BUREAUCRACY, BAMAKO and BASIC HEALTH SERVICES:
Reflections on Community Participation and National Programmes

By Reginald Herbold Green

> We must look our mistakes
> squarely in the face,
> lest we fall into repeating them.
>
> - Rui Balthasar Santos
> Rector Eduardo Mondlane University

Introduction

Community participation, user charges, universal access to basic health care, liberalisation, better governance, prioritisation are all slogans or themes frequently referred to, and bowed down before, in a wide array[1] of studies on the crises afflicting Sub-Saharan Africa in the 1980s and, more particularly, on ways to overcome them. None is particularly new - the initial community development enthusiasm at state level in Africa dates to the late colonial era of the 1950s and early 1960s. User charges for basic health care in rural areas were (faute de mieux) central in Christian health care work in Africa at least from the 1920s. Universal access to basic health care was a frequent - and not purely rhetorical - political goal and an occasional priority in resource allocation in SSA at least one and one-half decades before "Health for All by the Year 2000" was declared in Alma Ata under WHO leadership at the end of the 1970s. At least one central support system cum community staff cum community payment for drugs and local staff had existed on a fluctuating but moderately broad base from the late 1940s until the post-1987 Somalian civil war destroyed it (at least for the time being). Nor is prioritisation either new nor necessarily associated with advocates of narrowly limited state roles, e.g. "To plan is to choose" is a quotation from President Nyerere's launching preface to Tanzania's 1969-74 Five Year Plan and its operational meaning is illustrated by the phasing of literacy and universal primary education build-up over fifteen years even though both were genuinely high priorities throughout the period. Better governance in the sense of administrative reform has been a pervasive policy (or more accurately policy study) theme for decades - the tomes on staff structures, training schemes and

procedural regulations prepared (and in some cases implemented) in Sub-Saharan Africa since 1945 would fill a fair sized library and take a reasonably long academic lifetime to read. To do so might not be a very fruitful prioritisation, as one striking characteristic is the limited number of themes and approaches and another the tendency to move in loops or circles from one approach to another and often back to the starting point. This journey is characterised by almost always seeking structural change as an initial option; rarely trying to build on the strengths of what existed and virtually never sticking with any one approach long enough to have any very clear reason to suppose it could not be made to work.

To look at this record, even by personal recall over a quarter century or by dipping into a non-random selection of contemporary documents and studies suggests several things:

a. a tendency for "new" initiatives to be remarkably innocent of any serious analysis or understanding the historic context out of which (often in reaction to which) they arose;

b. abiding concern with certain quite real problems sometimes leading to cumulative change - e.g. the shift toward primary health care from the late 1960s; but more frequently

c. rapid changes of direction both in international development institution and academician's themes and priorities, frequently fairly characterisable as "fashions", contrasting oddly with these same bodies' and persons' calls for long term perspectives, institution building and building up predictability and continuity;

d. parallel to substantial changes in actual policy and resource allocations in Sub-Saharan Africa, by no means wholly resulting from - nor on the same timetable as - the international "development fashions";

e. a tendency to move in circles (or if one is very optimistic, spirals) returning to or near the starting point - but without recognizing it, much less knowing it for the first time, more frequently than on a coherent sequential path with occasional diversions or backtracking;

f. a relatively blind faith in the ability of professionals[2] (bureaucrats, economists, doctors, etc.) to "get the job done" if only they could be properly trained and motivated and "structures" reformed, combined with relatively little analysis of contextual or philosophical problems and a good deal of abuse of present and past actual performance by present and past actual professionals;

g. a near total lack of serious reflection on how central national programmes initiated by high politicians and professionals in the capital (at least in the articulated operational sense even when at least partly in response to genuine self-perceived problems, needs demands of ordinary people and communities) could be linked to genuine community participation (which is inherently diverse and uneven to the point of driving a normal bureaucrat up the wall);

h. a failure in official statements and programmes or quasi-official analytical to address political system, political process, power allocation and maintenance and related macro political economic issues seriously with most economic academic writing either duplicating the official lack of specific attention and/or referring to these issues in non-operational symbolic terms ("honesty", "political will") and the specialist political science work often in such narrowly political and country specific contexts as to be little more integrated into policy programme or personnel structure formulation or resource allocation prioritisation even at country and still less at cross-country level.

To each generalisation there are exceptions. The largest clusters are the "Africa has set out wrong"[3] group. Many are close to being mirror images of the mainstream writings (of the same time or of a decade before). At least implicitly most are based on prophetic models of what ought to be in contrast to the apocalyptically denounced present and recent (often very recent and not wholly typical) past.[4] In fact the underlying models (modernisation, pluralism, various varieties of Marxism, neo-liberalism) are the same as those of the more positive writers. As a result nearly every set of such approaches has at one time or another been seen actual attempts at articulation and implementation. These have rarely been

notably more successful than those proceeding directly from affirmation without previous systematic denunciation. Indeed in some cases (including notably Dumont himself) the progenitors after transitory enthusiasm have denounced the programmes they helped inspire as even worse than the practice they sought to replace!

The temptation after surveying this record is to echo sad reflections on mortality from "when all is said and done more is said than done" through "le plus ca change, le plus c'est la meme chose" and "vanity of vanities... nothing new under the sun" to "twenty years largely wasted". That too has its limitations:

a. it is not an approach open to actual Africans in Africa whether ordinary women in the fields and men on the street or bureaucrats and other professionals or politicians. Despair and detached criticism with neither expectation of, nor hope for, positive change are primarily amenity consumer goods (or for some writers working capital) of outsiders;[5]

b. It is unduly negative - a rather impressive catalogue of partial successes in governance, in administration, in institution building, in rising literacy and falling infant morality, in production, in thwarting externally designed and/or executed military intervention, in survival, in continuing to hope and to try can be compiled. Similarly, in some areas - including primary health care - there has been forward progress on a cumulative basis in conceptualisation and training which provides some real foundation for rehabilitation of quality and expansion of quantity if resources (not least for living wages to personnel) and foreign exchange (especially for drugs) can be mobilised. The relative failure to do so relates in part to "good news is no news", in part to treating the successes as a matter of course needing no comment[6] and in part to an understandable prioritisation on what needs to be done that is not now being done (or not done well);

c. it also fails to be contextual, taking diversity into account (at levels ranging from macro continental to basic community). The governance of Tanzania or Zimbabwe is not that of Uganda nor Zaire

either on a snapshot nor an historic moving picture basis. Nor are the economic performances of Botswana or Kenya very similar to those of Mozambique or Ghana. As a result it frequently fails to provide even a rough blueprint of the specific present of any country nor a sketch design as to how it might be altered.

