
Power and pro-poor policies: the case of iCCM in Niger

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Abstract

Analyses of health policy in low- and middle-income countries frequently mention but rarely adequately explore power dynamics, whether or not the policy in question targets the poor. We present a case study in Niger of integrated community case management (iCCM), a policy to provide basic care for poor rural children sick with malaria, diarrhoea and pneumonia, which has contributed to measurable reductions in child mortality. We focus on the three dimensions of power in policymaking: political authority, financial resources and technical expertise. Data collection took place March to August 2012 and included semi-structured interviews with policy actors ($N=32$), a document review ($N=103$) and contextual analysis. Preliminary data analysis relied on process tracing methodology to examine why iCCM was prioritized and identify dimensions of power most relevant to the Nigerien case; we then applied theoretical categories deductively to our data. We find that political authorities, namely President Mamadou Tandja, created the underlying health infrastructure for the policy ('health huts') as a way to distribute rents from development aid through client networks while claiming the mantle of political legitimacy. Conditional influxes of financial resources created an incentive to declare fee exemptions for children below 5 years, a key condition for the policy's success. Technical expertise was concentrated among international actors from multi-lateral and bilateral agencies who packaged and delivered scientific arguments in support of iCCM to Nigerien policymakers, whose input was limited mainly to operational decisions. The Nigerien case sheds light on the dimensions of power in health policymaking, particularly in neo-patrimonial African regimes, and provides insights on how external actors can work within these contexts to promote pro-poor policies.

Key words: Africa, child mortality, health policy, power, rural health

Key Messages

- Research on health policy, particularly in low- and middle-income countries, has rarely focused on questions of power as they impact policy decisions.
- We offer a policy analysis of integrated community case management of childhood illness (iCCM) in Niger based on the three dimensions of power: political authority, financial resources and technical expertise.
- We find that power dynamics embedded in governance structures and political economy features of the Nigerien state were decisive in key policy decisions and helped motivate a pro-poor agenda; well-timed injections of external funds and the combination of international agencies' scientific expertise and Ministry officials' operational know-how were also pivotal.
- International agencies and policy actors often fail to sufficiently understand local power structures, thereby passing up opportunities to successfully promote pro-poor policies.

Introduction

Despite widespread declines in child mortality rates in recent years, an estimated 6.3 million children below 5 years still die each year, many from preventable, treatable diseases including pneumonia (15% of deaths), diarrhoea (9%) and malaria (7%) (You, Hug *et al.* 2014). Integrated community case management of childhood illness (iCCM) is an evidence-based strategy to provide life-saving curative care for these diseases to children in low- and middle-income countries (LMICs), using health workers at the community level (Young *et al.* 2012). While not explicitly marketed as a 'pro-poor' policy, iCCM primarily benefits poor rural populations, with few direct benefits to segments that already have access to the health system. The World Health Organization (WHO) and UNICEF promoted iCCM in a 2012 Joint Statement (WHO/UNICEF 2012); powerful bilateral agencies and civil society actors such as USAID, the Canadian international development agency Save the Children and the Gates Foundation have also supported its development and implementation. Nonetheless, a survey of UNICEF country offices in sub-Saharan Africa found that while many countries had adopted policies supportive of community-level treatment of childhood illnesses, fewer had implemented integrated approaches to CCM at any scale (George *et al.* 2012).

In recent years, scholars of health policy in LMICs have observed that power dynamics can be decisive in policy outcomes, for example via the exercise of political power in priority-setting processes and policy reform (Reich 1995; Shiffman and Garcés del Valle 2006; Shiffman and Smith 2007) and the ability of front-line health workers to limit or shape the implementation of decisions made at higher levels (Lipsky 1980; Erasmus and Gilson 2008; Lehmann and Gilson 2012). Nonetheless, the concept of power is often evoked without a specific theoretical exploration of what is meant by the term (Gilson and Raphaely 2008; Buse *et al.* 2009a). A better understanding of the concept of power is necessary to tease apart how and why LMICs adopt and implement health policies targeting poorer populations less likely to exert significant power in policy reform.

In this article, we provide an analysis of power in the policy process using a case study of iCCM development and implementation at the central government level in Niger. Access to healthcare for Niger's poor, rural populations has historically been extremely limited; the country's health system has been described as one of 'urban privilege' (Raynaud 1987; Körling 2011). Nonetheless, in 2007, Niger became one of the first countries in sub-Saharan Africa to adopt iCCM and it remains one of the few where it has been implemented at a national scale. Furthermore, effective implementation of iCCM and surrounding policies was found to contribute nearly a quarter of Niger's 43% reduction in child mortality between 1998

and 2009 in a study using the Lives Saved Tool (LiST) to calculate the impact of interventions on child mortality (Amouzou *et al.* 2012).

To understand power in Niger's iCCM policy development process, we first examine theories of power and select the three dimensions of the concept based on preliminary analysis of case study data. Next, we describe data collection methods and apply an analytical framework for understanding power in the Nigerien case. Finally, we discuss findings and the case's significance for understanding how pro-poor health policies can be promoted in countries with similar political and economic contexts.

Background

The concept of power remains elusive both conceptually and empirically (Hyden 2008). Foucault (1994) called power the 'most hidden' part of human relations and the very concept may be 'essentially contested', meaning the subjective assumptions needed to analyse it are inherently value-dependent (Gallie 1955–6). Stephen Lukes (2004a) suggests the term itself is 'polysemic' and can be defined to include or exclude a range of phenomena such as authority, influence, coercion, force, manipulation and domination. And while many analyses of power cite Robert Dahl's (1961) classic definition, 'A has power over B to the extent that he can get B to do something that B would not otherwise do', others argue this formulation captures only overt, compulsory forms of power, ignoring more subtle phenomena such as those encompassed by Bertrand Russell's (1938) power of 'propaganda or habit' or Gramscian 'hegemonic ideas' operating unnoticed in the background (Gramsci 2012).

