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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7 - ROLES OF THE PUBLIC, PRIVATE AND LOCAL ORGANISATIONS IN THE DISTRIBUTION OF THE PRIMARY HEALTH SERVICES IN THE COUFFO REGION

In the present chapter, we will focus on the strategy, structure, and core capabilities of the public, private, and local organisations in the distribution of primary health services (PHSs) in the Couffo region. The aim is to assess whether the definition of a strategy and the prescription of a structure correspond to long-term goals.

Following Zwi and Mill (1995), a comprehensive evaluation of the health policy reforms must underlie the extent of development in the health-care and health systems. During the evaluation process, the emphasis must be on equity concerns and the realignment of the institutional linkages, what Frenk (1994) defined as the health system. This notion will be pursued later on, when evaluating the institutional development in the health sector. The health-care system, on the other hand, comprises a range of strategies and means aimed at the distribution of health services following some standard rules for efficiency purposes. Indeed, user-charges and other health costs are purposely set to achieve either efficiency or effectiveness.

We shall point out from the outset that the distribution of the PHSs is considered here from a government intervention perspective. Recall first that the public sector held the monopoly rights to distribute health services free of charge from the 1960s to the early 1970s. The emphasis then was on curative care that health personnel, who were all civil servants, used to administer as in-patient services. But, due to the failure to achieve improved health status for a large majority of the citizens, a number of reforms were initiated from the late 1970s onward. These reforms concerned a change of strategy in the first place, namely the shift from curative to preventive care during the 1980s. It was found that the government alone could not afford the resources needed for such a strategy to live up to expectations. It was then suggested that liberalisation and, more importantly, people's participation would take care of equity concerns. In the wake of the reforms, it was clear that the public sector was not committed to recede from the distribution of health services. Not only has the public sector kept the upper hand on the distribution, through the so-called PHSs, but it also released certification only to private clinics in locations where no PHSs exist.

Regarding the public-sector organisations in charge of the distribution of health services, the emphasis will be on allocative inefficiency with respect to the distribution of these services. It will be argued that the adjustment of health personnel for regional equity purposes by the Ministry of Health in 1991 was not only reverted the following year, but this also aggravated the initial rural-urban bias. More importantly, the implementation of the cost-recovery scheme, proposed by the World Bank, also aggravated the initial preventive-curative care bias. Recall that the cost-recovery scheme is mainly based on user-charges, which may compensate recurrent health costs. But this scheme has turned out to be a framework for a total transfer of financial responsibilities to the beneficiaries. As will be shown later, this scheme has contributed to the contraction of the demand for PHSs, in spite of recent efforts to improve the distribution of health services.

With respect to the private clinics, these are operating on the defensive and are forced to engage in a search for new niches and untapped coverage. This situation has not only led to unqualified practices, but it has also attracted increasingly higher numbers of non-health professionals who believe they can make a living in health practices. The pressure from the public sector was so high that some initially known private outlets were turned into the formal
PHSs. The latter option was hardly resisted, as more people preferred working within the public-sector bureaucracy to working outside it.

Drawing from the perspective of the institutional environment, it is instructive to recall that two types of organisations are also in place at the village level, the so-called COGEC or LHMCs, and grassroots organisations. For the purpose of spatial differentiation, the notion of local organisations is used to encompass both types as opposed to higher territorial-level organisations. LHMCs and grassroots organisations will be acknowledged separately when explicit distinction is needed. As it has been substantiated throughout the earlier chapters, health reforms contain a strategy based on structural changes and supported by a learning process. But, these may only live up to expectations if the process helps various actors to acquire the core capabilities needed to further health goals.

The present chapter will draw mainly from secondary-source data. The main objective being an illustration of the impact of health-policy reforms on the health-care system and the health system, this chapter is organised into seven sections. The first section discusses the strategy of the public-sector organisations in the distribution of health services. The second section will deal with the structure of the public-sector organisations in the distribution of primary health services, while the third section concerns itself with the core capabilities of the public-sector organisations in the distribution of primary health services. The fourth section will discuss the strategy, structure, and core capabilities of the non-governmental health organisations. The fifth section will address public-private roles in the distribution of primary health services. The sixth section will then focus on the strategy, structure and core capabilities of local organisations in the distribution of primary health services. The seventh section will present some concluding comments.

7.1 Strategy of the public-sector organisations in the distribution of health services

Recall that strategy derives from the identification of a set of basic long-term goals and objectives, and the subsequent courses of action and allocation of resources necessary for carrying out these goals (Chandler 1997). The present section will then address issues related to long-term goals, course of action and allocation of resources necessary to achieve the stated goals.

7.1.1 Long-term goals of the public-sector organisations in the distribution of health services

It was said earlier that the government of Benin abides by the World Health Organisation’s (WHO) constitution stating that the enjoyment of the highest standard of health is one of the fundamental rights of all human beings (cf. chapter 1). In practice, however, the implementation of such a perspective seriously departs from genuine expectations. Obviously, promoting preventive health-care systems and liberalisation urges a new strategy that is not necessarily incompatible with the first perspective. A second perspective is to view health care as consumption goods supplied by the private clinics in the long run. A third perspective is to consider health care as an investment through an enhanced integration between the health sector and other sectors, agriculture, for instance. The requirements for a synthesis of the three perspectives on health stem from ascribing equal weight to the health system and the health-care system. This is unlikely, given the present unbalanced development of the formal PHSs.

Initially, the ultimate goal of restructuring the health sector was to externalise the related administrative, information and market exchange costs, so as to minimise government investments while securing a steady rise in health status in the rural areas. The government then maintained its goal of full coverage in the distribution of PHSs concomitantly with the
Roles of the public, private and local organisations in the distribution of the primary health services in the Couffo region


7.1.2 Course of action in the public-sector organisations for the distribution of primary health services

Recall that the government sector reserved a monopoly role in the distribution of health services until the early 1990s. Recall also that the restructuring of the health sector was planned to enhance health-policy goals towards promotional health activities. Recall finally that the World Bank concomitantly advocated the cost-recovery scheme, in order to ease financial strains on the government budget (Azefor and Bradley 1996). Contrary to the agricultural sector, the restructuring of the health sector came about because of a strong commitment of the government to withdraw from the sector. It rather addressed measures that could enhance and consolidate the role of the public sector in a partnership with private and local organisations.

Enhancement and consolidation of the roles of the public-sector health organisations

The formal non-governmental health sector is still covering a very thin demand. It should be noted here that the sector under consideration includes both the certified private clinics and the confessional hospitals. The parallel channel of the modern health services, on the other hand, is categorised as part of the informal non-governmental sector.

At least three major reasons justify the thinness of the demand covered by the formal non-governmental sector. The first derives from the past policy effects in the health sector. The second reason is that the public-sector health organisations are resisting the reforms. One aspect of their resistance encompasses regulation and deregulation in the non-governmental health sector. This is not to assert that counter-performance in this sector is solely due to resistance from the side of health officials, but the structural characteristics of the private practitioners also matter to some extent. The third reason is that the government sector has deliberately chosen to foreclose competition from the private sector. For example, a number of village health posts and even initially established private clinics were turned over to the government sector in 1997, overemphasising the rather blurred delineation between both sectors. The underlying rationale will be dealt with later on.

7.1.3 Resource allocation in the public-sector organisations for the distribution of primary health services

The policy of retrenchment in the public health sector imposes restrictions on the recruitment of new health personnel. Contrary to the agricultural sector, however, no staff cuts have been advocated. It was rather acknowledged that a fair distribution of the existing health staff among and within regions would improve coverage to a great extent. This was the primary justification of the adjustment of health personnel that the Ministry of Health undertook in 1991. The subsequent effects will be evaluated below.

In this sub-section, emphasis will be on the evolution of the size of health personnel and staff salaries, in order to document the extent to which reforms are resisted within the public-sector organisations. The rationale is to derive inference on welfare bias, drawing from the case study of health personnel.

Public-sector health organisations in the Mono-Couffo region: allocative inefficiency

Table 7.1 presents the evolution of health personnel in the Mono-Couffo region over the period 1985-97. The first four columns present the personnel by professional category, from medical doctor to midwives. The next two columns, on the other hand, present the size of personnel by the budget-source of their salaries. As displayed in the table, the national budget
is still concerned with a large share of health personnel, while donor- and community-budgets take care of the remaining shares. However, the growing sizes of the personnel categorised for the latter budgets warrant some further clarification.

