Resisting reforms. A Resource-based perspective of collective action in the distribution of agricultural input and primary health services in the Couffo region, Benin
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The 1980s witnessed rural development lagging behind in most sub-Saharan African countries and Benin in particular. One major problem is related to the distribution of agricultural input and primary health services in rural areas. Although the distribution of both services has evolved to some extent in the aftermath of the liberalisation reforms, rural dwellers have to contend with insufficient coverage. The rationale for the choice of both services for this study derives from four observations. Firstly, we know that both services are dedicated to furthering rural development. Secondly, government and market failures are constraining the access of rural dwellers to those services. Thirdly, local participation can reduce the cost of distribution in both instances. Fourthly, mention has to be made of the close relationship between people’s participation in the distribution of the primary health services and agricultural performance, namely cotton production. Indeed, farmers’ organisations commonly called *Groupements Villageois* (GVs) and *Local Health Management Committees* (LHMCs) have played a leading role in the distribution of these services.

A conceptual definition of the problems under study will draw from the resource-based (R-B) perspective of firms, in addition to the Institutional Economics’ (IE) theory. This study attempts to draw some lines of analogy between firms and village communities, focusing on the distribution of agricultural input and primary health services. Accordingly, the R-B perspective of firms appears to be the relevant approach that may capture the distribution features of both services. This perspective calls for a focus on the *strategy*, *structure* and *core capabilities* of firms. *Strategy* derives from the identification of a set of basic long-term goals and objectives of firms or groups of people, and the subsequent courses of action and allocation of resources necessary for carrying out those goals (Chandler 1997). This definition applies to the distribution of agricultural input and primary health services within the Couffo region in Benin. *Structure* refers to the design of an organisation through which a firm or a group of people is administered (Ibid.). Since effective problem solving requires bridging the gap between efficiency in resource use and people’s needs, a structure for the distribution of services may bring various actors together following some initially set rules, norms and values with the aim of defining and achieving a certain strategy, given the resources available to them.1 *Strategy* and *structure* shape *core capabilities*. The concept of *capabilities* derives from the appropriate knowledge, competencies and skills necessary to achieve a challenging strategy, given the resources at hand. It also invokes the concept of management, for instance, *organisational management* and *knowledge management*. *Core capabilities* are fundamental to carry out the distribution of agricultural input and primary health services. Therefore, the R-B perspective will provide insights into the reforms underway within the two sectors.

In order to pursue their goals, actors co-operate following a set of rules, norms and values. However, given unforeseen outcomes that may result from interactions between heterogeneous actors, the emphasis is on understanding the structure that governs the distribution of services. In this respect, the ‘Institutional Economics’ (IE) perspective, which stresses the role of rules, norms and values in understanding how and why actors interact, appears very relevant (Ostrom 1986). More importantly, *collective action* (CA) appears to be the ultimate structure that may solve social dilemmas resulting from both government and market failures.2 It follows that CA is coupled with the R-B perspective not only to stress the organisational aspects of the analyses to
be carried out, but more importantly to infer that an organisation needs a strategy and core capabilities.

This study deals with collective action (CA) of the public, private and local organisations involved in the distribution of agricultural input and primary health services. Specifically, it sets out to inquire into the so-called liberalisation reforms underway in Benin from the late 1980s onward. This period marks a shift of emphasis, from a government-led to a market-led development process. However, it should be pointed out from the outset that what takes place on the ground is less straightforward than is generally presented in policy documents (cf. FAO- PNUD 1990; FAO/ PCT- Bénin 1988; IMF 1998; OMS- BRA 1993). The organisation of both sectors is based on collective action (CA) where public, private and local organisations play a role. Market and collective action (CA) are not necessarily incompatible. However, there is a need for a better understanding of the discrepancy between both stated and applied sets of policy measures as well as the underlying organisational and distribution effects in the agricultural input and primary health services.

1.1 Problems in the distribution of agricultural input and primary health services

This section will provide substance on the nature of the problems in both sectors and the underlying rationale for an inquiry into the distribution and organisational effects.

1.1.1 Problems in the distribution of agricultural input services (AISs)

In Benin, agriculture supplied approximately 70 per cent of the household incomes and contributed about 40 per cent to the Gross National Product (GNP) in 1991. Throughout the eighties, it was the most dynamic sector of the economy, having grown by 63 percent between 1982 and 1991, compared with 21 percent for the overall Gross Domestic Product (GDP) in 1985 prices. The government has assigned particular importance to matters associated with agriculture in general and agricultural inputs in particular, for they can reduce poverty in rural areas and contribute to the goals of the social dimension of the structural adjustment programmes (SAPs). More specifically, improving the distribution of agricultural inputs means alleviating the plight of rural women, representing 25 percent of agricultural workers and approximately 90 percent of the workforce in the field of agricultural trade.

Initially, the public-sector agricultural input services are concerned with seeds, fertilisers, pesticides, agricultural equipment, etc., and mainly endorse cotton promotion. Subsequently, these services have a very limited impact on the food-crop production. The case of maize seeds is illustrative. In 1988, more than 80 percent of the total area in the sub-Saharan Africa was cropped with local varieties, while around 74 percent and 71 percent of the total area in Asia and Argentina were cropped with improved varieties respectively (Dalrymple and Srivastava, 1994). In the Republic of Benin, NGOs such as SASAKAWA GLOBAL 2000 invested a great deal of effort in promoting and sustaining the use of agricultural inputs, namely fertilisers and improved varieties of maize seeds. However, this endeavour only scaled up the use of improved varieties of maize to the level of 12.3 percent of the total area cropped for maize in 1993 (Dédéhouanou et Zannou 1997).

A widespread use of agricultural inputs is not only hampered by the distribution and credit constraints, but farmers' own characteristics also play an increasingly important role. In the Republic of Benin, as elsewhere in the sub-Sahara African countries, farmers want agricultural inputs for different crops. They also want different inputs with varying chemical components to allow for the varied physical environments in which they plant each crop and the numerous end uses of each crop, and to enable them to cope with the riskiness of cropping seasons without a
large use of externally supplied inputs. For an extensive use of inputs, though, and depending on the crop and the context, the requirements include low labour input, pest and disease resistance, particular processing, cooking and taste qualities, storability, and a good yield of non-grain biomass (leaves, stalks, etc.). It is unlikely that the formal sector has fulfilled these demand-side requirements. Much more emphasis has been on improving the supply-side conditions, instead.

