Resisting reforms. A Resource-based perspective of collective action in the distribution of agricultural input and primary health services in the Couffo region, Benin

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The present chapter deals with the performance of collective action in the distribution of primary health services (PHSs). Performance here is concerned with people's effective demand for health services, notably people's attendance at the existing health centres. It is also used for assessing the coverage of a given health centre, especially as to the demand and its spatial spread. Overall quantitative indicators will then be aligned with the strengths, weaknesses, opportunities, and threats involved in the distribution of PHSs, in order to derive the performance of collective action.

Recall that the government sector had reserved the right to supply health care free of charge from the 1960s to the early 1970s. The emphasis then was on the curative care that health personnel, who were all civil servants, used to administer as in-patient services. But, due to the failure to achieve an improved health status for the large majority of the citizens, a number of reforms have been initiated from the late 1970s onward. These concern the change of strategy in the first place, namely the shift from curative to preventive care. In order to allocate the required resources for such a strategy, it was found that the government alone could not afford overall costs. It was then suggested that liberalisation and, more importantly, participation of the beneficiaries would take care of equity concerns. It follows that health policy reforms entail a strategy that may be assessed through the health-care system, a structure that evolves as more actors feel concerned with the PHSs. However, health reforms may only live up to expectations if the process helps various actors to acquire core capabilities for furthering collective goals.

In the chapter 7, it was claimed that organisations and institutions are far from given in a rural development context, nor are they within the health sector. For instance, actors, with relative success and according to their interest and their temporary motivation, model health organisations and institutions. It was found earlier that the public-sector organisations play the most important role in the health sector, whereas a leaner and more cost-regarding state was expected. The non-governmental health organisations and institutions, on the other hand, are very insignificant, at least in this transition stage. However, we lack reliable information on the importance of the non-governmental health organisations, the scale at which they perform and the nature of their non-visible part. The health-policy reforms may either count on or adapt to the integration of formal and grassroots organisations. The extent of success or failure of health-sector reforms still hinge on such integration and the underlying mechanisms. Yet, the extent of the resistance to the reforms from the side of various actors should not be underestimated. To this end, policy responses of all three major organisations involved in the health sector have been assessed, and various counterproductive modes of resource allocation have been uncovered. Moreover, it was found that regulations and rules are not obeyed, leading to a skewed institutional development.

In the public-sector organisations, the emphasis has been on allocative inefficiency with respect to the distribution of civil servants. Staff salaries escalated relative to overall health costs, in spite of the freezing of the public-sector health personnel. Rural-urban bias worsened following the policy of regional adjustments of health personnel. The public-sector health personnel hardly involved village representatives in the health programmes. There is also a restrictive licensing procedure with respect to non-governmental health organisations seeking to formally perform.

Regarding the non-governmental health organisations, it was found that they are operating on the defensive. There are reservations about the qualifications of private
practitioners and about the relevance of their approach to health care. More importantly, there are growing concerns about the parallel channel, notably the underground practices of modern health care. The confessionals, which have been performing very well in the past, are now losing ground in favour of the formal primary health services (PHSs).

With respect to grassroots organisations, their marginal involvement in the reforms contributes little to furthering people’s participation. People get stranded, being promised too much, and getting too little from the health-care system. As a result, they barely change their health-seeking behaviour, attending instead the formal health centres as a last resort.

Arguments have then been pursued to demonstrate various existing biases influencing the health reforms, biases toward user-charges and curative care at the expense of promotional activities and preventive care. Originally, the bias toward user-charges negatively influenced the promotional health activities, which are free of charge. Preventive care also shrinks as a result of declining promotional health activities. The overall pervasive nature of the health-policy reforms has been extensively discussed. This is not to draw only on the negative side of the reforms; for instance, collective action as a structural component of the new health policy is expected to curb down the deviant behaviour of actors.

In order to inquire into the performance of collective action, this chapter is organised into four sections. The first section discusses the performance of collective action in the distribution of PHSs. The second section investigates the strengths, weaknesses, opportunities, and threats of collective action in the distribution of health services. The third section concerns itself with the synthesis of strategy, structure, and core capabilities of collective action in the distribution of the PHSs. The fourth section will present some concluding comments.

8.1 The performance of collective action in the distribution of primary health services

As in the agricultural sector, it should clearly be stated that the performance of collective action is identified with people’s attendance at the primary health services (PHSs). Performance must also reflect on the resource-based perspective, focusing on how the mix of strategy, structure, and core capabilities of various actors may lead to a more effective distribution of PHSs. This section will address the formal health sector, notably the public-sector and the certified non-governmental health services.

8.1.1 People’s utilisation of the formal primary health services

The following section presents the results of people’s utilisation of the existing PHSs within the Couffo region between 1992 and 1996. These results are based on 317205 entries surveyed in the health-record books of the existing public-sector health services, each entry having been checked for the village of residence of the patient, for spatial coverage purposes. The results substantiate the extent of revealed needs and subsequent patterns of spatial utilisation.

Recall that the distribution of PHSs is assessed from a government intervention point of view. It follows that the health reforms assign a complementary function to the non-governmental sector where the government fails to establish a formal health centre. That is why the relative weight of both sectors will be analysed separately. In fact, a comparative approach will not do any justice to the non-governmental health services, owing to the long-standing monopoly of the public sector in the past and the role assigned to the non-governmental sector to date.

Attendance at the existing formal PHSs between 1992 and 1996

The histograms in graphs 8.1 a, b, c, d and e mainly portray the supply side of the PHSs. This is the total number of visits paid to the existing PHSs each year. As for health attendance and
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Graph 8.1: Relative attendance statistics (number of visits per 100 inhabitants) at the local primary health services (PHSs) in five sub-prefectures in the Couffo region
vaccination records, presented respectively in tables 6.4 and 6.6 in chapter 6, the consideration of the absolute values is meant to evaluate the work load achieved within each administrative jurisdiction, henceforth the performance of the existing PHSs. The figures at hand comprise utilisation from both within and outside the sub-prefectures. More importantly, the location of origin remains unidentified for a large proportion of the attendance figures. This is to assert that either the recorded location information was not readable or the location was simply omitted. From graphs 8.1a, b, c, d, and e, it can be derived that Aplahoué is foremost the supplier of PHSs within the Couffo region. This sub-prefecture carries the largest shares both from inside and outside the Couffo region, compared to the other sub-prefectures. The second-best supplier is Djakotomey, followed by Dogbo, Klouékannè and Toviklin, respectively.

A drop in the health attendance figures was expected after the franc CFA devaluation in 1994. Although overall figures seem to increase from 1992 to 1995, there is a drop during 1996 in most sub-prefectures of the Couffo region. Only two sub-prefectures out of the five experienced increases in 1996, for reasons probably related to the opening of new outlets (Djakotomey and Toviklin). Details on the new PHSs will be presented later. For now, a tentative explanation of the drop may point at the new outlets, diverting patients from the existing PHSs. In addition, it also appears that the hardship subsequent to the devaluation, as the promised accompanying measures lapsed, influenced people’s utilisation of the PHSs. The behavioural changes thus incriminated may have caused a drop in the health attendance figures in some, but not all, PHSs, prompting the inference that it is not only cost arguments that explain people’s reluctance to seek health care in the existing PHSs. The related arguments will be discussed hereafter, drawing from people’s perception of constraints on the access to health services.

Revealed needs for primary health services in the Couffo region (1992-1996)

The histograms in graph 8.2 a, b, c, d and e are illustrative of the revealed needs for primary health services (PHSs) within each of the five sub-prefectures. The notion of revealed needs stands for effective utilisation of PHSs by the so-called beneficiaries, i.e. the demand expressed by the people effectively living in the service area.1 These histograms then represent the relative weight of the demand expressed by residents within the Couffo region. The left side of the histogram is obtained by taking the total health attendance figures of residents within the jurisdiction of the residential sub-prefecture weighted by the estimated population figure for each year. The right side of the histogram is obtained by taking the attendance figures of residents outside the jurisdiction of the sub-prefecture, but still within the Couffo region, weighted by the estimated population figure of the same sub-prefecture for each year. The cumulative weight derived from both parts may partly express the demand side of the PHSs within any given sub-prefecture if the possibility of residents seeking health care outside the Couffo region is carefully considered. The lesson learnt from such histograms is that people move outside the different sub-prefectures of residence to seek health services. Recall that graphs 8.1 a, b, c, d, and e provide substance of the flows of visits inside each of the five sub-prefectures. Therefore, it is expected that two sub-prefectures with significant flows of visits in and out on either side may need to initiate some co-operative actions for health care. We claim here that this is a field in which very little can be achieved by a sector other than the public sector.

With respect to the linkage between sub-prefectures, there are cases of significant flows of visits from within the Couffo region to a given sub-prefecture (cf. graphs 8.1 a&b). The cases of Aplahoué and Djakotomey are illustrative. There are also cases of significant flows of visits outside the residential sub-prefectures (cf. graphs 8.2 a, b, and e). This may be explained by an under-representation of PHSs in certain sub-prefectures, indicating potentials to be tapped.
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Graph 8.2: Relative attendance statistics (number of visits per 1000 inhabitants) at the local primary health services (inside and outside the sub-prefecture) in the Couffo region, 1992-96
Another explanation may be that some people are nearer to PHSs outside their sub-prefecture and even outside their commune centre than that assigned to them. Yet, it seems relevant to indicate the sub-prefectures with increasing trends and those with decreasing trends.

Concerning visits from within the Couffo region inside a given sub-prefecture, both Aplahoué and Djakotomey experienced increasing trends between 1992 and 1996. The propensity of the other three sub-prefectures to attract visits from within the Couffo region stagnated. Regarding visits of residents outside their sub-prefecture of residence and within the Couffo region, Djakotomey and Toviklin experienced increasing trends, while Aplahoué experienced decreasing trends between 1992 and 1996. The results suggest that the existing PHSs in Aplahoué are about adequate for the targeted service area. More importantly, those PHSs may provide additional services to non-residents. Residents of Toviklin, on the other hand, preferred seeking health services outside, while the existing local PHSs were running idle capacity. Djakotomey offers examples of both perspectives, receiving visits from within the Couffo region as well as residents visiting PHSs outside their sub-prefecture.

According to the size of the demand for PHSs, Aplahoué (200 per thousand inhabitants) still holds the first place, followed by Djakotomey (100 to 190 per thousand), Toviklin (120 to 175 per thousand), Dogbo (100 to 140 per thousand) and Klouékannè (less than 100 per thousand), respectively (cf. graphs 8.2 a, b, c, d, and e). Graphs 8.2 show that two sub-prefectures experience growing trends with untapped potential demand (Dogbo and Toviklin). If the case of Toviklin seems justified, that of Dogbo appears much more related to the growing disaffection of people for the large confessional hospital, namely St. Camille’s hospital. Recall that this health centre is located within less than half a kilometre from the public-sector referral health centre in Dogbo. Initially, it used to attract more people than the latter because of its facilities and the expatriate health personnel. However, the health services have seriously deteriorated lately, explaining the growing trends observed in the public-sector health centres.