Power is fundamental if mysterious force in health policy as in all human endeavours and in recent years scholars have called for empirical studies of power in health policy to advance understanding and ultimately 'tackle the global political determinants of health' (Buse *et al.* 2009a; Marten *et al.* 2014). We began from a largely agnostic position on the dimensions of power most relevant to health policymaking processes, considering theories encompassing both the sources of power (e.g. in personal charisma, procedural reason, physical force) and the mechanisms by which it is exercised in society (Russell 1938; Weber 1948; Giddens 1984; Foucault 2002; Lukes 2004b). Given the theoretical cornucopia at our disposal—and early stage of the health policy literature in tackling this topic—we decided to focus on dimensions of power most relevant to the Nigerien case, as revealed by preliminary data analysis. Other forms of power, such as those based on personal characteristics or physical or military force, while excluded from this analysis, may be of greater relevance to other studies and contexts, but did not appear

to be of primary importance in the Nigerien case. The three dimensions of power that emerged as most salient and are discussed here are (1) political authority, (2) financial resources and (3) technical expertise.

The first dimension of power, political authority, can influence policy development processes in both direct and indirect ways. Indeed, policy reform is a ‘profoundly political’ process as it explicitly decides who in society receives valued goods in society (Reich 1995). Possessors of political authority (e.g. presidents and prime ministers but also lower-level political officials) can directly advance or hinder specific health policies by drawing attention to issues, controlling financial resources and regulatory regimes and selecting health policy actors and applying pressure on them (Croke 2012; Shiffman and Garcés del Valle 2006); furthermore, political cycles and incentives can be exploited by policymakers to improve the chances of policy reforms (Reich 1995). Holders of political authority can also have indirect impacts on policymaking, e.g. by creating institutional incentives and constraints or setting up trade-offs with competing priorities. Furthermore, less overt sources of power such as political legitimacy can provide leeway to actors possessing it or motivate policy decision-making.

The second dimension of power, financial resources, is in some way the simplest: funding is the *sine qua non* of the policy enterprise, especially at the level of implementation. Beyond the mere availability of financial resources for the policy in question, however, it is relevant to consider who possesses or controls these financial resources, as these actors have inherently greater advantages in the political (and policy) arenas (Wright Mills 1968; Buse *et al.* 2009b). In the arena of health policy, actors exercising financial power at the national level include politicians exercising control over state budgets or international donors in the position to offer funds for the health or other sectors. Financial resources are thus inseparably linked to the power of political authority, in that revenue flows (stemming from sources both internal and external to the state) bestow power on actors, who choose where to allocate funds among various policy options. Actors may also support the spread of policies through the ‘manipulation of economic costs and benefits’ of choices, as has been observed in the international policy diffusion literature (Dobbin *et al.* 2007).

Third, technical expertise is intrinsic to government action in the modern era, and control over knowledge and information is a crucial dimension of power in policymaking (Haas 1992; Rose and Miller 1992). Technical capacity to produce, interpret and disseminate knowledge and information is differentially distributed among actors within the policy sphere, particularly in LMICs, where powerful international actors often proliferate (Pallas *et al.* 2015). The type of actors exercising technical power depends on who possesses the training that confers these capacities (and the diplomas to prove it), but would typically include technical officers in ministries and international organizations. Actors’ technical education and training not only condition the epistemic and normative frameworks guiding their practice but also confer power in and of themselves: in global health, Shiffman (2014) finds that holders of expertise claim authority based on a privileged relationship to the truth and a superior procedural way of moving towards the ideal policy outcome. At lower levels, actors can also exercise technical power via regulatory and operational decision making (Lipsky 1980; Erasmus and Gilson 2008; Lehmann and Gilson 2012). Finally, since Foucault (1994), we understand knowledge itself to be the product of power relations in the society that created it, meaning the way problems are presented and the scientific or technical arguments used to support policy positions must be reflected upon critically.

Across all these dimensions, incentives and constraints affect the choices made by those in possession of power, as power is ‘a dispositional concept, comprising a conjunction of conditional or hypothetical statements specifying what would occur under a range of circumstances *if and when* the power is exercised’ (emphasis added) (Lukes 2004a). This ability to act or not act in favour of a policy (or anything else) is what Bachrach and Baratz (1970) call the ‘two faces of power’. Indeed, all three dimensions of power identified here can be exercised according both active and passive mechanisms: endowing funds, or withholding political support, making scientific or technical arguments in favour of a policy, or remaining conspicuously silent. In our study of the Nigerien case, we will seek both positive and negative examples of the use of power.

Nigerien context

Since independence in 1960, Niger has experienced alternating periods of autocratic rule and democratic governance, punctuated in the past two decades by *coups d'état* in 1996, 1999 and 2010. Political authority in Niger conforms to classic models of neo-patrimonial governance in Africa, characterized by a strong executive branch, reciprocal clientelism and extensive patronage systems (Bratton and van de Walle 1994; Therkilsden 2005; Bach 2012). Power in such regimes ‘is concentrated and personalized, entailing discretionary control over broad realms of public life’ (Lewis 1996). In countries with multi-party electoral systems, as in Niger, large partisan operations are marshalled in the service of reciprocal clientelism (Olivier de Sardan 2004; Tidjani Alou 2012). When public finances and government services are weak, as in Niger, rulers are further incentivized to cultivate electoral support via patronage instead of promises of future programming, as voters view skeptically the government’s ability to deliver on said promises (Kaufman *et al.* 2008; Kelsall 2011b).