During the 1970s and early 1980s the Government sector provided a large extension service. Each field extension officer was in charge of no more than two villages and was sufficiently equipped with agricultural inputs and subsequent extension messages. It was expected that those measures would propel the intensification of agriculture. To the contrary, however, rural people became more dependent on materials maintained within the community, or materials adapted and incorporated into the farming system by them. More peculiarly, traditional rites for rains, productivity, on-farm works, cropping pattern and the like, continued to be effective in local agriculture from a farmers’ perspective (Agbo 1991, 1995).

Before the reforms, it was suspected that the Government sector failed to rally a large majority of farmers because the inputs and the extension messages did not fit the local conditions. More importantly, critics found no correlation between the size of the extension service and agricultural performance (cf. FAO-PNUD 1990; FAO/PCT-Bénin 1988). Therefore, the distribution effects persisted, though physical accessibility improved to some extent. Input costs were reported prohibitive in spite of large government subsidies. Advocates suggested a tailor-made approach to the distribution of agricultural inputs as a solution to the discrepancies between what people need and what is supplied. For instance, they claimed that farmers know what their needs are and how to achieve performance given the prevailing context. More importantly, they urged to integrate the fact that local organisations of the saving-credit type were already engaged in providing agricultural credit to their members. Moreover, they recorded local organisations that were also involved in mediation in conflicts impinging on the distribution of agricultural inputs. Logically, the integration of farmers’ knowledge, competencies and capabilities into the distribution of agricultural inputs may significantly change the pace at which supply and demand adjust. Consequently, the participation of beneficiaries in the organisations in charge of the distribution would certainly provide arenas for the integration of the missing competencies and capabilities.

Following the reforms during the late 1980s and the early 1990s in Benin, the government sector took steps to phase out subsidies, to drastically reduce the field extension staff and to involve the private sector as well as farmers’ organisations in the distribution of agricultural inputs. It should be stressed, however, that the so-called public sector remained in command of the distribution process for several reasons. The first reason derives from that a sudden retreat of the public sector would do more harm than good to the agricultural sector. Another reason stems from that the government, as a collective interest holder, felt bound to monitor quality and maintain rules and regulations in the handling and use of certain types of agricultural inputs. An additional reason concerns health and environmental standards that could not be reconciled with private interests. Far from solving the distribution problem, the involvement of the private sector and farmers’ organisations in agricultural input market hinges on unexpected constraints.

The private input market has stagnated because of the public-sector monopoly until recently and the present stringent licensing procedures. In addition to these external constraints, some specific requirements of an evolving market, such as the profit motives at the least costs, economies of scale and others, dictate the apparently cautious behaviour of private entrepreneurs. Furthermore, agriculture usually holds a low profile in the portfolio of private investors in developing countries, because of the thinness of demand, the spatial dispersal of small family farms and the associated prohibitive costs of individual delivery, the state of transport links, the subtlety of the skills and education of private entrepreneurs to negotiate on
equal footing with large multi-national companies, and so on. Unless the government sector helps both private entrepreneurs and farmers to meet these requirements, there will hardly be a full-fledged agricultural input market.

Unlike the macro effects of the reforms, which are satisfactory from a government point of view, the micro-level distribution effects are strikingly uneven. An over-emphasis on the cotton sub-sector and the zero-option for other crops add to the present inequalities. This is to assert that cotton areas enjoy a higher status compared to food-crop areas. More importantly, if the cotton-growing villages benefit from a minimal extension service, this is not the case for mainly food-crop villages. Put in another way, farmers distribute agricultural inputs on their own. This implicitly suggests that the agricultural sector could dispense with field extension personnel. However, such an implicit inference derives from a shortsighted view of agricultural development. Farmers on their own cannot achieve quality requirements and market standards. Adequate counselling on farming practices is needed. The drastically curtailed field extension staff can hardly discharge this role. Because agricultural knowledge, competencies and capabilities are missing in the new distribution process, additional measures regarding the effective integration of the public-sector extension service are needed to enhance and promote local capabilities. It follows that the design of the right mix of public, private, and local organisations will rest on a trial-and-error process.

1.1.2 Problems in the distribution of primary health services (PHSs)

The state of the health situation in Benin before the reforms has been among the most critical in Africa. It was estimated that total public and private expenditures devoted to non-traditional health care have been on average CFA F 9 billion per year, or 2 percent of the GNP. This figure was very low compared to the average costs of the most basic of primary-care packages calculated by the World Bank. Critics urged that the distressing situation was caused by the gap between $2-3 a head per annum incurred by most governments in sub-Saharan Africa and the calculated $12 advocated by the World Bank (The Economist, October 7th 1995, p.122). The figure reported for Benin, although limited to the period 1991/92, stigmatises the low profile of health concerns in the investment portfolio. The public health sector represented approximately two thirds of the total health expenditures and employed 83 per cent of the available medical doctors, 94 per cent of the nurses and 96 per cent of the midwives during the early 1990s.

The health sector was characterised by a low level of health and vaccination coverage and, despite the efforts, there was a high incidence of malaria, measles and diarrhoea diseases. The position of vulnerable groups, women included, worsened. For instance, women had to contend with insufficient maternity care, i.e. 55 percent of the women giving birth without the presence of qualified personnel. For the primary health services, there were 1.22 beds for 1,000 inhabitants and 1 physician for more than 26,000 inhabitants, instead of 1 for 10,000 as advocated by the World Health Organisation (WHO). The inter-regional situation was strikingly uneven, given the skewed distribution of health centres in Benin. Within the Couffo region itself, the urban-rural bias was so intense that certain urban centres easily met the standard while the rural areas had not more than 1 physician for more than 40,000 inhabitants.

It should be pointed out that the situation described earlier derives from government failure to secure a full health-care coverage free of charge, as initially endorsed. Progressively, though, popular participation significantly shaped the distribution pattern from the late 1970s to the 1980s. For instance, the expansion of cotton production is concomitant with the construction of health facilities by the beneficiaries. Undoubtedly, the physical infrastructure is not the only requirement for the establishment of a PHS. Staffing with skilled health personnel and equipping, amongst other things, still remain government responsibilities. Obviously,
government efforts hardly live up to expectations. The first reason is that much of the resources available to the public sector, and that are needed to staff and equip locally initiated health services, do not keep pace with newly built health facilities. The second reason is that some of the health facilities hardly fit the requirements in terms of norms and standards. Resources are hardly sufficient for a full coverage given the set of rules, norms and values. It follows that slack and redundant health facilities are found in villages where pressure groups have successfully pushed forward their request for PHS. At the same time, villages in need are not served, either because of their lack of resources to provide the physical facilities, or because of their lack of luck.