Recall that overall sizes of each category of health personnel have not changed in the whole country after the reforms. However, the sizes of all categories of government health personnel significantly increased in the aftermath of the inter-regional adjustment in the Mono-Couffo region (cf. chapter 6, table 6.2). Although the increases were genuinely undertaken because of the low profile of this region during the pre-reform years, health staff quickly withdrew in 1992, only one year after the adjustment. The new rises from 1993 onward are the effects of communities or donors’ commitment rather than of the government (cf. table 7.1). Therefore, the evaluation of community involvement must not be on equal footing from one health outlet to the other. Clarifications on the role of resources committed are necessary.

Table 7.1: Evolution of health personnel, 1985-1997, in the Mono-Couffo region

<table>
<thead>
<tr>
<th>Years</th>
<th>Health Personnel per Category</th>
<th>Health Personnel per Budget</th>
<th>Total</th>
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<tbody>
<tr>
<td></td>
<td>Medical Doctor</td>
<td>Medical Assistant</td>
<td>Midwifes</td>
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<tr>
<td>1985</td>
<td>16</td>
<td>130</td>
<td>26</td>
</tr>
<tr>
<td>1986</td>
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<td>136</td>
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<td>1987</td>
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<td>153</td>
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<tr>
<td>1998</td>
<td>46</td>
<td>153</td>
<td>51</td>
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</table>

Source: DDS-Mono (statistical office 1986 through 1999)

The outcome of such a biased behaviour in the presence of presumably counteractive reforms is appalling. Following table 7.1, the increasingly sizeable proportion of contracted health workers from 1991 onward is characteristic of the sacrifice borne by a large majority of the rural people. More importantly, the magnitude of the imbalances between urban and rural areas in terms of health personnel is such that large shares of the cost-recovery scheme are destined to hire personnel for the rural PHSs. Therefore, the increases of health costs borne by the rural population, whose plight is initially aimed at, are for all to witness.

The reforms addressed at health personnel are one example of policy intervention fallacy. Far from achieving its institutional goals, it reinforces the existing inequalities. The nagging question is how successful health personnel are in evading coercive reforms forcefully acknowledged by high-ranking health officials and political decision makers in the government? Yet, the inter-jurisdictional as well as the geographical perspectives of the allocation of rights on health personnel are at stake here. The inefficient geographical allocation of personnel, for instance, enlarges the gap between well-endowed urban areas and rural localities. It should be stressed that, as soon as formal and informal arrangements differ, it may be possible to make inferences about the relative net benefits of institutional
arrangements to different groups. The health personnel really benefit from the post-reform institutional arrangements, as they easily influence staff allocation to the formal health centres. Their dislike of the living conditions in rural areas and their subsequent establishment in urban areas also contribute to the expansion of the parallel channel of health services.

The empirical evidence of low-ranking health staff influencing their position in the public-sector health organisations strikingly urges to look for an implicit collusion in hierarchical relationships between health officials at the top and health personnel at the bottom. This perspective is similar to that argued in Tirole’s framework of a three-tier principal-agent problem, in which he showed that an incentive problem is caused by the possibility of monetary side-payments between the low-ranking agent and the higher-ranking official (Tirole 1986). In cases where monetary transfers are not pursued, it is argued that an implicit kind of collusion arises because the higher-ranking official cares about the utility enjoyed by the subordinate. The author suggested that the agent’s incentive scheme be used to give incentive to the official. Interdependence between incentive schemes then results from utility interdependence.

We rather opt for an alternative view on the outcome of the reforms that may be fully grasped if aspects other than monetary side-payments, utility and incentives, so familiar to economists, come to the fore. These other aspects are social values, social capital, social networks (kinship, brotherhood, alliance, etc.), religious ties, power relations and the like, which are enlightening in the socio-anthropological literature. Economists, on the other hand, may suggest breaking down the ties between both groups, through the provision of adequate working conditions for health personnel. This is unlikely, at least in the short run, due to increasingly higher demands for PHSs even in remote villages. However, the liberalisation of the health sector, which entails a broad notion of participation, might set a proper context and fairly favourable working conditions for development workers, health personnel included.

Having discussed above the extent to which health reforms are fraught with allocative inefficiency in addressing the shortage of public-sector health personnel in the Mono-Couffo region and the subsequent equity concerns, below we will discuss the same issues in the light of staff salaries as well as operating costs.

Public-sector health organisation in the Mono-Couffo region: ineffective adjustments of personnel and operating costs

Recall that health costs keep a low profile in comparison to overall national budget over the period 1985-1996. The share of health costs reached a peak of 8.81 per cent in 1987 and a bottom value of 3.22 per cent in 1992 (MSP/CE 1999:6; MS/SESP-Bénin 1986 through 1997). After the devaluation in 1994, this share increased to 4.07 per cent and it has steadily increased thereafter. However, the latest values remain around 5 per cent, illustrating the allocative prejudice from which this sector suffers. Nowadays, there is a significant improvement in the financing structure. Public health expenditures, including donors’ contributions, lately reached a peak of 20 billions of the local currency, equalling on average 8 times the contribution of all beneficiaries during the period from 1995 to 1998. More importantly, total national health expenditures, including public and private shares, hit the per capita target of FCFA 7000, the equivalent of $ 12, during the 1990s. This suggests that the Republic of Benin has achieved the per-capita health cost target strongly urged by the World Bank (The Economist October 7th 1995, p.122). However, as will be shown below, this achievement hardly accounts for both efficiency and equity concerns in the health sector.

Graph 7.1 provides substance to the alleged allocative inefficiency of financial resources within the government health sector country-wise. Overall national health budget followed a reversed V-shaped curve from 1985 to 1989. Then it increased up to the reforms in 1991, after
which its two components, staff salaries and other operating costs, depart from one another. From 1991 on, other operating costs continued to increase, whereas staff salaries decreased up to 1993. However, in 1994, nominal staff salaries abruptly peaked in comparison with other operating costs, and this trend has continued ever since.

Owing to the trends in health costs described above, the reforms hardly live up to expectations. For instance, the sharp increase in salaries after 1994 was unexpected since the size of health personnel remained at the pre-reform level. The other argument, which may justify the rises, correlates with changes in the remuneration of staff members. As referred to in chapter 5, the 1990s marked the success of most labour movements for salary increases subsequent to the democratisation process. Therefore, we contend that the postulated goal underlying the reforms, which advocated a better use of the existing human resources and the stabilisation of the level of health costs, was missed following two arguments. First, health costs escalated in spite of the freezing of the recruitment of health personnel on the national budget. Second and last, the skewed distribution of health personnel between the six regions of the country and even between localities in the same region got worse after the reforms compared to the situation before. The subsequent implications for the rural population will be discussed in the sections ahead.

**Graph 7.1: Evolution of health costs (staff salaries and other operating costs) over 1985-96, Ministry of Health, Benin**

Another source of failure for the reforms concerns the large share of staff salaries within the overall health budget. This is the more odd because the freezing of the recruitment of health personnel was aimed at shrinking its usually large shares of the whole health sector budget in favour of other operating costs. For instance, the lowest share of health-staff salaries over the period 1985-1996 is 67 per cent of the overall budget in 1993. This convincingly illustrates the low level of resources other than human committed to health care in Benin.

It should be stressed that the structure of the health budget is misleading in connection to the committed human resources. The case of the Mono-Couffo region is very illustrative in this respect. The ratio of 1 physician to 33385 inhabitants, though improved compared to 1:40000 in 1990, illustrates a low coverage (MSP/CE 1999). The ratio of midwives to the number of anticipated births is also low in the Mono-Couffo region compared to the national
The devaluation of the CFA currency in 1994 played a corrective role by curtailing health costs. In fact, the devaluation drove down the real values of domestic expenditures to half their nominal values compared to foreign earnings. Likewise, overall health costs dropped in real terms. However, the effect is not similar for both personnel and other operating costs. If the devaluation was successful in driving down the other operating costs, keeping their real values in the same limits as during the early 1990s, the case of staff salaries was much different. Although the impact of the devaluation in 1994 was more intense on staff salaries than on other operating costs, staff salaries increased very fast through socially driven processes.

The question whether the public-sector health organisations suffer from a low status within the medical profession, which tends to overlook resource-allocation issues, or whether present shortfalls result from a scarcity or lack of resources, remains unanswered to date. As claimed by Zwy and Mills (1995), it is the clinicians, not the health planners and policy makers, who influence the allocation of resources within the health sector. Given the evidence substantiated above, one of the thrusts of the health-sector reforms might be an attempt by the profession to hollow out control over health resources, and to empower health managers. Arguably, health managers are not immune to the intrigues of social processes; the long-term effects of their prominent role in the health reforms have yet to be proved.

