacity of local authorities to fully play their role in local governance, and on the other hand, a relative disenchantment of the populations at the base with regard to local institutions (….).

Decentralisation is a process through which the community fully participates in the management of its affairs. It must be accompanied by a transfer of skills which constitutes a sine qua none condition for its success. What are these conditions really like (transfer of power, appropriation by local actors, etc.)? Beyond these questions, decentralization involves multiple and varied aspects, only it is important to know that we are still in the experimentation phase, that is why it is punctuated with obstacles, especially on the transfer from central state powers to local arenas.

✓ *Local Arena and Local Governance in the Context of Decentralisation*

This part highlights the different local actors of decentralization, namely traditional chiefs, political parties, local elected officials, nationals, religious... and their contribution to local management according to specificities.

On this subject, Christian (1995) underlines how local land actors act on their positions and take advantage of their resources to preserve their prerogatives on access to land. According to him, in Niger, the traditional chiefdom enjoys the status of auxiliary to the administration and has the privilege maintained by colonization in relation to land rights. Land is a sign and a symbol of political authority and local power. It is therefore a field of permanent tension and issues constantly negotiated between the holders of “traditional” management power who also maintain a local clientele and relationships of subordination essential to the process of maintaining mobility. Beyond this aspect, Oumarou (2011) detects an intertwining of powers in the commune of Bermo. According to the author, the mayor comes from the chief family, he is also the president of the local section of his party, this has an influence on the freedom of choice of the populations.

It is also the opinion of Lutz, et al (2004), that traditional rulers often have functions that relate to land allocation, natural resource management and conflict resolution. In Niger and Senegal, they keep their position for life and only members of an elite lineage, or “caste” can become chiefs, Ribot (1999:10 in Claude, F. et al, 2006). Local governance comprises a set of institutions, mechanisms and processes through which citizens and their groups can express their interests and needs, negotiate their differences and exercise their rights and obligations at the local level.

All these actors participate in local management according to their specific model of governance. This is why Olivier de Sardan (2009) lists eight (8) almost common local governance modes in West Africa. The author explains the ways in which some of these actors (traditional chiefs, local elected officials, religious leaders, etc.) emerged, they were transformed, their origins changed (example of the chieftaincy mode is illustrative), as well as the way in which they operate and concretely deliver their services to the populations. Starting from an experience, from a conception that aims to be empirical, descriptive and analytical of the concept of "governance", the author makes a classification of different modes of governance in West Africa. It should be noted that this concept is not unanimously accepted in the social sciences. Olivier de Sardan considers that any organized form of delivery, operating according to particular standards and implementing specific logics, is a mode of governance. This definition given by the author focuses on a particular function of collective action, authority or regulation which was previously associated with the State, but which currently can be implemented by several types of actors and of institutions. Local governance emphasizes concrete forms of exercising local power and its interactions with the users of public services.

The first mode of governance is the “chieftaincy mode” which, according to the author, refers to the administrative or traditional chieftaincy, which has undergone many transformations over time and which continues to deliver many public services to the populations. The author lists a certain number of characteristics of this mode of governance (patrimonialism, confusion of power, predation and corruption, patronage habits, no accountability to the citizens, aristocratic ostentation, internal rivalries, defense of an

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aristocratic and patriarchal ideology). The "associative mode" is implemented by the development institutions of the North to ensure the management and operation of the structures financed by themselves. This mode imported from the North is not autonomous and its operation remains critical.

The third is the communal mode, it was born with the decentralization in Senegal. It is characterized by an election of members of the municipal council, the establishment of political parties, etc. In this mode, the nationals of the region have a weight in the different activities of the society and they also have many privileges and informal privatizations are granted. It is this mode of governance that interests us particularly in the context of this research work. This is why we will try to come-back to some of these aspects throughout this work for the purposes of clarification.

The other modes are "the projectal mode" (development projects), the "state mode" (here we are talking about the local state or state services at the local level), the "mecenal mode" which is led by a few actors such as merchants, politicians or local citizens, the "religious mode" through religious organizations that deliver public services to populations and finally the eighth and last, is the "merchant mode" in which private economic operators constitute the appeals framework at the local level. According to the author, these eight modes of governance overlap in fact. Some of these modes are more visible than others (chiefly mode) depending on the locality. They can also provide the same service in a complementary or competitive manner.

It can be noted through this literature that the concept of governance is perceived but also applied differently depending on the actors and the discipline. The context of application also varies depending on whether you are in town or in the countryside.

b. Health: A Subject with Multiples Challenges

The health issue is still the subject of debate throughout the world, because it allows the maintenance of stability and social balance. Illness, unlike health, compromises the proper functioning of society because it diverts the individual from his social roles and his professional activity, Philippe and Herzlich (1999). This is why, despite the scientific and technological progress recorded in the world, health remains a global concern.

✓ ***History of Health Systems and Public Health Policies***

There is a wealth of social science literature on health systems issues and healthy public policy.