Neo-patrimonial political authority is predicated on rent sharing (via patronage); however, Nigerien authorities have historically had limited access to financial resources and few revenue-generating capabilities. Niger’s tax-to-GDP ratio is well below the West African Economic and Monetary Union target of 17% and the extractive sector, a main source of government revenue, suffers from insufficient profit monitoring and diversion of funds (AFD 2011). The resulting chronic fiscal weakness and recurrent deficits have been mitigated by large aid flows; as a result, government policymakers in all sectors are heavily dependent on aid to finance basic programming. Table 1 shows Niger’s main sources of revenue from 2005 to 2007, the only years for which tax revenue data is available (these years also coincide with the period during which iCCM policy was tested and adopted). These figures demonstrate Niger’s advanced level of aid dependence, particularly as Goldsmith (2001) has suggested countries with overseas development aid (ODA) >10% of gross national product are likely to have ‘questionable sovereignty in key policy areas’.

Compared with other LMICs, Niger has limited technical capacities in health policymaking, with a small tertiary education system drawing from a population with a low literacy rate (29%) (UNESCO 2012). While the uranium boom in the 1970s financed the creation of a relatively strong public administration, structural adjustment policies in the 1980s and 90s caused a major degradation in institutional planning capacities. At the same time, there was attrition of the technocratic class, whose brightest members were lured by significant salary differentials at aid organizations. The result was prolonged technocratic atrophy in the government sector, whose effects are apparent today in the degraded planning

Table 1. Nigerien government revenue during iCCM policy development (2005–07)

	2005	2006	2007
Gross national income (GNI) (thousands of US\$)	3 396 604	3 645 126	4 290 093
Tax revenue (thousands of US\$)	323 295	363 813	415 957
Tax revenue (% of GNI)	9.5	10.0	9.7
Net official development assistance (ODA) (thousands of US\$)	604 460	611 060	565 150
Net ODA (% of GNI)	15.4	14.9	12.7
External resources for health (% total expenditure on health)	34.9	32.8	31.6

Source: Based on World Bank data

capacity of state agencies (Lavigne Delville and Abdelkader 2010). Currently, international organizations continue to employ large numbers of Nigerien and international technical staff, with human and material resources that often dwarf their government counterparts; the UNICEF campus in Niamey alone counts over 55 technical experts (including 25 local and 30 international staff), not including consultants hired on a temporary basis (H. Touré, personal communication).

Methods

Case study methodology is useful for reconstructing phenomena holistically to reveal underlying processes (Yin 1994). We used a document review, semi-structured interviews and contextual analysis to document the iCCM policy process in Niger and analyse how the three dimensions of power—political authority, financial resources and technical expertise—contributed to policy outcomes.

Primary data collection took place from February to August 2012 and included (1) an extensive document review and (2) interviews with Nigerien and international officials involved in formulating iCCM (Table 2). For the document review ($N=103$), we combined close reading of documents on iCCM from sources such as government ministries, international organizations and public sources, with systematic data extraction across such categories as the document's type/purpose, authorship, justifications put forward, budgetary data (when available) and scientific or technical argumentation. In-depth semi-structured interviews ($N=32$, $n=28$ in country) were conducted with individuals involved with the iCCM policy process and identified through the document review and snowball sampling. Interviews were conducted in French and transcribed in-country. We complemented these data sources with secondary analyses of Nigerien political economy, political history and quantitative economic indicators.

For preliminary data analysis, we used process tracing to combine multiple sources of information establish causality, reveal political and social processes and minimize bias when describing events and processes in the policy cycle (Yin 1994; Shiffman *et al.* 2004). As such, we compiled a timeline of iCCM policy development using information gleaned from interviews, the document review and secondary analyses of the Nigerien political context. Interviews were coded on categories related to the policy actors, processes and content; political and financing issues; technical expertise and scientific argumentation and mentions of power using NVivo 9 (QSR 2010). We then interrogated our data using questions and theoretical categories drawn from the literature on power

Table 2. Primary data collection

Document review		
	N	Examples
Official policy	22	<ul style="list-style-type: none"> – National strategies for child survival, family health practices, malaria control – Policy declarations or directives in the area of health – Human or health sector development strategies (Health Development Plan, Poverty Reduction Strategy ...) – Training manuals for health workers
'Grey' literature	29	<ul style="list-style-type: none"> – Preliminary or draft versions of health policies – Internal documents (meeting minutes, PowerPoint presentations from workshops, supervision reports ...) – Project proposals/funding requests for donors – Reviews of IMCI in Niger and region (WHO, WAHO, UNICEF ...)
Scientific data/evidence	31	<ul style="list-style-type: none"> – Articles in international journals on health programs or policies in Niger – Doctoral students' dissertations in health/public health – Surveys from Nigerien statistics agency or external organizations – Socio-anthropological research on the Nigerien context – Action research studies (e.g. on family health practices)
Other	21	<ul style="list-style-type: none"> – Laws and regulations – Cooperation agreements between Nigerien government and external actors – Articles published in Nigerien newspapers, other newsletters or publications – Historical documents on the implementation of IMCI
Total	103	
Semi-structured interviews		
	N	Examples
Government sector	19	<ul style="list-style-type: none"> – Senior and mid-level Ministry officials in departments of reproductive and child health, community health, health education, nutrition, etc. – Officials at regional health offices and the national malaria program – Clinicians at national reference hospitals and maternities and IMCI trainers – Ministry of Communication (community radios program)
Donors and technical assistance	10	<ul style="list-style-type: none"> – WHO-Niger program officers (child/reproductive health) – UNICEF-Niger program officers on child survival, health communications, etc. – USAID staff working on BASICS, BASICS II and AWARE-RH programs – International consultants hired for research, training, report writing, etc.
NGOs and civil society	3	<ul style="list-style-type: none"> – Country staff at international and local development NGOs – Members/leaders of health worker professional associations
Total	32	