In order to grasp whether the drop observed in 1996 is due to a significant shift of the demand toward new health outlets, or rather to the hardship following the devaluation, figures on the demand expressed by residents of the new locations within the Couffo region are analysed over 1992-1996 (cf. graphs 8.2 a, b and c). The rationale is that attendance figures drastically rose in the sub-prefectures with new health outlets in 1995, Djakotomey and Toviklin. This may complicate the arguments advanced earlier on the post-devaluation effects, which prompted the drop of the attendance figures in 1996. The arguments of potential demand still untapped may better depict the situation at hand.

Graph 8.3 a, b and c trace the locations of the PHSs visited by people of the three communes before and after the creation of new health outlets in 1995. The three groups of histograms then represent the relative weight of the demand expressed by residents within the Couffo region between 1992 and 1996. For each year, the histograms are obtained by taking the total health attendance figures of residents of the commune concerned within a precisely defined sub-prefecture, weighted by the estimated population figure of the commune in each year. For each sub-prefecture of the Couffo region, attendance figures are traced back to the three communes with new outlets, and histograms are constructed by weighting those figures with the estimated population figures of the commune of residence in each year.

The case of the three communes with their new health outlet depicts two situations of interest in the planning process of PHSs, the first being that of a commune without a health centre, and the second being the opposite. More importantly, the latter situation shows the evolution of a new health outlet and residents’ response to the organisational strategy implemented by the local health management committees (LHMCs). For instance, the case of Gohomey in Djakotomey is very striking in the sense that residents’ attendance at the local PHSs within Djakotomey underrated their overall health attendance within the larger entity of the
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Graph 8.3: Spatial distribution of residents' visits to the PHSs within the study area before and after the creation of a new PHS in 1995

a) Residents of Gohomev in the sub-prefecture of Diakotomev

b) Residents of Kpoba in the sub-prefecture of Djakotomey

c) Residents of Adjido in the sub-prefecture of Toviklin
Couffo region from 1992 to 1994 (cf. graph 8.3 a). However, a drastic shift in the demand was observed from the other sub-prefectures to Djakotomey after the creation of a new health outlet at Gohomey in 1995. Subsequently, attendance figures of residents of Gohomey at the local PHSs within Djakotomey overrated attendance figures outside the sub-prefecture. It could be inferred that the creation of a new health outlet stimulated new demand and also attracted the existing demand formerly addressed outside Djakotomey.

The case of Kpoba in Djakotomey, on the other hand, may be interpreted as demand for PHSs locally geared in the sub-prefecture. Indeed, both new and former demand for PHSs were locally managed and hardly involved other sub-prefectures within the Couffo region.

Alike the situation observed in the commune of Gohomey in Djakotomey, the case of Adjido in Toviklin invokes new demand and a shift of demand from other sub-prefectures. Originally, more residents of Adjido used to attend the PHSs in Djakotomey than those in Toviklin before 1995. However, the creation of a new health outlet in Adjido switched the demand from those sub-prefectures to PHSs in Toviklin in general and Adjido in particular. Undoubtedly, new needs arose because of residents’ proximity to a health outlet and because of the strategy of distribution implemented by the local health management committee.

The following observations may be derived from graphs 8.3 a,b, and c. For the case of Djakotomey, the new PHSs at Gohomey and Kpoba, it can be conjectured that the creation of new outlets stimulates new needs not yet tapped before. However, the case of Toviklin, with one new health outlet at Adjido, reveals a shift of the former demand to the new outlet. Therefore, the argument of hardship prompting a drop in the demand remains untouched. This may presumably be substantiated through people’s evaluation of their utilisation of the PHSs in the next section.

It is instructive to note that graphs 8.1 through 8.3 only provide one-sided inferences on the effective utilisation of the existing PHSs, as the non-governmental sector is excluded. The next section will provide substance to mitigate the latter inferences.

8.1.2 People’s utilisation of the non-governmental health services (cf. graph 8.4)

The interpretation of the statistics on attendance must be hedged with caveats despite their extensive nature. Attendance figures in the Couffo region amount to not less than 40000 visits to the non-governmental clinics over 1992-96, of which 19582 have been processed from the health record books for identification of the localities of origin. For several reasons, the figures processed underscore the real weight of this sector.

The first reason to be acknowledged, relates to the existence of parallel channels, i.e. non-certified clinics whose owners or managers made the choice to conceal rather than reveal information on their performance. It follows that the clinics whose data are processed and presented below, are either from the formal sector, or were undergoing such a certification process during the study period. It should be noted that not every confessional clinic might hold a license. Some may be operating on the basis of general agreements signed by the local Roman Catholic Church officials and the regional health authorities. The second reason of interest stems from the lack of information in some health clinics, which emphasised the patient’s leaflet rather than the health-record books so forcefully advocated in the health reforms. Recall that the reforms integrate aspects of instrumental policies, whereby medical personnel collect and evaluate performance. Non-compliance with such advocacy is a tacit form of resistance to the reforms. This practice, although not endorsed by the health authorities, is also common in the public sector and really influences the availability of health statistics. In addition to the concealment of information, which may be fair in a situation of competition, it should be stressed that there is a lack of tradition for keeping records. A further reason relates to the largest confessional clinics (Hôpital Saint Camille), whose data are only
processed for 1996. In fact, the management of the hospital found it inconvenient to proceed with information processing from the health-record cards over the period 1992-96. Accordingly, it tolerated one-year data processing in addition to total yearly attendance figures.

Having clearly set the limits of the statistics subject to analysis, people’s utilisation of the non-governmental clinics is sketched in graph 8.4 a, b, c, d and e. As mentioned earlier, these attendance figures are supposed to complement those of the government sector with respect to people’s utilisation of the PHSs. Thus, it is purposeful to display all the histograms over 1992-96 for the five sub-prefectures. These results complement those of the public-sector health services for the formal channel. In addition, attendance data have been processed following five segments of coverage: the first is within the commune of location, the second is within the sub-prefecture of location, the third is within the Couffo region, the fourth is outside the Couffo region and the last is *Not identified* data. However, their interpretation for characterising people’s demand must be carried out with care.

From graphs 8.4 a, b, c, d and e, two important comments are derived on the supply of PHSs by the existing non-governmental clinics. First, it should be stated that this is essentially oriented toward the satisfaction of the local demand for primary health care. Nevertheless, this does not exclude the provision of a few beds for in-patient clinical observations. Overall demand satisfied within the commune of location carries a relatively large weight compared to the *formal channel*, except for the confessional hospital *St. Camille*. This is because the latter used to be a large referral hospital during the 1970s and early 1980s. But, due to an alleged drop in the quality of its health care subsequent to the withdrawal of expatriate medical assistance, affluence shrank seriously until the study period.

Second, overall significance of the non-governmental sector with respect to health coverage is low compared to the public-sector health services. There is an estimated record of 317205 visits to the formal PHSs against an estimated figure of not less than 40000 visits to the non-governmental clinics, a ratio of eight to one. However, it should be pointed out that substantive incremental advances have been witnessed lately. For instance, in 1996, the non-governmental sector in the Couffo region covered up to 9500 visits against 69000 visits to the government sector. More importantly, some sub-prefectures and even localities present better prospects for the establishment of non-governmental clinics than others. Examples of sub-prefectures with dynamic prospects are Dogbo and Aplahoué. The sub-prefecture of Klouékannè seems a good candidate, but a few years are still needed for a conclusive analysis on the existing experimental social mutuality scheme. For the sub-prefectures of Toviklin and Djakotomey it also seems to be too early to evaluate the performance with respect to attendance.

Regarding people’s demand, the attendance figures demonstrate that the establishment of most non-governmental clinics responds to real local demand, except for clinics located close to the borders with Togo, another West African country located to the west of Benin. In the latter clinics, there are more visits from outside the Couffo region, especially from Togo, than from within the commune of location. The same observation was made earlier with respect to the government sector. It should be stressed that demand analysis is not applicable in cases where the share of *not identified* visits is high. This is the situation for Gbowimè in Klouékannè.

For an improved performance, it is expected that health officials will set up a steering board to scrutinise both ill- and well-performing clinics, in order to raise health standards. Consequently, adequate monitoring and, eventually, technical support from the government sector may be scheduled. But, as Zwi and Mills (1995) rightly warned, conflicting goals may result from the three perspectives on health defined earlier. For instance, at least four health
Graph 8.4: Attendance statistics at the non-governmental health services in the Couffo region, 1992-96

a) Aplahoué

b) Djakotomey

c) Dogbo

d) Klouékanmè

e) Toviklin
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centres with erratic attendance, two former UVSs and two privately owned clinics, have been converted to the government sector in 1997. Arguably, officials from the regional health services may base their choice on the perspective of granting the recipient populations the rights for PHSs, although this is at the expense of performance. Taking the perspective of health services seen as consumption goods may suggest otherwise. In the Couffo region, at least three non-governmental clinics are operating with an average number of visits comparable to those of the existing PHSs. These are Foncomè and Hounsia in Dogbo and Agodogou in Aplahoué. For Agodogou, located at more than 30 km from the sub-prefecture centre, government support may be useful to raise the quality of health care and alleviate health costs for the people. Substantively, the two private clinics may get technical as well as material support, while the third clinic, the community-financed village health post (UVS), may be upgraded as a formal health outlet.

8.2 SWOT analysis of collective action in the distribution of primary health services

SWOT analysis entails people’s evaluation of the distribution of primary health services (PHSs). Two dimensions are considered, the first one dealing with the internal strengths and weaknesses of the distribution, and the second concerning opportunities and threats from the external environment.

In the chapters 6 and 7, it was argued that rural people use different channels for PHSs, the formal and parallel channels. Strategy, structure and core capabilities of the formal channels have been extensively discussed in chapter 7, and their underlying constraints spelled out. Recall that the parallel channels are the underground counterparts of the non-governmental health services. In addition to the two formal sectors, the public-sector and the certified non-governmental health services, there is still traditional medicine, presumably with large shares of coverage unaccounted for in the formal record books. It was also assumed that not all the blame might be attributed to the governmental health-policy reforms. Equally relevant in the understanding of the performance of the reforms are the structural characteristics of the rural people.

8.2.1 Strengths and weaknesses of collective action in the distribution of primary health services

Before proceeding to people’s evaluation of the distribution of health services, some quantitative measures of people’s structural characteristics will be presented as part of the strengths and weaknesses of the distribution of health services.

Structuring people’s behaviour in the utilisation of the existing health services

In the first section, we presented the state of people’s utilisation in both public-sector and non-governmental health services. For now, people’s utilisation will be looked at from the perspective of the friction caused by a combination of the attributes of various health outlets and the structural characteristics of the beneficiaries.

People’s utilisation of PHSs entails a seasonal as well as a spatial variability. Concerning the seasonal variability, climatic as well as occupational variations notably influence people’s health and their ability to resort to health services. More importantly, there are seasonal outbreaks of diseases (malaria, for instance, is very common during the raining seasons). On-farm activities, on the other hand, correlate with traumatic injuries. Exhausting the list of seasonal diseases is not to the point here.