As to allocative efficiency and equity concerns, technical efficiency is hindered by different factors, among which the interactions between the public-sector health organisations and the so-called LHMCs. An inquiry into the interface government-participatory sectors will underlie later the mechanisms of technical inefficiency. With respect to the monitoring and evaluation of the process of health reforms, substantial accounts of the ways in which these are conducted have been documented in Chapter 6. More importantly, it has been tentatively alleged that the cause for misleading evaluation reports may lie behind the loss of privileges and the rural-urban biases in the distribution of health personnel. The next sections will provide evidence to the ways in which the public-sector health personnel subvert health reforms in general, and the retrenchment argument in particular.

**Government health organisations: evaluation of the reforms**

The evaluation report performed by the national *Ministry of Health* reflects a very optimistic view of the implementation of the reforms (cf. Sanoussi 1994). According to this report, the Mono-Couffo region has performed strikingly well in community participation for the provision of health services, compared to the other five regions in Benin. It has the best scores for overall indices developed in the evaluation process (the range is between 83 percent and 97 percent for the five sub-prefectures). Therefore, the Mono-Couffo region has a high profile with respect to community involvement, even though warnings about steep differentials between regions have been attributed to evaluators’ sensitivity. It is instructive to note that the criteria used for the evaluation are biased toward service provision, and do little justice to community involvement. Community participation is therefore taken as the presence of village-level representatives within the LHMCs, suggesting that villagers have their stake in the decision-making process. The structuring of the criteria, however, leaves little room for an effective people’s participation in the production and distribution of health services. This critical view is corroborated by the concluding remarks of the same report, pointing at weaknesses in community involvement (Ibid).

Stretching the arguments on truncated community involvement, the local branch of the World Bank launched an evaluation which reported the following findings: *the LHMCs are*
poorly organised, inefficiently managed, and inadequately informed - members of these committees need to be better educated on how to promote health centre activities other than cost recovery and cleaning of the premises' (Azefo and Bradley 1996, p. 52).

Despite the World Bank's report, the public-sector health personnel consider that the whole system has improved for both the beneficiaries and themselves. They actually enjoy a relative autonomy in their daily tasks. However, they blame the growing size of the parallel channel as a threat to their profession. The most important reason, in their view, is that rural people usually seek modern health care as a last resort, and the intervention of a parallel health supplier is likely to further delay this process. They recommend government scrutiny of professional qualification as a major entry criterion to the health sector.

The underlying rationale of the public-sector health personnel falsifying reports derives from that the ultimate goal of restructuring the sector is to externalise the administrative, information and market exchange costs and minimise government investments, while securing a steady rise in health status within the rural areas. Recall that the initially presumed victims of the policy of retrenchment in the public sector are the health personnel. But, it appears after all that they have successfully undermined the expected results, justifying their falsification of true achievements.

7.2 Structure of the public-sector organisations in the distribution of primary health services

As sketched in chapter 6, the Ministry of Health is organised following a pyramid-like structure that denotes a hierarchical bureaucracy (cf. figure 1, annexe F). The structure of this Ministry has extensively been presented in chapter 6. Now, the emphasis will be on the lower part of that structure, mainly focusing on the regional, the sub-prefecture and the village levels.

Recall that the Mono-Couffo region has suffered from neglect, and that people had to contend with the sub-prefecture level health centres until 1997, when a full-fledged regional hospital was erected. Recall also that health facilities play an important role in the structure of the public-sector health organisations.

Health facilities (cf. map 6.1)
Among the five sub-prefectures of the Couffo region, Aplahoué and Klouékannè are the most endowed with health facilities, while Toviklin, Djakotomey and Dogbo are the least endowed. As to the equipment and health personnel, Klouékannè is well behind Aplahoué, although both health centres are established in similar facilities. Indeed, these two sub-prefectures benefit from donor-funded facilities, whereas the modes of equipping and staffing are dissimilar. In the first instance, there was a government decision to entrust the health facilities at Aplahoué with a full-fledged hospital vocation, while those at Klouékannè were given the much looser status of second-order referral centre, with only one generalist medical doctor. Therefore, the situation of health personnel is very skewed between different sub-prefectures of the Couffo region, explaining some inequalities in the supply of health services. As it appears, physical facilities are much less prominent in the quality and quantity of health-care packages than are other aspects, like equipment and personnel.

Health personnel (cf. table 1, annexe G)
The level of health services provided to the people is certainly subsequent to the qualification of the medical personnel operating at the health outlets. The focus here is mainly on the health services located at the periphery, the first-order health services in the rural communes.
Nonetheless, table 1 in annexe G helps establish the extent of prejudice borne by those services compared to their counterparts in the centres of the sub-prefectures. The main argument to support such a bias is based on the double roles conferred to the latter health services, which function as both first-order PHSs and second-order referral centres. At the sub-prefecture level, overall health personnel range from the medical doctor to the enrolled midwives, whereas those of the rural PHSs essentially consist of medical assistants grade 1 and 2, and rarely include midwives.

A medical doctor with a generalist vocation usually attends a seven-year training at the National University of Benin (UNB) after a successful completion of the two levels in a secondary school. At least thirty to fifty new generalists complete their training each year and may enter the national health system. It should be stressed that some medical doctors are also trained abroad. However, most of the latter holding west-European certificates are employed outside the country nowadays. In fact, the condemned phenomenon of brain drain, from the developing countries to countries with higher living standards, has aggravated after the freezing of the recruitment in the public-sector organisations in 1986, and this situation has further deteriorated with the implementation of the Structural Adjustment Programmes (SAPs) in the 1990s.

The medical doctor is the human resources most lacking in the health system. The provision of one medical doctor per sub-prefecture was well below the accepted prescribed standard of one to 50 000 inhabitants (Cf. MS/SESP-Bénin 1985 through 1997). Needless to say that most doctors were kept busy with the administrative activities in their jurisdiction, leaving little time for medical tasks and even much less for field supervision of the rural PHSs. Nowadays, the situation is improving with the provision of a second medical doctor operating full time compared to the first one.

A Medical Assistant constitutes the second most important practitioner among health personnel. The group of medical assistants consists of two categories, the medical assistant grade 1 and the medical assistant grade 2. The first grade is based on four years of secondary school and the successful completion of the related degree plus three or four years of vocational instruction at the medical training college in Cotonou (the economic capital of the Republic of Benin). The second grade is junior to the first grade, with an adequate level of secondary school plus three or four years of vocational instruction at the medical training college in Parakou (the regional capital centre of Borgou in the north of Benin).

The medical assistant grade 1 seems to be the most relied upon for carrying out health-care tasks in the PHSs in general. More frequently, midwives are substituted for by medical assistants grade 2, who have lower qualifications. On average, the number of inhabitants per medical assistant is about adequate in the initially created sub-prefectures of Aplahoué, Dogbo and Klouékanmè, while those figures seem a bit higher for the last created two sub-prefectures of Djakotomey and Toviklin (cf. table 1, annexe G).³

A midwife has the same level as the medical assistant grade 1, but her training is much more orientated towards maternity care. Wherever possible, midwives are among the health personnel of the PHSs. As is shown in table 1 of annexe G, midwives are under-represented in the Mono-Couffo region (cf. chapter 6, table 6.2). Two important hypotheses can be put forward to explain the disaffection of midwives for the rural areas, an urban bias complex, and their marital position, according to which most of them are married to medical doctors, having been trained partly together. The over-representation of the medical assistants grade 2, on the other hand, may be explained by the conversion of the female personnel of this category to midwifery in the rural areas.

A graded dresser and an enrolled midwife are health personnel who completed a primary school certificate with a few months to one year of vocational training in a specialised school or
a hospital. Some of the personnel concerned are native of the villages where they perform some communication tasks as brokers. Therefore, the graded dressers and enrolled midwives are more effective in rural than in urban areas. In urban areas, those two categories of personnel are more involved in the cleaning tasks, and hence are rarely counted on as health personnel, whereas in rural areas they really do perform health-care tasks. This may explain the absence of figures for these two categories in the referral health centres centrally located in the sub-prefectures, as compared to the PHSs at the periphery (cf. table 1, annexe G).

In sum, the situation of health personnel has not improved much between 1992 and 1997 (cf. table 1, annexe G). The reason, though, stems from that the adjustment reforms aimed at overcoming shortage and slack of health personnel in certain regions exacerbated rather than attenuated the extent of personnel shortage in the Mono-Couffo region. Also deceiving were the outcomes of the reforms stressing the linkages between referral centres and peripheral health units.

After this brief account of the structural components of the health-care system in the Couffo region, an evaluation of the health system will be pursued below drawing from the subsequent learning process. Indeed, the contribution to the health-care system sketched above omits some relevant features, of which user-charges and other health cost, drug costs, for instance.