Table 3. Framework on power for a policy analysis of iCCM in Niger

	Concept	Questions to guide inquiry and analysis
Political authority	Systems of governance	<ul style="list-style-type: none"> – Which persons or groups hold decision-making power? What rules condition its use? – By what mechanisms is political authority exercised? Is the political system presidential, parliamentary, authoritarian, etc.? – What forms of political participation exist and are effective? – What interests and factions exist within the state?
	Institutional incentives and constraints	<ul style="list-style-type: none"> – What demands (financial are otherwise) are put on political authorities? What are the institutional limits of political authority? – What incentives do political authorities have to align themselves with segments of the population? What disincentives? – What accountability mechanisms exist and are enforceable? – Is power in the political regime viewed as legitimate? What is the basis of this legitimacy (electoral, redistributive, rhetorical, etc.)?
	State capacity/weakness	<ul style="list-style-type: none"> – To what extent are official channels of authority respected or challenged? Does the state control what happens within its borders? – In which areas is state capacity strongest/most limited?
Financial resources	State sources of revenue	<ul style="list-style-type: none"> – What are the main sources of state revenue and in what proportion? <ul style="list-style-type: none"> ○ Internal sources: tax base, extractive or other sectors, etc. ○ External sources: trade flows, aid intensity and/or dependence
	Loci of control over resources	<ul style="list-style-type: none"> – Which actors or groups control financial resources? In what other spheres do they have leverage? – Which actors have the ability to manipulate the economic costs and benefits of policy decisions?
Technical expertise	Availability of resources for the policy	<ul style="list-style-type: none"> – Which resources could potentially be used for the policy in question? How liquid and/or fungible are they? – What other priorities compete for the same resources? – What trade-offs come with accessing available financial resources?
	Technical capacity	<ul style="list-style-type: none"> – Which actors or groups are best equipped to produce, interpret and disseminate technical knowledge? Which are less well equipped? – What is the relative level of capacity of state and non-state actors? – Who are the main sources of knowledge and how is knowledge transmitted within and between policy circles? – What potential viewpoints or biases might stem from technical education/training, disciplinary backgrounds, etc.?
	Decision-making autonomy	<ul style="list-style-type: none"> – What is the role of technical staff in health policy decision-making? – What is the relationship between health policy actors and holders of political authority? – What operational and regulatory levers and constraints exist and who is in a position to control them?
	Nature of technical knowledge	<ul style="list-style-type: none"> – What are the origins of the frameworks, norms and ideas that shape technical inquiry? – How are issues framed? What is the stated problem to be addressed? What arguments are used during discussions? – What are recent trends in prioritization and technical content in the policy area?

discussed earlier, focusing on the dimensions of power that emerged as most relevant during preliminary data analysis (Table 3). Our analytical strategy was thus both inductive (selecting dimensions of power to focus on based on preliminary analysis) and deductive (applying theoretical concepts drawn from the political economy and health policy literatures to the data).

The elusive, contested and value-laden nature of power analysis gives rise to particular challenges. Prior to and throughout data collection and analysis, we kept detailed ‘reflexivity memos’ to interrogate our assumptions and values and how these could impact data collection, analysis and findings. We also used regular debriefings to confront the analytical perspectives of authors from different ‘power perspectives’, namely those from western institutions and West African researchers more intimately versed in local political dynamics and cultural norms. This research was approved by the relevant committee.

Study limitations

This study has some limitations. Not all targeted stakeholders, particularly high officials within the Ministry of Health (MOH), were able to be interviewed and some key documents were unavailable due to the destruction of WHO-Niger servers by fire in 2007;

budgetary data were difficult to obtain. As in any qualitative study, respondents may have sought to portray events strategically; we triangulated between respondents and other data sources to understand how a respondent’s position might affect his or her words, remaining vigilant for the ‘double-speak’ characteristic of West African bureaucracies (Olivier de Sardan 2004).

Results

Origins and policy precedents of iCCM in Niger

The development of iCCM in Niger can be traced from the late 1990s to its full implementation in 2011 (Figure 1). Historically and into the 1990s, Niger suffered from extremely high rates of child mortality (estimated at 226 deaths per 1000 live births in 1998) which, combined with high fertility rates, meant that most Nigerien families could expect to lose at least one child (Amouzou *et al.* 2012). Efforts to introduce policy to combat this situation in the 1990s were hindered by ongoing political instability; however, in 1997 MOH adopted and began implementation of a major child survival program called Integrated Management of Childhood Illness (IMCI). IMCI included three components: clinical case