On this subject Polton (2003), states that the decentralization of health systems can take several forms depending on the country. The author explains how the Scandinavian model developed through a long-tradition of political decentralization at “fine territorial scales”. In Denmark, elected committees are responsible for both financing and managing health services. In this country, 70% of the budgets is allocated to the health sector and 87% of this funding is provided by local taxes levied. In Norway and Finland, this decentralization is even more accentuated, especially in Finland where the management of health services is decentralized to the level of the 448 municipalities.

However, Olivier de Sardan and Ridde (2011), retracing the history of the West African health system affirm, during French colonization, care was free and reserved only for the urban population and concerned vaccinations, especially those related to the fight against major endemics and epidemics. After the years of independence, health facilities will be opened in the villages accompanied by a policy of free care. A financial crisis shook Africa in the 1980s and affected basic social sectors, including health. But, for these authors, independence has seen the birth of a proliferation of health facilities in each country, particularly in rural areas, the question of free healthcare remaining in force. However, at the beginning of the 1980s, when the States were plunged into serious financial difficulties, this system experienced a deep crisis: the consultations remained free, but the health facilities no longer had medicines available. They therefore issue prescriptions to users for the drugs that they had to buy at a high cost in pharmacies that are sometimes far away.

In addition, Gobbers and Pichard (2000) in their analysis of the West African health system, had to identify a certain number of commonalities in the various sub-regional health systems. For them, the system results from the will of the legislative and executive powers to shape an environment to maintain and improve the state of health of the populations. They note that all the countries in the area remain marked by the mode of organization of health services set up by the former colonial powers. The presence of international organizations has meant that all countries have superimposed on their territorial organization the concept of health district in which the district management team must act, as recommended by the resolution of the “Bamako initiative”.

Throughout the area, the financing of the health system is mainly public, the care structures are also public to a large extent, which is why the authors have tried to talk about the common features between the different systems. But an unprecedented crisis marked the 1980s, structural adjustment led to increasingly degraded performance of public health structures with the decline in budgetary resources. This is how the issue of cost recovery becomes the rule. Different national health development plans in different presentations have increasingly recognized that the state alone can no longer support the health sector. Consumers now pay for care services at varying levels depending on the country, according to a “social pricing” set by the political authorities. The administration is characterized by different services. Finally, according to Gobbers and Pichard, the West African health system is also marked by the lack of sufficient staff and the concentration of this staff in urban areas. In addition, those who drive the public sector are also those who drive the private sector.

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We understand with some authors that health systems depend on countries. At this level, it should be noted that the available literature has enabled us to observe an almost similar scope of health systems, especially in West Africa.

✓ ***Policy of Exemption from Direct Payment for Care***

On this subject, Ridde (2012) states that the primary objective of this policy is to solve the various problems that exist despite the Bamako initiative. Even if the objective assigned to this policy is the same in all countries, according to Ridde the reasons for its application vary according to the country but also from time to time because they do not have the same daily realities. In countries like Uganda, Ghana and Kenya it is the adverse effects of payment on health care utilization and the health of the population that is the motive. Several African countries have adopted this policy of abolition of direct payment depending on the context, the most striking of which is political. It is a sudden decision in an eminently politicized context just before or after an election. According to the author, in countries like Niger, South Africa and Madagascar, decisions were made by the presidents.

According to Diarra (2011 in Ridde 2012), in Niger, the announcement of this policy was made with trial and error between the dissemination and the start of application of the abolition. This decision surprised some technicians (from the Ministry of Health) because of its hasty and improvised nature.

However, for Olivier de Sardan (2014), in Niger and Mali the direct payment exemption measures have been very personalized around the person of the President of the Republic. The announcement of this policy by the various presidents was sudden, even the technicians of the ministries of health were "short-circuited" by the presidential announcements. Without the background of electoral deadlines and presidential ambitions, in Niger and Mali, gratuities were presented to the people as a "gift" from the president with a strong moral discourse around the fight against poverty, generosity of the Head of State and the national, even nationalist character of the measures taken.

Through this literature on the policy of exemption from direct payment for care, we understand that it is a policy born following the failure of the Bamako Initiative. It is also a hasty and improvised policy generally for reasons of political ambitions of the various presidents.

✓ ***Problems of Access to Quality Health Services***

There are several writings on the basic reasons that prevent patients from accessing quality health services. We can list, among other things, the problem of reception, the lack of quality staff, the lack of equipment, the absenteeism of agents, the contractualization of the system, the feminization of the sector, the non-functioning of health committees, etc.

Jaffré and Olivier de Sardan (2003), emphasize hospitality. Indeed, according to them, it is a very important step that links caregivers to patients. It should not be limited to simple greetings, technical gestures consisting in observing, touching, diagnosing and prescribing, but in a broad way, it should include all the elements that contribute to putting patients at ease. It is also a staging, it is above all a face to face which puts in relation the patient in search of a better state of health on the one hand and on the other hand the career with whom this patient is recover to help him recover his health. This question in our countries leaves something to be desired according to the authors, because health workers do not reserve a warm welcome to patients, socio-professional status, social ties, etc., very often condition the quality of the reception.

