Juggling with the norms. Informal payment and everyday governance of health care facilities in Niger

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Abstract 200 words :

Based on a five-month participant observation at the emergency service of National Hospital of Niamey (Niger), this paper looks at the daily functioning of a healthcare facility from inside. In acute conditions, the life of patients does not only depend on the quality and efficiency of the services provided by the medical staff but it depends as well on the qualifications of the persons (relatives, friends) accompanying the patient. The patient's attendant is a crucial component of the division of labour and the effectiveness of the service. A good attendant should be able to understand the practical norms of the service if the patient would survive. He or she should be able to react promptly in a context of chronic lack of time, materials and equipment. Yet this context is not a given but the result of systemic petty corruption and artificial shortages created by staff. Although everyone knows the consequences of such practices, they are practiced by all. By looking at the discourses deployed by health actors to justify their practices or to denounce those of the others, the author explains how medical staff deals with official norms, social norms and practical norms between illegality and illegitimacy.

Keywords: health governance, informal payments, practical norms, emergency service, Niger.

Introduction

Corruption in health sector constitutes a particular major concern for policy makers in most part of the world including transition economies in Central and Eastern European countries, transition countries and the former Soviet Union (Lewis, 2000, 2007; Ensor, 2004) as well as most Asian and African countries (McPake et al., 1999; Blundo and Olivier de Sardan, 2006; Gaal et al., 2006; Onwujekwe et al., 2010). Corruption and related illegal or informal practices in healthcare as well as in other interface bureaucracies in Africa and other developing countries have attracted a growing interest for policy makers and scholars. In health sector, a large piece of the literature addresses the issue under the umbrella concept of 'informal payments' while the term 'corruption' seems more often cautiously avoided[1]. A range of related notions such as 'out-of-pocket' expenditures, 'under-the-table' payments for services, 'unofficial payments', are also employed to uncover users-providers of health services' exchanges of money (or other resources) beyond the fees officially or legally determined by public authorities. The diversity of terms does not only reflect a multiplicity of practices but also disagreements among scholars about the definition of the phenomenon under study (Gaal et al., 2006).

Economically oriented and mostly based on surveys, this informal payment literature distinguishes two types of such payments: the donation and the fee-for-service. The donation is given by grateful patients to doctors after the service has been provided. This type of ex post payments is generally seen as a benign form of unofficial payments. Most authors give socio-cultural explanations to such 'voluntary' behavior which is said to be related to an endemic culture of gift in Asia, in Central, Southern and Eastern European countries (Ensor, 2004: 238; Gaal and McKee, 2005: 1446). Importantly, this kind of payments is often legal and seen as legitimate. They are not thought to generate inequalities among patients or to affect the distribution of health services (Liaropoulos et al. 2008). Authorities, unions of physicians and media justify this tolerance as a right of patients to express their satisfaction and a manifestation of respect and gratitude toward those who cured or saved the life of a relative. Such practices are presented as compatible with social norms and not contradictory to the legislation. The second kind of informal payment of this literature is the fee-for-service form. It is described as an ex ante unofficial payment received by health workers prior to the delivery of the service. This form is perceived as unethical and is morally condemned. Economic explanations of fee-for-service emphasize inadequate salaries and survival strategies of civil servants. They also insist on contexts of economic crisis and decline in government funding of health sector. These explanations somehow justify these practices and some scholars even underline their positive effects such as a better quality of care for the paying patients thanks to the incentive provided by under-the-table expenditures and a greasing of the health system that allows it to function (Orosz, 1992; Balázs, 1991 quoted by Gaal & McKee, 2005: 1449). Yet less attention is paid to the negative impacts of these practices (see *infra*). Another type of economic explanation

[1] With the work done by Blundo, Olivier de Sardan and other scholars related to LASDEL being exceptions.

focuses on the distortions that monopolistic and quasi-monopolistic situations imply for health care markets. According to this explanation, health personnel act as service providers who exploit their (quasi)monopolistic position on the market to extract a payment from patients (Ensor, 2004: 239-240). This perspective is interesting because it introduces a power dimension into the practitioner–patient relationship which appears to be asymmetric and detrimental to patients.

In Asian contexts, some authors particularly insist on cultural explanations to the practice of informal payment given by patients to doctors (*renqing* culture). For example in Taiwan, *red envelopes* (containing money) were seen as an expression of gratefulness for a successful treatment or were associated with traditions and the building of a relationship with doctors in order to receive a better care. In this case, the distinction between ex post and ex ante payments is not seen as valid. Interestingly Chiu et al. (2007) explore the changing meanings and legitimacy of informal payments through print media. Until the introduction of a national health reform, anticipatory and post-treatment practices were depicted by newspapers as legitimate, normal and appropriate. Newspapers even encouraged such practices (Chiu et al., 2007: 524-525). After the reform outlawed informal payments, newspapers started to describe the practice in terms of power asymmetries and pursuit of self-interest of the doctors abusing of their control over scarce medical resources (Ibid.: 526). In the absence of an ideal health care system, bribes were portrayed by media as 'necessary evils' in the context of poor salaries allocated to doctors and a dysfunctioning system where both doctors and patients are victimized.