Drawing from utility functions and preferences in economics, people’s utilisation of health services is relatively driven by the principle of multi-purpose trips, health visits combined with the marketing of agricultural produce, for instance.
Above all, household characteristics are reported to influence utilisation. For instance, participation in different social networks may assist or hinder the utilisation of certain types of services. As discussed in chapter 7, some social networks and their cultural legacy may be specific to certain ethnic communities and not to others. It is then relevant to analyse the different modes of expressing the demand for health services. At first, this analysis seems irrelevant because it lacks information on people's socio-economic characteristics. It is true that attendance figures may hardly provide any detailed information of the kind that might be needed for characterising certain segments of the population with respect to health services. These figures are unlikely to reveal people's purchasing power, for instance. However, attendance figures may reveal preference, which is of a central value in the market theory in economics. Having an accurate knowledge of people's preference may shed light on the organisational aspects of the supply. As Zwi and Mills (1995) warned, it is not sufficient to get detailed information on the health-care systems, but it helps to integrate relevant information on the health systems. In other words, while inquiring into people's preference, sight might be kept of their involvement as actors in the distribution process.

In the Couffo region, patients from within the commune of location visit the PHSs most. This is also true for the non-governmental sector. However, both sectors do not abide by the same management rules. In the private sector, for instance, certain clinics may not survive competition or under-utilisation, whereas in the public sector there are PHSs that are running idle capacity and yet continue to operate. Therefore, analysing utilisation may help diagnose possible management issues in the public sector.

People's utilisation of the rural PHSs (see map 8.1)

Recall that the evaluation concerns people's utilisation from within the communes in which the PHSs are located to three nested levels, the sub-prefecture, the Couffo region, and outside the Couffo region. With respect to the coverage at the commune level, all sub-prefectures, except Aplahoué, have at least one health outlet in need of management reforms. Examples of these PHSs are Houédogli in Toviklin, Djotto in Klouékamè, Madjrè in Dogbo and Houégamè in Djakotomey.

It is equally relevant to evaluate people's utilisation of the rural PHSs with coverage beyond the jurisdiction of the commune. With respect to the coverage at the sub-prefecture level, only the health outlet at Adjintinmey has steady attendance figures over 1992-96 (see Map 8.1).

An evaluation of attendance figures for PHSs with a regional niche points at only one rural health facility, viz. the one located in Houégamè. Unexpectedly, though, Houégamè neither covers a substantial demand from within the commune, nor does it draw sufficient numbers of visits from the sub-prefecture of origin, Djakotomey.

Some PHSs have substantial coverage outside the delineated region. These are facilities located on the fringes of the Couffo region and in very specific localities. More precisely, those facilities in the south are on the market route, and those in the north are close to the borders with Togo (see Map 8.1).

Recall that the sub-prefecture of Lalo in the southeast of the region has a large share of Aja ethnic group, with social networks and market relations within the Couffo region. This explains why people originating from this sub-prefecture constitute a large share of the health attendance figures at Tchikpè in Klouékamè and Madjrè in Dogbo. The sub-prefecture of Aplahoué, on the other hand, has a number of villages with their counterparts in Togo. Thus, as usually do most people living at the frontiers, villagers use services from one side or the other, subject to certain factors like the level of satisfaction and their own structural characteristics. As reported by villagers from Atomè and Lonkly, their brothers from the other
Map 8.1: Characteristics of Attendance and the Coverage at Selected Primary Health Services in the Couffo Region

- Primary health care centre and others
- Low coverage at sub-prefecture level
- High coverage at sub-prefecture level
- Low coverage at commune level
- High coverage at commune level
- Coverage from outside jurisdiction
- Tertiary road
- Secondary road
- Primary road
- District capital centre
- Commune capital centre
- Village
- Boundary of district territory

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side of the border started using health services in Benin during the early 1990s, after the collapse of the health services in Togo. On the other hand, the health centres located on the other side of the border used to draw mostly patients from Benin.

Having evaluated the rural PHSs, it is of equal interest to question the functions assigned to referral health centres at the sub-prefecture level. It is assumed that their performance may explain the level and quality of the health services provided at the communal level by the rural public-sector health centres.

People's utilisation of the referral hospitals at the sub-prefecture level (see Map 8.2)

Recall that facilities at the sub-prefecture level operate as both PHSs and referral hospitals. From this perspective, it is of interest to evaluate their coverage at the commune level and at the sub-prefecture level. Concerning health coverage at the commune level, all five centres have a relatively good score. However, some centres are extensively used while others are not. For instance, the ratio between visits to the health centre of Klouékannè and that of Aplahoué is one to five (see graph 8.5).

According to total coverage at the sub-prefecture level, two health centres seem under-utilised compared to the other three. These are the centres at Dogbo and Klouékannè. However, their low utilisation may be due to the substantial number of not-identified visits. In fact, thousands of visits have not been traced back to the villages, communes and sub-prefectures of origin. Toviklin, with a much more reasonable figure of 900 not identified visits over 1992-96, is an exception. This is the rationale why this characteristic is not explicit on map 8.2.

In connection with the regional coverage, at least two centres are located at strategic positions. These two are Azovè in Aplahoué, and Djakotomey located on the densely populated Plateau Aja with more than 300 inhabitants per Km2 (INSAE 1994). In addition, their locations are well connected to the triangle formed by the three most important markets of the Couffo region, Klouékannè, Dogbo and Azovè (Aplahoué). However, it should be pointed out that the market argument is a necessary, but not sufficient condition for a health centre to endorse a regional influence. For instance, Dogbo and Klouékannè locate two of the three markets, yet their health coverage is not of regional importance.

It could be conjectured that Klouékannè is an enclave with respect to the road network, compared to the other two market-locations. More importantly, however, its competitive advantages in the production of tomatoes and groundnuts and in the processing of vegetable oils and other foodstuff notwithstanding, Klouékannè suffers from neglect because of its low profile in the cotton sector. This may explain why the market at Klouékannè, and henceforth the referral health centre, attracts much less people from the Couffo region than do the other two markets. The case of Dogbo, on the other hand, may be argued following the competitive effect from the confessional hospital, Hôpital Saint Camille, located only 500 meters away from the public-sector health centre and the market.

The other example of a health centre without a regional coverage on the market route is that of Toviklin, located between two markets, viz. Dogbo and Klouékannè. This is unexpected, given the quite good performance of the referral health centre at the local level. When looking for an explanation, a peculiar antagonism was reported between inhabitants of Toviklin and those of the other localities, from which the Toviklin area had seceded in the 1970s. This story may corroborate, but not explain the low regional profile of the health centre at Toviklin. As for Klouékannè, Toviklin is well known for its hard-working women and their know-how in the food-processing sector. People from Toviklin compete for niches in all three markets, whereas as their neighbours from Klouékannè they strive to keep their local niche.
Collective action in the distribution of primary health services

Map 8.2: Characteristics of Attendance and the Coverage at Five Referral Hospitals in the Couffo Region

- Insufficient coverage external to sub-prefecture
- High coverage external to sub-prefecture
- Insufficient commune coverage
- High commune coverage
- Attendance source from outside the sub-prefecture
- Tertiary road
- Secondary road
- Primary road
- Boundary of district territory
Concerning the coverage outside the Couffo region, Djakotomey seems the least and Aplahoué the most endowed. Dogbo and Toviklin score average, and Klouékanmè follows after them. If a large share of visits accounts for people's moves to the three important markets, the high number of Togolese visiting the health centres at Aplahoué strikingly indicate the level of interaction among the Aja ethnic group on both sides of the borders. The results confirm the existence of some social, economic and cultural networks that overlook decisions on the allocation and distribution of resources.

Graph 8.5: Total attendance statistics at the referral health centres at the sub-prefecture level over 1992-96 in the Couffo region

Note: W Commune stands for within commune; W Sub-pre stands for within sub-prefecture; W re Area stands for within the research area; O re Area stands for Outside the research area.

**People's structural characteristics and resource management in the health sector**

Overall utilisation of both types of health services, the rural PHSs and the referral hospitals at the sub-prefecture level, seems to be guided by two principles, proximity and market route. According to the first one, attendance is higher on the densely populated Plateau Aja than in the less populated Lonkly Savannah in the north, the area along the Couffo River in the east and the sub-prefecture of Dogbo in the south. The second principle, on the other hand, explains to some extent the pressure on the health services alongside the market route. It also contributes to explaining why certain services are utilised more by outsiders than by the resident population.

Regarding proximity as a guiding principle for people's utilisation, this is not unexpected. It confirms the fitness of the health-policy reforms, hence the advocacy of bringing health services closer to the users. This then corroborates why under-utilised PHSs are in need of management restructuring, because reasons other than people's willingness to use those centres are necessarily at the heart of the present state of utilisation.
As to the second principle, the market route, this begs for paying critical attention to a number of unresolved issues related to the structural characteristics of village communities, like household budget, purchasing power, intra-household relations, decision-making and market integration. Recall that household budget and purchasing power have been touched upon in chapter 6. Decision-making and market integration will be dealt with below, followed by a discussion on intra-household relations.

The market principle may reconcile the concept of sacrifices attached to *traditional medicine* with that of investment peculiar to the modern health sector. Regardless of the parallel between the utilisation of the existing PHSs and market integration, it is unlikely that people's quests for better terms of change, lesser inter-seasonal variability of agricultural product prices, lower transport costs as well as lower administrative and information costs, and the like, will be met only through participating in market exchanges. A more appropriate macro-economic policy environment is needed to foster people's response to the market mechanisms.

*Intra-household and gender considerations in the utilisation of PHSs*

The volume of health expenditure is in the same order as that of attendance figures, although it should be stressed that costs related to surgery and maternity care are disregarded. The results suggest that children are cherished for their future worth, confirming the perspective on health as an investment. The difference between women and men also challenges the gender discourse on the low status of female partners within the households. In the Couffo region, similar conclusions could be reached from a simple observation of crowds of patients. Nevertheless, inferences ought to be based on hard facts, with a guarantee of statistical significance, time dimension and spatial variation. Concomitantly, it is important to admit their limitations, given evidence that policy is only for a small part driven by data. Priority-setting and decision-making systems for policy choices, however, need to be alert to local concerns at less quantifiable levels.

With respect to gender differentials in service utilisation, the results of interviews with household-heads hardly substantiate such a gender-based segmentation (see table 8.1). For instance, more than 95 per cent of women respondents claim to have visited a PHS in the Couffo region. Recall that women have more than double probability ratios for visiting health units compared to adult male household members. The rationale stems from the alleged inclination of women to avail themselves of health services more often than men. They seek medical treatment for their own sake and, as mothers; they may also do it for their children, and for other relatives under their responsibility. The striking situation is that more than 96 per cent of male respondents also claim to have revealed their needs for PHSs, a figure that is unexpectedly similar to that for women (cf. table 8.1). However, it should be stressed that the figures for both women and men are quite absolute values, and their interpretation must be hedged with caveats. Those figures do not tell the number of visits paid to the PHSs, nor do they indicate the household member with the largest number of visits. Observations, interviews and group discussions unequivocally illustrate the larger shares of women visits compared to those of men.