However, for Philippe and Herzlich (1999), the disease is a matter of groups and not only of individuals, it presents itself in the public space and not only in the private space of the doctor-patient relationship. For the proper functioning and normal development of health facilities, appropriate staff, capable of giving a warm welcome to the patient, as well as quality technical equipment, are needed. The disease takes on a collective dimension, which is why, according to them, the meeting with medicine and the appropriate doctor is always a crucial moment for the patient but also for the doctor. An appropriate doctor must take into account the patient's point of view if the latter is to comply with the various prescriptions that will be made to him, he must show emotional neutrality in his relationship with the patient, and his concern must be that of the well-being of the patient. This is also the opinion of Michael (1961 in Philippe and Herzlich 1999), the author develops a theory of therapeutic efficacy based on what he calls the medical remedy. According to him, listening to and paying attention to the patient can heal in the same way as medicine.

Beyond reception, Oumarou (2009) identifies a number of factors that undermine the health sector in Niger. According to the author, the body of Nigerien health workers is characterized by a progressive feminization, women occupy an important place in terms of number in the body. Another problem in the health sector is chronic absenteeism, which is attracting more and more attention from the population. This system is also threatened by excessive contracting, which is relatively high throughout the country. The management committees set up, supposed to "manage" health at the level of the municipality, remain almost everywhere non-functional due to ignorance or the problem of mastery of the circuit by the actors.

It should be noted that beyond these aspects mentioned by the authors who play a preponderant role in access to quality health services, natural obstacles (rivers, hills, a bad road ... which are generally at the base creation of health areas) are important elements of the dysfunctions of quality health services. We can also talk about the distance between health centers, the shortage of products in health facilities, especially during the winter period (high rate of malaria), etc.

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IV. Health Areas, a Difficult Management

The management of health areas in Tibiri, as in several health facilities in Niger, is threatened by a variety of difficulties. These include the lack or shortage of products and often the total absence of necessary molecules (syrup for children, iron etc.), report of consultation fees and products received, the absence of pharmaceutical deposits besides, the use of products from Nigeria, the behavior of agents, absenteeism, problems related to evacuations, home births, etc.

Several respondents return to the shortage of basic necessities in health facilities, especially during the so-called malaria period. Indeed, it should be noted that the huts receive the products of the CSIs at the end of each month, these products generally end in the first week of the month and the amount collected is paid into the Integrated Health Center (CSI). This unity of fund very often has consequences on the actions of goodwill which help the centers as testified by the president of the COGES of Tombo-Bouya.

"The populations of our village once gave medicines to the health hut but at the end of the stock given by the CSI, the agent used the products of the populations in order to pour the sum collected into the fund, since then, they decided not to give any more products in support" (Interview conducted in Tombo-Bouya with the president of COGES).

This rapid rupture leads to the use of products from Nigeria given its proximity to the area. It should be noted that a large part of the city of Tombo-Bouya (gateway for products) is on Nigerian territory and that there are more than ten (10) private pharmaceutical depots managed by Nigerian wholesalers in this same city. This question also favors the use of these products by itinerant people. Users complain about the cost of the product at the center when with a modest sum one can have the same products at the market. Very often, the agents often end up prescribing prescriptions due to the lack of products or certain specific molecules.

When it comes to evacuating the sick or pregnant women to the health huts or to the CSI, serious problems are encountered because the ambulance does not provide village/Health Center or Health Center /CSI shuttles, this is done on donkeys, on cattle carts or sometimes on motorcycles if the case is not so serious. The lack of awareness on the attendance of pregnant women for ANC and childbirth is a serious problem mentioned by all the agents. The high rate of home births is also a difficulty encountered in these centers. This is often explained by the lack of awareness but also the vulnerability of the population to bear the cost.

"My husband was not there when my pregnancy came to term, he is an exodus and I had nothing on me, I would prefer to go back to my room to bear my pain while waiting to see what Allah will do with me than to experience the humiliation and contempt of the agents because of this amount that we are asking for" (Interview carried out in Toullou-Madi with a patient).

The women who go to the centers refuse the vaginal examination and even those who accept do not make it easy for the agents who consult them. Accompanying persons often want access to the delivery room and this disrupts the smooth running of the agents' work. There are women who completely refuse sutures after tears.

There are a multitude of constraints that these health areas of the urban municipality of Tibiri face in this context of integral communalization. These constraints are a major problem in the functioning of health services. Indeed, decentralization is adopted with the aim of strengthening grassroots democracy (Ousmane: 2005) and giving municipalities the management, creation, equipment, maintenance, supply of drugs.

a. Sanitary Division Logics in the Urban Municipality of Tibiri

✓ *"Official Standards" of Sanitary Division in Niger*

It should be noted that there are rules that determine the attachment of a health hut to an integrated health center. This is mainly the question of the distance between the health hut and the Integrated Health Center (CSI). The delimitation of a health hut is calculated in relation to a standardized geographical area with a radius of 5 km around an integrated health center (CSI).