Similar to the distribution of agricultural inputs, that of health services also partly hinges on the supply-side constraints. If physical accessibility used to be the driving constraint until the late 1980s, cost constraints have taken the lead since the introduction of user fees in the aftermath of the health sector reforms. In addition, there are location-specific organisational constraints or advantages: sufficient drug availability, outpost visits to users, promotional healthcare activities, etc. In order to launch health-care activities at a new location, there are advertisement-related conditions that influence the distribution pattern within a quite significant area. These are low user fees, a drastic reduction of drug costs and unusually warm contacts between newly appointed health personnel and patients. The consideration of those location-specific conditions is the justification that the demand for health care does not face uniform supply.

It should be stressed that demand-side constraints also influence the distribution effects of health services. Heywood (1991) found that home treatment is first and foremost relied on in Benin after the symptoms of illness appear. Then, when symptoms persist, the family clairvoyant is consulted and three possibilities for healing are offered depending on the clairvoyant’s perceptions of the origin of the health problem: spirit medium, herbalists and health centre. Indeed, such a health-seeking behaviour gives prominence to self-medication, mystical worship and traditional medicine. That is why, when rural people do seek modern health care as the last resort, it is quite unlikely that the nearest PHS is the adequate referral health centre. Health outcome, being a function of the stage at which an illness is referred to the health centre, is such that people may draw as much satisfaction as they quickly turn to the PHS. This is not to assert that traditional medicine and other mystical attempts have no curative power. But the extent of final referrals to the PHS fully explains the deceiving nature of these modes of healing. Similarly, the modern health services hardly cure all diseases, even when quick referrals to the PHS are made. Therefore, there is a fundamental problem regarding health knowledge that are not sufficiently shared among actors in the health sector.

Logically, the health reforms of the 1990s should address those distribution effects through enhancing the effectiveness of health programmes, i.e. the degree to which institutional goals are reached, and the degree to which the credibility that local communities ascribe to those services, given competing alternatives, is upgraded. As a matter of fact, supply-side as well as demand-side constraints ought to be addressed locality-wise. Health reforms, on the contrary, mainly aim at offsetting the emptiness left over for the parallel channel and traditional medicine. To this end, two important themes of those reforms are the cost-recovery scheme and the participation of beneficiaries to the health sector. The cost-recovery scheme is mainly based on user-charges and on community financing of essential drugs for primary health care (Hubert 1994; Lennart et al. 1996). This suggests a definition of minimum health-care packages in line with health reforms. These packages are organised into activities, following a strategy to ensure success. Participation, on the other hand, involves electing people’s representatives in the local health management committees (LHMCs). This assumes correcting the distribution effects referred to earlier, through raising the awareness of the beneficiary population with
respect to health issues. More importantly, this assumes the promotion of health-related activities, including functional literacy, food security, safe drinking water and a healthy environment, in addition to a clear delineation between curative and preventive care.

It appears that the above-stated health reforms have achieved substantial results, given the number of dynamic LHMCs and the recent outbreak of private clinics in the country in general, and in the Couffo region in particular. However, there is evidence that much still remains to be done in order to satisfy felt needs. About half a dozen out of thirty-four capital centres are still missing their PHS. Concomitantly, more than ten private clinics are queuing to get their formal certification (DDS-Mono 1993 through 1998). It is obvious that health reforms are facing remarkable resistance at the implementation stage.

Recall that the public sector initially endorsed the responsibility of a full coverage free of charge, and that the failure to achieve such a goal was at the origin of the reforms. Unexpectedly, though, the reforms have prompted the government into a policy of retrenchment. For instance, the cost-recovery scheme turns out to be a framework for a total transfer of financial responsibilities from the government sector to the beneficiaries. By adding to the plight of the people, this scheme contributes to further contract the demand for modern health care through the formal channel. The promotion of people's participation in the health sector has also been limited to the management and control of the cost-recovery scheme, implying the neglect of promotional health-care activities.

The private sector, although still at its infancy to date, has progressively been involved in order to ease financial strains on the government. It was expected that the reforms would induce the development of a health market, i.e. the demand for and supply of PHSs would spontaneously adjust. However, this objective supposes a number of prerequisites that the government sector has failed to achieve. Those shortcuts were not perceptible in the statement on the health policy reforms, but have lately showed up during the implementation stage. By overestimating the extent of protection that rural dwellers need against malpractice and other unqualified health treatment, the reforms introduce some regulating aspects that subvert the principles of a free health market. For instance, the stringent licensing procedures constitute some firm barriers for new private clinics. The underlying rationale stems from the low level of health awareness generally ascribed to the rural people. This is also the most important justification for the creation of the LHMCs and the subsequent decentralisation of health services to the level of the commune and even that of the village. It should also be stressed that the decentralisation process impairs the involvement of the private sector. The certified private clinics do not face the same management costs as the formal health outlets. For instance, drugs in use within the PHS are exempted from taxes, while this is not so for the private clinics. The salaries of personnel and the equipment costs hardly account for the structure of the health costs within the public sector, while they do in the private sector. Therefore, competition rules are biased against the latter sector, and the health market is distorted.

Similar to the private clinics, confessional hospitals and their local outlets, which initially held their grip on the rural people, also began to lose ground. Facing unfair competition from the formal primary health services, private health clinics resort to unqualified practices. First, they skip the necessary medical checks such as blood tests and X-rays, as rural private clinics cannot afford the necessary health equipment. The private practitioners believe that asking patients to have those tests done in the public-sector outlets may either delay the healing process, thus questioning their competencies, or promote these public-sector health outlets instead. Second, they administer the medical treatment based on a patient's report on felt symptoms and following a trial-and-error process. The absence of medical tests implies that it is not possible to distinguish between malaria and other kinds of
infections, for instance. Third, medical treatments are rarely targeted to specific diseases but embrace a large spectrum of suspected current illnesses. Any patient with a high temperature is then administered anti-malaria medicines combined with antibiotics. It follows that the private clinics pay much less attention to the low purchasing power of their clients. Given such conditions, both confessional and private clinics operating on the defensive, they essentially fail to integrate rural people's needs in their medium and long-run perspectives.

Obviously, health reforms prove deceptive in terms of long-range goals. It was originally noticed that government monopoly failed to achieve health goals. This situation has hardly improved to date. The lack of co-ordination in the provision of health facilities, the bias of the cost-recovery scheme, the defensive non-governmental sector, and the deceived beneficiaries are very characteristic in this respect. It follows that the reforms still need to innovate in management through allowing for the right mix of public, private and local organisations.