7.3 Core capabilities of the public-sector organisations in the distribution of primary health services

Core capabilities will be addressed with respect to both the whole Ministry of Health and the PHSs at the village level, drawing from organisational as well as knowledge capabilities. In the case of the agricultural sector, it was argued that the learning process is handicapped, given the organisational search approach to change. This applies also to the public-sector health organisations. The rationale will be pursued below.

Primary health services (PHSs) and organisation capabilities

Social values are seen as prominent in structuring the demand for health care, justifying the premium given to health-promotional activities within the reforms. Improving the health-seeking behaviour requires the involvement of those groups of people who are likely to be interested in health care in the first place, women and children. The reasons why no differentiation is made between these groups of users in the study have been presented in chapters 1 and 2.

The gender issues invoked in chapter 6 are up to date within the perspective of the LHMCs. Originally, the village health committee was structured in such a way that women's participation was not secured, in spite of the explicit statement on gender considerations in the bylaws of the committees. A steady improvement of the health status at the village level was expected, with an increase in women representatives within the LHMCs. However, group discussions substantiate that the user-charges, compounded with the sharp increase in drug costs, turned out to be prohibitively expensive for women. Recall that this category of health seekers has the least access to financial resources at the household level, while drug costs and purchasing power constitute the main constraints on access before and after the reforms, respectively. According to the respondents, the inflexibility of the formal sector is also prohibiting any kind of arrangement to ease financial access. This certainly explains why more and more villagers take recourse to the parallel channel.
Primary health services (PHSs) and knowledge capabilities
The missing knowledge dissemination will be extensively discussed in the next chapter, when addressing collective action in the distribution of PHSs. For now, it is noteworthy to state that health services have further lapsed following the implementation of the reforms. The coordination between vertical and horizontal levels of the respective interfaces (Ministry of Health – PHSs, and health personnel - village representatives), has suffered from collusion in hierarchical relationships and knowledge sharing, respectively.

7.4 Strategy, structure and core capabilities of the non-governmental health organisations

The distribution of health services, initially carried out by the Ministry of Health and its decentralised structures, is presently performed by non-governmental health organisations, notably the private sector where government failure really applies. Although the reforms clearly acknowledged the integration of certified private clinics, stringent certification in the health sector pushed most private candidates to take defensive stances, explaining malpractice and other unqualified methods. Aspects related to malpractice and unqualified methods will be extensively developed below.

7.4.1 Strategy of the non-governmental health organisations
This sub-section will portray the infancy of the non-governmental health sector in the distribution of PHSs. Recall that the reforms in the health sector have acknowledged the abandonment of the existing public-sector monopoly. It was then acknowledged that new actors would participate in furthering health-care strategies, in addition to the public sector. However, Azefor and Bradley (1996) called our attention to the primacy of the public-sector health organisations as compared to the counterparts in the non-governmental sector. The rationale derives from that the non-governmental clinics are only given formal certification, to compensate for the absence of formal PHSs. According to group discussions with rural beneficiaries, the non-governmental health services and the formal PHSs are also exclusive. Given such a perspective, the non-governmental sector is assigned goals and targets through the licensing procedure. However, empirical observations clearly substantiate that the certified private clinics free-ride, and their course of action then departs to a significant extent from that prescribed by the public sector. Regarding their resource allocation, this sector only minimally invests in health facilities, equipment and personnel, which clearly explains the difficulties encountered in achieving performance in the distribution of health services. The underlying rationale will be discussed below, drawing from the structure and core capabilities of the non-governmental sector.

Non-governmental health organisations and evaluation of the reforms
The private clinics operating in the formal sector endorse the idea of professional qualification for entry, as do their colleagues from the public-sector health organisations. According to them, this is one way of reducing undue competition from the parallel channel. They claim to supply the appropriate services to people because of their flexibility to adjust to the rural context. Their commitment to secure credit and to establish new relationships with the beneficiaries is to be encouraged. They also claim that health care is granted when evidence is given for expected cash receipts in a near future (the case of cotton farmers, for instance).
7.4.2 Structure of the non-governmental health organisations

In this sub-section, aspects related to the structural characteristics of the non-governmental sector will be addressed first, followed by the contractual underpinnings between this sector and the public-sector health authorities.

**Structural characteristics of the non-governmental sector** (cf. table 7.2)

The health centres of concern comprise a large range of health facilities that would have been better organised under different headings for a comprehensive approach. Although it is admitted that their structural characteristics matter, to the extent that who manages and for what purpose bear on the level of performance, the emphasis here will be on inquiring into the alleged competitive process that might have resulted from an adequate deregulation in the health sector.

The private rural clinics are owned and managed by health practitioners who may be medical assistants. But, more often than not, gradeddressers and other non-professionals operate non-certified clinics.

The co-operative clinics are of two types (table 7.2). The first one is a health clinic co-operatively owned by young practitioners graduated from medical colleges or the National University of Benin. This scheme usually gets the blessings of the Ministry of Health and eventually benefits from donor support. One such co-operative clinic was established at Kissamey (commune of Houngbamey in the sub-prefecture of Aplahoué) in 1993. The second type of clinic derives from a co-operative of consumers based on an experimental health insurance scheme. An example is found in Gbowimè (commune of Lanta in the sub-prefecture of Klouékanmè) founded in 1996. Originally, the latter scheme was inspired by the success of local communities in hosting a rural bank, Caisse Rurale d’Epargne et de Crédit (CREP), fully managed by the farmers themselves. The clinic operates on a social mutuality basis and is supposed to cover the village origins of the bank clients.

**Table 7.2**: Evolution of the non-governmental health services over the period 1992-1996 in five sub-prefectures of the Couffo Region

<table>
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<tbody>
<tr>
<td>Aplahoué</td>
<td>1 (CO)</td>
<td>1 (COO)</td>
<td>1 (PRI)</td>
<td>3 x (PRI)</td>
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<tr>
<td>Djakotomey</td>
<td>1 (CO)</td>
<td>1 (UVS)</td>
<td>1 (PRI)</td>
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<tr>
<td>Dogbo</td>
<td>1 (CO)</td>
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<td>Klouékanmè</td>
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<td>Toviklin</td>
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<td><strong>Total</strong></td>
<td>3</td>
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<td>2</td>
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<td>8</td>
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</table>

Source: Compiled from survey data, 1996-97

Note: CO stands for confessional hospital or clinic; COO stands for co-operative clinics; UVS stand for village health post; PRI stands for private certified clinics.

The confessional clinics and hospitals are under the supervision of the Roman Catholic Church. At least four such clinics are recorded in the Couffo region, in addition to a full-fledged hospital located at Tota (village of the commune of Tota in Dogbo district).

The community clinics or village health posts are organised and run by villagers themselves, the so-called Unité Villageoise de Santé (UVS). These are relics of village health worker’s projects actively promoted during the 1970s and early 1980s.
Roles of the public, private and local organisations in the distribution of the primary health services in the Couffo region

Among the different contenders for the establishment of health clinics, officials from the Roman Catholic Church seem to have a privilege compared to others. This is not to infer that they evade established rules, but more importantly, they are known for having accumulated a bulk of knowledge through their long-standing provision of health care and their moral status, all characteristics that are very significant in the licensing procedures.

After characterising this miscellaneous sector, it is of equal interest to inquire into the integration of this sector with the health system of the Couffo region.

Public sector led integration of non-governmental health organisations in the Couffo region

A progressive involvement of the non-governmental sector in the health system is observed within the Couffo region. Except for the confessional clinics, which were coupled with the Christian faith at early stages of the colonisation, and the community take-overs of government-initiated village health posts, full-fledged private clinics have great difficulties overcoming the stringent barriers for entry. These barriers are of two kinds. The first kind relates to the formal procedure, which requires a long-standing bureaucratic process. In fact, requirements include the professional qualification of the recipient and a scrutinised statement on the health facilities and the premises. Red tape and other bureaucratic tricks make such a process complex and cumbersome. Although managers of private clinics are warned against corruption, rent seeking seems unavoidable in such circumstances.

The second kind of barrier stems from the monopoly rights granted to the formal PHSs at the expense of the private clinics. Two major reasons justify a less privileged position to the private clinics within the health-care system. The first reason derives from that the government is unable to meet the information costs that might be involved in protecting unaware rural people against the malpractice and unqualified methods of private practitioners. Recall that the government has long restricted this sector to clandestine health-care practices. It follows that there were no clean private health-care practices before the reforms, qualified and unqualified professionals being treated on an equal footing. This has left an unattractive stigma that certified private clinics would have to spend time to clear up. Owing to the preceding reason, private clinics are essentially established to take advantage of the local demand, since, but for a few exceptions, their niche rarely expands beyond the village boundaries. The second reason appeals to that public and private health services rarely compete on an equal footing. On the cost side, tax alleviation and a subsidy on health equipment and drugs enhance the privileged position of the formal PHSs compared to the private clinics. These additional costs raise the overhead costs of health care in the latter establishments. Yet, the private sector is more sensitive to the production of irrelevant services than is the public sector. This is to assert that this sector faces essentially unfair competition from both the public sector and the clandestine health-care practices.