African countries are no exception to informal payments in health facilities (Jewkes et al., 1998; Foley, 2010; Onwujekwe et al. 2010; Jaffré and Olivier de Sardan, 2003; Blundo and Olivier de Sardan, 2006). Bribing in African public health sector in order to access a better service has become a common practice. In Niger, the corruption of health workers and bureaucrats is well known to all. A case of mismanagement of 1,8 billion CFA francs (false billing) in the health sector was discovered in August 2011[2]. The case involved high level bureaucrats (the Payeur Général du Trésor National, the Director of the Budget, the Financial Controller of the Ministry of Finances) appointed during the Military Transition (february 2010-april 2011). Corruption affects the highest levels of the administration as well as the lowest ones. In its 1998 country report, UNDP described the access to health in Niger as highly problematic because of informal payments imposed upon clients.

'Poor and badly dressed people without money are roughly treated by medical staff and patients are often forced to pay informal fees to get access to services' (UNDP, Rapport National sur le Développement Humain – Niger, 1998: 41-42).

The same distinction between legitime ex-post and illegitime and illegal ex-ante gifts is generally done by health workers in Benin and Niger. Yet Olivier de Sardan et al. (2005: 7) distantiate their

[2] http://wadr.org/fr/site/news_fr/1710/Niger--14-personnes-%C3%A9crou%C3%A9es-pour-corruption.htm (accessed 26 April 2013).

analysis from the discourses of medical staff. They notice that the frontiers between legality and legitimacy are blurred as health workers often ask patients for gifts in contexts where small present are also thought as socially acceptable. Moreover these authors insists on the embeddedness between corruption and favoritism (*op. cit.*).

Thus corruption in health sector has become a major concern of public debates in Niger. It is discussed by ordinary people on street corners, by print media and among civil servants and policy makers. Corruption is not restricted to health sector but pervades the functioning of all kinds of public authority from local chieftaincy providing justice in rural areas to the highest level of the administration (see Olivier de Sardan, 1999; Blundo and Olivier de Sardan, 2006). So to say, corruption has become a social institution. It is recognized as endemic to all areas of Nigerien society. However the consequences of these practices in health sector are particularly damaging as a number of studies point out. Corruption increases the price of health service without a guarantee for service improvement for the consumers, introduces a price barrier to service, reinforces structural inequalities between the rich and the poor, affects the quality and performance of health care, affects the implementation and efficiency of health reforms… (Ensor and San, 1996; Souley, 2001).

Health public service in Niger is a world of paradox and contradiction marked by 'inhospitable hospitals' and dispensaries that do not dispense medical care, a lack of incentives to attract suffering populations and practices of confinement of patients against their will, ambulances playing the role of private taxis for doctors and hearses for dying patients and dead bodies, and where unconnected patients[3] are lining up to receive uncertain treatments and inevitable expenses (Jaffré and Olivier de Sardan, 2003; Masquelier, 2001; Souley, 2003; Olivier de Sardan et al., 2005; Hahonou, 2001). Despite sometimes heavy expenses, anxiety and resentment toward medical institutions, most people do use public health structures. As I will argue, this paradox can be explained precisely because corruption and other methods or strategies are available to access health services. Despite asymmetric power relations, customers of public health services are not only victims of a system. They also participate in it and eventually benefit from it.

This article based on a five-month participant observation conducted at the emergency service of the National Hospital of Niamey (NHN) in 1999 offers a brief description of the overall context of health care in Niger and the place of the NHN and the emergency service in Nigerien Health system. I then describe the daily functioning of the emergency service with its erratic rhythm and its routine. I focus on two characteristics of the daily governance of the service. The first one is the role played by users in the functioning of the service. I particularly shed light on the role played by the patient's attendant. I argue that in acute conditions, the well being or the life of the patient does not only depend on the quality and efficiency of the services provided by the medical staff but it depends as well on the qualifications of the persons (relatives, friends) accompanying the patient.

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[3] The term 'unconnected patients' refers here to patients who don't have connections to powerful friends or members of the medical staff that would allow them to avoid paying fees and to receive privileged treatments.

The patient's attendant is a crucial component of the organisation and the effectiveness of the emergency service. After a few interactions with the staff, the attendant should be able to understand the pragmatic behavior to adopt if his/her patient would survive. The second characteristic is the recurrent shortages of medicine and equipment. These shortages largely result from the strategies of medical staff and affect the quality of the service delivered. Although everyone knows the negative consequences of such practices, they are practiced by all, including customers who are willing to pay for stolen drugs. Breaking the official rules by stealing public goods and selling them to their own benefit is a practice that allows the staff to earn additional revenues while clients who can afford extra costs enjoy a rapid and hopefully efficient service. I explore how medical staff deals with official norms, social norms and practical norms, juggling with legality, medical ethics, informality, legitimacy and their own feelings. To a large extent users in asymmetric power relations with health providers have to adapt to existing practical norms but they also have rooms of maneuver to transform these norms. Their behavior is contributing to either reinforce the practical norms or erode and transform them when they interact with health workers.