1.1.3 Similarities of problems in both agricultural input and primary health services

In general, both agricultural input and primary health services have experienced a high degree of state involvement in the recent past. Equally similar is the image of the state that is receding from those services. Although the reasons proclaimed so far diverge to some extent, the processes of state retreat from both services are similar. Whereas the policy of retrenchment in the public sector is central to the liberalisation of the agricultural input service, health reforms mainly derived from low health indicators. The reforms underway in both services assume that the public sector alone can no longer sustain the entirety of resources that are needed to attain some sector-specific goals. More specifically, it is acknowledged that knowledge, competencies and capabilities in the public sector taken alone are insufficient to carry out some development goals. It follows that the need to organise all actors in such a way as to pull together the resources within their reach is justified.

It was claimed earlier that the reform processes in both sectors are similar. Mention has to be made of the close relationship between people's participation in health services and agricultural performance, namely cotton production. Indeed, farmers' organisations, or Groupements Villageois (GVs), and Local Health Management Committees (LHMCs) have played a leading role in the distribution of social infrastructures and services in the rural areas. For instance, a dynamic GV, or a village with a high cotton production, usually receives substantial premiums from the national marketing boards to reward collective services, namely the collecting, weighing and boarding of cotton. This collective revenue is mainly destined to social purposes and may be managed by the LHMCs. Cotton production then appears to be a potential leverage for collective investments in the social sector, namely the primary health services. Where this does not exist, stagnation and pauperisation of the vulnerable groups prevail.

Owing to the bias toward the promotion of cotton, there is a dysfunction in the local participation in the distribution of primary health services. Since no single crop benefits from an organised marketing channel such as that of cotton, the difficulty for farmers non-cotton growers to get substantial cashes is real. This not only holds back individual opportunity to participate, but more importantly, it precludes the leverage mechanisms for collective action in the distribution of primary health services. It should be stressed that the absence of such mechanisms does not necessarily result from a lack of willingness on the side of the rural people to overcome a social dilemma, but rather from the skewed articulation of government intervention with their participation. The further restriction of the marketing scheme to cotton not only limits the financial disposals to be collectively spent at a given location, but also has crowding-out effects for the primary health services. Given that the cotton-marketing scheme is mainly linked to the
agricultural input services, there is a causal relationship running from the agricultural sector to the primary health services.

Conversely, the primary health services have some relevant linkages with the cotton-marketing scheme. These linkages may not be readily generalised. There are some mechanisms that necessarily make the cotton scheme work in the sense of complementing the health sector. Implicitly, village communities who seek to get their local PHS are pressed to organise themselves and pursue collective action that may generate cash. We know that, in the past, only cotton production fitted unequivocally in such a framework. However, there also are some defaulting mechanisms that indeed make the cotton scheme diverge from initially stated goals. By contrast, there are certain unusual cases where individual cash earnings from activities other than cotton production are used collectively. Given that people's ability to avail themselves of health services is highly linked to the cotton scheme, there is a causal relationship running from the health sector to the agricultural input services.

If the overall policy reforms prove to be conclusive from a macro-economic viewpoint, the micro-level distribution effects are strikingly uneven. In the agricultural sector, the overemphasis on the cotton scheme and a zero-option for other crops add to the present inequalities. In the health sector, on the other hand, a bias toward user-charges, at the expense of promotional health-care activities, does not alleviate the plight of the rural poor. This suggests that additional measures are still needed to enhance local capabilities to take advantage of the policy reforms.

As indicated earlier, an improvement of the rural health status is hindered by government failure on the one hand, and agricultural policy bias on the other hand. The assessment of the distribution effects of policy reforms in both sectors then questions the liberalisation process and people's participation in the distribution of services.

1.2 Theoretical relevance of the topic under study

An 'Institutional Economics' (IE) perspective is relevant to the topic under study. However, such a perspective falls short of the underlying rationale for the lack of success observed with the sector-specific reforms. There is a passive resistance to the reforms, although not one actor formally objects to them. For instance, there is no full co-operation among actors with respect to knowledge-sharing, competence-sharing or capability-sharing. A traditional 'Institutional Economics' perspective as stated in Ostrom (1986) is useful to understand actors' interactions as such, but is not sufficient to inquire into the complex processes involved. Recall, however, that similar institutional issues with complex ramifications to tangible and intangible resources have been documented in the literature on firms, on the one hand (Hunt 1997). Other scholars, on the other hand, have critically explored the existing analogy between firms and village communities (Cremer et al 1994; Picot and Wolf 1994, Willis 1968). Therefore, the Resource-Based (R-B) perspective of firms as expounded in Nelson (1997) and Foss (1997a&b) appears insightful for the definition of the strategy, structure and core capabilities that might be needed by actors at the village level to significantly improve the distribution of agricultural input and primary health services. The R-B perspective and its relation to the distribution of the two services will be highlighted below.

The definition of a strategy that integrates the agricultural input and primary health services as means to attain rural development goals derives from a more general theoretical foundation. In the literature, there is an enlightening account on the role of services for furthering development (Gore 1991a&b; Ahmed and Donavan 1992; World Development Report 1994).

As stated in the introduction, a structure brings all actors together with the aim of defining and achieving a certain development strategy, given the resources available to them. Structure implies the design of an organisation and the related institutions, i.e. the set of rules, norms and
values. Parallel to the search for the organisation suitable to administer the public, private and local organisations implementing together a single development strategy, there is a debate in the literature that revolves around state and market. A structure, as a social construct, evolves through time following a trial-and-error process. The underlying theories are turned to later.

The R-B perspective considers core capabilities as management attributes. For instance, the distribution of agricultural input and primary health services requires some knowledge as well as organisational capabilities that differ from one village to the other and certainly explain the relative degree of success achieved locality-wise. In this respect, the debate on management is relevant. However, management is a function that accrues to individuals or groups taking decisions on behalf of the public, private and local organisations. There is the debate on leaders, pressure groups and how those specific actors influence rural development. This debate will be expanded in the next chapter.

Knowledge and organisational capabilities are very relevant to the adjustment of the distribution of services supplied and services demanded. This supposes that needs are assessed and adequately adjusted to the necessary resources for the distribution of services. It also supposes that the necessary knowledge to ensure an efficient resource allocation is within the reach of the beneficiaries. Therefore, an input–output perspective is implicit, drawing from both the cost-benefit analysis and equity concerns. Indeed, because of the low purchasing power of the large majority of rural dwellers organisational capabilities need to be poverty-focused, as the members are poor.