These points are not unique to Africa - they apply in varying degree to work (applied or otherwise) on development, on governance and on administration much more generally. The African 'case' may pose them more starkly because of the high levels of failure common since 1980 (and in some cases much longer), the rapidity of change in Sub-Saharan Africa and - even more in perceptions of it (by Africans and non-Africans alike) - since the 1950s, and the degree of abiding external influence on policy and praxis in SSA which makes it more attractive to those wishing to make experiments and see their ideas put into practice.[7]

That this paper focuses on the interaction of community participation, national prioritisation and resource mobilisation in relation to basic health services in certain Sub-Saharan Africa contexts over the past few years has five reasons:

1. basic health care is important;

2. community participation both normatively and operationally has substantial potential;

3. coherent national priorities' interaction with diversity relating to local preferences, possibilities and needs is a topic of abiding importance and difficulty;

4. the Bamako Initiative (on "health for all by the year 2000", community participation and resource mobilisation) and especially its partial implementation (or perversion in implementation depending on ones viewpoint) brings together most of the themes or slogans sketched and cursorily surveyed above;

5. the author has been working on this set of issues in Sub-Saharan Africa, most immediately and concretely in Mozambique from 1986, but in a broader sense in many more countries since 1960.[8]

Before looking at the Bamako Declaration as adopted and the Bamako Initiative as partly implemented (Bamako 1 and Bamako 2 as some critics call them) it is useful to glance at health service administration/bureaucracy and at the community participation case as usually made in respect to health.

Of Bureaucrats and Bandages

Classic health service administration is at first glance the very model of a model Weberian bureaucracy. It is hierarchical and maintains very substantial autonomy from outside interference in its functioning (especially by clients). It receives cases and screens them into, a) nothing to do (i.e. not ill, no preventative programme needed); b) handleable at this level (i.e. routine case or prevention activity); c) referral upward (i.e. special problems) - in some systems at four or more levels (health post, health centre, rural hospital, urban hospital, reference hospital plus parallel or associated preventative service levels).[9] Criteria for screening and action or referral are laid down uniformly for the system and - at least in principle - known to all staff. At each level most cases are screened out or acted upon within the prescribed framework and only a minority (usually a small minority) referred upward. Individual cases (i.e. implementation) rarely if ever reach top officials let alone Ministers.[10] Policy operates in the opposite direction - largely proposed and totally articulated by experienced bureaucrats (who may or may not be medically trained) with professional inputs and political initiatives.[11] It is set out in concrete terms and sent down the line to be acted upon. Functional coordination (e.g. physician-surgeon in systems practising that odd historic division) is common at middle levels within the service, but strategic (e.g. district medical stores - district health officer) is very uneven and inter-institutional (e.g. with agriculture on the availability side of nutrition or commerce and finance on nutrition's cost/income side) are rare, very high level or specialised institution encapsulated (entombed?) and recent.

But in three other respects health service bureaucracies are atypical. First, they give a much higher role to the medical[12] professional vis a vis the specialist administrator than is normal. Ministers and top level civil servants are frequently doctors; hospital heads (and actual administrative bosses) were until recently usually doctors. Only educators in education and - more recently - economists, especially but not only in finance, have been even vaguely comparable in successfully establishing the professional specialist as boss and the professional administrator as supporting staff.[13] One has Surgeons General (and Chief Economists); one does not have Engineers or Architects General (nor engineering heads of government wide engineering cadres).

Second, health services administration is rather more decentralised than structural charts would suggest, especially on the curative side. Hospitals do not in practice treat (or not treat) patients identically. They often do not provide comparable services at the same level nor have even vaguely comparable internal administrative processes nor unit costs.[14] This may result from the professional specialist domination noted above because the specialist professional has less built-in respect for general orders than the professional administrator.

Third, health services historically have either begun the screening process at a higher than normal level (e.g. doctor not nurse or para-medic) or referred a very high percent of cases to professionals at higher levels of skill than are necessary, (i.e. doctors rather than nurses and medical aides).[15] At least the devolution of the bulk of cases to primary health units with basically paramedical personnel, limited basic drug and vaccine stocks and guidelines for referral which is at the heart of the 'phc revolution' makes no sense unless the previous practice suffered from this error on a grand scale. In administrative theory/bureaucratic process that is inefficient, e.g. primary schools do not refer all examination results and homework to the Head, pump repair technicians in water are expected to handle routine maintenance and repair without reference to the District Water Engineer.

There have been some patterns of change in administration of health services as in other branches of administration. The role of specialist administrative professionals has expanded and other professions than

clinical medicine have been given wider roles (e.g. in running physical facilities and managing stocks and flows, e.g. of drugs and vaccines but also in policy formulation, health service economies and the preventative/public health sector). This has parallelled an attempt to reduce certain aspects of decentralisation at least largely in the service of cost control. For example, national drug lists and standard "hotel-keeping" cost targets for hospitals, do reduce unit or professional level autonomy and in that sense at least are centralising tendencies. Less uniformly there have been attempts to reduce hierarchicalism and to empower 'lower' level staff (variously titled) to deal with the up to 80-90% of cases which do not require a doctor's judgement as to treatment or non-treatment. This empowerment has three aspects - additional training for low level staff or new intermediate cadres, broadening the scope for action at that level and more detailed guiding rules on action or referral.

There can be tension between these two types of shift. National drug lists centralise and increase hierarchical dominance; on the other hand, authorisation for paramedical personnel (or medical aides and sub-pharmacist dispensers) to diagnose and prescribe for certain common illnesses from a limited drug list decentralises and reduces hierarchical dominance. Many primary health care strategies overtly, and for good reasons, advocate and seek to operate on both fronts.

Both the centralising and decentralising shifts have in general been achieved (to the extent they have) in the face of opposition from a majority of medical professionals. They do not make the health services bureaucracy more open to inputs or influence from clients. For example, a potential or actual patient-doctor association for a hospital is virtually inconceivable except as a public relations or fund-raising device, although parent-teacher associations for schools are relatively common and do at least discuss policy and professional practice even, if their influence on them is usually rather marginal.

Of Communities, Participators and Patients

The colonial African community development/animation rurale drives of the late 1940s were not primarily concerned with health but with social welfare, adult education and production. However, they came to include

pure water supply, nutrition (on the dietary and food preparation side) and environmental sanitation plus - less usually - basic health education and village dispensaries.[16] Thus they did have a not insignificant public health/health support component.