The present analysis addresses the internal variation between both sexes within the sub-prefectures. This variation shows an advantage of men over women in Aplahoué (96 per cent against 88 per cent) and Klouékannè (93 per cent against 90 per cent). The reverse situation is observed in the other three sub-prefectures, Djakotomey, Dogbo and Toviklin. As noted previously, interviews with health personnel and observations of the record books also bear out the dominance of women over men in terms of the number of visits.

The aggregate figures on attendance displayed in graphs 8.1 through 8.3 hardly tell the whole story. Indeed, these figures readily encompass the number of visits per year in each sub-
prefecture. However, due to the mode of recording there are people with one and even more visits during the same period, while there are also people who, although in need, refrain from visiting the PHSs because of either alternative solutions or simply resignation. In sum, there are people who may continue to visit the PHSs because of earlier satisfaction, whereas others, the group of dissatisfied or resigned people, may interrupt their visits. There are also people who, although dissatisfied in the past, are ready to give it a new try. Undoubtedly, the linkages between the relative weight of respondents with dissatisfaction and those with interrupted visits (or those who do not maintain contacts with the PHSs) are for all to witness (see table 8.2).

Table 8.1: Distribution (%) of a sample of respondents according to their preferences for the formal PHSs in five sub-prefectures of the Couffo region, 1996-1997.

<table>
<thead>
<tr>
<th>Prefecture</th>
<th>Men</th>
<th>Women</th>
<th>Both sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aplahoué</td>
<td>95.6 (%)</td>
<td>88.2 (%)</td>
<td>94.9 (%)</td>
</tr>
<tr>
<td>Research area</td>
<td>96.2 (%)</td>
<td>95.2 (%)</td>
<td>96.1 (%)</td>
</tr>
<tr>
<td>(N=321)</td>
<td>(N=34)</td>
<td>(N=355)</td>
<td>(N=1637)</td>
</tr>
<tr>
<td>Djakotomey</td>
<td>96.7 (%)</td>
<td>97.8 (%)</td>
<td>96.9 (%)</td>
</tr>
<tr>
<td>(N=338)</td>
<td>(N=45)</td>
<td>(N=383)</td>
<td></td>
</tr>
<tr>
<td>Dogbo</td>
<td>97.6 (%)</td>
<td>98.6 (%)</td>
<td>97.8 (%)</td>
</tr>
<tr>
<td>(N=250)</td>
<td>(N=69)</td>
<td>(N=319)</td>
<td></td>
</tr>
<tr>
<td>Klouékanmé</td>
<td>93.2 (%)</td>
<td>89.7 (%)</td>
<td>92.8 (%)</td>
</tr>
<tr>
<td>(N=308)</td>
<td>(N=39)</td>
<td>(N=347)</td>
<td></td>
</tr>
<tr>
<td>Toviklin</td>
<td>99.0 (%)</td>
<td>100 (%)</td>
<td>99.1 (%)</td>
</tr>
<tr>
<td>(N=210)</td>
<td>(N=23)</td>
<td>(N=233)</td>
<td></td>
</tr>
</tbody>
</table>

Source: Compiled from survey data (1996-97)

People's perception of the formal PHSs

Table 8.2 sums up respondents' critical perception of the functioning of the PHSs at the sub-prefecture level before and after the reforms. The results are based on the interviews with 1637 respondents (all household-heads), and on the synthesis derived from group discussions held in a sample of 34 villages in the Couffo region. We shall first clarify some concepts that will be extensively used in this section.

The concept of revealed needs derives from that respondents decide to seek health services only after evaluating their interests in the formal PHSs and the set of alternatives they face. However, it is instructive to point out that the decision to seek health care at the nearest formal health centre is made after exhausting alternatives such as self-medication, traditional medicine, and the like. Usually, people seek health care at the formal PHSs as a last resort. Needs are said to be satisfied if people perceive no spatial, organisational and cost friction infringing on their access to the formal PHSs. In reality, there are always some kinds of friction, but people seem to overemphasise primarily those related to costs, and secondarily spatial and organisational friction. Contacts maintained, on the other hand, derives from the willingness of some people to give it a new try after earlier dissatisfaction. For those people who were initially satisfied, contacts maintained derives from a logical option.

Table 8.2 illustrates that more than 95 per cent of respondents are aware of the PHSs through which they have expressed their needs either before or after the reforms. The high level of awareness observed, however, departs from the alleged ignorance officials generally assumed to be the cause of the low rate of health-service utilisation. The differences between the percentages of respondents who revealed their needs at the sub-prefecture level and those of satisfied respondents capture people's dissatisfaction. Dissatisfaction seems more significant after the reforms than before. However, people's dissatisfaction after the reforms, illustrated through the low percentages of respondents with contacts maintained, needs not be interpreted in absolute terms. As substantiated through group discussions and individual interviews, frustration with the health services increased after the reforms counter to expectations. Respondents with contacts maintained are commensurate with their level of satisfaction or
dissatisfaction after some previous utilisation. Consequently, table 8.2 indicates that the percentages of respondents with contacts maintained are very close to those of satisfied respondents.

Table 8.2: Distribution (%) of household-heads according to their perception of the primary health services before (Be.) and after (Af.) the reforms in five sub-prefectures of the Couffo region, 1996-97.

<table>
<thead>
<tr>
<th>Sub-prefectures</th>
<th>Aplahoué (N=355)</th>
<th>Djakotomey (N=383)</th>
<th>Dogbo (N=319)</th>
<th>Klouékanmè (N=347)</th>
<th>Toviklin (N=233)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revealed needs</td>
<td>95 95</td>
<td>95 95</td>
<td>81 81</td>
<td>88 88</td>
<td>89 89</td>
</tr>
<tr>
<td>Needs satisfied</td>
<td>87 12</td>
<td>93 90</td>
<td>74 70</td>
<td>86 14</td>
<td>87 37</td>
</tr>
<tr>
<td>Contacts maintained</td>
<td>93 15</td>
<td>93 91</td>
<td>76 71</td>
<td>86 13</td>
<td>89 38</td>
</tr>
</tbody>
</table>

Source: Compiled from survey data, 1996-97.

Table 8.3 presents the distribution of a sample of villages into four quartiles, following the rate of people’s perception of the formal PHSs. Recall that each row of the table is defined for one of the five sub-prefectures, and that the four quartiles are arranged in ascendant order from the bottom up. Annex E gives a detailed description of the meaning of quartiles and their relevance to the study. The lowest quartile corresponds to villages with negligible weight regarding the perceived attribute under consideration, while the highest quartile refers to villages with a very significant weight. For the ease of understanding, the quartiles with no villages are left out the table.

Table 8.3: Breakdown of a sample of villages according to quartiles of respondents for their perception of the primary health services before (Be.) and after (Af.) the reforms in five sub-prefectures of the Couffo region, 1996-97.

<table>
<thead>
<tr>
<th>Sub-prefectures</th>
<th>Aplahoué N=7 (51;23)</th>
<th>Djakotomey N=7(55;46)</th>
<th>Dogbo N=6(53;46)</th>
<th>Klouékanmè N=8(43;57)</th>
<th>Toviklin N=6(39;37)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revealed Needs</td>
<td>75%&lt;X=100%</td>
<td>7 7</td>
<td>7 7</td>
<td>6 6</td>
<td>8 8</td>
</tr>
<tr>
<td>Needs</td>
<td>75%&lt;X=100%</td>
<td>7 7</td>
<td>7 7</td>
<td>6 5</td>
<td>8 1</td>
</tr>
<tr>
<td></td>
<td>50%&lt;X=75%</td>
<td>- 1</td>
<td>- -</td>
<td>- -</td>
<td>- -</td>
</tr>
<tr>
<td></td>
<td>25%&lt;X=50%</td>
<td>- -</td>
<td>- -</td>
<td>- -</td>
<td>- -</td>
</tr>
<tr>
<td></td>
<td>X=25%</td>
<td>- 6</td>
<td>- -</td>
<td>- -</td>
<td>- -</td>
</tr>
<tr>
<td>Satisfied Needs</td>
<td>75%&lt;X=100%</td>
<td>7 1</td>
<td>7 7</td>
<td>6 5</td>
<td>8 1</td>
</tr>
<tr>
<td></td>
<td>50%&lt;X=75%</td>
<td>- -</td>
<td>- -</td>
<td>- -</td>
<td>- -</td>
</tr>
<tr>
<td></td>
<td>25%&lt;X=50%</td>
<td>- -</td>
<td>- -</td>
<td>- -</td>
<td>- -</td>
</tr>
<tr>
<td></td>
<td>X=25%</td>
<td>- 6</td>
<td>- -</td>
<td>- -</td>
<td>- -</td>
</tr>
</tbody>
</table>

Source: Compiled from survey data, 1996-97.
Notes: N stands for the number of villages per sub-prefecture; (a;b) stands respectively for the average number of respondents per village in the sub-prefecture and the relative standard deviation; X stands for the first, second, third and fourth quartiles.

As we see, each village of the sample is distributed into the highest quartile for people’s revealed needs. Consequently, all of the surveyed villages have a very high rate of people’s needs revealed to the formal PHSs. The implication is that each respondent has at least made use of the
formal PHSs. Regarding people's satisfaction after revealing their needs, there is unanimity of perception in the sample of villages before the health policy reforms. However, the situation is different after the reforms. For instance, while there is agreement on dissatisfaction in Aplahoué, Klouékannè and, though to a lesser extent, in Toviklin, almost all villages of Djakotomey and Dogbo have very high rates of satisfaction. As to respondents with contacts maintained, the trends observed for the distribution are commensurate with those for satisfaction or dissatisfaction.

The results seem to imply location-specific constraints, as most villages of the same sub-prefecture have almost similar rates of satisfaction or dissatisfaction. It was found that the two sub-prefectures with satisfactory outcomes for the health reforms are very accessible from the regional capital centre (Lokossa), while the other three are land-locked with some remote villages. However, as will be shown below, most respondents claim that reasons other than physical accessibility to explain dissatisfaction.

**People's perceived constraints on the formal PHSs**

The rationale for people's refraining from visiting the PHSs is dissatisfaction or simply resignation. Both notions embrace a number of constraints, such as distance, cost, organisation, and alternative services like traditional medicine (cf. table 8.4). For the pre-reform period, the average share of respondents with health costs as a constraint on the utilisation of PHSs in the Couffo region is 49 per cent. The figures for individual sub-prefectures range from 40 per cent in Aplahoué to 63 per cent in Dogbo. The sub-prefecture of Klouékannè also scores high for this constraint (52 per cent).