1.3 Statement of the research problem

The problem under study derives from the difficulties surrounding the co-ordination of various actors operating within the distribution of agricultural input and primary health services. The stated co-ordination role is concerned with the design of the right mix of the public, private, and local organisations responsible for carrying out the distribution of services. What seems to be a straightforward institutional problem, actually entails very complex mechanisms. For instance, the public, private, and local organisations may not stand on equal footing from the outset. Equal participation is the rule, but the government monopoly of the past distorts role-sharing and biases the leadership role toward the public sector.

Recall that, early after the independence, the government of Benin has reserved the monopoly right to distribute development services. The 1960s were characterised by government effort to meet the expectations of citizen. However, in spite of good intentions, the government lacked the necessary resources to invest in rural development projects in general, and in the distribution of both agricultural input and primary health services in particular. The policy of inward looking, from the early 1970s to the late 1980s, has aggravated the plight of the rural people. It should be pointed out that community involvement was initiated during this period. Consequently, villagers endeavoured to contribute to development services through the construction of meeting centres, schools, health facilities, warehouses, etc. A large amount of resources were then mismanaged because of the lack of co-ordination. During the late 1980s and the early 1990s, the crises in various sectors were so intense that structural reforms were necessary to reverse the gloomy trends.

The implementation of the reforms and the pace at which these contribute to improve the plight of the rural people are subject to analysis in order to derive inferences on the future achievements and hopefully stimulate some adjustment measures.
1.4 Objectives and research questions

This section will present the objectives of the study, and analyse their rationale.

1.4.1 Objectives

The present study will pursue one main objective, which is to critically assess the co-ordination of the distribution of agricultural input and primary health services and derive the division of responsibilities between the public, private and local organisations.

Drawing from three aspects of the resource-based perspective, strategy, structure, and core capabilities, this study will address the following specific objectives:

i) Assess the strategy of the public, private, and local organisations with respect to the distribution of agricultural and health services.

ii) Assess the structure of the public, private, and local organisations with respect to the distribution of agricultural and health services.

iii) Assess the core capabilities of the public, private, and local organisations with respect to the distribution of agricultural and health services.

iv) Assess the extent of overlap between the strategy, structure, and core capabilities of the public, private, and local organisations.

1.4.2 Justification of the objectives and research questions

Recall that policy reforms succeeded government failure in the distribution of agricultural input and primary health services. Recall also that policy goals have long depressed private initiatives in both sectors, leading to market failure. It follows that reforms must consider, at least from the beginning, these double failures. This is to assert that organisational concerns are very relevant to the present research.

The rationale for making use of the Resource-Based perspective stems from the competitive nature and heterogeneity of factors in the distribution of agricultural input and primary health services. For instance, villages with substantial organisational resources sustain competitive advantages in the distribution process when compared to villages without. Although this may not be a strict-jacket, organisation-based competitiveness is increasingly having some bearing on the distribution of both services. Villages are also never homogeneous in resource endowments to start with, seldom are they homogenous in their performance goals. Heterogeneity of resources, goals, and performance is increasingly accepted, as each village is a unique case on its own.

It should be stressed that organisation covers a very broad perspective, justifying why aspects of strategy, structure and core capabilities originally discussed in the resource-based (R-B) literature are relevant to the distribution of agricultural and health services at the village level. The application of such concepts derives from a twofold rationale, one is theory-oriented and the second policy-oriented.

Regarding the policy orientation of the objective, applying the R-B perspective to the village-level organisations in charge of the distribution of agricultural and health services has the merit of drawing from the dynamics observed within industries and firms to inspire the reforms underway in most sub-Saharan African countries, and Benin in particular. It is equally insightful to learn that even firms function neither as pure market, nor as pure hierarchy, and derive subsequent organisational learning to inspire the liberalisation process in Benin.

Concerning the theoretical orientation of the objective, applying the R-B perspective to the village level will enrich it with dimensions other than those of the firm. Such a perspective will help uncover specific features of the public, private and local organisations within very specific
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contexts. And, more specifically, this approach will uncover features relative to the strategy, structure, and core capabilities of the public, private, and local organisations within the context of a developing country. By achieving such objectives, this study will then provide the conceptual framework to bridge the gap between Development Economics and the resource-based perspective of firms.

At a more specific scale, an assessment of an organisation entails identifying its strengths and weaknesses together with the tangible and intangible resources available to it. The intangible resources include, among others, the core capabilities. Similarly, aspects concerning opportunities and threats from the environment are relevant to the analysis of an organisation. These aspects derive mainly from the strategy formulation within an organisation. Concomitantly, the objective is to assess the potential capacity of an organisation to take advantage of perceived needs or to cope with attendant risks.

In the course of achieving the stated objectives, research questions will be organised following the three aspects of the resource-based perspective, strategy, structure, and core capabilities.

i) What are the strategy, structure and core capabilities of the public-sector organisations involved in the distribution of agricultural input and primary health services?

ii) What are the strategy, structure and core capabilities of the private organisations involved in the distribution of agricultural input and primary health services?

iii) What are the strategy, structure and core capabilities of the local organisations involved in the distribution of agricultural input and primary health services?

iv) What mix of the strategies, structures and core capabilities of the public, private, and local organisations involved in collective action may make the distribution of agricultural input and primary health services more effective?

1.5 Methodology

This section will present a brief account of the research area, the sampling method, data collection, data analysis and the limitations of the study. A detailed methodological description will follow in the next chapter in order to make the model under study operational.

1.5.1 Research area

The Republic of Benin is initially sub-divided into six territorial units of which Mono is chosen as the research area. This research area effectively covers five sub-prefectures located in the northern part of the initial Mono region, presently delineated as the Couffo region, except the sub-prefecture of Lalo. Those five districts comprise 39 communes and 304 villages. The latter are diversely populated, with population sizes ranging from 140 to 4,426 inhabitants. Although a great deal of information has been collected at the regional level, attention has been paid to more micro-level changes, using investigations carried out in thirty-four villages (see map 1.1).