Nor were these drives particularly participatory in the normal sense of that term. The British and French colonial patterns were basically Fabian corporatist and French left Catholic as to ideological and philosophical foundations. Development from Below[17] was a target. At least implicitly was Small is Beautiful[18] and development largely carried out and financed by those below. But that development was to be along lines set by the professional community developers and preached to (at?) those who were to carry out its precepts to "better themselves". In practice the nature of preaching and of participation was very diverse. Rigid authoritarianism (both overt right colonial bureaucratic and pseudo-Freirian left or right subliminal) was common but so was pragmatic, moderately listening and sympathetic education with the cd officer responding to villagers' (cd and ar were overwhelming rural oriented) expressed ambitions, aspirations and proposals.

One frequent problem with community development was that it had a Western individualistic component which consorted oddly with its community focus and that its practitioners rarely bothered to study African community structures or - except by accident - to relate to them. This may relate to a second common weakness - failure to develop sustainable, long term community resource bases. A contributory factor was continued dependence for initiatives, professional inputs and programme development on the cd cadres, i.e. an absence of cumulative community institution and skills building. Where closer links with, up to engrafting on to, historic community structures happened the record on continued finance, institutional sustainability and - to a lesser extent - access to specialised skills were often overcome. However, the failure - except in adult education - to build inter-community links meant that even in these cases the new programmes tended to remain dependent on the cd organisation as patron and channel to resource allocators with the communities as isolated dependent clients.[19]

This form of top down community development has survived - e.g. the Harambee dynamic in Kenya, locality (including absent member) groupings in many African countries. From the administrator's point of view it has usually been seen as a useful complement to government programmes constrained by resources (and thus like church schools and hospitals to be taken over by the state when finance and personnel permitted). Concomitantly, however, it has been viewed as rather disorderly, hard to control and in danger of pre-empting government resources when it took the form (as it often did) of providing infrastructure for health, education, roads or water which were then to be operated by the state.

Community participation in health conceptualisations are related to the public health, environmental sanitation, water and adult education aspects of traditional cd. They assume that communities will increase their involvement in and make added resources available to programmes with which they are integrally involved. The Front Line Health Worker approach stresses education, promotion, first aid and very basic (say 20-25) drug distribution for the commonest diseases to be carried out by community chosen, at least partly community financed persons, provided with state (or external agency) training. That approach goes beyond the traditional doctor/hospital model in two senses: it is a more financially feasible route to universal access to health services and it takes a broader public health/environmental context approach rather than a narrower clinical/curative one.[20] But it does not really address the issue of patient participation in own health and treatment nor does it resolve the problem of how the nexus of central health programmes and targets together with local accountability of front line workers can be resolved if <u>what</u> the flw's do as well as <u>how</u> they do it is part of accountability. In the cases in which it has assumed near total support of the front line workers plus payments for drugs from the communities after moderate and brief initial resource injections, it has usually, but not always,[21] proven to be unsustainable. Successes tend to have outside as well as community resource bases plus very dynamic community (or cluster of community) leaders. They are also usually in areas with above average (by the standards of that country's rural areas) household cash incomes and with a context of community action broader than health services alone to carry out concrete projects or programmes. The number of demises of apparently stable programmes with the loss of the programme's leader, the key link person with the state (or Christian) medical system and/or of external (including state or

Christian medical system) partial funding suggest much more analysis is needed of replicability and sustainability requirements.

Bamako - Basic Reaffirmation or Betrayal?

The Bamako Declaration of the African Ministers of Health and the Bamako Initiative it launched have aroused enthusiasms and criticisms of some vehemence with somewhat surprising membership in each category.[22] Both the generation and the implementation of the Declaration/Initiative illustrate some of the complexities and problematics of health politics. On the face of it the Declaration appears to seek to further an agenda based on universal access to basic medical services by the year 2000 target set out in the Alma Ata Declaration. Its themes include beginning with primary preventative and curative health care, decentralisation and community involvement in fund raising and fund use. Two pre-existing community/national health service/external cooperating body programmes - in Benin and Senegal - probably drawn on in drafting the Declaration are usually seen as having had that impact.

The 1987 Bamako Declaration of African Ministers of Health can be seen as a reaffirmation of Health for All by 2000 and an exploration of how it can be made more than a slogan under conditions of extreme economic stringency with low growth, stagnation or decline in real resources available to central health budgets. Rapid progress in broadening access to health services in Sub-Saharan Africa in the 1960s - albeit from a very low base - began to falter in many countries in the 1970s and to go into reverse in a majority in the 1980s. Maintenance, equipment and transport were early casualties followed by drugs and other operating supplies including patients' food and linen. Reduction of real salaries damaged health personnel morale further and led to skill drain, as well as to privately imposed user charges in nominally free facilities and to open corruption. In respect of drugs, as well as of equipment and transport, foreign exchange constraints often choked off actual availability even when local currency finance was provided. Overall the quantity, quality and range of services eroded and in some countries and many peripheral areas (largely, but not only, rural) declined to near the vanishing point.[23]

The initial deficit pruning by expenditure cutting phases of several, though not all, structural adjustment programmes (e.g. Ghana and Mozambique but not Tanzania) led to further erosion of real resource availability. In certain cases this was offset, so far as drugs went, by additional grant aid but such aid rarely was prioritised, allocated and programmed coherently enough to be effective (i.e. it left glaring structural gaps which in many cases made drug and personnel use relatively inefficient for want of complementary inputs). World Bank attempts to reverse these shocks and the longer running erosion of health services[24] have included restoration of central governments real financial allocations to pre-SAP levels, additional soft foreign finance and user fees. The case for the latter was a combination of a neo-liberal belief that users should pay and a pragmatic (if not necessarily correct) perception that such fees could augment total resources available to health services significantly.

Bamako faced these challenges and initiatives by calling for greater resource provision by: external donors, central governments and communities/patients. The external donor role was perceived as crucial to breaking the foreign exchange bottleneck. It was also (rather optimistically[25]) seen as a means to support establishment of national basic drugs lists (by level of care) and improving efficiency of purchasing to lower costs. The central government appeal appears to have been more a call for halting real cuts or restoration to levels well below those of - e.g. 1980 - than a serious attempt to gain substantial increases. So the communities and individual users were seen as the main hope for restoring adequate health service finance. In this context it was argued that users did value health services and, in fact, were spending more on private ones because public services were deteriorating. Those payments could be clawed back to augment Ministry of Health budgets.