The number of the population of the box or the CSI is a norm which explains the attachment. Indeed, according to the WHO, a type 1 CSI must serve a population of 5,000 to 10,000 and a type 2 CSI must serve a population of 10,000 to 15,000. To respect this standard, health huts are often attached to a remote CSI because the one next door is full.

The conflict between the populations is a factor of separation of health facilities. When the population of a health hut is in conflict with the population of the nearest CSI, it is requested to attach this health hut to another CSI that is more distant. The competence of the agent of a CSI can also be a reason for attachment, ... PDS (2011-2015).

Among the health areas of the urban commune of Tibiri, only the health hut of Gobawa-karé complies with this WHO delimitation, it is located about 5km south of the CSI of Maikalgo. But we note that, despite the non-respect of this WHO delimitation, all the health huts of Tibiri attached to the CSI of Maikalgo are closer to this CSI than that of Tibiri (among them, the closest is 17km from Tibiri, the furthest is 21km away, on the other hand the box of Gobawa-karé and Jikata are respectively located at 5 and 7km from Maikalgo and that of Tombo-Bouya at 15km). It can therefore be noted that the attachment of the health huts of Tibiri to the CSI of Maikalgo is a function of distance.

Most of the respondents from the health huts attached to the CSI of Maikalgo think that health has no borders and consider their attachment to be normal, given the distance that separates them, the quality of the reception and the service provided to the CSI.

"Health has no borders, as proof there are many people from Nigeria who come here for treatment and why not us. We are all from the canton of Tibiri, we have the same ancestors, the same culture, the same language, therefore I see no problem. Moreover, this division

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was made before the municipalities. Finally, we are not differentiated from those of the commune of Koré Mai-Roua when it comes to treating us or anything else in the field of health" (Interview carried out in Tombo-Bouya with a patient).

It is also important to note that there is a good road infrastructure (lateritic) that connects the health center of Tombo-Bouya to Maikalgo via Gobawa-karé. But it should be noted that this sanitary division was made before this laterite.

Regarding the competence of the health worker, the major of Maikalgo is a reference in the area. He is an agent who hosts a program on health (reproductive health, the importance of property in maintaining health, etc.) on radio dallol in Tibiri every Saturday from 10:00 a.m. to 12:00 p.m. and enjoys the esteem of the population that attends the CSI.

"The little one knows his job well, which is why he did ten (10) years. He respects the sick and he gives a lot of advice to people about their health. (Interview carried out in Maikalgo with a companion of a patient at the CSI).

Another official reason why the other health huts of Tibiri must be attached to the other CSIs is the number of the population of this commune. The only CSI in the commune covers twelve (12) of the sixteen (16) health huts of the commune, which explains the burden in terms of population at this CSI.

✓ ***From Official Standards to "Practical Standards": Political Considerations as a Reason for Attaching a Health Hut to an Integrated Health Center in Tibiri***

The questions of connecting a health hut to an integrated health center in the urban commune of Tibiri are variously appreciated. It should be noted that, despite the age of this scheme (health division), it was modified to remove the Toullou-Madi health hut which was historically attached to the Tibiri CSI in order to be attached to the new Birnin N'Falla.

Indeed, the first division linked the Toullou-Madi health center to the Tibiri CSI and the Birnin N'Falla health center to the Douméga CSI. After the latter was transformed into a type 1 integrated health center, the Toullou-Madi health center was removed from the Tibiri CSI to be attached to the new Birnin N'Falla CSI.

It should be remembered that this decision was taken without respecting the basic rules that condition the attachment of a health hut to an integrated health center. The delimitation of the distance, the health hut of Toullou-Madi is closer to the CSI of Tibiri (9km) than that of Birnin N'Falla (17km). The two populations have also been in conflict for years (contradictions between the two village chiefs). This misunderstanding between the two leaders is also shared by several people from two villages.

Despite these problems, for which (rules) a health hut should not be attached to an integrated health center, the health hut of Toullou-Madi was attached to this CSI of Birnin N'Falla. This is why several respondents raise the interference of politics in the revision of the old division in order to attach their health unit to a CSI of the municipality of Douméga.

"The point of view of the population was never asked, only the major had come to tell us that from now on our CSI of attachment is Birnin N'falla, he tells us that the question comes from the top. While historically everyone knows that we are from Tibiri, they are our parents and on the other hand we have a long-standing contradiction with the people of Birnin N'falla, wanting to attach ourselves to them can have negative impacts on the health in our country, it's really politicians who make these kinds of decisions for their own interests (Interview conducted in Toullou-Madi with the village chief).

Several respondents believe that the nationals of Birnin N'falla expressed the need to have an CSI and based on this need, they exploited their relations with politicians. For this project to be carried out, health huts must be removed from the other CSIs, it is for this purpose that Toullou-Madi (CSI of Tibiri) and Mai Zabbi (CSI of Douméga) are attached to the new CSI of Birnin N' failed.