Public health care in Niger

Health in Niger has long been characterized by a heavily centralized system, a weak geographic coverage resulting in a difficult access to health centers (especially in rural areas) and a strong dependence on international aid. After 1987, the principle of cost recovery in health sector was introduced and progressively implemented in Niger[4]. In 1995, the government of Niger decided to generalize the so-called Bamako Initiative which entailed user fees, community participation and the utilization of essential drugs. This policy has constrained access to health for the poorest and increased inequalities in contexts of growing poverty, eroding family solidarity and political instability (Weaver, 1995; Hahonou, 2001; Ridde and Diarra, 2009). Niger today hosts 14 million inhabitants of which 61 per cent live under the level of poverty. While less than 10 per cent of Nigerien population live in Niamey, 50 per cent of medical staff stay and work in the capital city or in its surroundings. Despite this unequal distribution of health resources to the detriment of rural populations, only a small percentage of urban dwellers really enjoy the benefits of living close to health centers (Raynaut, 1990). This point underlines the problem of the social access to health in Niger.

Nigerien hospitals and dispensaries are widely perceived both as places of death and sufferings (Masquelier, 2001: 268). There is no doubt that such description reflects popular representations of public healthcare system. Despite evidence of the low efficiency of health services (Gay-Andrieu et al. 2005) I would argue that health facilities are also spaces for hope and cure for users who recognize the competence of the personnel (see also Jaffre and Prual, 1994: 1069-1070). Although it is not the focus of this article to grasp popular representations of health care in Niger, it is important

[4] The organisation of healthcare system on the basis of the Bamako Initiative has radically changed the access to health service in Niger that under colonial rule and until the late 1980s were free of charge.

to underline this paradoxical picture if we want to understand the interactions between patients and hospitals employees.

As Masquelier correctly noticed it, hospitals have long been negatively perceived. Early studies in the mid-1970s already mentioned how a departmental hospital was associated to a death place in popular discourses (Sabbou 1974: 35). In her 2001 article Masquelier explores the popular imaginations of the State through discourses and rumors on the inefficiency and coerciveness of rural health institutions in Niger. As she argues, since the economic crisis of the mid-1980s rural dispensaries don't dispense medical care but prescriptions and discipline. She depicts the general disenchantment and distrust of populations facing a decaying and powerless medical system characterized by inhospitable infrastructures where corrupted medical staff exploits poor and ordinary patients. Health institutions are rather described as places where people die than places where patients are cured (Masquelier, 2001: 268-270, 286-287). Moreover the introduction of user fees tends to discourage poor people from using public health facilities[5]. Whereas what Masquelier describes and denounces reflects largely what has been observed elsewhere (in both rural and urban centers), it would be exaggerated to reduce public health centers as empty shells hollowed out by greedy corrupted staff. First, all hospitals and dispensaries are not the same. Some of them are rarely used or used reluctantly by people because of the bad reputation of a particular medical worker while other structures are very well known for the quality of their service and the kindness of its staff. People may even adopt strategies where specific day are chosen in order to avoid being host by badly renowned civil servants[6]. Second, if people continue to use public health institutions it is most probably because they do provide services and save lives. The lack of alternatives is certainly not what motivates people to use the services offered by hospitals. In Niger, there is no shortage of alternatives from auto-medication based on cheap drugs provided by street-vendors ('pharmacie-par-terre')[7], official pharmacies or local healers (*zimmey* and *bori* healers) to recourse to private or confessional clinics or hospitals. Users in quest for better health may eventually use successively various health providers and the hospital is not necessarily the last chance[8]. If people

[5] This is true for people who know they won't be able to avoid these fees because they are unconnected (see infra).

[6] Daily pavement-radio discussions disseminate rumors about the quality of various health facilities and more especially the quality of reception by medical staff. These rumors shape both people's expectations and behaviour within health institutions. Klein (2007) taking her point of departure in the under-utilization of public health facilities in Benin reports similar findings regarding the importance of the reception of patients, the politeness of staff.

[7] Jaffré (1999)

[8] Although many users originating from remote areas may consider hospitals as an ultimate recourse, the trajectories of various patients I followed indicate a more nuanced picture. By the way, the NHN is also referring patients elsewhere. For instance, patients with a (simple) broken arm or leg coming to the hospital are often proposed by the hospital staff to be released after the radiography in order to be cured by traditional healers in town who are renowned for their efficiency.

use public health facilities it is because they recognize their compentence. It is nonetheless important to note that for specific diseases (such as severe malaria attacks) public health services facilities occupy a quasi-monopolistic position which gives little room of maneuver to poor and unconnected users but to pay what they are asked to pay. Therefore health users most often go to the hospital with anxieties and distrust. The hospital is an unfamiliar space for most users. Its specific structure, its size, its functional and organisational logics make the hospital a very particular and uncertain universe for first users, most of them coming from rural areas.