Although with more than one year of non-governmental sector experience the private clinics have lately expanded their coverage in a few sub-prefectures, the increasing number of new demands for certification may raise the level of competition among the private clinics, and hence reduce to a great extent the survival rate of the existing ones. This does not apply to the confessional clinics, where the operating mode could be categorised as not for profit activity. Failure to sustain competition in the health sector is at the heart of the incriminated growth of the parallel channel.

7.4.3 Core capabilities of the non-governmental health organisations

This sub-section will address organisational as well as knowledge capabilities of the non-governmental health organisations.

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Non-governmental health sector and organisation capabilities

It was said earlier that certain village-health posts and even private clinics were turned into PHSs, implying a fuzzy delineation between the so-called non-governmental health organisations and the public-sector health services. It should also be stressed that, during the 1970s, the public-sector health organisations initially relinquished part of their privileges to people’s organisations as far as the village health worker’s projects were concerned. This observation mitigates Therkildsen and Semboja’s (1995) claim that the post-independence expansion of state agencies has led to reversals, contributing thereafter to the increased embezzlement of state resources. If originally the village health posts (UVSs) met with such fairly tacit adjustments of the role division between the state and the other actors of the health systems within the Couffo region, their limited number indicates the low level of appropriation by people’s organisations. More precisely, it illustrates that village communities either lack the logic of maintaining the created village health worker’s projects, or cannot secure enough resources to keep up these health activities.

Non-governmental health sector and knowledge capabilities

The stringent licensing procedure, forcefully applied in the Couffo region, was meant to protect rural dwellers against unqualified private health practices. This perspective is aligned with the creation of the LHMCs, whose role is to ensure knowledge dissemination through promotional health activities. However, the public sector using the licensing procedure frustrates the linkages between the LHMCs and the non-governmental health sector. In fact, new certified private clinics are only confined to villages without formal PHSs, hence villages without LHMCs. In the absence of a collective interest holder lobbying for the village community, a role that the non-governmental sector is unlikely to endorse, the latter sector operates in a rather challenge-free environment that is hardly conducive of knowledge production and dissemination.

Another perspective of the stringent entry barrier is the introduction of the former biases that the reforms were supposed to circumvent. As Ngalande-Banda and Walt (1995) contended, individual health-care practitioners face more barriers because of the difficulties which resource- and skill-constrained Ministries of Health may have in regulating private-sector activities taking place at a variety of small sites. This situation, rather than clarifying the intricate nature of the health systems, contributes to the involution of patronage networks whereby the reforms are resisted. We contend here that the queuing of candidate private clinics in a situation of non-satisfied needs is illustrative of the claims that public-sector officials resist the reforms.

7.5 Public-private roles in the distribution of primary health services

It was said earlier that, unlike in the agricultural sector, the public-sector health organisations were not committed to withdraw from the distribution of health services. This is explained by the low status granted to the non-governmental health sector. The conditions for competition are biased against the private clinics, if they successfully pass the first entry barrier, the licensing procedures. The latter are then operating on the defensive. As an illustration, the cost structure for the treatment of a common disease, malaria, will be discussed in both the public and the private sector.

Cost structure for malaria treatment in the public sector and in the private sector (see annexe G, table 2)

Malaria treatment, which is one of the most prominent services initially endorsed by the PHSs, seems critical for the functioning of health-care system. This is not to assert that other
Roles of the public, private and local organisations in the distribution of the primary health services in the Couffo region
diseases are not relevant, but an analysis of the cost-structure of malaria treatment will certainly provide substance for the biases introduced in the cost-recovery scheme. In addition, this will offer some aspects for a comparison between the formal PHSs and the private clinics.

Table 2 (cf. annexe G) indicates the cost-structure of malaria treatment in the two formal sectors, the formal PHSs and the certified private clinics. Data are obtained from interviews with key actors in selected public and private health centres, and figures are average costs. It should be noted that there is a general inclination to even health costs within each of the two sectors, eliminating then any variation of costs.

Regarding malaria treatment, two cases are considered given blood test or the body temperature, the severe case and the not severe case. In addition, patients may be classified as adults or children. The interest here is to compare health costs across the public and private sector. Beyond the examination costs, which are apparently equal from the outset, the diagnostic tests lead to very dissimilar health costs following the public or private lines, irrespective of the degree of sickness. For instance, the formal PHSs systematically request blood tests, while the private clinics rely on the body temperature. Thereafter, the treatment will diverge according to the diagnosis, so will health costs.

In order to justify the differences in health costs, the private practitioners claim the right to keep patients in. One aspect of such behaviour is to cut down health costs by keeping the examination costs stationary. From the viewpoint of private professionals, patients rarely return after being requested to have blood tests, to be carried out in a public-sector health centre. It should be stressed that some remote PHSs are still lacking the proper medical laboratory for blood tests. The situation depicted in the table is then the ideal, and all PHSs are requested to fulfil such requirements.

In terms of the period of treatment, most private health professionals advocate ad hoc treatment commensurate with the ability of the patients to pay and their motivation to recover in a very short time. In any case, the period of treatment for malaria rarely exceeds six days in the private clinics, while a period of not less than seven days systematically applies in the formal PHSs.

Regarding drug costs, the two sectors are incompatible. The treatment costs are almost double in the private clinics compared to the formal PHSs. Therefore, while keeping the examination costs apparently at the same level as in the public sector, the private clinics are very expensive in terms of drug costs. Unlike the private health professionals, those operating in the formal PHSs appeal more to therapeutic diets and exercises than rely on vitamins and other health-building drugs (cf. table 2, annexe G).

It was said earlier that the health-cost structure in the formal PHSs and the certified private clinics would explain the behavioural differences between health professionals within the two sectors. More importantly, it may help unravel the extent to which people’s welfare is ensured in both sectors. From the perspective of ensuring the welfare of village communities, individuals are losing out because of the financial strains characterised by large investment costs in the public-sector health centres. The argument here runs as follows. First, a sizeable share of staff salaries, incurred at a remote formal health centre, could be avoided if an adequate distribution of health personnel was achieved. Second, due to the skewed distribution of health personnel, well-endowed PHSs are over-staffed, suggesting insensitivity to the costs of over-producing (Dunsire et al. 1988).

With respect to the private sector, the application of extreme treatments hardly secures people’s welfare. The same applies to the alleged malpractice and unqualified professionalism usually ascribed to this sector.
Public-private roles and health issues

The first issue of interest is that related to the cost-recovery scheme. Recall that this scheme is meant to release financial strains on the government sector through the introduction of user-charges. If the logic behind this scheme is socially desirable from the outset, the implementation reverted an initially non-lucrative scheme into a profit-making framework. Following various adjustments of user-charges because of recurrent increases in the costs of health personnel in remote villages, the better-endowed PHSs ended up with large monetary surpluses, amounting to billions of the local currency at national level. The bias toward profit making applies to the formal PHSs of the Couffo region.

In line with the public-choice argument, the monetary surpluses obtained with the implementation of the cost-recovery scheme contradict the initial ideal of this scheme. Indeed, management and leadership conflicts brought about dysfunction within the health systems. For instance, mutual allegations of financial embezzlement and information concealment had led both civil servants and village representatives to seek arbitration at higher levels of the government (Yaka 1999). Neither public opinion nor government officials will find an easy way out of such social dilemmas if no adequate amendments are incorporated into the cost-recovery scheme. Spatial pricing and compensation schemes are very relevant, given the circumstances. For instance, equalisation of user-charges in remote villages must not be on the rise because of an under-endowment with health equipment or personnel. Equalisation must target non-location specific costs that arise in the course of the distribution of health services.

Why is there a conflicting issue resulting from the perspectives on the health-care system? Phillips rightly stated that: whilst generally short of resources, systems are rarely short of patients and potential patients, and in many cases the sheer weight of numbers threatens to overwhelm public provision (1990, p. 63-64). This argument is even more acute in a country undergoing the structural adjustment programmes, like Benin, where neither people’s economic surpluses nor government revenue can keep up with demand. Local initiative may be enough to start the construction of a health facility, but external support is needed for running it. The acquisition of such support, which is critical to the health systems, bears a great deal of responsibility in the unforeseen ingredients hindering the health reforms.