The community/patient involvement theme is, in all fairness, advocated on broader grounds than rescuing Ministry of Health finances and medical professionals' incomes. Community participation is seen as contributing to health for all by causing more effective communication between communities and health service professionals and more personal consciousness of healthy and unhealthy behavioural and living patterns. And in the Declaration community control of uses of funds is advocated, albeit how this is to be achieved in the case of revolving drug funds (whose expenditure is on centrally set lists

and goes straight to the centre) is less than self-evident. This point is crucial both to what the Declaration may have meant at Bamako and does mean in practice since.

That is so because the main instrument proposed is revolving drug funds, initially funded by the counterpart of drug donations, but kept going by user fees. These it appears are to be set drug by drug, paid by the user, collected by the community, paid over to the state health service locally and largely or totally remitted to the central Ministry.

Ironically, the starting point for the drug fund concept, rural Tanzania, was not a relevant example of such a programme. Tanzania adamantly rejects full cost charging of drugs to patients as inherently in contradiction with universal access.[26] It is prepared to finance the local currency cost of basic drugs from the budget. The basic problem was, and is, import capacity which cannot be solved by local currency drug charges. In practice it is arguable that a reductionist version of Bamako can and in some states will be used with highly negative results - including letting the government off the hook on its duty to provide phc, and of stifling community initiative as opposed to subordinated community actions taken at the behest of the centre. Or - to put it differently - it can result in maximising central extraction of resources from poor, peripheral communities.

Synthesis or Unresolved Conflict?

Bamako represents an attempted synthesis of three very different (and ultimately contradictory) health politics approaches. The first is partly ideological and neo-liberal and partly a pragmatic response of hard pressed resource mobilising/allocating ministries (ultimately finance but also health). In the neo-liberal vision basic health care is arguably not a state duty and fees are of value in and of themselves. The resource mobilisation/allocation focus accepts that normal state revenues cannot be made to cover a basic primary-secondary-tertiary health services system (normally untrue) and seeks either to raise more funds from patients/communities to expand services (Health Minister optic) or to substitute them for allocations from general tax revenue (some Finance

Ministers' view). From this optic, community participation is useful to increase resources collected and to lower collection costs and personnel problems for Health and Finance.

A middle approach is committed to health for all and - to varying degrees - to community participation well beyond finance and is quite pragmatic as to means. Community finance is perceived as raising total resources, increasing community influence over programmes as well as making health staff at least partially accountable to communities (users), and providing a first step toward broader (than paying) community involvement in improving their members' health. This is the largest bloc of proponents but also the one tending to have the least clear and the most co-optable agenda. For example, UNICEF's commitments to benefitting the poorest and to community participation in policy decisions is very real (albeit not always fully served by emergency campaigns composed of simple, centrally provided components which are initially vertical and may or may not be integrated into subsequent primary unit programming) are quite genuine. But how centrally imposed, full cost drug charges/revolving funds (which UNICEF backs) are compatible with either is hard to comprehend.

The third strand - largely ngo and church medical services based and relatively weak in Africa - is committed to health for all but shares the neo-liberal aversion to state involvement It sees community (or patient as such) payment as a necessary means to replace an incompetent, intrusive, manipulative state presence and to empower/enforce community determination (guided by platonic guardians from the promoters) of health services and health programmes.[27]

At the level of general declarations an alliance can be forged (in both meanings) among these strands. Practice is likely to be rather different.

One - not uncommon - approach is for the centre to set up patient fee systems by service and by drug (perhaps with complex, hard to work exemption and cap provisions[28] plus complex access, low resource backing social funds). These charges are then to be collected by communities or local health units for the state and largely or wholly remitted back to the centre. This may well not be the intent of the Declaration; it tends to be the operating face of the Initiative.

That is a parody of community participation and a clear case of an authoritarian, inflexible structure for sucking resources out of peripheral communities with no guarantee of an equal, much less a substantially larger, return inflow. It is more likely to be an aggravation of the problem than even part of the answer.

To posit this danger is neither to be alarmist nor to assume ill-will, malice or duplicity. Ministries of Finance are hard pressed - any cost reduction or revenue augmentation looks like manna from heaven, especially if someone else is to bear the bother of collection. Ministries of Health, under the combined influences of needing more funds and being subjected to World Bank missionary zeal for fees, are all too prone to adopt complex, rigid charge systems with no serious consideration of access, administration personnel or net revenue considerations and with no or unworkable safeguards for access by the poor. (Predictably doctors are not very good at devising such systems nor working through their impact. The skills needed to do so are not clinical.) Further, Weberian bureaucratic central revenue collection systems, fee or charge schedules with defined, fixed amounts and few judgemental exemptions are desirable; indeed arguably necessary. But in terms of allowing real community participation or avoiding denial of access they are often nearly fatal.[29]

Community Based Successes - Miracles, Fautes des Mieux or Mirages?

At this point it may be useful to glance back at two success stories - Somalia and Benin - to see whether, to what extent and why they are successes. (The Somalia case is considered as of 1987. 1988/89 civil war convulsions would have destroyed any broad access phc system, not just the one that existed in half of rural Somalia.)

Somalia has a recurrent budget 90% engulfed by security, debt service and general administration; all objectively underfunded. Recurrent health spending as of 1987 was about $1.5 million ($0.3 per person). External funds (largely used outside or in joint ventures with the Ministry of Health) were of the order of $25 million and community inputs $5 to $7.5 million. In blunt terms there was neither a serious national governmental health system nor any

chance of creating one and donors needed channels to reach the rural population of whom at least half are seasonally migratory ("nomadic") livestock growers or mixed farmers.

Communities chose part-time health workers to be trained for 6 weeks to 6 months (by agencies which sometimes hire in government personnel) in simple diagnosis, prescription and health education. On their return they served the communities in return for payment in milk, meat, animals. Basic drugs were imported and delivered to pick up points by agencies (again hiring-in some government personnel) with the community (on any basis it chose) paying more or less the landed wholesale cost. Especially in the northwest where it goes back almost 50 years, the system worked reasonably well. But it was chosen faute de mieux, not as an intended demonstration that a state medical system was dispensable.[30]

The Benin case is rather different, albeit it also includes charges for drugs. It operates to shore up a debilitated state medical service, not to substitute for it. The division of costs is - nominally at least - roughly for the state to provide and pay personnel, the patients to pay for drugs and the community to organise/carry out repairs to health posts and clinics. In practice donors provide most of the drugs to the state so that directly or via counterpart funds the cash paid out by the communities in fact goes to salaries or general administration, not to increasing the supplies of drugs available. The only non-problematic community element would appear to be the facility maintenance one. However, even if the changes de facto go to health service personnel this may improve service if they would, in fact, otherwise be paid erratically. In that case it is another faute de mieux case.