The choice of thirty-four villages in such a large sub-region is purposeful. It mainly derives from the quest to reconcile agricultural and health services. In order to achieve such a goal, thirty-one villages, representing the capital centres for their respective rural communes, are selected. In addition to those villages, which must presumably locate primary health services and farmers' organisations, three other villages are selected for the following reasons. The first village represents an advanced case of people's participation in the agricultural development process coupled with a community-funded health facility, Lagbavé; the second represents an advanced case of people's participation in the primary health-care development process with an experimental health insurance scheme, Gbowimé; and, the third one represents an exceptional case of a maternity care outlet not yet coupled with a dispensary service, Hoky. It is also of
interest to mention that most territorial units with urban characteristics have been left out of the sample of villages involved in an intensive use of questionnaires, although the health attendance investigation has covered the whole research area. Therefore, the capital centres of the five sub-prefectures located within the research area are not surveyed by means of questionnaires. Aside those territorial units, one rural commune centre has mistakenly been left out the sample of villages because of its recent position as a commune centre, Kinkinhoué. This information had not been updated in the census record at hand (INSAE-MPAME 1994, p. 12), and only transpired later during the research process.

Justification of the choice of the Couffo region

The choice of the Couffo region is due to three reasons. The first reason of interest derives from that this region has benefited from two major government interventions. The first one concerns the ‘Houin Agamé’ development programme, during the 1960s, based on large industrial oil palm plantations. The second is related to the Integrated Rural Development Programme initiated in the Mono region around the early 1970s. Notwithstanding the richness of government interventions, the Couffo region scores low for both agricultural and health services. It is one of the most lacking in health-care facilities of all six administrative regions of the country and only has 5% of the doctors, while it represents 15% of the population (INSAE-MPAME 1994). In addition, agricultural indicators have declined lately in the Couffo region as compared to its counterparts.

The second reason to be mentioned stems from that doing research in the Couffo region has become a tradition for the Faculty of Agricultural Sciences, my institute of affiliation, which has established a long-standing research project in this region from the early 1980s onward. It should also be acknowledged that most research projects funded by foundations such as the Dutch Organisation for International Co-operation in Higher Education (NUFFIC), the Royal Tropical Institute (KIT) and the Netherlands Development Organisation (SNV) have established headquarters in this region. According to an executive officer of the inter-University co-operation, the rationale behind such a spatial focus is to overcome the dearth of reliable data and information that long characterised this region of Benin. Research topics carried out in this region address various issues, from village monographs to in-depth nutrition studies. In the field of agriculture, most studies address soil fertility decline (Brouwers 1993; RAMR 1987 through 1989), land tenure issues (Dissou 1992; 1975; Biaou 1991; 1996) and agricultural markets (Lutz 1992, 1994; Fanou 1994). Obviously, socio-economic characteristics of farmers have been touched on from different perspectives (Daane 1992, Den Ouden 1989, 1997; Wartena 1987, 1997). The list of development projects is also long, ranging from the Farming system approach of agricultural research (funded by the KIT), to the more development-oriented project (PADES-Mono funded by the Dutch Ministry of co-operation through SNV). Most research activities as well as development projects include, among other objectives, the building up of regional capacity in information accessibility for development purposes. However, I must point out that the apparent intensification of researches over the last few years has suffered from a limited coverage of inter-sector development issues. Some attempts by PADES-Mono to bridge the gap between various sectors, by means of people’s participation at both the design and implementation stages, have failed to live up to expectations due to conceptual flaws (Boon et al. 1997). This is, therefore, a justification for this region being a testing ground for an inter-sector development study, focusing on the distribution of agricultural input and primary health services.
1.5.2 Justification of the choice of the units of analysis

Village communities are chosen as the units of analysis, and households are the social units attuned for the survey on the evaluation of the distribution of agricultural input and primary health services. The rationale for the choice of village communities derives from the perspective of collective action acknowledged for the distribution of both services. The village level is the lowest territorial, administrative and social unit where the public, private, and local organisations can interact. It is also the level at which any meaningful co-operation is socially desirable and cost effective for the distribution of agricultural and health services. Recall that villages have on average two thousand inhabitants (cf. table 1.1).

The theoretical justification calls forth the analogy between firms and village communities. As firms compete to produce efficiently or effectively for a certain market segment (Hunt, 1997), village communities struggle to improve their members' access to the distribution of agricultural and health services. The choice of villages also derives from the perspective dealt with by Porter (1990), who assessed the competitive environment set by nations for home-based firms to evolve internationally. The conditions relative to the competitive environment of nations with respect to firms are applicable to some extent to villages when focusing on the distribution of services. If having the right institutions and policies is the requirement for nations, the village level needs a great deal of organisational changes to fit in the restructuring processes underway. The perspective investigated by Porter is then relevant to shed light on the distribution of agricultural and health services at the village level.

Table 1.1: Average population size and average number of households of a sample of villages in five sub-prefectures of the Couffo region

<table>
<thead>
<tr>
<th>Sub-prefecture</th>
<th>1982*</th>
<th>1992**</th>
<th>1996***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aplahoué</td>
<td>853</td>
<td>147</td>
<td>1155</td>
</tr>
<tr>
<td>7 villages</td>
<td>(25)</td>
<td>(26)</td>
<td>(45)</td>
</tr>
<tr>
<td>Djakotomey</td>
<td>1116</td>
<td>164</td>
<td>1853</td>
</tr>
<tr>
<td>7 villages</td>
<td>(28)</td>
<td>(30)</td>
<td>(36)</td>
</tr>
<tr>
<td>Dogbo</td>
<td>1121</td>
<td>160</td>
<td>1279</td>
</tr>
<tr>
<td>6 villages</td>
<td>(32)</td>
<td>(31)</td>
<td>(39)</td>
</tr>
<tr>
<td>Klouékamè</td>
<td>857</td>
<td>140</td>
<td>1162</td>
</tr>
<tr>
<td>8 villages</td>
<td>(39)</td>
<td>(39)</td>
<td>(40)</td>
</tr>
<tr>
<td>Tovikin</td>
<td>882</td>
<td>129</td>
<td>1144</td>
</tr>
<tr>
<td>6 villages</td>
<td>(43)</td>
<td>(45)</td>
<td>(35)</td>
</tr>
</tbody>
</table>

Source: * Adapted from DDPSM (1982); ** Adapted from INSAE/MPAE (1994); *** Compiled from survey data (1996)

Note: Pop. stands for average population size per village; Hous. stands for average number of households per village; ( ) the figure in brackets stands for the relative standard deviation; [ ] the figure in columns stands for the number of villages in the sample.