The private sector in particular generally concentrates on lucrative curative health care, while the public sector is generally struggling to provide preventive and promotional health care as well as curative services in inadequate infrastructures and with insufficient funds. This certainly explains why health systems grow increasingly complex, and why the range of inappropriate or marginal private clinics expands, while the formal linkages between the public and private sector, often deteriorate. More importantly, underpaid medical and nursing civil servants have to moonlight in private practices to make a living. As Zwi and Mills (1995) reported for most developing countries, the boundary between the government and the private sector has been blurred by the private practice of government health workers.

7.6 Strategy, structure, and core capabilities of local organisations in the distribution of health services

This section is concerned with local organisations. Recall that the health system is essentially organised around the partnership between the public-sector organisations and local organisations. The private sector is still at the margin of such a co-operative undertaking. The latter entails the management of an intricate relationship between the health-care system and various actors of the health system. This is to ascertain that the production and distribution of PHSs are intimately linked. Policy documents as well as communication-oriented workshops and seminars bear out the legitimacy of the reforms in the health sector. However, the
implementation of such complex reforms in the health-care system is largely shaped by the evolving health system. People’s participation is one major component that influences to a great extent the making of the health-care system, the supply of and access to health facilities, for instance.

It was noted earlier that health facilities have become the means by which village communities show evidence of their involvement in the strategy for the distribution of PHSs. People’s participation, as reported, entails the supply of in-kind resources, such as labour and local building materials, or financial resources derived mainly from the cotton scheme. The role of the government sector has initially been circumscribed to the supply of health personnel and equipment. However, the situation has evolved lately, with a drastic decline of government contributions and a perceptible increase of both people’s participation and donors’ projects.

The extent of success or failure of health policy integrating formal organisations with grassroots organisations hinges on the following mechanisms. It was said earlier that the public sector did not commit to withdraw from the health services, as opposed to the reforms in the agricultural sector. Moreover, the public sector confined the non-governmental health organisations to remote villages only, where new demands still need to be unfolded. Furthermore, the approach has remained top-down, since the public-sector health personnel have taken most of the initiatives.

In order to assess the role of local organisations in the distribution of PHSs, this section is organised into three sub-sections. The first will deal with the strategy of local organisations. The second will unfold the structure of local organisations, while the third will discuss core capabilities of local organisations in the distribution of PHSs.

7.6.1 The strategy of the local organisations in the distribution of primary health services
It should be noted here that the reforms emphasise the LHMCs, while local grassroots organisations are simply discarded from the formal distribution of PHSs. This is to assert that different strategies may be in place at the village level, although there is an apparent compliance of rural people to the prescription of the public-sector health organisations. This sub-section will describe the formal strategy as well as the more disguised strategy of grassroots organisations.

Long-term goals of the local organisations in the distribution of primary health services
Recall that local organisations encompass both the Comité de Gestion de la Commune (COGE C) or local health management committees (LHMCs), and grassroots organisations.

With respect to the LHMCs, a tentative definition will be provided and their institutional goals spelled out. At the origin was a committee of five local persons who were supposed to be wise about money, life and health, and on how the community worked. It was also specified that at least one or two women would be included. Its role has been to help validate experts’ analysis of systemic and programmatic problems that contributed to poor health care at the local level. Systemic is meant to address issues related to the health system, notably actors and their interactions. Programmatic, on the other hand, refers to efficiency derived from the definition of cost-effective packages of services, the so-called health-care system. Later, two major amendments were incorporated in the LHMCs, the first referring to the democratic mode of electing of village representatives, and the second entailing a legal contract between the village concerned and the Ministry of Health or the Ministère de la Santé Publique (MSP), listing the responsibilities of both parties in improving the health status of villagers.

The so-called COGEC was created by a government decree in 1988, but only became fully operational with real authority and autonomy in the 1990s. This committee is supposed to function as a framework within which village communities throughout Benin manage cost-
recovery funds and participate in the planning, implementation, and evaluation of health activities carried out within the jurisdiction of the local PHSs.

Regarding the goals of grassroots organisations in the distribution of PHSs, these are mainly characterised by people's health-seeking behaviour in general. The notion of social values seems very relevant to the health goals pursued by these organisations. The fact that people first consult the family clairvoyant is symptomatic of the social inertia that illness entails. Social inertia here refer to the cultural status of individuals or groups of individuals to which one belongs. Therefore, it is likely that local organisations pursue social goals with respect to illness. For example, the issue of illness is so crucial that people devised purposeful organisations and institutions to take care of the resulting consequences. These entail spontaneous help, in kind or in cash, dispensed to people unable to work in their field because of sickness. These schemes are categorised as non-mandatory reciprocity or what could be called affective self-help, which takes place among members of religious or solidarity groups. Examples of affective self-help are Habobz and Egboh in the Couffo region.

Grassroots organisations are not only involved in solidarity matters nowadays, some organisations mute to concern themselves with members' access to the PHSs. Vodouhè (1996) documented one such an organisation in the Couffo region, the kugbe group, which was initially created as a rotating-credit organisation for the funeral ceremonies of members' parents-in-law. The difficulties surrounding the adaptation process of kugbe will be substantiated in the next chapter. Other grassroots organisations are also involved in members' access to traditional medicine. It follows that health issues are increasingly on the agenda of grassroots organisations.

Course of action of the local organisations in the distribution of primary health services
This will address the course of action of the LHMCs and that of grassroots organisations in the distribution of health services.

Local health management committees (LHMCs)
The intervention policies entail a great deal of structural changes, yet these are administered through a top-down approach. The Primary Health Service (PHS) or Centre Communal de Santé (CCS), and the LHMC or COGEC, are all government-initiated organisations. Hence, they operate according to some formally prescribed set of rules and norms by which members (health personnel, village leaders and personnel from other sectors) and patients must abide. This is to assert that the LHMCs hold their legitimacy from formal institutions; yet, the debate within these committees illustrates some deviation from stated rules and norms. In fact, a structural approach to government intervention may not cause direct behavioural changes, although behavioural changes may be induced through collective synergy.

It has been reported above that a legal contract binds the LHMCs to the Ministry of Health. A brief account of the contract specifies the role of the Ministry, which mainly covers the design and the technical expertise for achieving health targets. The LHMCs are to manage local resources and provide assistance to the health personnel in the promotion and implementation of health programmes. However, aspects of incentives or sanctions are missing in the bylaws of the LHMCs or COGECs.

People's participation in the LHMCs
Raising the issue of participation in the LHMCs unavoidably invokes a quick glance at past experiences, which generally left rural people perplexed by the government's contradictory behaviour. The distribution of health facilities started in the colonial outposts, a great majority of which later on became the administrative centres of the new sub-prefectures and communes (cf. 176
Roles of the public, private and local organisations in the distribution of the primary health services in the Couffo region

chapter 6, Lonkly, in table 6.3). The locations were carefully chosen for their strategic interest (colonial settlement, mining area, outlet for agricultural business, etc.). In short, the provision of health facilities was linked to the economic activities of interest to the colonial power (Manning 1982). Missionaries, on the other hand, furthered the distribution of health facilities in remote rural areas, where they spread modern health practices as well as the Christian faith.

The post-independence era was marked by government-induced distribution up to the late 1960s. During this period, the three health facilities recorded in the Couffo region bear the marks of either government-donors or government-community partnerships in their financing mode (cf. chapter 6, table 6.3). However, as long as the political scene was characterised by a multi-party system, health infrastructures remained part of the deal between the political elite and the rural electorate up to 1972. This political atmosphere helped maintain the illusion that people should be assisted, contrasting with government impotence in the face of the growing demand for health facilities.

During the 1970s and 1980s, the disaffection of the rural population to the political rivalry felt through the distribution of health infrastructures, turned into an avenue for people's participation. In this respect, some of the new facilities are totally financed by the local communities while others are co-financed by either government or donors (cf. chapter 6, table 6.3). A clear picture may hardly be drawn up, since a single facility may benefit from different sources of finance, at one or in different periods of time. Different sources may intervene in one or more components of the same health facility, for instance, a dispensary, a maternity clinic, or housing for health personnel.

The 1990s renew with externally funded health facilities, prompted by the multitudes of NGOs acting as brokers between the rural people and external donors. However, the situation has changed lately, and evidence shows that the rural people are keen on contributing, at least in kind, to the construction and later to the maintenance of the premises. This suggests some requisites in terms of institutional as well as material endowment. For this to be realised, there is a quest for achieving consensus at the village level or at a higher level of the territorial administration. Thus, people's participation brings into play the role of both formal and grassroots organisations in the villages and the confidence attached to them. More importantly, it calls upon local leadership and its ability to enrol a large number of fellow-villagers.