Community Participation Reconsidered

Serious rethinking of community participation - with an emphasis on flexibility and community located use of community mobilised resources my be needed for Bamako to mark a positive point of departure:

a. the community would decide in what form it will provide resources, e.g. food (or help in fields to grow food) for health workers, materials and labour for health post and housing construction and/or maintenance may be

more readily mobilisable than cash but equally useful in augmenting central resources available for health service delivery;[31]

b. the community would select the means to mobilise resources (user charges, annual assessments, semi-progressive "contributions") rather than being handed a rigid system from on high. The same principle applies to exemptions from/ceilings on charges - the community and community located health workers (at least in rural areas but also in many poor urban neighbourhoods) have the knowledge and the social matrix to operate these while the central government rarely does;

c. preventative and educational services (including well baby clinics, family planning, nutrition, sanitation) would be exempt at least until a firm, broad demand base, resting on personal experience of the value of these services has been built;

d. cash raised at community level would be spent there (e.g. drug charges if levied as such used to pay post and clinic salaries) both to reduce administrative/bookkeeping nightmares and to assure the community its money really does augment its health services; [32]

e. communities could usefully be encouraged to view health services, pure water, fuel, nutrition and food security as inter-related and local level government health personnel provided with basic training to help develop that approach. In many contexts significant community resource mobilisation for these health supporting sectors may be more practicable than for health services proper. Thus, if one views the health context broadly, they may be more hopeful ways of augmenting total central government resources devetoed to enabling people to be healthy than direct health service user charges;

f. extension, promotion, education need to be extended, backed up and catalysed by community chosen, government trained, community based "animateurs" who may be full or part-time. In very poor communities - or in disaster periods as in Mozambique since 1983 where communities can, as a result of South Africa's proxy war of aggression, no longer afford to

pay their animateurs - full or partial state finance would be needed. In such cases the principle of empowering communities to act for health overrides that of fiscal self-reliance.

These guide-lines would seek to maximise increases in health and health conducive services, not in central government revenues. Health fees are unlikely to raise by more than 1% of state budget revenues (or 10% to 20% of recurrent health costs).[33] That amount can usually be raised by fairly minor indirect tax shifts (e.g. $0.1 per bottle of beer or packet of cigarettes). Whether a government unwilling to give that much priority to furthering health for all can reasonably be expected to use community raised resources to increase health budget provisions (let alone those to phc and rural areas), rather than to substitute them for tax revenue sources then redirected elsewhere, is at best an open question.

What these guide-lines do not posit is the appropriate interaction between state and community structures and the problems it is likely to create for each. Accountability to a community and carrying out even broadly defined national programmes can lead to tensions. The relationship between an administrator and a community based worker partly funded by the community cannot usefully be viewed as identical to that with his own 'lower' level staff. How intractable these problems are is less than clear because they are rarely articulated fully in advance and overcoming them is not normally set as an administrative priority

Diverse Communities, Flexible Systems and Central Coordination/Administration

In principle community choice of how to raise which resources poses few problems if the level is agreed. In practice it does if patterns vary significantly from district to district - as it is likely to do. How raised is less problematic except as it interacts with which resources (e.g. if poor households make payments in labour and food then those resources are not fungible into drugs or fuel). The problem may not be insuperable if there is a total financial allocation per district allowing for - say - 10% of total costs to be community raised and the specific uses of the central and community contributions are negotiated and specified in the budget at district (or at most regional/provincial) level. That,

however, requires a degree of budgetary decentralisation which is quite unusual and, probably, hard to operate.

A second problem is how much or what proportion of district costs should be community funded. The easy route of a uniform per cent for all districts (or even all communities within a district) certainly is inequitable if the intent is equal burden relative to income above physical survival requirements and may be unworkable (especially if a substantial portion is to be in cash) in some very poor districts (and communities). The equal effort approach (either progressive in relation to community average income or proportional above some minimal survival level) would be equitable and, if it took actual specific surpluses (of labour, food and/or materials) into account, would be workable. It is the basis on which Australian fiscal allocations between different levels of government are made albeit in that case all allocations are in cash. But, if it is to operate at district/community level (for health or education or extension services), a rapid capacity appraisal technique will need to be devised which is understandable/acceptable to communities.

Whether operational waiver provisions are a problem depends on the contribution system. A community lump sum payment based on other than user fee sources obviates the need for waivers as there is no fee at use level. It is in fact a simple health insurance (more accurately illness insurance) system. (Sanctions on households who fail to contribute could still be a problem but, probably, a lesser one.) Otherwise the need to have the primary contact level (nurse, medical aide, dispenser) decide whether the would be patient is unable to pay is hard to square with standard administrative practice which abhors large numbers of judgemental decisions at base/'low' levels. Further the contact medical personnel may or may not have adequate knowledge to evaluate poverty status. But reference upward for decisions takes time and - quite literally - can kill. If a percentage of absolutely poor people (allowable waivers) could be agreed for each district or community[34] and the community could provide a list of who fell within that category this would be workable both for health personnel and Treasuries. But the identification would be a very large "if" - certainly central government cannot do it and one may have doubts as to how many communities can.[35]

A fourth problem relates to accountability of personnel. If both community front line health workers and primary level (curative and preventative) state employees are partly financed by and accountable to both state and community, what is accountability to mean in practice? Central government ability to discipline except for gross mal- and non-feasance tends to be low. Oddly, community sanctions might be easier where a significant portion of food, housing and/or wages comes from that source.