Household-heads are surveyed on the ground that these actors are at the heart of the decision-making process in their socio-economic units. It is then their responsibility to set the level of services needed and to evaluate the extent of satisfaction achieved. This is to claim that care must be taken in drawing inferences on needs and satisfaction from a representative sample of household-heads.

As limitations to the choice of village communities, households and household-heads, this study does not address issues specifically related to various ages-groups, children, adults and
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elderly people. However, gender differentiation is catered for, since some women are recorded as household-heads and are surveyed accordingly. Yet, the plurality of decision-making units within households does limit the choice of household-heads as legitimate representatives of households in the assessment of the demand for agricultural input and primary health services (Biaou, 1997). More importantly, more women take decisions on behalf of their household in case of deceased or town-based male household-heads, though in limited fields of rural development.

It should be stressed that the choice of village communities as units of analysis hinders an appropriate use of certain variables, for instance, household size and farm size. In a certain sense, most of those variables are biased when aggregated at the village level, and they hardly inform on their great variability. However, the use of village-level ratios for professional occupation, membership of local organisations, degree of satisfaction for agricultural and health services, and other factors is enlightening.

1.5.3 Data collection
I started my field research with a Rapid Rural Appraisal (RRA), which was meant to streamline the study objectives. After the field of investigation was clarified, I used a stratified sampling system to choose five districts and thirty-four villages.

This research is based on a survey of various actors operating in both agricultural input and primary health services in the Couffo region. Mainly, 1632 household-heads were interviewed in the thirty-four surveyed villages. An initial census of heads of households has been conducted right from the beginning with the help of four field assistants together with the village-elected councils. This has been useful to draw samples of respondents representing 20 percent of the village total. Table 1.1 gives some background information on the evolution of population and household statistics within the sample of villages in three different periods, 1982, 1992 and 1996. All five sub-prefectures are characterised by rapid population growth. Regarding households, growth figures are lower than those on population but still in the same range.

In order to get insights into how various actors perceive the strategy, structure and core capabilities underlying the distribution of agricultural input and primary health services and the ways in which these contribute to improved access, a combination of interviews and group discussions has been pursued. A special emphasis has been on the beneficiaries of those services, inquiring into how they perceive agricultural and health services, and how performance might be improved. This unavoidably appeals to their appreciation of both the costs and the benefits of these services.

In order to avoid some straightforward answers on performance, a holistic approach has been considered. Performance entails the spatial, cost, and organisational dimensions of people's access to services. More importantly, performance is a dynamic process and can only be evaluated for two clear-cut periods in time. Therefore, there is a need to trace performance according to some crucial events that have affected rural life. A record of these milestones has been effectuated using the rapid rural appraisal and the before and after methods of the economic cost-benefit analysis.

The evaluation of the distribution of both services has integrated people's decision-making. People's decisions to avail themselves of the services entail two analytically different processes. There is the initial decision to purchase or avail oneself of the services for the first time. This decision supposes an implicit cost-benefit analysis, implying expectations as to performance. Then, there is the subsequent decision to (dis)continue the demand for services, if (dis)satisfaction is obtained from the first attempt. Such processes are evaluated for both the before and after situations of the reforms. More importantly, those processes are value-laden.
For instance, the (dis)continuation to avail oneself of services is attributed more weight than a stated perception of (non)performance.

With respect to the two services, a distinction is made between different suppliers. Recall that at least two types of services are considered within each sector: the modern agricultural inputs (imported stuff) and the traditional inputs, notably from the community input system - the modern health care and the traditional medicine. On the other hand, the so-called modern agricultural inputs and health care are subject to different market organisations, the formal sector (government, domestic and multi-national commercial companies and any other organisations that are formally constituted and involved in the supply of services) and the so-called informal sector or parallel channel (individuals and a wide range of informal groups who operate in the sector without certification). Thus, three channels of distribution have been distinctively considered to match the demand, the formal sector, the parallel channel and the traditional source.

The detailed formulation of the questionnaires and the discussion guides has taken great account of the concepts and definition given earlier.

With respect to secondary source data, the concerns have been on investigating people’s utilisation of both services. In the agriculture sector, secondary data were collected on the purchases of inputs and the sales of cotton output over five years. Data covering the period before and after the reforms were also collected in order to assess how the policy of retrenchment in the public sector was implemented. In the health sector, on the other hand, secondary data on attendance were collected in order to have an overview of the utilisation pattern region-wise. Data on human as well as financial resources were also collected to control the state of resource allocation in the aftermath of the reforms. An important emphasis was then put on investigating the location of origin of patients attending the primary health services. In the public sector, 317 205 entries were surveyed over the period of 1992 to 1996 in the health record-books of the existing formal health outlets, each entry being controlled for the village of residence of the patient for spatial coverage purposes. The results were to substantiate the extent of revealed needs and subsequent local and regional patterns of utilisation during this period. In the non-governmental health centres, more than 40 000 visits were recorded over 1992-96, of which only 19 582 have been processed for identification of the localities of origin. For several reasons, the figures processed underscore the real weight of this sector.

1.5.4 Methods of data analysis
Most studies of rural change traditionally incorporate the measurements of social, cultural and economic status of the communities concerned. However, the present approach is different. It is essentially based on the ex-post project evaluation approach, using actors' perception of the distribution processes of agricultural input and primary health services.

The method put to use is based on the valuation technique adapted by Crane (1988) and comprises two stages. The first stage consists of assessing the purposive justification of the organisations in charge of those services. At this stage, both the internal and the external environment of organisations in charge of the distribution of services are assessed. The second stage consists of assessing the present performance of both services according to the viewpoints of the sample of household-heads.

For example, family care, immunisation and maternity care are three primary goals of the primary health services, while the distribution of improved varieties of crops, fertilisers and pesticides to farmers is the most relevant goal of the agricultural input services. Therefore, at the first stage, the standards and norms defined by the Benin government, in terms of numbers of physicians, medical assistants or midwives per thousand inhabitants, have been used. At the second stage, the validity of the national standards is questioned by proceeding with what Crane
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(1988) refers to as social scaling (cf. also Goddard and Powell 1994). Although debatable, Crane suggested to identify first, who makes the decision? and second, who are the beneficiaries? Then, it is the responsibility of the identified group of beneficiaries to set the levels of development that are acceptable to them.

Crane’s techniques have been adapted to fit in both institutional economics (IE) and resource-based (R-B) perspectives of the distribution of agricultural and health services (see annex A). Accordingly, the co-ordinating mechanisms (public, private or hybrid organisation) between the supply of and the demand for services have served as central locus to the analysis. In addition, the environment of the organisation, deriving from sector-specific policies and the social and economic characteristics of rural people, has been analysed for policy implications.