The Hospital of Niamey was created under colonial rule in 1922 and was progressively constituted as the main health center of the colony of Niger. When it became the National Hospital of Niamey in 1965, it was composed of a surgery service, medicine, a psychiatry service and a section for contagious diseases. It has been progressively equipped with a full range of services from radiology and pediatric to neurosurgery and cardiology. The status of the NHN was transformed in 1992 in order to partially integrate the cost recovery policy a few years before the Health sector policy was formulated (in 1995). The NHN constitutes a crucial element of the Nigerien Health System as it is situated at the very end of the health chain. The NHN is the main referral hospital. Patients who cannot be cured at lower levels (local primary healthcare centres) are referred to higher levels starting from integrated health centers at district level and hospitals at regional level, ending up at the level of national hospitals (Hahonou, 2001: 9-12). Since the implementation of the reform in 1995, fees are charged on users with official exception for government employees, students, and indigent patients[9]. As Weaver (1995) demonstrated the introduction of user fees has affected patient behavior. Patients with less income wait longer before seeking care and are more likely to be referred than exempted patients. Because the latter don't pay they wait less time before seeking care (Weaver, 1995). Consequently a number of referred patients directly arrive at the emergency service of the NHN.

The NHN is a complex organisation that receives more than 20.000 patients each year[10]. The hospital employed more than 500 agents in 2000. Yet highly qualified human resources are scarce at the hospital. 32 expatriated doctors with various medical or surgical specialties have been recruited to supplement 35 doctors working under local contracts. Doctors are also supplemented by medical students and junior residents completing their training. Together with a number of experimented nurses, medical students play a crucial role in the daily functioning of NHN multiple services. The lack of a sufficient number of trained doctors is compensated by a downward process of delegation of tasks and competences from highly qualified staff to less qualified workers. This is a common practice of most health institutions in the world (Véga, 1997). Yet, in Niger, this

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[9] The implementation of cost recovery policy is nowadays well known to public. It basically entails that all users have to pay various fees in order to access public health services. The official rate of each fee is publicly advertised on the walls in French, Zarma and Hausa languages: *furyaŋ nooru* (hospital admission fee), *fota nooru* (radiography fee); *daro nooru* (fee for a bed), etc.

[10] bulletin d'information de l'HNN, 1996.

practical organisation of the division of labour does not only entail a delegation of tasks that reaches the less qualified health workers (cleaner staff) but also, as we shall see below, users of health facilities[11].

This particularity is also observable at the emergency service of the NHN that is a full-service medical and surgical facility, opened 24 hours a day, seven days a week. This service is situated close to the main entrance of the hospital. The emergency service was created in 1996 as a distinct service from the 'concierge service' which assists patients and guests in finding locations. Patients who suffer from severe injuries or illnesses that pose an immediate risk to their life will normally be directed to the emergency service after having paid an admission fee of 1.600 F CFA at the official cash window. The service is divided in two blocks separated by a corridor and a door. The first block is a consult service where flows of patients are received creating an intense activity. Emergency-service staff (most often a nurse, a medical student or a junior resident) should normally make a diagnosis and recommend an immediate treatment or a re-orientation of the patient. Re-oriented clients may be sent to a different department or to the second block of the emergency service where patients who need a particular medical attention should be treated and stay for two to three days[12]. The most common causes for using the emergency service of HNN are severe malaria crises, heart attack and diabetes crises, broken legs or arms resulting from an accident. According to the statistics, one patient among eight dies at the emergency service of the HNN.

The fundamental function of an emergency service is to offer to patients a timely assistance provided by qualified personnel. As I argue the issue of the patient's health doesn't only rest on the shoulders of the staff since users (and more especially patients' attendants) play a crucial role in the practical division of labour. Before I examine this role in the following section it is useful to immerse into the daily routine of this facility by taking a look at an excerpt of my field notes.

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[11] See also Jaffre and Prual about midwives delegating their tasks to student midwives, cleaning staff and even women who just delivered (1994: 1070).

[12] Between 1150 and 2000 patients stay for some days at the medical block. Patients have to pay 11.000 F CFA (which is approximately a third of the basic minimum salary) to be admitted in this section of the emergency service.

August 1999, Night at the hospitalisation block of the emergency services

20.40 A nurse from the surgical block of the service come to ask us a drip. My nurse colleague answers: 'There is no drip!. Apparently frustrated, the first one says 'That's just incredible! Two days ago there were no syringes!'. My colleague stands up and take the keys of the pharmacy and go out to check if he can find a drip. When he comes back with empty hands, the other one has left. While we are chating, a continuous flow of attendants is arriving. They will spend the night at the NHN. The time for visits has passed but the guards let them enter.

20.55 A female attendant comes to inform the nurse that the serum of her patient is finished.

21.15 The nurse goes to place a new serum. I follow him. He makes me notice that he doesn't use medical gloves to do it. 'There are no gloves!' he says. He washes his hands when we go back to our room. A few minutes later a manoeuvre ask for a syringe for his sister-in-law.

22.20 A nurse from the Pediatric department succeeds in obtaining a valium dose for a suffering patient in her service

22.50 A male attendant comes to allert the nurse that the serum of his patient in room 2 bed 3 should be replaced. The nurse goes and come back.