People's participation in the health sector: is it costly to Exit or Voice?
Recall that the fundamental difference between the PHSs and the agricultural input services with respect to people's participation relates to the absence of a formal structure to which individuals must adhere prior to this access to health services. Contrasting with the GVIs in the distribution of agricultural input services, the whole population is granted the merit of membership to the village health community, of whom anyone may be elected as a representative in the LHMCs. Obviously, this assumes that the rights granted to individuals will seriously influence the participation process.

Given the distributive nature of health services, it is hard to exclude people from the benefit. Therefore, it could be assumed that the costs for exit are negligible as soon as access to PHSs is only subject to entrance fees. However, more often than not, the distance friction plays a major role in the choice of health services. Some slight differences between the costs of treatment among health centres also play a dissuasive role in such a choice. Those two constraints on the demand for health services will be analysed later in the light of people's perceptions. For now, it should be stressed that villagers who exit the opportunities offered through a local PHS to attend that of other villages will face higher distance friction than those who do not. The social costs of the exit options may be more or less greater than the physical friction of seeking health services outside the locality.

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The exit situations increasingly witnessed in most of the villages are caused by conflicts, either between segments of the same village or between people of two villages. Although not binding for individuals, leadership crises dissolve community cohesion, hence their adherence to the objectives of the local health-care system. As it appears, unclarities in the operating mode of the LHMCs and the dysfunction of the legal mechanisms may justify the increasingly large outcome differentials between the planned and the empirical realities.

The exit option also entails taking recourse to alternatives (MSP/CE 1999). As it will appear later, reasons such as physical access and the ease with which financial arrangements are negotiated for health care with the parallel channel play their part in explaining people’s disaffection with the public-sector health services. More importantly, the long absence of credible private clinics contributed to the development of the parallel channel, henceforth people’s faithful reliance on non-professionals. The exit option further entails taking recourse to traditional medicine, which necessarily derives from people’s health-seeking behaviour.

With respect to grassroots organisations, it was said in chapter 6 that very much depends on people’s health-seeking behaviour. It was also said that people originally devised purposeful organisations to take care of health issues. More importantly, these grassroots organisations are taking up new roles by addressing members’ health concerns even in the modern sector. From this perspective, the exit option may not be a socially desirable solution, although this may be justified on economic grounds.

*Resource allocation in the local organisations for the distribution of primary health services*

Resource allocation will address here efficiency-effectiveness issues, focusing on both the LHMCs and grassroots organisations.

With respect to the LHMCs, members are in charge of the cost-recovery scheme. Recall that one important theme of the health-policy reforms during the 1990s is the cost-recovery scheme, combined with people’s participation in the health sector through their elected representatives in the LHMCs. Recall that this scheme involves with raising user-charges so as to compensate recurrent health costs. Therefore, a prominent role with respect to the management of local resources as well as health programmes has been assigned to the committees. Yet, since government officials have taken most of the initiatives, the approach has remained top-down.

One venture, however, is that one of the committees’ responsibilities is to engage in wealth-ranking, in order to discriminate between people’s ability to pay and their willingness to pay. As you may guess, wealth ranking is fraught with aberrations in the whole of Benin, and more specifically in the rural areas. This may explain the lack of relationships between income groups and health expenditures referred to earlier (Czesnik et al. 1992; INSAE-MPREPE 1997). The question whether wealth makes a difference in the health-seeking behaviour of the population has received a lot of attention in the manifesto which was published in the 1993 World Development Report (*The Economist* October 7th 1995, p. 121; World Development Report 1993). The World Bank mainly derived its evidence of positive influences of wealth on people’s health-seeking behaviour from comparative regional studies, sub-Saharan Africa versus Latin America and Asia, and certainly failed to inquire into groups or populations holding the same social values. Focusing on groups with almost the same background and living under similar conditions may better assess the difference or indifference to wealth.

The financial resources within the reach of the LHMCs are from various sources. The first and major source is the cost-recovery scheme, mainly based on user-charges. This study challenges the equity issues, because of the merits of user-charges to assist the wealthier or its irrelevance when it comes to the really poor villagers (*The Economist* October 7th 1995). In the
same line of thought, *The Economist* acknowledged that it is hard to imagine how even the most innovative form of financing will be able to bridge the gap, given the low level of government expenditures on health care. It is instructive to recall that the cost-recovery scheme is a framework aimed at the total transfer of financial responsibilities to the beneficiaries. As it appears, this scheme has contributed to the contraction of the demand for PHSs, in spite of recent efforts to improve the supply side.

The second source of finance are the villagers' own contributions, through the GVs. The collective financial resources within the reach of farmers' organisations are used for health purposes, among other objectives. These resources are used for building health facilities in villages in need, for maintaining the health premises as well as for building drug stocks.

The third and major financial contribution is from donors, while the fourth source are national and local governments, which contribute very sporadically to village funds for health purposes.

Given this breadth of financial resources, the committees have, among other expenses, to hire health personnel and ensure the maintenance of the premises. In sum, the situation of health personnel has not improved much between 1992 and 1997 (cf. table 1, annexe G). The reason, though, stems from the failure of the personnel adjustments, aimed at overcoming the shortage and slack of health personnel in certain regions. As it appeared, the outcomes of the reforms were deceiving, as they exacerbated rather than attenuated the extent of personnel shortage in the Couffo region. Also deceiving were the outcomes of the reforms stressing the linkages between referral centres and peripheral health units, despite the relative autonomy of the LHMCs to hire additional personnel on a contractual basis (cf. annexe G, table 1).

Owing to the substantial level of funds generated at the PHS level, the management of the LHMCs is fraught with conflicts. Indeed, claims of corruption and financial embezzlements are increasingly made. For that purpose and in addition to the amendment of membership, the amendments introduced for 1995-99 take steps to clarify aspects of financial management and specify procedures for hiring, with LHMCs's own funds, independent auditors on a yearly basis (MSP/CE 1999). This may help, as anticipated in the policy document, to improve responsible financial management and trustworthiness between health personnel and mandated representatives of the communities on one side, and the large group of the beneficiaries on the other side.

With respect to the grassroots organisations, resource allocation for the distribution of PHSs is fraught with conflicts. The nature and the extent of these conflicts will be documented later on.

### 7.6.2 Structure of local organisations in charge of the distribution of primary health services

The LHMCs comprise five democratically elected village representatives, of whom at least one has to be a woman. However, a revision to the administrative text laying out the bylaws of the LHMCs introduced some major amendments for the period of 1995-99. First, membership will be expanded to include other partners working on related issues in the same commune (NGOs, grassroots organisations, school teachers, personnel working on relevant development projects such as water and sanitation, and so on). Second, two other seats will be established on the COGES that will be filled by one female member and one youth seating on the LHMC or COGEC. This is to ensure that these two traditional marginal groups are represented not only at the commune level, but also at the higher territorial and administrative levels, the sub-prefectures.

Grassroots organisations used to be simply structured in the past. But, nowadays the trends toward adapting to new goals force them to adapt their structure as well. For instance, kugbe is
one such a grassroots organisation. Owing to reciprocity motives, women are also members of this type of saving-and-credit group, the kugbe. Vodouhê (1996) substantiated the existence of kugbe networks operating beyond the administrative boundaries of the Couffo region. He then found that the existing formal organisations, the GVs and the LHMCs, inspire the management structure of these kugbe groups. Although he was right in that the same local leaders manage formal and grassroots organisations, there is a great deal of innovative management skills at stake within the networks of grassroots organisations. The challenge is then for the formal organisations to harness these innovative management skills, given the organisational search approach imposed by the government.

7.6.3 Core capabilities of local organisations in the distribution of primary health services

With respect to organisational capabilities, the COGEC or LHMCs are successfully managing the cost-recovery scheme. However, it was said earlier that aspects of incentives and sanctions are missing in the bylaws of the LHMCs. This necessarily led to some absurd situations wherein village representatives lack the motivation to fully participate. For instance, it is reported that only the president and the treasurer are very active, while other members attend meetings very sporadically. Although it is clearly stated in the statutes of the LHMCs, the mandatory election of one youth and one female representative is rarely implemented, and even if so, the latter representatives are bound to obey some other members in positions of power within the committees.