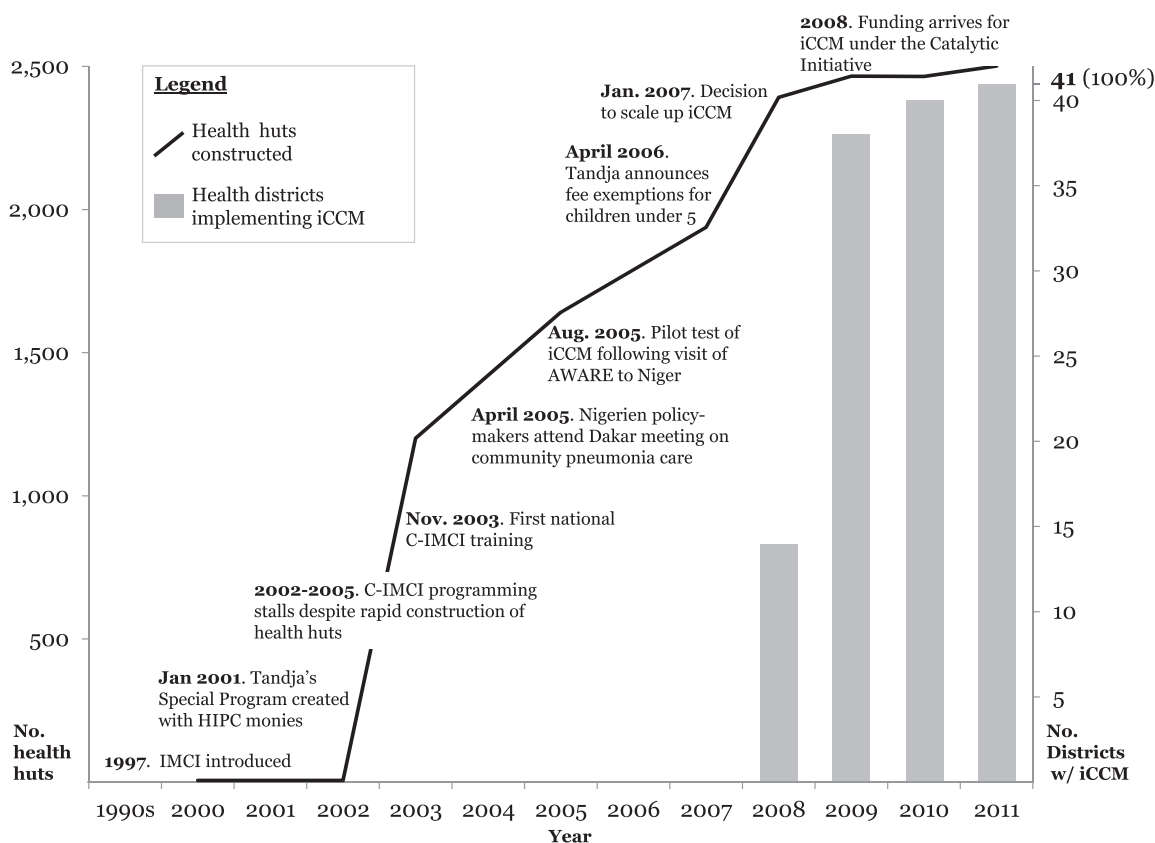


Figure 1. Timeline of iCCM policy development.

management, health system strengthening and a 'community' component to strengthen links between health facilities and the communities they served.

IMCI was designed to improve child survival rates; however, its implementation in Niger was mainly limited to health facilities and thus failed to reach a large portion of Niger's children, who lacked access to these facilities for economic, geographic and social reasons. And though political stability returned to Niger with the advent of the Fifth Republic in 1999, creating a more favourable environment to pursue policy enterprises, implementation of 'community' IMCI remained stalled, even following a national orientation workshop in August 2002 and initial training sessions in 2003–04 in Madarounfa and Matamèye. By 2007, only 10 of 42 health districts had initiated any activities on the community component (Hamsatou 2008):

At that time there were no funds, there was nothing for IMCI. Much later we got funds from UNICEF and WHO to conduct the first activities. (NIG-2012-7-12-2, IMCI officer, government sector)

Not only were funds missing to train personnel and carry out activities, community IMCI was meant to be operated out of a new type of health structure, the *case de santé* ('health hut'), created by ministerial decree in 1999. However, few health huts had been built by the time community IMCI stalled as a policy in the early 2000s.

Creating the infrastructure for iCCM: Tandja's health huts

The community-level health infrastructure onto which iCCM would be grafted began to be constructed in 2001 under the aegis of the 'Special Program' of President Mamadou Tandja, elected in 1999, re-elected in 2004 and deposed by the Nigerien military in 2010 after an

attempt to extend his rule known as *Tazartché* ('continuation' in Hausa). Tandja's 'Special Program', created in 2001 to administer funds following Niger's admission to the heavily indebted poor countries (HIPC) initiative, financed and oversaw the construction of over 2000 health huts, with construction advancing quickly under the supervision of officers reporting directly to the president (NIG-2012-7-11-1, NIG-2012-5-17-1) (Bensaid and Mistycki 2011). Funds were disbursed not through the government agencies but directly to Tandja's 'friends', merchants and entrepreneurs who executed development projects including the building of schools, dams, wells and the health huts (Olivier de Sardan 2010; Körling 2011). Investments under the Special Program won Tandja support from farmers in rural areas home to four-fifths of the population, and would be used by Tandja's supporters as an argument in favour of *Tazartché*.

In the health sector, a number of respondents spoke with grudging admiration of Tandja's decision to create the health huts ('a courageous and salutary act') and attributed him sole credit for the decision (NIG-2012-6-16, senior manager, international agency):

Tandja got the idea of health huts. The MOH was called upon [afterward]. (NIG-2012-5-17-1, senior manager, government sector).

At the Ministry, however, opposition to the health huts was widespread among leadership and personnel, who would have preferred to extend the 'official' health system rather than offering 'inferior medicine' to the poor (NIG-2012-7-11-1, NIG-2012-7-3-2). However, some respondents had a less conflictual view:

There wasn't a problem, because the MOH is answerable to the presidency; the MOH doesn't have its own separate policy. Its policies come from the president. It's what the country wants

and what the MOH implements. (NIG-2012-6-14, IMCI trainer, government sector)

Nonetheless, respondents suggested health huts were underutilized in the early years of their construction (they had a reputation of being used to house donkeys and other livestock) and the workers staffing them were not officially integrated into the MOH personnel hierarchy, suggesting possible contestation to Tandja's unilateral act among Ministry leadership and personnel (NIG-2012-7-3-2).