22.55 A nurse from the other block come to seek for sparadrap

23.07 The same male attendant from R2B3 comes to us and says his patient is complaining about pain. The nurse goes to the pharmacy to pick up some drugs. He comes back at 23.20

23.40 The same guy comes again to indicate that his patient is having a crisis. The nurse goes out to get help from a colleague. When he comes back the patient has passed away. He performs a simulacre of reanimation techniques and ask the attendant to recover the body with a sheet. Back to the office the nurse writes a piece of paper which is given to the manoeuvre who will transport the body to the mortuary. He then presents his condolences to the attendant who answers 'That's life! Everyone takes his turn'.

This is followed by a period of quiet and inactivity

03.00 A medical student brings us a patient suffering of asthma. The patient is a civil servant but there seems to be a problem regarding the institution that will support the expenses of his treatment. This is said to be regularised tomorrow. The attendant runs at the pharmacy outside the NHN to pay the drugs mentioned on the list written by the medical student. He comes back after 20 minutes and provides the drugs. The nurse treats the patient.

04.00 The service is totally calm and quiet. Nothing happens and everybody sleeps well despite mosquito bites.

08.00 Just before the time of the team shift, the nurse examines the files of the patients and adds a treatment he didn't provide to the guy who passed away this night.

The role of the patient's attendant in the division of labour and the fabrication of practical norms

As the previous excerpt suggests the patient's attendant plays a key role in the treatment of his/her patient. Patients together with their attendants generally arrive on their own at the emergency service. Only a few ones are transported by the police or by taxi drivers. Emergency patients generally rely heavily on their attendants to reach the place and often remain highly dependent on them during their treatment within the institution. These attendants are relatives or friends who attend to the needs of the patient and often perform tasks that should normally be taken in charge by the institution. Being a patient's attendant is a full-time job with high moral responsibilities. Attendants take care of their patient all along his/her trajectory at the hospital. Consequently attendants and visitors often reside at the hospital for several days or eventually more until the patient is released although an inscription at the main entrance of the hospital clearly indicates a tiny time schedule for visits[13]. Although attendants are 'recruited' by patients for a short period of time, the continuous flow of patients accompanied by their attendant and the role played by the latter in the division of labour at the hospital give the impression of permanence.

Beyond a moral support, attendants are in charge of many activities on which the well-being of the patient is relying. They especially perform the 'dirty work' that doesn't require technical qualifications such as cleaning the patient, evacuating his/her dejections, providing food and eventually feeding a weak patient, helping the patient to change position in the bed, staying awake during the night to ensure that he/she doesn't need acute medical help, etc. On the walls of the surgical room a flyer mentions '*Only one attendant per patient*'. This attests the recognition of the crucial role played by these persons in the daily functioning of the service. On the other hand the flyer also indicates that a distinction between visitors and attendants needs to be done and that order and discipline need to be maintained within the emergency service. Indeed a high number of visitors and attendants would hamper the circulation of physicians and nurses around patients and create obstructions to the provision of rapid and efficient care.

Occasionally, attendants also perform tasks that require the qualification and training of a nurse such as replacing a drip when nurses are too busy or unwilling to do the work or when inexperienced students do things the wrong way as in the following case.

Abdelrahamane's brother was admitted to the second block of the emergency service for observation and further treatment after a first treatment was delivered at the surgical block. He called a nurse when his brother's drip needed to be replaced. A nursing student came and replaced the drip. Yet Abdelrahamane started to contest the way the drip was replaced by the student. He explains: 'you know, I observed how they do in the surgical room. That's the real right way! First you need to cut the sparadrap in two pieces. You apply this one like that (miming it with his hands)

[13] Visits are allowed between 06.00-07.00, 12.30-14.00 and 18h30-21.00.

and the other one is creased like that. And then you place it. Well, the student didn't place it this way. And we had a harsh dispute together… '

As this case illustrates, patients' attendants – just as inexperienced nursing students or medical students (or any new comer in a service) – have to learn how they should behave by observing 'best' practices. These practices differ from the official rules and set of techniques (and the ethics) learnt by health students during their education in health training schools and universities. This is part of the learning-by-doing process ('*apprentissage sur le tas*') and an important aspect of the fabrication of practical norms. In hospital settings, learning the right way is a constant process although most of this know-how is learnt during the very first days or weeks. Just as health students learn the practical rules that define each specific service in which they do their internship, patient attendants have to (quickly) discover and acquire the prevailing norms in order to behave in an appropriate manner.

If the role of attendant doesn't require specific technical knowledge, it is in the best interest of the patient to recruit a person who has a sense of improvisation and resourcefulness ('*débrouillardise'*). In most cases the treatment of patients at the emergency service requires drugs and medical equipment that are not provided by the hospital (as we shall see below). Therefore is the ability to read and to communicate with medical staff particularly important. A patient accompanied by an attendant who could neither speak French nor Hausa or Zarma (the most spoken languages in Niamey) would likely be neglected by medical staff, especially if he looks poor.