A second method of analysis is the traditional cost-benefit analysis. This method is used as routine to evaluate whether costs exceed beneficence in the production and distribution of services. A final method is that of SWOT analysis. This will entail people’s evaluation of the distribution of services. Two dimensions are considered, the first one dealing with the internal strength and weaknesses of the distribution, and the second concerning itself with opportunities and threats from the external environment. This method will shed light on whether prospects are gloomy or shining for the distribution of both services.

1.5.5 Limitations of the research

The present research has some methodological drawbacks that enhance rather than impede its theoretical and empirical stands. A research in the field of rural development may better be handled through an anthropological approach. Social anthropologists are interested in the behavioural regularities in everyday situations: artefacts, rituals, relationships, and the like (Miles and Huberman 1994). These regularities are often expressed as patterns or rules, and they are meant to provide the inferential keys to the culture or community under study. In order to capture such regularities, research is typically based on successive observations and interviews, which are reviewed analytically to guide the next move in the field. Such a methodological stand is very rewarding since it may help to collect reliable data.

Apart from the limitation peculiar to the choice of approaches, macro-micro considerations also limit data collection. In fact, two types of secondary source data are considered in the fields. Macro-data are available on a yearly basis and are found in the annual reports of most institutions, but the micro-data, on which the macro-ones are based, are not available. The lack of conservation facilities seriously impairs the availability of raw data in public-sector offices. The problem derives from the need to assemble these raw data once again, in order to adjust them to the territorial limits set to this research. For instance, aggregate data may be available at the regional level, while the raw data from which these are calculated are no longer at hand.

This research deals with agricultural inputs and primary health care as two packages of relatively heterogeneous services. Within each package, one single component has its own particular characteristics. Nevertheless, sector-specific differences have not been given sufficient attention, whereas emphasis has been on the organisational aspects of the distribution of the services.

About the two theoretical perspectives adopted in the research, the impression is of fields that are sceptical not only about formal economic theory but also about econometrics (Posner 1993; Coase 1993). The evaluation method applied in this research, though not novel, is very insightful nevertheless. The before and after situations, lively in the development analysis approach, are indeed of great contribution in this regard.

Given the preceding limitations, and because of a lack of data, a detailed description and analysis of the distribution processes based on quantitative production figures (revenues, wealth accumulation, social indicators such as decrease in death toll, increase in vaccination coverage,
increase in literacy rate, number of physicians per thousand inhabitants, etc.) is unlikely. The availability of such quantitative data at different territorial levels on a yearly basis would have improved the results to a great extent.

1.6 Structure of the book

This book is organised in nine chapters structured as follows. Chapter 1 provides an overview of the problems under study. It gives the main objectives of inquiring into collective action in the distribution of agricultural input and primary health services.

In Chapter 2, we discuss the conceptual framework. This mainly draws from the resource-based perspective of firms, with a focus on the strategy, structure and core capabilities of actors in the distribution of agricultural input and primary health services. The Institutional Economics approach is also used for the clarification of collective action, and to shed light on the coordinating mechanisms and the underlying costs for various actors. In Chapter 3, we deal with background information on the agricultural input services. This chapter provides an overview for understanding the context within which the agricultural policy reforms are performing. Chapter 4 addresses the role of public, private, and local organisations in the distribution of agricultural input services. It mainly focuses on the strategy, structure, and core capabilities of the three groups of actors involved in the distribution of services. In Chapter 5, we essentially discuss collective action, notably the mix of strategy, structure, and core capabilities of the public, private, and local organisations that makes collective action more effective in the distribution of agricultural input services.

In Chapter 6, we present background information on the primary health services. This chapter provides an overview for understanding the context within which the health-policy reforms are performing. Chapter 7 addresses the role of public, private, and local organisations in the distribution of primary health services. It mainly focuses on the strategy, structure, and core capabilities of the three groups of actors involved in the distribution of services. In Chapter 8, we essentially address issues of collective action, notably the mix of strategy, structure, and core capabilities of the public, private, and local organisations that makes collective action more effective in the distribution of primary health services. In Chapter 9, we present a synthesis on both agricultural and health services, followed by some concluding comments.

NOTES

1 Rules, norms and values are defined from different perspectives. Social anthropologists consider them as behavioural regularities in everyday situations, artefacts, rituals, relationships, and the like (Miles and Huberman 1994). The institutional economists initially considered them as friction. Then, they identified two levels of analysis: norms are at the individual level, and rules are at the society level (cf. Wallis 1989). The following quotation from Williamson (1993) constitutes a full recognition of the social anthropologist's view of rules, norms and values. He suggested that:

institutional theory in sociology be credited with the value added accruing to economic organisation through the ritualistic and symbolic nature of organizational structures, procedures, and decisions. The rationale is that economic theory deals mainly with measurable and tangible outcomes, while the subtle efficiency consequences of organisations require that the micro analytic attributes that define culture, communication codes, and routines be
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uncovered (p. 118).

Social dilemma stands for situations in which the village community as a whole or an important part of it has to make a difficult choice between two courses of action. For instance, whether or not a community should provide a health facility must be considered in the face of government and market failures. Not taking action supposes no access to health services, while the opposite course of action will put strains on the community's scarce resources.


For the PHSs, requirements include, among other things, hosting PHS at the capital centre of commune -not hosting PHS within a radius of 5 km - availability of fresh water for health practices and social amenities such as school and infrastructure for community educational purposes, etc.

The non-certified private clinics, in addition to the health-care peddlers who visit long distance villages, fall into the parallel channel.

The cost-recovery scheme is mainly based on charging user fees at a level that exactly balances the financial inflows and outflows of the health centre. In Benin, participation of the beneficiaries is involved so as to cater for distribution effects, hence equity considerations.

From the resource-based perspective, knowledge, competence and capability address exactly the same concepts, but with different gradations (Kogut and Zander 1997). Lambooy (1997) also acknowledged three gradations of knowledge.

Organisational capabilities address the management of the production processes and the management of the relations amongst various actors. These then address internal as well as external issues related to organisational learning (human, material and financial resource management, relations with other organisations, etc.). Knowledge capabilities, on the other hand, relate to the lack of (or excess of) the dissemination of knowledge that may hamper (or facilitate) the efficiency in resource allocation. These are related to the learning aspects of the programmes or activities implemented by the organisation (scientific capacity building, applied knowledge, education, training, etc.).