**Table 8.4: Distribution (%) of respondents according to their perceived constraints on access to the primary health services in five sub-prefectures of the Couffo region (1996-97)**

<table>
<thead>
<tr>
<th>Sub-prefectures</th>
<th>Aplahoué (N=355)</th>
<th>Djakotomey (N=383)</th>
<th>Dogbo (N=319)</th>
<th>Klouékannè (N=347)</th>
<th>Toviklin (N=233)</th>
<th>Research area (N=1637)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance</td>
<td>27.9</td>
<td>-</td>
<td>43.1</td>
<td>5.2</td>
<td>23.8</td>
<td>5.3</td>
</tr>
<tr>
<td>Cost</td>
<td>39.7</td>
<td>94</td>
<td>46.2</td>
<td>84.6</td>
<td>63.0</td>
<td>85.9</td>
</tr>
<tr>
<td>Organisation</td>
<td>1.1</td>
<td>.3</td>
<td>5.5</td>
<td>6.3</td>
<td>5.6</td>
<td>6.0</td>
</tr>
<tr>
<td>Ignorance</td>
<td>.6</td>
<td>-</td>
<td>.5</td>
<td>-</td>
<td>3.1</td>
<td>.3</td>
</tr>
<tr>
<td>Traditional Medicine</td>
<td>25.6</td>
<td>.6</td>
<td>1.6</td>
<td>.5</td>
<td>2.2</td>
<td>.3</td>
</tr>
<tr>
<td>No Response</td>
<td>5.1</td>
<td>5.1</td>
<td>3.1</td>
<td>3.4</td>
<td>2.2</td>
<td>2.2</td>
</tr>
</tbody>
</table>

**Source:** Computed from survey data (1996-97)

**Note:** Bef. stands for before the reforms in 1990-91; Aft. stands for after the reforms in 1990-91.

No Response stands for the percentage of respondents who do not cite any constraint.

Answers are exclusive and respondents may give one of the constraints listed in the table.

For the post-reform period, on the other hand, 88 per cent of all respondents indicate financial access as a major constraint. The shares of respondents with financial access as a constraint are well above 80 per cent for all five sub-prefectures. This result is logically expected as people generally discriminate between access constraints on health services and the lack or shortage of those services, identified as organisational constraints. Distance friction is implicit in the absence of health costs. Distance friction may be equally important if the villages from which respondents are drawn are other than the commune centres. Although financial considerations have taken the lead after the reforms, it might be instructive to stress that respondents claim some spatially differentiated constraints for the period before. For instance, significant proportions of the sample respondents in Djakotomey (43 per cent) and Toviklin (36 per cent)
mention distance friction for the period before the reforms. The equally significant drop in the relative weight of sample respondents claiming distance friction after the reforms may be explained by the creation of new outlets in both sub-prefectures in 1995. Distance friction is also claimed as a constraint in Aplahoué (28 per cent) and Dogbo (24 per cent) for the same period, but with much less emphasis compared to Djakotomey and Toviklin. In the sub-prefecture of Klouékannè, 13 per cent and .3 per cent of respondents claim distance friction before and after the reforms, respectively. The latter figures suggest that distance is not a driving constraint on the utilisation of the PHSs in this sub-prefecture.

Apart from the access constraints, broader organisational aspects may also influence people’s decision to seek health care in the public-sector health centres. Aspects derived from the PHSs with significant increases in attendance figures after the reforms include, among other things, taking health services to users and supply promotions such as the absence of user-charge, a drastic reduction of drug costs, and an unusually warm reception of users by newly appointed health personnel. The organisational arguments, although insignificant both before and after the reforms, bear out that sub-prefectures with new outlets have increasing trends and those without new outlets have decreasing trends for the attendance figures.

Table 8.4 substantiates that ignorance is a minor constraint on the utilisation of the health services in the Couffo region. Figures for ignorance are very marginal, .9 per cent and .1 per cent for the period before and after the reforms, respectively. Those figures are equally insignificant for all five sub-prefectures. However, the perception obtained from one household-head may seriously diverge from that of the whole household, because of the plural decision-making units. Consequently, it might be instructive to keep sight of these limitations.

8.2.2 Opportunities and threats regarding collective action in the distribution of primary health services

The other locality-specific constraint refers to the availability of traditional medicine (cf. table 8.4). Respondents in Aplahoué (26 per cent) and in Klouékannè (25 per cent) considered that traditional medicine had some negative impact on people’s perception of the formal PHSs. This is not to assert that respondents of the other sub-prefectures hardly take recourse to traditional medicine. The failure to rank traditional medicine amongst the constraints on access to the PHSs derives from the strategic communication skills of rural people who avoid opposing their own world to that of the public and the modern health sectors. Far from an abdication, people simply consider health services in terms of performance. Accumulated knowledge on performance is conveyed from generation to generation, and some clearly set criteria other than physical cures are still in use. For instance, some mental as opposed to physical remedy may be necessary in the rural African context. Social inertia as well as leverage contributes to the choice of one alternative or the other. If rural beneficiaries do believe in modern health care for some specific diseases, they treat the claim for cure ascribed to this alternative with some scepticism. The criteria used, though, may vary with the location of settlements and some socio-cultural characteristics of the rural dwellers.

Concerning people’s perception of traditional medicine as a constraint on access to the formal PHSs, the decline in the rates from the period before the health-policy reforms to the period after could hardly be translated into neglect. Because of the driving costs, respondents put a premium on the latter constraint rather than on their perception of traditional medicine. As it will appear later on, most respondents seek traditional medicine in the first place.

Following interviews and group discussions, almost all respondents invariably take recourse to traditional medicine no matter their social position or their nearness to the formal PHSs and to the non-governmental health services. Regarding the rationale underlying their choice, both cost concerns and social belief are at the heart of people’s fondness of traditional
On the cost side, the rising health costs in the aftermath of the reforms and, more importantly, the impact of the franc CFA devaluation in 1994 eventually provoked a backlash against the formal PHSs. The subsequent implication is the rising demand for traditional medicine. For analytical purposes, both cost advantage and social belief are relevant in characterising the sample of villages.

With the implication of the non-governmental sector within the health system, the reforms brought about some new institutional development. People’s perception of the non-governmental health sector is illustrated below.

**People’s perceptions of the non-governmental health sector**

Treating the non-governmental health sector as external to collective action derives from the role assigned to this sector by health officials in Benin. Although this may seem contradictory, this sector may be part of the *formal channel*, but it may not readily be part of collective action as it applies in the Couffo region.

**People’s perceived advantages of the non-governmental health services**

Table 8.5 presents the extent to which respondents take recourse to the non-governmental health services at the sub-prefecture level. It should be noted here that the services under study include both the certified clinics and the *parallel channel*, respondents being indifferent to certification and non-certification. More importantly, people’s demand for health services from the *parallel channel* seems to carry more weight compared to the certified clinics, as the latter are still in their infancy. Contrary to the formal PHSs with very high demand, the rate of people’s demand of the non-governmental health services can be called fair. The highest rate is obtained in Toviklin, while the lowest is in Klouékamè. The results are justified on the ground that a better or worse coverage from the public sector corresponds with a higher or lower demand for non-governmental health services, respectively. For instance, there are more respondents from Toviklin, with one public-sector health outlet in addition to the referral health centre, taking recourse to the non-governmental health services than respondents of the sub-prefectures of Klouékamè and Aplahoué, with better public-sector health coverage.

| Table 8.5: Distribution (%) of respondents according to their demand for and perceived advantages of the non-governmental health services (certified and parallel channels) in five sub-prefectures of the Couffo region (1996-97) |
|-------------------------------------------------|---------------|----------------|----------------|----------------|----------------|----------------|
| Demanding non-governmental health services      | Aplahoué (N=301) | Djakotomey (N=335) | Dogbo (N=273) | Klouékamè (N=292) | Toviklin (N=189) | Research area (N=1390) |
| Demand for non-governmental health services     | 59%            | 67%            | 66%            | 55%            | 75%            | 63%            |
| Distance advantage                              | 15%            | 19%            | 16%            | 11%            | 9%             | 14%            |
| Cost advantage                                  | 42%            | 41%            | 47%            | 41%            | 61%            | 45%            |
| Organisational advantage                        | 2%             | 7%             | 3%             | 3%             | 5%             | 4%             |

Source: Computed from survey data (1996-97)
Note: N stands for the number of household-heads surveyed.
% is calculated in relation with the total number of household-heads surveyed.
Answers are exclusive and only respondents with positive demand are recorded.
health sector. For instance, drugs may be partially purchased or following a daily treatment. Health treatment may also be considered as a divisible package, while this is prohibited in the public sector. The case of malaria treatment described in chapter 7 is illustrative in this regard. Credit is also allowed, and intimate relationships are established between patients and non-governmental health professionals, while these things are highly unlikely within the public-sector health services. Apparently, this may seem unjustified if the stated participation of the beneficiaries is achieved. The clarification of the prevailing situation within the LHMCs will explain the absence of harmony among members in general, and between government health staff and the beneficiaries in particular.

Although organisation is not a driving advantage in the non-governmental health services, it seems better perceived by respondents in that sector than in the formal PHSs. Indeed, the perceived rates of advantage are higher compared to those of constraints observed in the formal PHSs at the sub-prefecture level (cf. tables 8.4 and 8.5). Respondents also make the linkage between how the non-governmental health sector may ease the payment of health costs on the one hand, and organisational performance on the other.

8.2.3 Is the institutional environment appropriate for the performance of collective action in the distribution of primary health services?

The present sub-section will address the institutional environment in relation to the health-sector results presented earlier. Recall that the institutional environment is not only shaped by government policy, but also by the so-called social norms and rules by which people abide. More importantly, a clear delineation between the private and the participatory sectors will be pursued in this section, in order to clarify the role of village communities in the making of the health-institutional environment. This section is organised following three dimensions, the first dealing with the health-policy reforms and the structural components of the government sector, and the ways in which these two shape the health-institutional environment, the second addressing the institutional environment in relation with the supply of the formal PHSs, and the third dealing with the institutional environment and performance in the non-governmental health sector.

Health-policy reforms and structural differentiation of village communities: the institutional environment

As applied for the agricultural input sector (cf. chapter 5), people's ability to avail themselves of health services hinges on the structural characteristics of village communities, among other factors. This is to assert that people's adherence to the concept and practice of primary health care may be linked with the type of social organisations in place in the villages. For instance, grassroots saving and credit organisations are very relevant in encouraging members through credits allocated to health-care purposes. Therefore, not only health policy matters in this sector, but also the so-called structural characteristics of the beneficiaries.

Structural characteristics of the village communities

Recall that the linkage between people's occupations and their membership in formal as well as grassroots organisations has been sketched in chapter 5. In addition to occupation, other socio-cultural factors seem to induce or constrain membership in the existing formal organisations. Social status, for instance, is a factor restraining women's membership in farmers' organisations, the GVs. Social belief, to the contrary, induces women's membership in the Saving-Credit organisations of the Kugbe type.