Accountability as to programme structure and priorities may prove an even more problematic area for "power sharing". National or provincial planning tends to set fairly uniform targets by district and by community (at least by community served at all) with limited campaign and localised disease exceptions. This may or not be consistent with most communities' preferences - it is unlikely to be seen as optimal by all. Indeed it is unlikely to be optimal for community members some of each. How far health planning can be decentralised to such structural issues as campaign vs integrated vaccination/immunisation thrusts and priorities among different preventative, curative and extension (animateur) components is unclear. It is certainly not common and requires both some limits on scatter and high skill levels of the health services/community negotiators to avoid serious loss of coherence and/or inefficient uses of resources. The bottom line problem is that both professionals and communities have both relevant knowledge and also limits to the scope/correctness of their vision.[36]

Finally what is to be done in respect to district/communities which place a low priority[37] on health/health services? One route is to compute their equal effort contribution and - if they refuse to meet it - to provide no health services. This is hardly consonant with universal access to basic services and may do little to educate potential patients to give a higher priority to health or health services. This is especially true if present low priority to paying for health services relates to negligible or bad past experience with them, not to a low priority to health per se. A second is to have a fixed ratio (e.g. if the equal effort level is 15% of total spending at district or community level to relate the government's 85% to actual contribution). The planning and administrative difficulties of such a system would be very high, particularly as contributions might be pledged and not delivered, which logically would require intra-year cutbacks. A third option would be to seek to provide a basic services level (including some basic drugs) to all districts/communities with

specific additional programmes (including larger numbers of animateurs and dispensaries and/or larger quantities of drugs) linked to contributions. This may in principle be optimal - the experience with the basic level (especially if it included significant educational and public health components) might well raise community willingness to contribute. The moral problem of denying any service would be averted. But it is not clear whether this option can be planned, financed or administered in most African countries. A fourth option is to ignore low or unfulfilled pledges and seek to provide uniform services on a universal access basis whatever community funding is (or is not) delivered. That is simple for programme design and coordination and for avoiding denial of access if the approach is fiscally practicable. However, it is likely to lead to fiscal problems and to become a classic "freeloader" case with the ratio of "freeloaders" rising over time as the reality of services not being related to contributions is observed.

Envoi

This paper has not sought to provide a comprehensive analysis of "Health for All", health service administration, community participation[39] or user contributions.[40] Rather it has sought to raise a limited number of administrative problems arising from their interaction. Whether these problems are self-evident is a matter for the reader. What can be said is that they are rarely raised in official health planning and budgeting, health service structure or sectoral advisory documents.[41]

Institution building and training are universally accepted as priorities in SSA. So, in a rather narrow sense, is administrative reform and, less uniformly, some form of decentralisation and community involvement. But restoration of classic administration[42] - useful as it would be and vital as it may well be in some aspects of health service provision - will not by itself be adequate for decentralisation incorporating serious power sharing between state and community levels or between bureaucrats/professionals and community members/leaders. The issues posed above do need to be addressed seriously to determine the desirable content and structure of reformed institutions, improved training, decentralisation and restoration of bureaucratic efficiency.

The appearance of posing more questions than answers and that of questioning each option set out are a reflection of reality. Candour

requires the admission that we know little, largely because posing the questions is - with rare exceptions - a precondition for serious analysis and dialogue on ways forward, which is in turn at least highly desirable before initiating widespread structural, strategic, policy programmatic, institutional and administrative changes.

Notes

1. e.g. from Unicef Within Human Reach, the Khartoum Declaration and UNECA's African Alternatives To Structural Adjustment to the World Bank's "long term study" Sustainable Growth with Equity: A Long-Term Perspective for Sub-Saharan Africa.

2. Which professionals in which disciplines varies from author to author. Both the most unquestioning upholders and sharpest critics of most sub-groups tend to be from within the sub-group.

3. The title is that of Rene Dumont's initial seminal volume. Ironically Dumont had a subsequent history of rather optimistic enthusiasm for a number of alternatives followed by speedy and deep alienation from their actual practice - a characteristic common in this genre.

4. The Bank's original 1981 Accelerated Development in Sub-Saharan Africa: A Programme for Action was - while very shy about saying so - in large part a savage attack on two decades of Bank policy and praxis in SSA as well as a neo-liberal apocalyptic condemnation of African and external state actors on grounds between 120° and 180° different from Dumont's (let alone Samir Amin's!).

5. Outsider as used here is not fully correlated to ethnic or national origin. Some African critics are in their intellectual stance outsiders whether now based in Africa or abroad. This is not per se intellectually unsound (Socrates was an outsider), but it is unlikely to be a productive starting point for policy oriented/policy influencing research.

6. e.g. Tanzanians see no particular problem in respect to smallholders (1 to 3 ha family farmers) backed by extension services growing reasonable quality Virginia tobacco - because that approach has worked for over 30 years. Until very recently Zambia assumed and acted on the assumption no such approach was practicable - because it had never been tried.

7. For a policy or strategy oriented researcher to hope that his ideas and concepts will be used is reasonable. For him to see initial attempts as experiments may be nearly inevitable, albeit it is not a perspective which can be welcome to the experimentee. The root problem in Africa is the relative weakness of African researchers, administrators and politicians vis a vis the external partners with whom they interact and the - sometimes unintentional - independence/dominance relation this creates. It is an unfortunate fact that even in SSA states seriously committed to self-determination and self-definition, expatriate proposals from a source carrying respect or finance frequently get a hearing far more readily than national proposals of equal quality (indeed sometimes the same proposals are rejected when made by nationals but acted on when re-channelled via a sympathetic foreign adviser).

8. And, therefore, is evidently open to a number of the criticisms made in the opening section including what he would now view as inadequate (even if abnormally high for a strategy and policy adviser) attention to administration.

9. This model is clearest in respect to curative medicine - which has historically accounted, and still accounts, for the bulk of medical service resources and activities. Preventative programming has had a higher proportion of centrally designed campaigns. But even there continuing programmes have had routine, primary unit level aspects with complications in respect to their implementation or results referred up.

10. Individual curative cases never reach top administrators of Ministers. In that sense medical service administration is almost an idealised archetype of bureaucratic process. But if several cases have a common characteristic overcoming which requires inputs beyond those directly under doctors' control - e.g. incubators for babies, heart treatment machines - a budgetary allocation and/or a prioritisation of overall resources issue are likely to arise from them.

11. Nominally doctors as doctors do not make policy. This is part of the broader intellectual construct for dividing technical analysis of options and implementation of decisions (professional, apolitical) from taking decisions and determining policy (non-professional, political). In its pure form the construct has never had global acceptance, at least partly because analysis of options can never be totally impartial nor value free and does influence policy decisions while implementation necessarily influences the results and indeed nature of such decisions. This is particularly true of health services because answers to technical questions have life or death consequences readily visible to lay-persons, and because medical professionals are more successful than most in convincing non-medical administrators and ministers that they, the doctors, do know better even on issues which pretty clearly have non-medical aspects, e.g. balance between primary and hospital care or preventative and curative.