"Douméga is with a former president of Niger, they have many privileges over us. The politicians at home do not look at the suffering that we are going to live, the main thing for them is a CSI at home and that's it(Interview carried out in Toullou-Madi with a patient).

We notice on the ground that the speech of the population of Toullou-Madi is not favorable to this attachment especially that now the CSI of Tibiri has a doctor. This is a benefit to which they are deprived. They wish to be attached again to the CSI of Tibiri which for them is above all their commune and on which they have a right of inspection and even of criticism because they pay their taxes there.

Several respondents believe that this repetitive rupture of basic necessities observed at the Toullou-Mada box is due to the fact that they are attached to a CSI of another municipality. They also emphasize that they are victims of a bad reception in this CSI compared to those of the town of Douméga who are natives. This is why their words reflect regret in relation to this attachment. This transcribed haussa adage confirms the passage.

"Better where the fire was on than where it has never been" (Interview carried out in Toullou-Mada with a matron).

In short, the health boxes of the urban commune of Tibiri attached to the CSIs of Maikalgo and Birnin N'Falla do not benefit from several advantages that the municipality is full of health in the field of health.

Indeed, it should be noted that the CSI of Tibiri is the largest in the area in terms of reception capacity and staff. In the field of care, it has a doctor while the CSIs to which these boxes are attached are managed by nurses and have an insufficient number of staff. In terms of support and partners, this CSI exceeds others because of its seniority, the attached population and the fact that it is in the chief town of the department, etc. These examples represent some of the advantages to which the health boxes of Tibiri attached to the other municipalities are private.

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b. Place of Municipality in the Mobilization of Health Partners

The intervention of a partner in health facilities can be direct or indirect. It is said to be direct when the partners go directly to health facilities and inform the town hall after. It is indirect when the partners go through the town hall so that it serves as an intermediary. In general, these partners go through the town hall to have legitimacy on their intervention ground.

The partners of the municipality in the health field (projects and NGOs) carried out various actions in the various health facilities of the urban commune of Tibiri.

One of the largest health programs in the urban town of Tibiri is an electrification program with solar panels in all health boxes and the installation of mini AEPs in collaboration with the town hall. Several CS of the municipality have already benefited from the program. The electrification was implemented by Electrician without border thanks to the support of several partners such as the UNDP, EDF, FEM ... The CSI benefited from solar fans, pliers and scissors as part of this partnership.

"When the materials of the implementation of the project arrived in Niamey, the mayor had to mobilize the nationals of Tibiri in Niamey to split them and transport them to Tibiri. But it should be noted that this partnership existed long before the second mandate (the vice mayor was even invited to France and the SG of the town hall received a training always in France) with the same partners. The image of the former mayor, current vice-president of the COGES of the CSI of Tibiri was forward in this partnership"(interview carried out there Tibiri with a municipal councilor).

We note through this example that elected officials can use personal relationships to bring partners. The outgoing mayor was able to take advantage of his relations with Alain, a French member of (Creusot) on a mission in Tibiri to negotiate the electrification of healthy centers. He continues to take care of the question even after his dismissal because Alain delegated him to manage the questions. So, this allows us to say that personality counts in the context of a partnership and the conquest of the achievements.

After the routing of these materials, the town hall had dispatched missions to the health boxes in a prelude to the implementation of this project. This project aims to electrify all CS but it is split into phases, each phase a limited number of boxes is chosen to benefit from it.

At this level, it should be noted that the criteria of choice are vague, which means that the populations do not master the criteria put forward. According to several advisers, members of the Coges and the SG of the town hall, the criterion is that of the village which pays its taxes in time and without problem. But according to the outgoing mayor, with whom the work has started and who continues to follow the question (which is currently vice-president of the COGES of the CSI) and a former advisor (who is also currently SG DU COGES of the CS of his village) , the main criterion chosen at the first mandate was to favor the most distant CS from Tibiri, but the new executive highlighted political criteria (the number of votes in their political party) to make a new choice.

Among the health boxes already electrified, two (2) belong to the health area of the CSI of Maikalgo (Jikata, Gobawa-Karé) and one (1) (Toullou-Mada) in the health area of Birnin N'falla.

This note that among the health boxes of the municipality belonging to other health areas, only the Tombo-Bouya health box is not yet electrified while that of Jikata has benefited from the installation of Mini AEP.

Apart from this electrification and installation program of water tower, several NGOs and projects are involved in the health field in Tibiri. This is the NGO VEDDN which leads awareness of reproduction health (SR), prenatal consultation and family planning (CPN/PF). She leads awareness campaigns on several themes in villages in the town.

There is also the intervention of the NGO Adra, which built the drilling of the CSI maternity hospital in order to relieve the parturients and their accompanying. The PCDII intervenes in the construction of healthcare rooms, maternities and ensure their fence. PAM and Gaded also intervene in the management of malnutris, generally WFP entrusts this task to NGOs or projects involved in the same framework.