This poses the question of the 'recruitment' of the patient's attendant. Diseases generally surprise patients in their daily life. All of a sudden, the case looks critical and it's time to take a decision regarding the opportunity to transport the suffering patient to a health facility. In Niger, this kind of decision is most often taken by the patriarch (husband, father) who will support all expenses related to the treatment. For a child the attendant will typically be designated among the parents or other relatives depending on the availability of various potential attendant. Sometimes a neighbour can temporarily play this role. But being a patient's attendant is a full time occupation which is much expensive and doesn't allow much breaks until the patient is out of danger. As the following example reveals, being a good attendant requires a number of qualities.

> Roger, young father of a 6-year-old boy suffering from a severe malaria crisis[14]. He explains the successful journey of his son. "Well, the doctor said to me 'If you really want to save your child, here is the list of drugs you need to buy!'. He made a long list… more than seven kinds of drug. 'These two are especially important' he said.' You should do all what you can do to bring back these two drugs. And quickly!' he added. He said he will cure my child. I went in town and brought back all seven items. Quickly he started his work. Then he wrote a prescription again but I had no more money! I was obliged to 'faire la course', to ask for loans and gifts from friends and

[14] Malaria is the commonest indication for admission at HNN and the first cause of mortality in Niger.

> family, and so on. Finally I was able to buy all the necessary and my child was saved!" (Roger, father of a child suffering from a malaria crisis).

Indeed Roger largely contributed to save his son because he was able to provide promptly the necessary drugs (quinine, serum) and basic equipments (syringe, drip, sparadrap…) to the physician. Thanks to his social network in town, Roger was also able to find additional financial resources to supplement the first treatment. A simple malaria crisis can rapidly develop into cerebral malaria or into resistant forms of malaria if the treatment is discontinuous[15]. Therefore an attendant must be committed to his patient, be able to act and react promptly, invent solutions to face new obstacles and constraints, mobilize his or her social network and have a sense of anticipation.

Not all attendants are equally qualified to attend a patient. A lack of competences, social network, financial resources, endurance and moral resources may critically affect the patient's health. The lack of any attendant is most likely to result in the death of the patient as illustrates the following case taken from field notes two weeks after my arrival at the emergency service in 1999.

> When I arrived at my service this morning, an old man was obstructing the access to the room where medical students use to take a break by lying on the floor in the corridor. The drop-by-drop intravenous solution in his arm seemed totally inefficient and useless since this was laying on the floor on the same level as the body. The patient was conscious but couldn't speak. He was ostensibly pushing his body on his legs while moaning weakly. All medical staff passed beyond the patient to access the rest room. I did the same. I then asked a student 'Why is this patient there?? What's his problem?'. 'Don't worry, don't ask!' answered the student who was accompanying me. The patient was still in the corridor when I left the emergency service in the late afternoon. Next morning I learnt that the patient passed on during the night. A nurse colleague told me 'Nobody wanted him. Neither the medical department nor the emergency service… This is because he doesn't have any attendant!'

This case is not an extreme case but rather a common feature of the daily routine of the emergency service. Observing was the way I learned the practical norms of the service. Attendants play a vital role in the medical trajectory of the patient and the issue of the disease and treatment. Patients without attendants are neglected by medical staff. The moral evaluation and selection of patients result in discrimination, inequalities, contradictions and even the death of patients. Patients who are most likely to follow such path are typically poor people coming from the countryside with very little social capital in town ending up at the emergency service in a bad shape after having eventually been referred from various levels of the Health chain. As Masquelier argues medical

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[15] The time factor is extremely important in malaria treatment since the parasites that affect the body develop rapidly. The treatment is generally to be applied for three days before the parasites are eliminated from the body of the patient.

staff invents their own rules instead of following official ones (2001: 285). They may arbitrarily define who might deserve a treatment and who might not as this case has illustrated. Neglecting patients without attendant is the practical norm. Although this obviously contradicts the law, the medical ethics and the social norms, daily practices most often follow this regulating principle[16]. It seems important to uncover the reasons of such behaviour among health practicioners.

The governance of feelings and the discourses about corruption

'It's disgusting. You see this guy passed away and nobody cares. The doctors are sleeping, nurses are discouraged. We can't even answer the claims of our patients. It hurts. Patients have nothing. And the hospital too!' (a medical student)

'We can't do anything, we are powerless. We use the pencil and the prescription paper!' (a nurse)

The daily governance of health care facility is also a matter of governing feelings. It would be misleading to believe that nobody cares. But caring for patients is a heavy load that is placed on the shoulders of the attendants. As these quotations indicate medical staff feel powerless but are sensitive to the situation faced by patients even when they seem not to care for patients. As I experimented it, caring for all suffering patients is individually unsustainable. This dimension of the daily governance of health facilities is often overlooked by scholars. That is where ethnographic participant observation offers invaluable insights. After I saw that therapeutic negligence could result in the unintended but expectable death of persons, my first reaction was to play the role of attendant for patients lacking social network and a protector in this inhospitable institution. I spent nights and days at the hospital, even during weekends, at the cost of my own private life trying to save anonymous patients. Having no technical competence my main task was to use my social relations among the medical staff to beg for favors: 'Please, help me to cure that guy!'. It worked! But at one point I had to stop. Being an attendant is a fulltime long-distance job paid in frustrations, feelings of powerlessness, sweat and tireness, with very few satisfactions. Being too sensitive was hard to manage. At that point I began to understand that medical staff cannot let themselves being governed by their feelings. Instead, feelings must be governed along the line of the principle that one cannot help everybody but at least some people. How can one distinguish people for whom one should care from others? What does such practical norm imply in practice?