12. Curative medical in almost all cases.

13. Whether this inversion of the professional administrator as boss and the specialist professionals as support staff model is desirable or not is unclear. There is a good deal to be said both for specialist training in administration and in the substantive content of the institution administered.

14. In Tanzania in the early 1970s, the differences were 16:1 at district and 4:1 at referral hospitals in respect to room and board costs. In no way could these differences be related to quality of facilities and only very partially to varying locality costs of food.

15. There are other - quantitatively significant - problems with the referral system. One is that bad transport often means patients physically cannot be moved. Another - exemplified by urban Zimbabwe - is that at city hospital level there is little differentiation of severity or complexity of cases between general and consultancy hospitals apart from a few specialties. Yet a third is that without very strict rules (and their application) on initial appearance at primary level facilities (except for emergencies), there is a tendency to go direct to hospitals rather than first to clinics or posts when both levels are accessible. However the number of cases

involved is much smaller than that from a traditional doctor as first screener system if, in fact, 80 to 90 per cent of cases can be diagnosed and treated (screened out) by nursing or medical aide level professionals.

16. An exception was then British Somaliland which built up central training and drug supply logistics for 'nomad' community selected medical assistants who collected for drug costs and were communally paid. This development from the late 1940s seems to have related to very exiguous colonial government finance and the difficulty in using standard clinic/dispensary techniques to serve mobile populations.

17. The title of a seminal 1950s OUP volume by Ursula Hicks.

18. Ernst Friedrich Schumacher's volume is of course of the 1970s but it is in the 1950s CD idiom.

19. The author owes this point to Professor Emanuel de Kadt. It is in fact a general problem of grass-roots or basic community organisations that they usually find building up regional or national networks or relating to central political, administrative or juridical bodies much more difficult than own organisation and direct action. The justification of many indigenous ngo's (e.g. in the Philippines, Sri Lanka and India - less frequently in Africa) is to provide support (or partial substitutes) for such links and a channel to central sources of power. While foreign ngo's occasionally play such roles they are usually more analogous to the historic cd organisations in their relations with communities (e.g. the German left ngos - Ruvuma Development Association saga in Tanzania which certainly did not raise productivity nor create stable communities but did - inevitably - create antagonistic relationships/lack of relationships between RDA and district and regional political and governmental units).

20. CD on the health front was in practice was public health/health support in focus, but largely because its links to mainline health services were usually weak.

21. Somalia was until its present implosion - the most widespread (perhaps 20% of rural population) and longest running (30 years albeit with vicissitudes) exception. Even in that case, cooperating agency costs in relation to primary health care at community level probably were 1.5 to 2.5 times those of communities.

22. e.g. UNICEF - normally very concerned about the impact of fees on access - is a fervent adherent and co-promoter. In this it parallels the World Bank's theoretical model on charging and its variant in favour of using local communities as "tax farmers" to collect fees - a model also favoured by USAID.

23. That drug availability (public and private) declined is not in dispute. Nor is there any doubt that, especially but not only in rural areas and at primary care level units, the shortages were frequently crippling. There is a reason to believe that the selection of drugs was not always cost efficient nor even appropriate clinically and that too high prices were paid for what was bought. National drug lists and bulk purchasing with a preference for generics are among the proposals made for these weaknesses.

Similarly poor inventory preservation and control have led to wastage and 'leakage' as has inadequate feedback on actual lower level unit needs and uses. Two-way communication on stocks, uses and needs from local to central level; better stock control and rehabilitated storage facilities (plus prompt clearance of arriving shipments have been proposed in this regard. Whether the drug shortages not soluble by these means related primarily to fiscal as opposed to forex shortages - i.e. whether local currency drug fees would have been of major help in alleviating them - is unclear and probably varies by country.

24. While the Bank still terms its "Human Dimension" or "Absolute Poverty Reduction" analysis and programming "Social Dimensions of Adjustment", it now interprets SDA broadly and positively to relate to basic service extension and poor household livelihood improvement whether or not their erosion or collapse related to the Structural Adjustment Programme or from the underlying context and trends which caused the SAP's adoption. This is particularly the case in Sustainable Growth with Equity.

25. Unless the channel for the funds is UNIPAC/UNICEF, external donor supply of drugs tends both to reduce national power to coordinate or define flows and also to increase the array of drugs provided. Even in that case it tends to deter purchases from domestic producers, who are asserted to be high cost and/or low quality even when these claims are less than self-evidently justified.

26. Tanzania has for 20 years had low user charges at primary level with higher ones at hospital level. Partial moves toward a cost recovery programme in 1989 do seek to provide for waiver to very poor patients - analogous to that more or less achieved in respect to education fees. Further, they do not represent an initiative seen as wise in service provision and access terms by the Ministry of Health nor as particularly important as a direct source of funds by the Treasury. Rather they are a limited, calculated, negotiated bargain to secure identified increases in external finance for the health sector which was conditional on higher user charges.

27. That some dictatorships with elitist health services systems and, indeed, some elected governments do resemble this model is not at issue. What is arguable is whether the way forward lies in replacing and excluding the state from the phc arena or seeking to compel it to accept its responsibility for it in both work and resource allocations. This is a hotly debated issue in certain countries, e.g. the Philippines both before and since 1986.

28. There is an inherent equity problem with full cost or even substantial cost recovery in the case of health services. The more a household needs such services, the lower (absolutely and relative to its own past levels) its income is likely to be. This is the case for health insurance. The community funding partial analogue to health insurance would be a sum per household (raised on whatever basis the community saw as desirable/practicable) not a collation of user fees.

29. In Mozambique urban use of services after new fees/drug charges were adopted in 1987 fell over 50% in two years while for exempted services it rose by about the same per cent. The lower flat rural

consultancy and drug fees had mixed effects. In some districts they did fall within most households' financial capacity and waivers seemed to handle the exceptions. In other districts, cash income was nearly nil so any cash fee at all was a well nigh insurmountable barrier to access for the majority. (Poverty in Mozambique, Consultant's Report by R. H. Green, Office of the Prime Minister 1989; UNICEF Study on Bamako Initiative (in Mozambique context, 1989.)

30. Based on Somali Government, UNDP and UNICEF data collected in the course of preparing an (unpublished) 1987 UNICEF country study.

31. The 1989 draft agreement between Mozambique and the World Bank on reviving the APE (community based front line health worker programme) does provide for the possibility of such contributions in kind. This amendment of the initial proposals was made on the initiative of Mozambique.