The management of health in this context of integral communalization requires the participation of all goodwill. Health being an area where work equipment is expensive. This is why, the town hall's resources do not allow him to take charge of the needs of this field, we must necessarily call on other health partners. The town hall of the urban town of Tibiri played an important role in the mobilization of certain partners in this area for the care of its citizens. Only it is that it should be emphasized in this part, apart from the policy of electrification and installation of the drinking water adduction (which is not as effective), the health areas of Tibiri are not counted among the beneficiaries of the other so high supports listed, because they are not attached to the CSI of Tibiri.

- ✓ ***Municipalities and Health Issues at the District Level***

As part of the health promotion at the departmental level, the district framework team (ECD) made up of five (5) members including 2 doctors trained in district surgery, a manager, an epidemiologist and a communicator, invites the different municipalities in the district GA (2 times a year). This is a moment of exchange between actors on all questions of departmental interest in health.

"All health issues are mentioned during these GAs, and if there is a situation, we ask the town halls to take care of, we consult and we take commitments especially we know that the administrative division did not affect the health cutting, so all the questions are technical and interest everyone" (Interview with Tibiri with the mayor).

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Administrative division is superimposed on health cutting throughout the country. In Doutchi as in other departments, this overlapping has attached health huts from one municipality to another it is what is called health area, suddenly the question binds them in actions and reflections.

However, we see that town halls do not associate themselves for the management of their health areas. At this point, it should be noted that the town halls have a single formal framework (meeting of the district team team in Doutchi twice a year) of exchange on health issues at the departmental level. In addition to this meeting of Doutchi, town halls do not have an exchange initiative specific to them or common actions in the management of health areas.

There is a kind of resignation from the municipal authorities in the management of their health training in this context of the integral communalization unlike the text of decentralization. Law No. 2002-013 of June 11, 2002 transferring skills to regions, departments and municipalities stipulates that the municipality participates in the definition and development of departmental plans and programs in terms of health development in compliance with departmental guidelines. Article 81 of the same law, gives municipalities the management of integrated health centers and health boxes. They are officially in charge of the creation, equipment and maintenance of the infrastructure of integrated health centers and health boxes located in their space, as well as their supply of drugs in compliance with the standards established in this area.

This provision which reserves a place of choice and responsibility to the municipalities is far from being applied by the municipality of Tibiri as well as the municipalities to which its health boxes are attached. This partly explains the dysfunction observed in health centers.

It should be noted, through this passage that the management of health areas in this context of integral communalization does not constitute a question in its part at the departmental level or in the urban commune of Tibiri. It is managed in the same way as all other health issues at the departmental level. The fundamental link between health areas and the health issue as taken at the department is hierarchical, everything goes first by the CSI of attachment.

✓ ***Electriciens Sans Frontières, an Unfinished Program***

Electriciens sans frontières is an electrification program and installation of a mini drinking water supply (AEP) in all the health huts of the urban municipality of Tibiri. This program piloted by Creusot bourgogne with the support of several partners such as UNDP, EDF, FEM ... is now fully executive in some boxes, in others in half and other health boxes are still waiting for its start. Among the health areas of the urban commune of Tibiri attached to the CSIs of Mai kalgo and Birnin N'Falla, the health center of Jikata benefited from a solar panel and a water tower, those of Gobawa- karé and Toullou-Madi have benefited from the solar panel and that of Tombo-Bouya has not yet benefited. This question leads to a difference in the visibility and operation between these health facilities.

The Jikata health center is now a reference in terms of equipment for this program and this has reinforced the quality of its service and its attendance.

"The water and electricity have made the Jikata health hut clean and visible because the other huts, especially in the commune of Koré Mai Roua to which we are attached in the field of health, have not been so lucky. The health worker now has electricity to treat at night, attend a delivery, etc. Accompanying persons do not need to go to the well to draw water after childbirth or for any other need, there is a pump in front of the hut" (Interview conducted in Jikata with the village chief).

The health center of Tombo-Bouya is the only one among the health areas of the urban commune of Tibiri attached to the communes of Koré Mai Roua and Douméga which has not yet benefited from this program. At this level, it should be noted that the selection criteria for the installation of a water tower or a single-cell solar panel are obscure. Several councilors underline the remoteness of the health center from the municipality and others speak of the regularity of the village in the payment of its taxes.

"We always ask for the criteria according to which they electrify a hut in Tibiri. Otherwise, we are the furthest box and which has the largest number of populations. Our village remains and always remains the first in terms of tax…, but all the boxes have benefited with the exception of us, we have been forgotten despite our repetitive grievances" (Interview conducted in Gobawa-karé with the treasurer of COGES).