Why is the membership in Kugbe groups relevant to the structural characteristics of village communities with respect to health? Beforehand, recall that the idea of constituting
Box 8.1: Social organisations, social values of the village communities, and conflicts in resource allocation for health-care purposes

Group discussions held in the sample of villages substantiated cases of credit allocation for primary health-care purposes. These examples are fairly distributed between three sub-prefectures. At Aplahoué, a dozen of cases of health-investment credit were recounted in three villages, two of which involving the Kugbe saving groups and the third a traditional type of Saving-Credit. At Dogbo, more than twenty beneficiaries were concerned in four villages. At Toviklin, at last, key informants from two villages considered that credit invested in health care gained momentum in response to people’s inability to pay health costs.

Although the morality underlying the health-care credit is for all to witness, several predicaments may deter creditors’ willingness to sustain the rising demand. The first one to be mentioned stems from that investing in health is still at odds with the common social belief. The representation of evil and blessings draw out abstract relations from ancestors to successors, which victims may bear or exorcise. Therefore, concepts such as sacrifice or offering in kind fit better in people’s context than that of investment. The way in which both perceptions may be reconciled will be discussed later.

The second predicament of interest derives from the lack of consensus that health is a means to an end as well as an end in itself (Zwi and Mills 1995). For instance, the social mutuality scheme established at Gbowimè, in the sub-prefecture of Klouékanmè, illustrates the failure to build on consensus for health-investment issues. The scheme, originally drawn up as a donor-supported part of the investment portfolio of the local bank, CREP, only won a hundred of the several thousands of the bank’s clients in 1996. Although the health centre has kept up with the increased affluence of non-bank members, the low involvement of members does question the fitness of the original institutional goal. To date, the situation evolves with better prospects for bank clients to adhere to mutuality goals in the health sector.

The third predicament relates to the likelihood of high costs involved in such investments, given the low quality of health services and the ensuing high mortality rates. The low probability of healing from sickness is likely to exclude any contractual form of health-investment credit. The absence of property rights on land, the only valuable physical asset available in the Couffo region, compounds the other deterrent effects. As is the case in agriculture, the adaptation to health-investment credit exposes some weaknesses due to default credit payment, increasing thereafter the fragility of the process of institutional development (cf. chapter 5).

A further predicament challenges the appropriateness of the current policy reforms for inducing investments in health. In this respect, the present research, far from exhausting the topics, points at some flaws in the health reforms. Policy measures are hardly criticised for being unethical and fundamentally inequitable, but critics rather charge the ease versus the difficulty to misapply, misapprehend and misappropriate policy measures, opportunistically or not.

An additional predicament worth mentioning cuts across the others. It derives from the imbalance between people’s health expenditures and other expenditures. The underlying arguments have been pursued in chapter 6.

The next predicament stems from the characteristics of households. For instance, the plurality of the decision-making units within households suggests that the results presented in tables 8.1 through 8.5 may be scaled up or down, given the structure of intra-household decision-making with respect to the distribution of primary health services.

The final predicament derives from conflicts linked to credit repayments. Ambivalence in the institutional settings is often at the disadvantage of the creditors. This observation perfectly accords with the claim of Bierschenk et Olivier de Sardan (1998:38) that local actors resort to institution shopping in the process of conflict resolution. Accordingly, transparency is unlikely.
such groups originated from the social dilemmas caused by people's inclination to ostensibly display a great deal of wealth for the funeral ceremonies of their parents-in-law (cf. chapter 2). In order to overcome such dilemmas, anticipated membership is contracted with a saving and credit group for meeting those unpredictable expenses. Kugbe is an organisation that has switched its institutional goals to include some tentative investments in human health. The belief that the funeral ceremonies of a beloved parent-in-law matter is taken advantage of and, to some extent, diverted to investments in members' own health (see Box 8.1).

Recall also that the distinction between the Saving-Credit groups and the affiliated self-help organisations is blurred. Most of them operate following the same mode, the fundamental difference being the established goals. Therefore, as reported in van den Brink and Chavas (1997), the flexibility of adjusting goals, allowing for credit on social as well as economic services, extends to most organisations of the Saving-Credit type. As discussed in chapter 5, such a deviation may unexpectedly lead to conflicts, which will endanger the very process of rural changes and transformation (cf. Box 8.1). As a result, no critical number of investment-oriented grassroots financial institutions is achieved, nor is there hope that the existing attempts may evolve to boost the rural development process.

8.2.4 Evaluation of performance in the primary health services
Overal quantitative performance of the reforms has been disappointing according to farmers' perceptions. However, costs impinging on the distribution of PHSs are hard to define in operational terms and are best understood in terms of their qualitatively significant deviation from the stated goals. Yet, it is difficult to get good quantifiable information on the scale and breadth of the deviation.

The present sub-section endeavours to provide some hints on the mechanisms underlying the pervasive nature of the alleged high costs by means of the framework in figure 2.1 (chapter 2). This figure sketches the different components of the post-reform situation of the PHSs. The bottom rectangle stands for village characteristics while the top rectangle represents those of the intervening organisations. On the sides are rectangles for inputs (on the left) and health output (on the right). It should be pointed out here that input and output are considered as performance characteristics. The ellipse in the central position of the four rectangles is the hypothetical black box within which mediation is settled for resource access and control, the so-called Institutional arrangements. Overall components are contained within the institutional environment, the village boundary seen as a theoretical construct. The dotted horizontal line is the blurred zone between the public sector at the top and village characteristics at the bottom. The private clinics do not appear in this scheme since their relative role in the system is still insignificant. Double arrows for reciprocity purposes illustrate the interaction between various entities. Each type of interaction is assigned a number, which ranges from 1 to 6.

For the purpose of this analysis, a set of variables has been defined to capture the characteristics of each component of the institutional settings (see annexe H, table 1). A linear correlation has been run in order to inquire into the direction of friction impinging on or facilitating various interactions (cf. chapter 2, figure 2.1). The results are summed up in annexe H, table 2.

Interaction 1, between village and performance characteristics (annexe H, table 2)
The results show a significant linear correlation between village characteristics (membership rate in Kugbe groups and occupation rate in agriculture), and performance characteristics (per capita attendance ratio at the PHS within the sub-prefecture of origin and per capita attendance ratio at the private clinics within the Couffo region). However, while the membership in Kugbe groups increases with a decrease in attendance at the private clinics, villages with higher rates of
occupation in agriculture have a lower per-capita attendance at the formal PHSs within the sub-prefecture of residence.

**Interaction 2, between the institutional environment and performance characteristics** (annexe H, table 2)

Two groups of linear relationships are represented. The first group relates to the constraints on the modern health sector. In villages with higher rates of perceived distance constraint, per capita attendance rates at the local PHSs are the lowest or even nil. In other words, villagers resent distance constraint more than anything else. The second group of linear correlations relates to the advantage of the *parallel channel* over the formal PHSs. Villages with a perceived distance advantage of the *parallel channel* are characterised by lower per-capita attendance rates at the local PHSs. In villages with a perceived organisation advantage of the *parallel channel*, on the other hand, per-capita attendance rates at the local PHSs are higher than otherwise. This suggests that organisation advantages carry less weight compared to distance consideration in the agenda of the rural population. But, organisational concerns are contemplated when the formal health outlet is readily available.

**Interaction 3, between policy and performance characteristics** (annexe H, table 2)

As originally thought, policy measures entail more organisational components nowadays than they did before. In this context, it might not seem straightforward to expect a direct influence on the attendance performance. Although not encompassing all organisational aspects, the ways in which policy measures shape and affect village attendance rates at the formal PHSs may be inferred from the following results.

The results indicate that villages located at greater distances from their sub-prefecture centre have higher attendance rates at the local PHSs compared to villages located nearer to their sub-prefecture centre. Recall that the second-order referral health service is located at the sub-prefecture centre and people prefer this level because of their health-seeking behaviour. Distance from the nearest formal health centre, on the other hand, is negatively correlated with per-capita attendance rates at the local PHSs. These results are expected since villages with and without local PHS are two extreme cases, with either a positive per-capita attendance rate or nil attendance, respectively.

Health coverage is higher in villages with higher per-capita attendance rates at the local PHSs. This is expected and confirms that distance is a major issue in the health sector. Recall that most villages of the sample have a health outlet, which is supposed to deliver PHSs to the whole administrative commune of origin. Therefore, villages with better physical access have higher per-capita attendance rates at the local PHS than otherwise.

Villages with higher rates of membership in GVs have higher health coverage than otherwise. This suggests some inter-linkages between the health coverage and people's participation in GVs. The latter seems to play a pull function for the health-coverage level.

**Interaction 4, between village characteristics and institutional environment** (annexe H, table 2)

The results are organised around three major village characteristics. The first village characteristic of interest is household size. In villages with larger households, respondents more resent the distance constraint on the formal PHSs than those in villages with smaller households. In turn, respondents in villages with smaller households more resent the cost constraint than those in villages with larger households.

The second characteristic of concern is the rate of occupation in agricultural product processing. Villages with higher occupation rates in this sector perceive a distance advantage of...
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the parallel channel over the formal PHSs. Villages with lower occupation rates in this sector perceive a cost advantage of the parallel channel over the formal channel.

The third and last village characteristic of concern is the rate of demand addressed to traditional medicine. Villages with higher rates of demand for traditional medicine are negatively correlated with villages with higher rates of demand for the parallel channel. Recall that the parallel channel is more represented in villages without adequate formal PHSs. This suggests a parallel between people's demand of health services with respect to the formal channel and traditional medicine. Likewise, villages with higher rates of demand for traditional medicine perceive neither cost nor organisation advantages of the parallel channel over the formal PHSs.

Interaction 5, between village and health-policy characteristics (annexe H, table 2)
From a panel of eight village characteristics defined, only two linearly correlate significantly with policy attributes. These are the rate of occupation in agriculture and the rate of occupation in agricultural product processing. Villages with higher rates of occupation in agriculture have higher health coverage than otherwise. This confirms the alleged inter-linkages between the health sector and the agricultural sector. However, it should be pointed out that villages representing the centre of the administrative commune have better physical access to the formal PHSs than do the other villages of the same administrative commune. In cases of higher rates of occupation in agriculture, mainly cotton production, the health coverage is enhanced.

Villages with higher rates of occupation in agricultural product processing, on the other hand, are distributed at greater distances from the nearest formal health centre. This suggests that the latter villages have much less health coverage compared to villages with higher rates of occupation in agriculture.

Interaction 6, between policy characteristics and the institutional environment (annexe H, table 2)
The results are organised into two parts. The first part concerns distance friction, which constrains people's access to the PHSs within the formal scheme as well as potential demand from indecisive health-care seekers. The result indicates that distances from the nearest formal health centre are greater in villages with higher rates of perceived distance constraint and lower rates of perceived cost constraint on the formal PHSs. As found earlier, villages located at greater distances from the nearest formal health centre have higher rates of perceived distance advantages of the parallel channel over the formal PHSs.

The second part concerns health coverage. Villages with higher rates of perceived distance constraint on the formal PHSs have lower health coverage than otherwise. This result is expected.