32. Unless basic drugs are largely domestically produced (rarely the case, albeit Zimbabwe is an exception) additional domestic currency resources may well not visibly and automatically lead to higher drug availability. If that happens, the credibility of paying more to get more and of the community structures relating to health are likely to be eroded seriously and swiftly.

33. Calculated from various World Bank Health Sector studies albeit the 1% figure is not stated in them. It comes from multiplying the 5% to 8% typical share of health in the recurrent budget by .1 to .2 and taking more or less the middle of the resulting 0.5% to 1.6% range.

34. In practice by having a limited number of categories, not detailed evaluation and negotiation of each case.

35. This is not simply a matter of knowledge. Mozambican grupos dinimisadores do know household characteristics quite well. But, as discovered in the course of the 1988 Urban Surveys, they do not pick out absolutely poor households (as identified by income, expenditure and malnutrition data) very reliably. Female headed households are particularly likely to be overlooked even by female grupo members.

36. To assert that patients and communities know a good deal about their health needs is one thing. To assert that they have adequate technical knowledge to design optimal priority packages is a different - and hard to defend - contention especially in relation to new (and thus unknown to the community) services.

37. The variation in revealed priority to health services exists nationally as well as at community level. In terms of commitment to, and attempts to sustain or restart, wide access phc systems Botswana, Mozambique, Zimbabwe, Tanzania, Kenya, Mauritius, Eritrea, Cape Verde and Senegal fall into a relatively high commitment category while Malawi, Angola, Zambia, Ethiopia, Somalia, Ghana, Nigeria, Cote d'Ivoire and Zaire fall into a low commitment category. Why is by no means entirely clear. Standard ideological categorisation does not correlate very well, nor does colonial heritage. Regionally Southern and Eastern Africa seem to have slightly higher average commitment than West and Equatorial Africa and the Horn but each sub-region has

a wide scatter. Nor do the degrees of commitment bear much relation to available resource levels and trends. Most oddly, they also bear limited relationship to raw budget share data. This may relate to larger off budget (programme aid in kind - drugs, personnel, equipment) resources mobilised by high commitment countries, to greater efficiency in resource use and/or to more a complex combination of factors. There is a correlation with a state's concern for the attainment of minimum levels of well-being by all - or almost all - of its people whatever the general approach to the role of the state and the public sector in economic activity or to the degree of commitment to egalitarianism in the sense of limiting income differentials. Whether the reasons for this "revealed preference" human condition concern in, e.g. Kenya, Mozambique, Tanzania and Senegal (or its apparent absence in Malawi, Angola, Ghana and Cote d'Ivoire) are uniform is much less evident. The problem from the optic of this paper - and of phc more generally - is what action is possible in the context of low state priority for health services generally and for phc in particular. The Somalia case cited earlier (external donor to community hiring in certain government health services personnel) is an extreme solution. On one reading, the Benin case (drug aid leading to counterpart fund de facto paying field level government health services personnel) is an intermediate one. Targeted basic drug kit and vaccine provision for phc (e.g. in Ghana and Angola) plus the creation (or recreation) of a gap-filling Christian medical service (largely small town and rural in Ghana and - at least in contrast to the government service - Angola) is another option where relatively low resource allocation priority to health services and especially phc is parallel to general government and health service goodwill toward them, if someone else pays.

38. A special factor here is the impact of not charging fees on external support for health services. It has been suggested that revolving drug funds (in general and in the Bamako context) are a device to lessen donor wariness for financing recurrent costs by seeming to provide a terminal date for such support and not a serious revenue raising gambit. As a general proposition that appears rather too Machiavellian (in either the colloquial or the technical sense of the term). But it is true that some fee systems (or increases) have been negotiated in large part because World Bank funding or mobilisation of bilateral funding for recurrent health services costs was essential and could not be secured without such changes in charging. That is not a normative comment on either party to such negotiations - the Bank believes in the usefulness and equitability of charges; the African negotiators perceived additional foreign exchange support for health services as essential to having worthwhile services accessible to larger numbers.

39. Indeed it has not tackled the issue of what is meant by community. In some countries (e.g. Tanzania) a village or other unit reasonably definable as a community is the base level administrative, political and/or local governmental unit. In others (e.g. Mozambique) districts with average populations over 100,000 form that base tier and are clearly not communities in the sense either of the Bamako Declaration or of this paper. Decentralisation to district level should pose fewer problems in administrative principle or practice, because most districts (sometimes excluding major cities) are basically Central Government staffed and financed with or without

elected local quasi-supervisory and consultative bodies whatever the formal status of local government. So long as a District is much larger than a community, the problems of resource mobilisation/fee collection are likely to be more analogous to those of the Central Government than of an organic community.

40. In respect to user charges the author has grave doubts that equitable, collection cost efficient, non-access denying, administrable central government fee systems which yield significant revenues can be devised and operated. A serious attempt in relation to drugs in Mozambique yields 4% to 5% collection relative to drug costs, chaotic problems of exemption and collection (not excluding corruption) and not insignificant loss of access by persons who cannot pay and believe (perhaps wrongly) they would have to do so. There are some exceptions, e.g. above basic level "hotel" (room and board) services which should be charged at full cost, but these are usually peripheral both as to services and revenues. User contributions based on the insurance principle are somewhat more promising. Assuming equity/equal effort are valid principles they should be at least somewhat progressive. Because only 5% to 20% of households in most SSA countries have incomes high enough for an income tax to be cost efficient a surcharge on or tax parallel to and collected with income tax would have a narrow base. A practicable option might be indirect taxes (tax increases) on products detrimental to health, e.g. cigarettes, cigars, pipe tobacco, beer, wine, spirits, saloon cars, motorcycles, cosmetics and medically useless patent medicines and tonics. These are - as a group - a rising proportion of household spending up to the top 1% to 3% of the income distribution.

41. This conclusion on general lack of attention is based on a probably non-random sample but includes national (especially Ghana and Mozambique), UNICEF and World Bank studies as well as the papers presented to the 1989 "Health for All in the Year 2000" international conference at the University of Washington co-sponsored by WHO and UNICEF.

42. Better (as to relevance and quality) training restoration of real wages and salaries to living levels, re-establishment of procedural and presence regulations (and sanctions for violating them) are aspects of bureaucratic system rehabilitation which, unlike the issues posed here, are fairly generally identified and valid in themselves whatever else may be needed.

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