C. Other Health People in the Urban Municipality of Tibiri

According to Philippe and Herzlich, the disease is a matter of groups and not only of individuals, it presents itself in public space and not only in the private space of the doctor-parturient relationship, the use of care depends on culture, representations, constructions of the patient and/or his entourage etc. This is why it is necessary to bring out the actors other than those of health that participate in the delivery of care in Tibiri.

✓ ***The matrons: the Role Confirms its Legitimacy in the Eyes of the Population***

In the urban commune of Tibiri, the system of matrons is characterized by a remarkable organization. In general, this body is made up of elderly women who exercised this profession long before the establishment of health facilities, especially in the villages.

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The matrons are responsible for monitoring all pregnant women in the city (by neighborhood) or the village (by small neighborhood or nearby villages) and encourage them to go from the 3rd month of pregnancy for the CPN. They encourage these women to respect the CPN calendar well and to consume the products received. As soon as childbirth is announced, the woman through her relatives calls on the matron of the neighborhood or the village to accompany him in an FS. The matrons of the villages which have an FS assist the healthcare agent for childbirth, wash the equipment of the delivery box before and after each delivery, clean up the delivery room, clean the newborn, wash the placenta, the plastic spread over the delivery bed, accompany the parturient in the observation room, often wash the clothes of the parturient and accompany them to the house. Sometimes, matrons provide certain tasks that fall under the medical field.

"Sometimes we cut the umbilical cord if the health worker is traveling or when there are several deliveries" (Interview carried out in Jikata with a matron).

Despite all of the above, matrons are an important and essential body especially in rural areas in the assistance of women when it comes to deliveries. They benefit from a social legitimacy pushed due to the nobility of the task which they work.

In this context of integral communalization, the text of decentralization stresses that the population must fully participate in the management of business concerning them. The matrons responded to their presence in the management of health areas in order to accomplish their share of responsibility to allow a proper functioning of these centers. The latter constitute an important group in the issuance of the services of childbirth, they follow women of pregnancy until often childbirth in difficult conditions.

✓ ***Bokas/Zima or Trades-Practians: A Permanent Tradition***

These actors involved in the management of diseases in the town of Tibiri are confused on both sides by the population.

Although the difference is not enormous between these terms, it is necessary to provide some details. There are simple traditions, who know the secret of the roots, bark and trees, which very often inherited their parents. They do not work with geniuses. There are also blacksmiths who treat fire burns with products and only take what they are given, themselves are generally heirs. These tradic-praticians are limited to the sale of their product against hemorrhoids (Zahi), tension (Hawanjini), Hématie (Sanyin kashi).

Bokas or Zima give roots or other products but these products are "recommended" by geniuses. They are consulted for children's convulsions, madness, "Kamun Doguwa" (which people confuse with tension), "Daji" (disease caused by bush geniuses), jaundice. The products are the roots, the bark, in flour or in liquid, the incense, powder to be suckled by the nose ... Generally, the consultation is free, and they do not require a fixed sum. The patient is committed to giving something (silver, black domestic animal, etc.) in case of satisfaction. Sometimes it is even geniuses that require the sacrifice of an animal or a bird with a specific color. Several bokas orient towards the FS when they note that the disease does not fall under jinns. In the urban commune of Tibiri, there are villages which are renowned for the use of bokas services: Salkam, Kola Gobirawwa etc.

✓ ***The Involvement of Customary Authorities in the Health Field***

The chiefs of villages and districts are first of all fully involved in the activities of the Coges, the elections of the members and those of the matrons are generally made before their court. They are invited to all general assemblies (AG). When there is a problem with a health box, the village chiefs are in front of the scene with the members of the Coges to find a solution.

We note that, at this hour of integral communalization, the customary authorities also participate in the management and promotion of health in their respective areas through awareness campaigns, participation in meetings. They remain in contact with health players and enjoy respect for their responsibility, which is why, they are invited by the municipality but also by health facilities in the event of health activities.

✓ ***Diaspora***

Diaspora are also actors who participate in the management of health facilities in this context of the integral communalization. They intervene in the purchase of gas candy for sting conservation in CSIs and health boxes (the example of the Afole box is quite illustrative). The latter also participate in the construction of housing of health workers or observations rooms, in the purchase of pharmaceutical products, etc.

They often intervene in the construction of health centers and the transformation of others (from a health box into a CSI). Diaspora also intervene in the assignment of health workers following the demand of the local population, etc.

"Goodwill is all over the world especially in the health field, diaspora have a historic responsibility to think of us that parents because we are nothing without them. If we suffer, they also suffer that is why they are of times they bring their contribution without being asked"(Interview with Tibiri with the President of Coges).

The diaspora of Tibiri also showed this desire when it was a question of transporting the electrification equipment of the boxes and the installation of the mini water adductions brought from France for Tibiri. The latter have cleared these materials to Niamey before transporting them to Tibiri.

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These actors are important in the management of health facilities. In this context of decentralization or the population must participate in the management of cases concerning them, they have contributed significantly to the issuance of health services through the purchase of materials and donation of products etc.