The results discussed are striking, and more importantly, enlightening for the translation of health-policy measures to the village level. It could be argued that villagers who are captured by the health intervention process more resent spatial friction to the formal PHSs than otherwise. Moreover, more villagers resent the distance constraint on the formal PHSs and the subsequent distance and organisation advantages of the parallel channel when a formal health outlet is not readily available. What strikes, however, is the concomitant preference for both formal PHSs and traditional medicine. In villages with higher rates of demand for traditional medicine, people resent health practices within the parallel channel.
**Synthesis of the linear correlation analyses** (see figure 8.1)

The linear correlation results show at least three causality relationships between village characteristics, institutional arrangements and performance characteristics of the health reforms. First of all, villages with larger households and with higher rates of perceived distance constraint on the formal PHSs, show a lower performance on per-capita attendance rates. In addition, the attendance figures at the regional and sub-prefecture level are very insignificant, implying then some frustrated demand. Secondly, villages with higher rates of occupation in agricultural product processing and with higher rates of perceived distance-advantage of the parallel channel over the formal PHSs, show a lower performance on per-capita attendance rates. Thirdly, villages with lower rates of recourse to the traditional medicine and higher rates of perceived organisation-advantage of the parallel channel show a higher performance on per-capita attendance ratios.

![Figure 8.1](image)

At least three causality relationships between policy characteristics, institutional arrangements and performance characteristics of the health reforms are illustrated by the linear correlation results:

First of all, villages with increased distances from the nearest formal health centre and with higher rates of perceived distance-constraint on the formal PHSs show a lower performance on per-capita attendance rates. Secondly, villages with increased distances from
the nearest formal health centre and with higher rates of perceived distance-advantage of the parallel channel show a lower performance on per-capita attendance rates. And, thirdly, villages with lower health coverage and with higher rates of perceived distance-constraint on the formal PHSs, show a lower performance on per-capita attendance rates.

8.3 Synthesis of strategy, structure, and core capabilities of collective action in the distribution of primary health services

Figure 8.2 indicates the possibilities for blending public, private and local organisations in the distribution of primary health services (PHSs). This figure takes care of the three dimensions of the resource-based perspective, strategy, structure and core capabilities. The objective of this section is to come up with a comprehensive representation of the reforms undertaken, and the relative contribution of each category of actors. The mix of public, private, and local organisations that may make collective action more effective will also be discussed.

8.3.1 Strategy of collective action in the distribution of primary health services
This sub-section will present the institutional goals of collective action, how participation is achieved and the underlying concerns for resource allocation. The definition of strategy expounded in the policy document takes up the cost approach to resource allocation peculiar to the private sector, liberalisation as the course of action, although concerns about full coverage remain. This is a logical justification for the distribution of PHSs by local health management committee (LHMC) at the village level.

Figure 8.2: Ellipses representing the mix of strategy, structure, and core capabilities of collective action in the distribution of primary health services
Cost recovery and people’s participation are the major ingredients of the course of action for collective action in the distribution of PHSs. The role of the non-governmental health services is marginal, at least in locations where formal public health outlets are available.

According to the World Bank, the cost-recovery scheme is meant to achieve people’s welfare as a group (see Azefor and Bradley 1996). This assertion derives mainly from the equity consideration, which supposes wider financial access. The extensive arguments on allocative inefficiency illustrate unjustified shortages of health personnel, while other well-endowed health centres enjoy excess. The increasing health costs subsequent to the bias in the distribution of health personnel necessarily induces some dysfunction in the so-called cost-recovery scheme.

In terms of dysfunction, the monetary surplus, amounting to more than two billions of the CFA currency, profoundly divide health authorities and elected community representatives at the national level (Yaka 1999, p. 21). Through a press conference, the latter informed the national public opinion about the discomfort caused by the decision-making on the end-use of those monetary surpluses. The situation thus created calls for a number of observations. The first observation of interest is that the implementation of the cost-recovery scheme is not context specific, although differences between health centres are observed. The structure of health costs then suggests a scheme, which departs from spatial pricing.

The second observation is that cost recovery does not encompass a compensation scheme, suggesting that surpluses as well as deficits are hardly anticipated. Consequently, short-term investments, monetary donations and equalisation grants are not involved. Rather, surpluses are saved in certain centres, while fees are levied in case of deficits in other centres. This prompts equity concerns among the public health centres, suggesting an absence of equity considerations in the cost-recovery scheme (MPS/CE 1999). It follows that the health-financing scheme is still incomplete. The absence of a guarantee for a structural financing rule between the state, the local government and the beneficiaries hardly suggests otherwise.

The third observation is that management conflicts among members of the LHMCs are more likely in case of monetary surpluses. In fact, remote villages are forced to recruit health personnel on their own budget, while well-endowed villages have excess government-paid personnel. Therefore, remote PHSs are less likely to experience managerial conflicts, while less peripheral PHSs, including referral hospitals located at the sub-prefecture centre, are more prone to conflicts.

The fourth observation, which derives from the above, is that both horizontally and vertically, the technical as well as the managerial support lapse in spite of policy rhetoric.

As a result, health performance indicators improve, though the impact of the reforms is location specific. For instance, the national infant-mortality rate has improved from 136.6 per thousand inhabitants to 94 per thousand between 1972 and 1996 (MSP/CE 1999, p. 8). This rate further improved to 86 per thousand in 1998 (WHO 1998; ECA 1999). However, the infant-mortality rate of 101 per thousand achieved in the Couffo region remains higher than the national average. As to the morbidity rate, on the other hand, the Couffo region has the lowest figures for the five groups of diseases with high prevalence (MSP/CE 1999, p. 9). For malaria, for instance, the Couffo region has a rate of 87 per thousand, against the national average of 111 per thousand. With respect to diarrhoea-related morbidity, the Couffo region also scores far better, with 14.4 per thousand, compared to the national average of 24.3 per thousand. In terms of traumatic injuries, the Couffo region (15 per thousand) still scores far behind the national average of 20.2 per thousand. The same observation applies for diseases, which may be prevented by vaccination and the sexually transmitted diseases (STDs). The positive profile exhibited for disease-related morbidity obscures the high disparity observed within the Couffo region. Inequalities apply with greater significance in the remote villages.
Collective action in the distribution of primary health services

8.3.2 Structure of collective action in the distribution of primary health services (figure 8.3)

The so-called Comité de Gestion de la Commune (COGEC) or the local health management committees (LHMCs) operate at the commune level. At higher levels are the committee of the sub-prefecture or Comité de Gestion de la Sous-préfecture (COGES), the regional committee in charge of monitoring, implementing and evaluating health programmes or Comité Départemental de Suivi, d'Exécution et d'Evaluation des Programmes du Secteur de la Santé (CDEEP), and an inter-sector committee at the national level or Comité National de suivi d'Exécution et d'Evaluation des Programmes du Secteur de la Santé (CNEEP). A detailed study of these committees is outside the scope of the present study, but their influence on the provision of primary health care is discussed below.

Characterisation of the demand for and the supply of primary health services in the Couffo region

Two periods are to be considered, one before the reforms, with state monopoly and a strongly centralised system running from the 1970s to 1989, and the other after 1990 when the private sector was formally involved and a relative autonomy was given to the public-sector health services at the periphery, under the guidance of the local health management committees (LHMCs).

![Diagram of the structure of the distribution of primary health services](image)

**Figure 8.3:** Structure of the distribution of primary health services in the Couffo region, 1996-97
The first period is characterised by an acute shortage in the supply of health services compared to the demand. One aspect of the shortage is related to the number of PHSs, which was well below adequate. At least ten communes were without their health outlets, as initially acknowledged in the health policy documents (cf. MS/SESP-Bénin 1986 through 1990; WHO 1984). Up to the 1980s, there were no alternative modern health services such as certified private clinics. Therefore, the demand for health care was more directed to traditional medicine than to the modern sector. However, in case of dissatisfaction with the traditional medicine, people usually take recourse to the modern sector. Consequently, an increasing demand for health care was directed either at the second-order or third order health care rather than at the first-order health services. The reverse was also true, in case of dissatisfaction with the modern sector people resort to the traditional medicine.

Another aspect of the shortage concerns the provision of PHSs, which has not followed the formal planning guidelines. In the Couffo region, although the government-initiated targets and standards stipulate that each commune must locate a formal health outlet with a maximum coverage range of five kilometres, their implementation seems to expose some weaknesses (cf. Dèdèhouanou 1993). There are cases with one and more formal health outlets within less than the maximum coverage range, and there are cases of communes without health outlet beyond the range of 10 kilometres. It is instructive to observe that a few villages locate PHSs or higher-level health centres where the commune centre fails to do so. Obviously, people’s participation has played an important role in frustrating government targets and standards in the health sector. These outcomes may also be the results of government failures.

Characterisation of the demand for and supply of PHSs after the reforms in the Couffo region
The second period corresponds to the contraction of the demand for health services compared to the supply. An overview of the demand for health services has to take into account several aspects, among which the utilisation patterns of various sources of health care, including traditional medicine and self-medication, in reaction to the introduction of user-charges and the sharp increase in drug costs subsequent to the devaluation of the franc CFA in 1994. Another aspect of concern is the quality of the health services, including skilled health personnel and the availability of essential drugs. The case of health personnel has been touched upon in the previous chapter. A further analysis of the skewed distribution of health personnel was presented earlier. The case of drug costs, although relevant for characterising the demand for PHSs, is not to the point in the present study. Drug costs were initially blamed for people’s reluctance to avail themselves of health services (cf. KIT 1991; Heywood 1991). This situation further deteriorated after the devaluation of the franc CFA in 1994. However, thanks to donor support and the availability of generic drugs, the plight of the population is expected to improve. In the light of the alleged disequilibrium, the focus will be on the efficient organisation to adjust demand to supply, and vice versa. In this respect, examples of supply superior to demand, and demand superior to supply, have been discussed earlier (see maps 8.1 and 8.2).

8.3.3 Core capabilities of collective action in the distribution of primary health services
Core capabilities comprise knowledge and organisation capabilities. Both capabilities will be evaluated, focusing on collective action in the distribution of primary health services (PHSs). Vaughan et al. (1985) claimed that the adoption of reforms in the health sector might be the first stage in making a national political commitment. But, converting policy into plans and then implement them has become a hurdle, because the health-care system is both an approach, with many interactions with other development sectors, and a set of activities which fall more directly under the influence of the health-sector administration. It follows that the implementation of reforms in the health sector needs to address various management issues: how to plan for better
health, the integration of vertical and horizontal programme-activities, the budgeting by programmes, and the implementation of decentralised management. It is instructive to view the components of the health reforms through the lenses of these management issues.

Recall that health reforms comprise the following components: peripheral or primary health services, the LHMCs, the intermediate-level support for PHSs from the sub-prefecture and even the regional level, the inter-sector activities particularly with respect to agriculture as a source of finance, the community and individual participation in all aspects of the PHSs, from health care to individual involvement in planning and organising services, and the co-operation and co-ordination between the public, private, confessional and other groups of providers.