This practical norm implies that users are basically divided in two categories: connected users and unconnected users. Connected users are people (patients or attendants) who have connections with health staff and who will consequently receive a privileged service (free service, no queuing, rapidity and efficiency). Such connections are generally known in Niger under the expression '*parents, amis et connaissances*' which means 'relatives, friends and acquaintances'. On the contrary unconnected people are treated anonymously which concretely means that people will endure an exhausting experience during their stay at the hospital. It is well known to the public that

[16] For a discussion on social habitus and statistical norms (regularity) see Olivier de Sardan in this special issue.

the access to public service is differentiated along these lines. If a user personally knows someone he will benefit a good service. If he doesn't, he would better try to get such connection by asking someone who knows someone working in the facility. Otherwise he will need money to bribe health care staff at various levels (from cleaning staff to nurses, students and doctors). Petty corruption allows users to build a personal relationship with the staff, to obtain careness and to get access to drugs and small medical equipment[17].

Individualized health care and privileged access to medical resources is a regime of exception and favors in an environment characterized by carelessness, lack of time and lack of basic resources. These are the conditions for the existence of a market for better service. As I demonstrate hereafter health staff don't hesitate to produce the conditions of such informal market by artificially creating shortages in time and medical resources.

When observing the daily routine of the emergency service, one singular aspect puzzled me. Every morning before 08.00 the head of the emergency service provided an amount of drugs and small medical equipment for the forthcoming 24 hours. However at 09.00 all these consumables disappeared from the shelves. Of course they were not all utilized in one hour. This chronic shortage of resources was created by medical staff who abundantly filled their pockets each time they had to take their shift. Stealing drugs and equipment from the shelves is a practice that allows the staff to earn additional revenues. If the stolen products were not sold to brokers or merchants to provide the renowned black market at the Grand marché de Niamey, they would either be sold to ordinary users or be given to well connected clients. Artificial shortages caused by the mismanagement of medical resources generate opportunities as well as contradictions. The system in which every one participates poses problems of consciousness to staff members: Who is responsible for these contradictions? In most cases, medical staff don't lack arguments to escape their responsibilities and justify their behaviour.

> - How would I say to a relative that he must pay for a service that I provide with ten fingers. Maybe I will use a blade, some disinfectant and cotton, that's all!
> - They (administrative staff) tell us that we must apply user fees before any intervention but they don't write that down because of the responsibility if the patient dies.
> - I tell you, if it's a relative I will do it gratis. This will not much affect the revenue collection of the NHN. Moreover we don't know how they manage these financial resources… (two nurses discussing in the corridor)
>
> Look at that. Is this a good work!? He (a medical student) is not the only one who didn't received his salary. Two months that we got our last salary. The houseowner shouts on me. Water and electricity must be paid. We cumulate 11 months without salary! (a nurse)

[17] See also Olivier de Sardan et al. (2005: 8-11) for similar attitudes in Benin and urban Niger.

> ‘You must pay these drugs. Why don’t you bring them back? Do you want your patient to die or what?! Hurry up tu buy these drugs!’ (a medical student scolding an attendant).

Everyday petty corruption takes its justification in high level corruption that allows ruling elites to enrich themselves rapidly and sometimes ostentatiuosly. Taking one’s share of the cake and serving the interests of relatives is somehow a way civil servants take their revenge on the State. Breaking official rules seems to belong to the weapons’ arsenal of weak civil servants. Responsibilities are rejected on a ever changing ‘Other’ that can alternatively be the general situation where salaries are irregularly paid[18], a corrupted hierarchy, other colleagues, the patients and their attendants… Yet providing free services to connected patients using stolen resources from the State and exploiting unconnected and poor patients are two sides of the same coin. That is where the paradox lies since health providers denounce a system in which they actively participate. The same goes for users who generally consider helping a relative as legitimate as long as their interests and those of care providers go hand in hand but denounce the system when they can no longer benefit from it. So to say double mentality is not the privilege of interface bureaucrats. Clients and civil servants constantly surf on the waves of legitimacy and legality by manipulating official norms, social norms and practical norms.

Sometimes practical norms and social norms combine harmoniously against official rules (access to health service requires the payment of user fees). They are mobilized to justify a social practice: a connected patient comes to the emergency service, he meets a relative or a friend who works there and allows the patient to benefit a free-of-charge rapid and efficient service. Another day, the same patient may arrive at the service without finding his/her personal relation. He would likely be treated as an anonymous and would have to pay not only official fees but informal fees as well in order to secure a better service. Tensions may then appear between practical norms (the payment of greasing money on the top of official fees) and social norms:

> ‘Going to NHN is not easy. It will exhaust your resources. They will start asking for money just to enter the hospital. Once you are inside and you don’t give money, they won’t take a look at your child. Even if the person is dying, if you don’t pay they won’t examine the person. That’s why if you have a patient it is better to avoid the NHN!’ (Aissa, mother of a yound boy who was victim of a car accident in Niamey).