iCCM policy arrives in Niger

From 2001 to 2005, health huts were built at a rapid clip; however, the training of the community health workers to staff them lagged behind in terms of both the number of workers trained and the quality of training they received (NIG-2012-7-3-2, NIG-2012-6-4). At the same time, global-level actors were beginning to coalesce around and promote integrated community-based strategies resembling iCCM, focusing a number of early efforts in West Africa; the West African Health Organization (WAHO) would also identify iCCM as a 'best practice' to promote in November 2005 (AWARE 2008; Dalgligh *et al.* 2015). In April 2005, a WAHO consultant travelled to Niamey to perform a situation analysis for iCCM on the basis of several criteria, and notably the existence of 'engaged [in-country] partners' ready to mobilize resources and share costs (Sall 2005; AWARE 2008). The same month, USAID's Action for West Africa Region—Reproductive Health (AWARE-RH) project sponsored a large meeting in Dakar along with UNICEF, WHO and WAHO, inviting officials from a dozen countries to discuss a common regional approach to treating common childhood illnesses and learn from a Senegalese project on pneumonia (AWARE 2008). At that meeting,

Every country presented what they intended to do at the community level. Niger stated that it will not limit itself to [pneumonia] case management... but will rather implement IMCI as it is learnt at the clinical level and implement it at the community level. (NIG-2012-5-18, clinician).

Following the Dakar meeting, AWARE and other partners including WHO, UNICEF and WAHO travelled to Niger for a follow-up visit to advocate for iCCM, and were met with a 'convergence of viewpoints' by Ministry officials (AWARE 2008). Respondents disagreed as to whether Ministry or external actors had provided the impetus to move forward:

[W]e had the idea to develop an iCCM module... with support from WHO, UNICEF and the USAID AWARE project. (NIG-2012-5-17-1, senior manager, government sector).

I don't think there was any difficulty... We paid a visit to all the key officials at the MOH and explained to them what iCCM is, and they all accepted it. (NIG-2012-7-12-3, IMCI officer, international agency).

In any case, a field trial was organized in Madarounfa district shortly thereafter, with financial and technical support provided by partners. Following the template of the Senegalese experience in community-level pneumonia care, international donors had initially favoured training a non-professional cadre of community health volunteers known as *relais communautaires* or *mères éducatrices*. However, the *relais* were volunteers with no official existence in MOH texts and were thus ineligible to receive financial compensation, supplies and medicines via the health system, effectively blocking their participation in iCCM (AWARE 2008). International donors entered into discussions with Ministry officials

to bring *relais* into the system; MOH 'didn't refuse but didn't say yes' (NIG-2012-5-24, senior manager, international agency). Reluctant to hang iCCM on so tenuous a peg, donors relented to use community health workers, the cadre of health workers previously created to staff the health huts. This was the policy that Nigerien officials decided to scale up in January 2007 following positive results from the pilot's mid-term evaluation (NIG-2012-5-24, NIG-2012-6-6) (AWARE 2008; Hamsatou 2008).

Aside from the necessity of a pilot project, Nigerien government respondents rarely mentioned the scientific evidence-building process leading up to iCCM, quite possibly since iCCM was seen as previously scientifically 'validated' by external actors such as WHO, UNICEF, WAHO and USAID. When prompted, Nigerien respondents said nonetheless that the decision to adopt iCCM was based on strong scientific evidence and that the policy was 'proven', often invoking the 2003 series on child survival in the *Lancet* as justification—a French-language summary of which UNICEF had distributed to Nigerien government partners (NIG-2012-5-30, senior manager, international agency). Indeed, Nigerien policymakers' access to the scientific literature appears to have been largely mediated by international agencies such as WHO and UNICEF, who introduced studies and technical guidelines to 'important professors and influential people' (NIG-2012-8-2, international consultant):

UNICEF is very powerful with respect to community-based components... They say, 'Here are the guidelines,' and I think that the Ministry just complies. In Niger the Ministry is not very tough, not tough at all. When evidence is provided, it complies. (NIG-2012-6-6, IMCI officer, international agency).

This influence could originate in the superior technical capacity of outside agencies compared with Nigerien government offices (recall UNICEF's 55 technical experts, far more than in the Ministry's child health office); further, Nigerien government documents tended to cite few or no articles from the scientific literature. Alternatively or additionally, state actors may have been influenced by the financial resources external actors could bring to bear to fund implementation of recommended policies (see later for a further discussion of this point).

User fees exemptions render care financially accessible

The steadily increasing number of health huts and decision to adopt iCCM were important steps towards making care available for children sick with common killer diseases; however, user fees for visits and medicines constituted an insurmountable financial barrier for many poor Nigerien families. This situation changed in 2006, when Tandja abolished user fees for pregnant women and children below 5 years, which he called his 'gift to the women and children of Niger', a decision that greatly increased the number of children able to benefit such improved care:

Now what is the relationship between the health hut and fee exemptions? I would say that it is the opposite, it is fee exemptions that led to the boom of [the health hut]... (NIG-2012-5-24, senior manager, international agency)

Among health care workers as well, a large majority agreed that the abolition of user fees significantly boosted utilization and health-care seeking behaviour among families of sick children (Ridde and Diarra 2009).