The committee members rarely feel accountable to their constituency, as general assembly and other mandatory meetings with the village communities are not held. There are more distortions, due to the ambiguity of the bylaws with respect to rewards and sanctions within the LHMCs. In order to correct such flaws, a new policy document provides some direction in which they might be improved (MSP/CE 1999). As to incentives, at least four measures are envisaged. The first concerns a better understanding of the role and functions of the members. The second is through the acquisition of skills in community financial management and group animation techniques. The third relates to the provision of opportunities to exchange information with other representatives at the regional and national levels. And the last refers to a financial remuneration, given the time spent on committee work. It should be stressed that the financial burden of these recommendations will be borne by the cost-recovery scheme, hence by the beneficiaries through the user-charges. As to sanctions, the natures of the infraction and, more importantly, the legal jurisdiction before which defaulters will be brought have not been specified.

Grassroots organisations have displayed a great deal of innovative organisational capabilities (Lemarchand 1989, van den Brink and Chavas 1999, Vodouhê 1996). This is not without difficulties. The long processes described by Vodouhê (1996) constitute an outstanding illustration for the learning process that structural adaptation and changes of goals entail.

Concerning knowledge capabilities, there is not as much interaction between village representatives and the health personnel of the LHMCs as initially planned. This is to assert that various trainings and health promotional activities, planned in the contractual agreements between the Ministry of Health and the COGEC (or LHMCs), have not been realised. The village representatives have been kept busy with the cost-recovery scheme, instead (Azefor and Bradley 1996). It follows that the goal of knowledge dissemination has not been pursued and health performance has thus suffered. From the perspective discussed earlier, there is a significant knowledge leakage from the formal organisations to grassroots organisations. The reverse is very much unlikely, given the inflexibility of formal organisations.
Roles of the public, private and local organisations in the distribution of the primary health services in the Couffo region

7.7 In conclusion

The distribution of PHSs could be characterised by a greater emphasis on decentralisation, even at the village level, after the Alma Ata conference in 1978. But since then, the process has reversed. The central concern has been the inability of health services to maintain supervision and drug supply at a low level during the 1980s. The freezing of the recruitment of health personnel in 1986, compounded with the personnel cut from 1989 onwards, has also undermined the initial objective of government health policy. The provision of drugs in the public health centres has further lapsed with the deterioration of the macro-economic conditions of the country. As reported in KIT (1991), the collapse of the peripheral health services has even reached the level of the sub-prefectures. Obviously, the resulting shortage of basic drugs, compounded with less motivated health personnel, caused widespread disaffection and loss of confidence among the beneficiaries.

On the contrary, the parallel channel evolved. This is to ascertain that some strategic changes in both health-care system and the health system might help suppliers tap the demand that was initially addressed to the non-professionals. For those changes to occur, a perspicacious enlightenment of the role of the parallel channel was envisaged. The interface between the public- and private sector organisations on the one hand, and the public-sector organisations and communities on the other hand, may provide an adequate ground for inquiring into such a process.

In connection with the instrumental policies whereby medical personnel collect and evaluate performance, the numerous reports and seminars may be useful, but they will not be sufficient to evaluate the reform process. However, rather than advocating an externally committed evaluation, it is suggested that health planners and managers be part of the process. Weaknesses resulting from a professional bias, as those developed in sections 1 through 3, may be misleading to the debate on the performance of the health reforms. It is unlikely that health officials identify personnel turnover and rural-urban bias in the distribution of health personnel as major constraints to a smooth running of the reforms. Consequently, to health authorities external expertise is a necessary condition to improve the evaluation of health programmes.

Market failure is substantiated by malpractice from the side of private practitioners. It was found that the parallel channel is at the heart of such an inclination. However, the absence of discipline amongst private practitioners and the driving profit motive may certainly justify the tight certification procedure. Some formal private practitioners admitted these weaknesses and pleaded for government regulation to induce transparency and credibility.

It is admitted that the skewed practices in the non-governmental clinics derive from the certification procedure, which is applied to non-governmental health services in order to compensate the absence of the formal PHSs.

The reforms in the health sector have profoundly subverted the existing monopoly. New actors are participating in furthering the health-care strategies, in addition to the public sector. However, the primacy of the public sector is still the rule in the decision-making process as far as health programmes are concerned. There is no evidence to the contrary even in the LHMCs. Put differently, village representatives in these committees are confined to the cost-recovery aspect of the health-care strategies, while government health professionals are in control of health programmes.

In section 6, high costs are anticipated to hire health personnel on a contractual basis, caused by the failure of the public sector to make the adjustment of health staff work. Equally relevant are the administrative costs imposed by the certification procedure, causing the parallel channel to fill the gap left open by the formal PHSs and the constrained private clinics. Spatial
friction being a constraint on access, the policy of retrenchment of the public-sector health organisations turns out to be counterproductive to the health reforms.

On the demand side, a long-standing process of people's participation, financial as well as in kind (labour, material, etc.), characterised the willingness of the rural populations to avail themselves of PHSs. However, two important elements of the issues identified at the household level were relevant to the magnitude of the demand for PHSs during the 1990s. First of all, the household members' willingness to pay was decreasing with the quality of health services. Secondly, their ability to pay has been curtailed given the strains on their purchasing power (cf. chapter 1; KIT 1991, p. 33). Therefore, the demand trend for health care was apparently declining, in spite of government effort to improve the distribution, both quantitatively and qualitatively. In the Couffo region, the PHSs have experienced the same trends, notwithstanding financial efforts from donor-funded schemes. Nowadays, the situation has improved to a great extent with a better distribution of health services. The cost-recovery scheme and the relative autonomy of the LHMCs to hire personnel contribute to improving the distribution of health services.

With respect to the discussion initiated above, the constraints faced by the rural population are not only the consequences of the structural adjustment programmes, but rather result from the way in which reforms are handled and implemented. The implementing organisations are not fully to blame, for there is evidence of health facilities fully operating in rural areas. There is also evidence of health personnel who are unhappy to leave rural health centres. And there is evidence of rural communities eager to keep health personnel that are leaving. A comprehensive alternative to new enrolment in the health sector must be envisaged through the decentralised body of government, the so-called local government. Henceforth, rather than restricting solutions to both central-government health personnel and community-hired health workers, paid from the cost-recovery budget, it is advocated here that local governments enrol health personnel partially remunerated from local resources and grants from the central government.

A reduction of the health staff salaries impinging on the cost-recovery scheme will reduce to a great extent the financial strains on the rural people. At first sight, this appears a loose proposition, as health reforms are subsequent to the government failure to finance even basic health services. It should be stressed, however, that such a proposition would hold because of two main arguments. The first argument derives from that the government in Benin abides by the World Health Organisation’s (WHO) constitution stating that the enjoyment of the highest possible standard of health is one of the fundamental rights of all human beings. In this connection, the government has the duty to keep the PHSS within its portfolio of priority investments. The second argument is that people must not so quickly feel left out, without any support, even insignificant as it might look. One way out of the government failure to directly finance the PHSSs is to allow for inter-sector resource mobility and inter-local compensation within the cost-recovery scheme. The first aspect will be stressed below while the second aspect is at the heart of the huge resource surpluses at stake, opposing government health authorities and village representatives in the LHMCs.

The question whether people's participation in a single sector can be safeguarded in isolation from the overall development context seems irrelevant, drawing from the discussion carried in sections 1 through 6. It is acknowledged that deriving monetary surpluses through the cost-recovery scheme is misleading, given the underlying straitjacket mono-sector consideration. It was also found that efficiency could not be analysed only within one sector taken alone, but also from assessing the inter-linkages between this sector and other sectors. Moreover, it was admitted that a real partnership between the public, private and local organisations is unlikely in the absence of trust. The creation of such inter-linkages between various sectors may pre-empt
Distrust and disappointment, and facilitate that actors' resources and true competencies are integrated for an effective success of the health reforms. The objective in the next chapter is not to establish an exhaustive inventory of the inter-linkages between various sectors within the rural development process, nor is it relevant to trace all weaknesses of the new partnerships between the public, private, and local organisations for furthering rural development. What is suggested, is to take a broader perspective of the development discourse, drawing from collective action.

NOTES

1 The social processes to which reference is made have been sketched in chapter 4 while discussing similar increases of salaries for the extension service, CARDER-Mono.

2 A hospital generally includes more than two medical specialisations. The one at Aplahoué has surgery, dentistry, gynaecology and ophthalmology.

3 In fact, the sub-prefecture of Djakotomey was initially part of both Aplahoué and Dogbo, while that of Toviklin was part of Klouékanmè and Dogbo. The restructuring of the territorial division in the 1970s and early 1980s intervened with the creation of two new independent territorial units, formerly called Districts and more recently called Sub-prefectures.

4 Here, the notion of Social values refers to the gender, intra-household and intra-community relations to health care. For instance, women represent a large group of health-care seekers within the rural areas (see KIT 1991, Heywood 1991). Social values refer to the cultural status of individuals and of the group.