Masquelier argues that medical staff and clerks ‘invent their own rules’ because of state’s dysfunctioning and fragmentation (2001: 285). Rather I would suggest that practical norms are co-produced by health civil servants and users along their daily interactions, as well as they are shaped

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[18] Interestingly health labor unions erratically organize strikes motivated by bad working conditions or poor salaries but they rarely fully follow these strikes since these movements prevent the hospital workers from earning their daily money. Although the hospital of Niamey is officially a non-profit institution owned by the state, the daily appropriation of the hospital by the staff turns it into a profit-oriented service (Hahonou, 2001).

by official norms (laws, rules, ordinances) and social norms. Patients are not just 'disillusioned customers' or passive victims of the norms imposed by civil servants, they can also actively contribute to the transformation of the practical norms. Like in any other interface bureaucracy, users may contest the practical norms (which would tend to their erosion, transformation or shift) or accept them (which would rather lead to their reproduction).

> - 'Hey, is this because I am Tuareg and have a white skin that we are neglected?! I am nigerien just like you. Do your work!' (a Tuareg attendant challenging a medical student).
>
> - 'Hey Madam! Your hospital, wouldn't it because we have little choice, we wouldn't come!' says a frustrated user to a female medical student of the emergency service while he is leaving.
> - 'You are free to go in town!' answers the medical student.

Most of the time patients and attendants accept locally constituted practical norms either because they benefit from it or because they are in a difficult situation to exert pressure for claiming or negotiate their rights. In emergency services corruption practices can often entail a difference between life and death for suffering patients. Therefore those relatives who accompany the suffering are occasionally proactive in corruptive practices[19]. Sometimes they give money after the service has been provided as a form of gratitude. In some cases attendants are left with little choice but to find the amount of money requested by medical staff to save an ailing kin. Yet tensions rise from time to time and unlike the abovementioned case of Aissa (strategy of avoidance) clients may contest and challenge the prevailing norms as these two last examples attest. In any case health facility users participate in the process of fabrication of the practical norms that shapes interactions between practitioners and clients.

Conclusions

The exploratory concept of practical norms is useful to capture the behavior of civil servants in interface bureaucracies and to explore the production of public services as a result of the interactions between civil servants and users. In this article I draw particularly attention to the role of users in the division of labour and the production of health public services in Niger. Not only do users contribute to the quality of the service by performing a number of tasks (and not least by having the responsibility to care for the patient) but they shape the practical norms to which social actors refer to regulate interactions and activities.

Since the use of health services is not free of charge most patients prefer to postpone the decision to go to health centers and often start using less expensive alternative treatments. In case such

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[19] While I was conducting this fieldwork at the emergency service, together with a nurse colleague I was once bribed by a client who gave me an unsollicited present of 5.000 F CFA. This client was the father of a young female deaf teenager suffering a malaria attack. The man said 'Enjoy your lunch!'

alternatives are inefficient the disease may worsen and patients become weaker when they arrive at a public health institution (local clinic, district center, hospital). They end up in an emergency situation where the lack of time and the scarcity of medical resources will be very similar to the situation observed at the emergency service of NHN. The conclusions drawn from this case study may therefore be extended to other public health facilities in Niger and other countries.

The inhospitable environments created by public health institutions in Africa generate asymmetric relations between health providers and health seekers. Two main strategies allow the latter to secure their access to health care. For those who have connections within the hospital or know someone in town who knows an employee of the hospital (be it a volunteer, a maneuver or a director), the strategy consists in connecting to these people who will facilitate the process. These patients will access to privileges and favors at the expense of unconnected users. For unconnected users, bribing health civil servants becomes a way to access the service. Although the frontiers between unconnected and connected users are not closed, not all patients have the possibility to shift from one category to the other. Even connected users may occasionally experience the harsh trajectory of being treated as an anonymous patient. This results in an expanding loss of confidence in health public services.

The literature on informal payments especially highlight the consequences of corruptive practices in health sector and assesses their legitimacy. Yet as I showed here corruption in health sector is one of the many ways by which users access health public service. This perspective allows us to explore the agency of users and practitioners in health facilities. In acute conditions, the life of a patient does not only depend on the quality and efficiency of the services provided by the medical staff but it also depends on the qualifications of the persons (relatives, friends) accompanying the patient. The patient's attendant is a crucial component of the organisation and the effectiveness of health facilities in emergency situations. After a few interactions with the staff, the attendant should be able to understand the dominant practical norms that rule the service if his/her patient would survive. Users do know that chronic lack of materials and equipment is a result of systemic petty corruption and artificial shortages created by staff. They do know that they contribute to the reproduction of this system when they bribe health workers. Although everyone knows the consequences of such practices, they are practiced by all. Neither health workers nor users are just victims of a system or a set of cultural practices. Both contribute to the fabrication of the practical norms that regulate the daily functioning of health facilities and shape people's behaviour.

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