**Primary health services and the local health management committees**

Empirical observations substantiate that people’s participation in the construction of health facilities logically results in a better maintenance of the premises (KIT 1992, Carrin and Vereecke 1992, Cassels 1995, Mogedal et al. 1995). Azefer and Bradley (1996) underlined the effectiveness of this link in their case study of Benin, although they strongly warned against putting a premium on the activities of cleaning and cost recovery, and not on community education and the promotion of health activities. Although there is a need to mitigate what appears as participation, given the skewed nature of the process described by Azefer and Bradley (1996), it is certainly one step among several of policy sequencing in the field of primary health care.

As to the maintenance of the premises, hiring health personnel, drug costs and other operating costs are claimed to be part of the criteria for people’s adherence to the goals of the primary health services (PHSs). However, owing to allocative inefficiency within the public-sector health services, a direct link between participation and cost recovery is misleading. Five propositions are put forward to improve the cost-recovery scheme and also promote participation. First of all, it is of interest to maintain the link between the administration of the health budget and that of health care as it currently operates. Secondly, it must be the level of the health costs, which determines people’s financial access and, henceforth, the utilisation of health services. Thirdly, other factors (such as information dissemination, community education and the training of local leaders, transparency in the management and decision-making) may contribute to an increase in both participation and utilisation. Fourthly, it is of interest to devise a full-fledged compensation scheme for assisting a number of deprived PHSs. And lastly, contrary to the uniform level of health costs advocated within the Couffo region, it is rather suggested that spatial pricing may improve the utilisation of public facilities when handled with care.

Ye and Yezer (1992) claimed that spatial pricing is a solution to effective utilisation of health services. Although this claim must be taken with care, we argue that the utilisation patterns discussed earlier allow such a management measure with minimal spill-over effects. Following the proximity and market-route principles underlying the utilisation of health services, which have been extensively discussed earlier, spatial pricing might be manageable if combined with charging richer people for health services in the Couffo region. A hazard, however, is that wealth-ranking is fraught with aberrations in Benin, especially in rural areas.

**Intermediate-level support for primary health services from the sub-prefecture**

Following Vaughan and Smith (1986), the implementation of primary health-care policies exposes the need for more effective management support at the intermediate or sub-prefecture level. Indeed, the supervision and monitoring of the PHSs are part of the function of the referral centres at the sub-prefecture level. The latter, however, are subject to conflicts between health professionals and members of the LHMCs. Village representatives stated that indistinct planning of supervision and control would exhaust the meagre community resources available. Consequently, members of LHMCs successfully opposed supervision from the intermediate
level. This signals a misapprehension of the organisational reforms. At least two reasons may be advanced. First, there is a deliberate action to evade control from above. This can only happen when representatives of the village communities believe that government support for the local PHSs is lacking, maybe because the bulk of the operating costs are fully covered by local health budget. Second, community representatives cannot link supervision with any incremental improvement of quality and productivity, as they believe it should be. In both cases management issues have remained unresolved, since technical efficiency is unlikely to be achieved without equity concerns and a clear set of goals applied with transparency.

Inter-sector activities particularly with respect to agriculture as a source of finance
It should be readily stressed that, given the health sector’s low endowment with resources, most inter-sector initiatives may evolve from other well-endowed or resource-creating sectors, agriculture, for instance. This aspect of the inter-linkages between the health sector and the agricultural sector is one objective of the present study.

Community and individual participation in all aspects of the primary health services
It was found that people’s health-seeking behaviour barely changes and that technical inefficiency prevails in overall health services. These results derive from the partial involvement of the elected village representatives in health programmes. Accordingly, Sanoussi (1994) and Azefor and Bradley (1996) urge the expansion of promotional health activities and less emphasis on cost-recovery within the local health management committees.

Co-operation and co-ordination between the public, private, confessional and other groups of health-care providers
The need for steering committees other than the committees in charge of the health-care system is crucial. Although the existing committees may be enlarged to accommodate other actors of the health system, the bias towards the health-care system prompts to a special focus on resolving not only material issues related to the cost-recovery scheme and the maintenance of the premises, but also institutional issues related to the effective involvement of beneficiaries.

Synthesis of collective action in the distribution of agricultural input services (cf. figure 8.2)
Figure 8.2 indicates the possibilities to blend public, private and local organisations throughout the distribution processes. First of all, the definition of strategy expounded in the policy document takes up the cost-recovery approach that fits the goal of full coverage. Secondly, the structure of the distribution brings into play more than one group of actors who interact during the processes. The adoption of a cost approach is only characteristic of market relations. The relations between buyers and sellers are more hierarchically managed. Therefore, the structure of distribution is fairly hybrid, neither pure hierarchy nor pure market. Thirdly, core capabilities are singularly confined to the public sector, owing to the long-standing monopoly during the first three decades after the independence. Unlike the agricultural sector, there are knowledgeable private practitioners looking forward to starting private clinics, but the certification process and the absence of fair competition between the private sector and the public sector handicap them. In such circumstances, the bulk of knowledge production and dissemination remains with the public sector. Nonetheless, one should be aware that the public sector is very weak in organisational management. This logically justifies the adoption of structural reforms. More importantly, the public sector is much less familiar with collective action as a hybrid form of organisation based on the bottom–up approach.
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In figure 8.2, the ellipse with the solid line may represent the present state of the distribution of health services, while the ideal type of the distribution is the one represented by the dotted line. In fact, reforms advocate a new strategy that shifts from the costless approach of the public sector to the costly approach, although the concern about full coverage remains. The structures of distribution may blend both market and hierarchical relations. Recommended core capabilities, during the transitory stage of the reforms, on the other hand, are those of the public sector. This is explained by the deprived situations observed within the other sectors before the reforms and the long-standing monopoly of the public sector.

In the long run, however, the delineation between both ellipses will blur, because the government may soften the regulation of the private clinics concomitantly with alleviating its role in the distribution of PHSs. This supposes that the public sector will contribute to a great extent to defining the strategy for the distribution processes. At the same time, the structure of such a distribution will be consolidated as a hybrid type of organisation, fostering actors' ability for negotiation. Concerning knowledge capabilities, their dissemination will be led by the private sector as soon as the dynamics of this sector is released. The rationale is that the characteristics of this sector fit well the requirement for PHSs. This also supposes that the public sector concentrates on curative and more in-patient health care. To date, however, if the private sector singularly excels in organisational management, the public sector remains the last resort for knowledge production and dissemination. What remains constant, though, is that the structure is unlikely to revolve around pure hierarchy or pure market, as originally thought.

8.4 CONCLUDING COMMENTS

It was found earlier that the public-sector organisations play the most important role in the health sector, whereas a leaner and more cost-regarding state was expected. The non-governmental health organisations and institutions, on the other hand, hold a very insignificant weight at least in this transition stage. The health reforms hardly live up to expectations because of government failures.

The failure on the side of the government invokes two important issues. The first issue relates to the freezing of recruitment in the public sector. The World Bank's advocacy regarding retrenchment in the public sector has been applied indiscriminately across sectors. As observed earlier, the health staff shortage is acute in the Couffo region, especially in rural areas, leading to the rise of health costs through hiring health personnel. The second issue concerns the certification procedure, which favours rather than discriminates against the parallel channel. Although people voice against malpractice within the parallel channel, red tape and rent seeking practices in the certification process leave them with no alternative but to avail themselves of health services from the incriminated channel. Therefore, the government fails to bring about equity, trust and transparency through the reforms.

Regarding people's utilisation of health services, it was found that new needs arose because of residents' proximity to a health outlet, and the strategy of distribution implemented by the LHMCs. Concerning proximity as a guiding principle for people's utilisation, this is not unexpected. It confirms the fitness of the health-policy reforms, hence the advocacy of bringing health services closer to the users. This then corroborates why under-utilised PHSs are in need of management restructuring, because reasons other than people's willingness to use those centres are necessarily at the heart of the present state of utilisation.

It was found that the extent to which health reforms influence people's utilisation of the formal PHSs hinges on the other non-governmental health services, the certified clinics, the parallel channel, and traditional medicine. Indeed, people's utilisation shrank after the reforms,
mainly because of the rising health costs. Concomitantly, people felt the distance friction with less intensity after the health reforms. Apart from the access constraints, broader organisational aspects may also influence people's decision to seek health care in the public sector. Aspects derived from the PHSs with significant increases in attendance figures after the reforms include, among other things, taking health services to users and supply promotions such as the absence of user fees, a drastic reduction in drug costs and an unusually warm reception of users by newly appointed health personnel. The organisational arguments, although insignificant before and after the reforms, bear out that sub-prefectures with new outlets show increasing trends and those without new outlets show decreasing trends in attendance figures.

Regarding the relationships between different sectors, people rarely oppose the modern health services to the community health services. People resort to traditional medicine or alternative medication in the first place. Then, they do consult the modern health sector as a last resort. Based on people's perception, however, the formal PHSs and the parallel channel are incompatible. The rationale derives from that the non-governmental clinics are given formal certification to compensate for the absence of formal PHSs. According to people's evaluation, the non-governmental health services and the community health services are also exclusive. Recall that one has to be emphatic with perceptions obtained from household-heads on the distribution of primary health services. These may overrate or underrate the overall perception of household members, because of the plurality of decision-making units within household.

Although there is a need to mitigate what appears as participation, given the skewed nature of the process described by Azefor and Bradley (1996), it is certainly one step among several of policy sequencing in the field of primary health care.

One way out of the government failure to directly finance the PHSs is to allow for inter-sector resource mobility and inter-locality compensation or equalisation 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 the governmental health authorities and people's representatives in the LHMCs.

It should be pointed out that this chapter has addressed the cost-recovery scheme in the health sector taken alone. Recall once again that most sectors are undergoing re-organisation, and that one sector hardly stands on its own. Moreover, efficiency in a sector must not be assessed in isolation from other related sectors, complement being the rule rather than the exception. For instance, substantial resources are extracted from the agricultural sector, in order to finance the health sector. Overall performance of the cost-recovery scheme suggests substantial monetary surpluses, questioning then the equity concerns of the reforms. Recall also that remote villages are prone to high user-charges because of the nature of the health costs. These costs comprise high shares of personnel costs, to compensate for most civil servants' reluctance to work in the rural areas under severe living conditions. Recall further that the cost-recovery scheme, on which the health reforms are based, nearly collapses because of the alleged misappropriation of the monetary surpluses by the government sector. Deriving surpluses through a scheme initially aimed at alleviating financial strains on the poor segments of the rural population may be the least evil, but ignoring the other deprived social sectors, such as agriculture, really does significant harm to the rural development process. It appears that, for a sustainable local development, an overall consideration of the financing issues, all sectors included, may yield a better balance between the health sector and other resource-needy sectors.
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NOTES

1 The service area for a formal first-order health outlet is the area covered by the commune it intends to serve. The group of beneficiaries consists of the resident population of such a commune.

2 The notion of awareness may be aligned with that of revealed needs. The level of awareness derives from that people decide to seek health care at a formal health centre only after evaluating their needs and the set of alternatives they face. However, it is instructive to point out that a visit to a health outlet is hardly a first-instance choice. More often, people exhaust all other alternatives before resorting to the nearest formal health outlet.