Far from originating among Nigerien health policymakers at MOH or elsewhere, the abolition of user fees for children below 5 years appears to have been a World Bank conditionality for releasing budgetary assistance during negotiations with the Nigerien

Ministry of Finance in April 2006 (Ousseini 2011). Tandja was particularly sensitive to such inducements following the 2005–06 food crisis, which also created a crisis of government legitimacy (Körling 2011). Nigerien health authorities did not learn of the decision until a senior MOH official was pulled out of a meeting to quickly write up and sign the ministerial order (Ousseini 2011). Such hasty decision making meant that planning for the reform was essentially non-existent, and today the state's reimbursement system for health facilities remains highly dysfunctional, plagued by double-billing and poor record keeping, and is in arrears up to 20 billion CFA (US\$42 million) (Ousseini 2011; Ousseini and Kafando 2013). Respondents said such insufficient technical and managerial preparation for policy change was not unique to the decision on fee exemptions:

You know, here [in Niger], political decisions always come before technical decisions. (NIG-2012-7-6, high official, government sector)

Similar cases of government sensibility to outside funding incentives were also reported under current President Mahamadou Issoufou:

[T]he government is very sensitive to the World Bank's suspension of the subsidy. That's why no later than last week, the President of the Republic decided to unblock an envelope of 800 million [CFA] to buy medicines, mosquito nets and quinine to cope with the [malaria] high-transmission period. (NIG-2012-7-19, senior manager, government sector)

Financing and implementation

Funding for implementation arrived in October 2007 with the signing of a co-financing agreement between UNICEF and the Canadian international development agency as part of the global Catalytic Initiative, which focused on strengthening health systems to deliver high-impact and cost-effective interventions at the operational level. The Canadian agency pledged US\$ 10 million for iCCM over 6 years (2007–13), which was matched and administered in Niger by UNICEF. A massive training campaign for community health workers took place in 2008–09 and by 2012 over 3000 health workers had been trained (MSP/DGSP/DOS 2012). The supply of essential drugs was provided by UNICEF and delivered to the district level (NIG-2012-5-24). As a result, the number of operational health huts increased from 1666 in 2007 to 2501 in 2011, with all districts implementing iCCM by the end of the period (Oliphant *et al.* 2011).

Alongside the state's contributions to iCCM in the form of Tandja's network of health huts and payment of health worker salaries, the provision of external resources to fund specific training and medicines suggests an interplay between government and external actors when deciding who pays for what. Just before the arrival of iCCM, in the 2005–09 Health Development Plan, Ministry staff recommended formulating the health budget such that reproductive and child health programs existed as separate entities, rather than integrating them into regular Ministry functioning (MSP 2005). 'These [programs] will certainly require specific funding', the document states, presumably referring to funding from external sources and later invoking the supposed availability of UNICEF funding for IMCI programming over the 2004–07 period. The same year (2005), Nigerien government expenditure on health per capita was at a relative low at \$4.2, whereas the country was experiencing an influx of development aid towards maternal, newborn and child health, which increased by 209% per live birth and 474% per child between 2003 and 2008 (Amouzou *et al.* 2012). While only

circumstantial, this suggests Nigerien policymakers may have waited to see how donors would direct funds before acting themselves, though no specific evidence of strategizing or negotiating is contained in our data.

Discussion

Over a period of a decade, Nigerien policymakers and their international partners co-operated to successfully prioritize, develop and implement iCCM, a policy benefiting mainly the poor, contributing to a significant reduction in child mortality. Previous policies had not significantly reduced child deaths because of Niger's limited health system, under which many or even most families did not have access to basic curative care. An analysis of three dimensions of power in health policymaking in the Nigerien case helps link events and suggest causal explanations. First, power dynamics emerged from the political economy of the Nigerien state, including governance structures that enabled strongly centralized and personalized rule, created dependence on external financial resources, and set the political imperative of distributing rents through patronage. These dynamics were evident in 2001, when President Tandja began using an influx of HIPC funds to rapidly build over 2000 health huts, simultaneously distributing patronage and gaining support among rural voters, as well as in 2006, when Tandja acceded to a World Bank conditionality that Niger adopt fee exemptions for children below 5 years, making iCCM accessible to many more Nigerien families. In late 2007, the large sums of money needed to pay for health care worker training and essential medicines and thus scale up iCCM also came from international sources. Indeed, many policy decisions related to iCCM originated at the interface between state and non-state spheres, with external exercising financial dimensions of power, whereas internal actors enacted political power, whether at the presidential level or inside the Ministry. In terms of technical expertise, we found domination by international actors over 'scientific' expertise, whereas Ministry officials exercised power via operational or health systems expertise. Global-level partners in West Africa, including USAID, UNICEF, WHO and WAHO, promoted iCCM as a 'best practice' whose technical content and 'evidence-based' bona fides originated mainly outside of Niger; however, in 2006–07, Ministry personnel re-oriented the policy with respect to important operational details, notably the choice of health care worker and link to Tandja's health huts. Throughout the policymaking process, the three dimensions of power overlapped in ways that were difficult to separate, e.g. the mixed technical and financial power of external norm-setting agencies like WHO and UNICEF.

Our case study of Niger focused on a country with a neo-patrimonial system of political economy, features of which warrant highlighting for our analysis to take on its full meaning. First, West African neo-patrimonial states are characterized by a confusion between public and private spheres, whereas in western states the separation between the two provides the foundation of procedural forms of power and governance (Olivier de Sardan 2004). Indeed neo-patrimonial states only appear to operate according to Weberian rational-legal principles in the form of modern bureaucracy while instead being driven by the logic of patronage and reciprocal clientelism (Bratton and van de Walle 1994; Therikilsden 2005; Bach 2012). This presents special challenges for researchers, who find that in state business the 'formal' and the 'real' hardly coincide, official organograms mask real-life power relationships and budgets are 'pure fiction' (Olivier de Sardan 2004). In our case study, we observed that procedural power often held little sway, as when MOH was excluded from health policy decision making and

powerful actions took place outside of the usual government channels, as with the Special Program.