✓ ***Pharmaceutical Deposits: A Local Service***

The urban town of Tibiri has pharmaceutical deposits, the latter actively participate in the issuance of health services.

It should be noted that the rupture of drugs is a tradition in almost all health facilities and especially in the municipalities. In the event of a rupture, the agents prescribe prescriptions for users in order to pay the products. These orders prescribed to the CSI or in health boxes are directed to pharmaceutical deposits.

The CSI and health boxes also refuel in these pharmaceutical deposits in the event of product breaking or when a specific product is finished. Some of these deposits attract customers by granting a donation or surplus of products with all supplies.

"Health box managers come to refuel here almost every week especially during the period of malaria, the CSI also comes for certain products, with each refueling I give them a donation of 20,000F to 30,000F, which means that the partnership between us is strong" (Interview with Tibiri with the manager of the Guingarey Sawki pharmacy).

Apart from the products given after each supply, these deposits often make donations of products to the town hall for health facilities.

It also constitutes a response to the repetitive rupture of products observed in all health facilities in the municipality of Tibiri.

This part devoted to the various players in the management of areas in this context of the integral communalization gave a brief overview of everyone's participation in the issuance of health services in Tibiri. It appears that these actors participated in one way or another in the management of health areas and that a remarkable work is shot. Only, despite the efforts made, much remains to be made. It must also be said that a lack of coordination in the interventions is observed. This coordination problem is due to the large number of stakeholders in management.

Conclusion and recommendations

Health and decentralization are two public policies faced with multiple challenges in Niger. It should be remembered that the objective set for this study was to understand the constraints encountered by the municipality of Tibiri in the management of its Integrated Health Center (CSI) attached to the Integrated Health Center (CSI) of Maikalgo and Birnin N'Falla (communes of Koré and Douméga) in this context of integral communalization.

Indeed, these boxes carry aspects in them which explain their belonging to other health areas. This is mainly their geographical position in relation to these Integrated Health Center (CSI).

This article made it possible to understand that all the health (boxes) with the exception of that of Toullou-Mada are closer to the Integrated Health Center (CSI) of attachment than that of the municipality of Tibiri. Other rules also explain this health division in Tibiri (overcrowding of the Integrated Health Center (CSI), the right communication route, etc.). Only, it should be noted that aspects contrary to the rules were noted in the context of this health division. When there is a conflict between two or more villages, the regulations of the health require separating them from the (care center) (the conflict between the population of Toullou-Mada and Birnin N'Falla, the distance between this Health Center Toullou-Mada and the Integrated Health Center (CSI) of Birnin N'Falla compared to the Integrated Health Center (CSI)of Tibiri…,).

Likewise, this article has made it possible to better understand the complexity of health and decentralization, in their aspects of maintaining social balance and the promotion of democracy at the base. These two policies participate in the construction of a nation, hence their importance on a global scale.

However, it should be noted that at the national level, the financial constraints are real, imposing difficult choices on the public authorities, which suggests that the question of health still remains, in Niger, a commodity whose access is Not within everyone's reach. The urban municipality of Tibiri does not have the necessary financial means allowing it to take charge of the needs of its health training as provided for in law 2002-013 of June 11, 2002. Despite the difficult applicability of this provision by the urban municipality of Tibiri, it has carried out some actions even if they are deemed insufficient by the communities.

We can also note, the problem of transfer of skills of the central state to the municipalities which is however fundamental in a context of decentralization. In addition, the majority of actors who animate decentralization have a low level of experience in administrative management. All these constraints, explain the difficulties encountered by the municipality in the management of its health centers.

Another obstacle to the management of health areas that must be emphasized and not the least is the superposition of administrative division to health cutting. In the municipality of Tibiri this superposition poses a problem of management of health areas by the town hall which considers that these boxes are attached to the health field to the Integrated Health Center (CSI) of Maikalgo and Birnin N'Falla (Koré and Douméga).

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The logic of decentralization implies a participatory community democracy (Ribot: 2001). Faced with all of these constraints, we note, an intervention competition for several skills (town hall, NGOs, projects, matrons, nationals, customary chiefs, bokas/zima, coges etc.) All these people and structures each contribute to this concerns them and according to their means of edge to the preservation of the health of the populations. If we are delighted with the stone that each one brings to the construction of the health of the populations themselves, it should be noted that a coordination problem arises when we know that the multiplicity of stakeholders often leads to confusions.

The study ends up with some key recommendations for a better the management of health services in the municipality of Tibiri. These recommendations are:

- ✓ Municipalities must be strongly involved in the creation, equipment and management of health facilities as provided for in the texts of decentralization
- ✓ The municipality of Tibiri must intensify the control of pharmaceutical products from Nigeria to prevent the impact on the attendance of health areas in the urban commune of Tibiri
- ✓ The Government must build a district hospital with modern equipment in Tibiri to impact the forms of collaboration between health facilities and the municipality.
- ✓ The transfer of skills in the field of health must be effective to enable municipalities to fully play their role

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