Indeed, key decisions around iCCM were highly personalized around President Tandja and strategically oriented towards his political longevity, notably because they (1) enabled the smooth functioning of his patronage machine and (2) allowed him to credibly claim political legitimacy. First, the Special Program has already been discussed as an efficient patronage distribution system under Tandja's control, which he used in part to create the underlying infrastructure for iCCM. However, Tandja's reliance on external resources to fund government and political activities meant he was vulnerable to conditionalities set by external actors able to offer financial backing or relief. Indeed, with a ratio of development aid to total government expenditure as high as 91% in some years, Nigerien authorities relied on outside financial resources for everyday government expenditures, including patronage (Moss and Subramanian 2005). Times of crisis exacerbated this dependency: in 2006, Tandja badly needed funds to quell unrest following the 2005–06 food crisis and tax increases on food, water and electricity, perhaps rendering him especially amenable to the World Bank's conditionality on fee exemptions for children below 5 years (Körling 2011; Ousseini 2011).

Second, Tandja's decisions around iCCM reflect efforts to further his career by establishing political legitimacy beyond the 'instrumental legitimacy of systematic patronage', a difficult task in neo-patrimonial states, whose governance mechanisms are imported from the West and are thus not linked to traditional African forms of legitimacy (Englebert 2000). To this point, when Tandja called the user fee exemptions his 'gift to Niger's women and children', we see resonance with the 'Father-Chief' archetype of African political authority, who gains legitimacy by taking care of the nation/family (Kelsall 2011a). Similarly, Tandja's decision to build the health huts (alongside other development projects under the Special Program) was cited by supporters as evidence of 'how much [Tandja] has invested himself in improving life conditions for the average Nigerien' and used as an argument for extending his rule under *Tazartché* (Guede 2006). As such, Tandja positioned himself as the chief who is entitled to eat well (and retain power) only 'if his children are [not] suffering' (Kelsall 2011a).

Such rhetorical orientations are not incidental, and indeed help us understand the governance systems in question, offering clues about conditions under which the poor are most likely to benefit in similar political contexts (Kelsall 2011a). In neo-patrimonial states, positive development outcomes for poor populations may be more likely when leaders (1) centralize rent seeking and rent management and (2) are oriented towards the long term (Kelsall 2011b). As Kelsall explains, this is because centralization allows leadership to play a productive, co-ordinating role, steering funds into areas that favour economic gains or political stability; longer time horizons favour broader investments into a country's future instead of leaders' short-term consumption (even if the ultimate goal is to improve leaders' prospects for collecting rents from a wealthier population in the future). Our results are fully in line with these findings: health huts for the poor were built under Tandja's centralized rent management scheme (the Special Program) and his long-term time horizon (*Tazartché*, continuation) was clearly stated. If these forms of governance seem in conflict with tenets of western-style democracy, it is because they are; hence calls for global policymakers to 'go with the grain' of implementation countries and work within their cultural and institutional contexts (Commission for Africa 2005; Kelsall 2011a). Indeed, calls to improve governance in African countries and

other LMICs often do not recognize that a range of institutional arrangements can support better development performance (Wild et al. 2015). Even if some African states, like Niger, may have further to go to achieve a more transparent and a fully democratic system, our case study provides fodder to re-examine assumptions that often underlie development work in Africa and further afield.

One feature of this case study was the relatively small role for MOH technical expertise beyond operational and regulatory decisions; indeed the Ministry emerged as significantly less powerful than the person—and possibly the office—of the president. Ministry officials gleaned scientific information from international agencies connected to large transnational networks of experts working to synthesize research evidence; the core technical content of iCCM was imported from a pre-existing model. Further Ministry technical staff was entirely left out of several major policy decisions underlying iCCM, learning about the fee exemptions only when asked to issue the ministerial order; many also opposed the health huts at their debut. Nigerien government officials did organize implementation of iCCM, with subsequent evaluations showing good quality of care; they also exercised power in linking incoming funds from the Catalytic Initiative to the health huts and resisting the use of *relais* in favour of paid community health workers, a key factor in ensuring iCCM's geographic reach and sustainability within the health system (Seidou 2008; Bensaid and Gali 2009).

Our case study of power in policymaking in Niger reveals iCCM to be founded on political conditions favouring positive outcomes for the poor, well-timed injections of external funds (the HIPC monies and Catalytic Initiative implementation financing), a (sometimes unstated) pro-poor agenda at external agencies, and the ability of Ministry officials to complement 'scientific' evidence with operational and health systems expertise. Among others, the UK Department for International Development and the Swedish development agency (Sida) have used power analyses to inform policy initiatives; however many development programs fail to consider such issues and, we argue, risk squandering their resources. Health policies in particular tend to be more context-specific than other policies, as they involve political, social, economic and cultural considerations (Walt and Gilson 1994)—but while accounting for political and contextual dynamics 'might seem obvious... it is rarely the norm' (Wild et al. 2015). Researchers and proponents of pro-poor health policies in LMICs should consider placing more attention on understanding individual country contexts, particularly as policies are unlikely to be successfully transferred when they conflict with national power structures (Reyna 2007).

Conclusion

In the literature on health policy reform, power is frequently invoked to explain outcomes but more rarely defined or analysed, especially in studies focusing on LMICs. We identify dimensions of power relevant to a case study of iCCM in Niger—political authority, financial resources and technical expertise—and apply these to show why this pro-poor health policy was successfully developed and implemented in Niger.

Understandings of power in policymaking in LMICs would be strengthened by multiple case studies, which are needed to test theoretical claims; however, the deep understanding of national context required makes such research practically difficult to undertake. Case study series and international collaborations by researchers interested in questions of power may provide a way forward in exploring

power, an important if enigmatic determinant of health policy and population health.

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Ethical approval

This research was approved by Niger's national ethics committee (Comité consultative national d'éthique) and Ministry of Higher Education and Scientific Research; it was deemed exempt from ethical review as part of a multi-country study of iCCM policy formulation in Africa by the Johns Hopkins Bloomberg School of Public Health.

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