

- PN-ABT-396 -

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The Politics of Health Reform in Chad

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Introduction

This paper examines an attempt at reform of the health system in Chad, a particularly poor and troubled country. The thesis of this paper is that both the choice of reform and the probability of implementation depend in greatest part on the participants' (policymakers') concerns for their own and the regime's political survival and only marginally for the survival of their particular sectors of the bureaucracy. Thus, some variant of a pure politics model that takes into account a multiplicity of loyalties, obligations, and antipathies seems more appropriate than a standard bureaucratic politics model for describing the outcome of this sectoral/organizational reform in Chad.¹

The analysis is in four parts. In the first part, we examine Chad's economic and political situation in 1985 as the context in which the question of reform of the health sector arose. Second, we examine Chad's choices for reforming the health sector and why it chose as it did. Third, we turn to the implementation of the reform, and finally, we discuss how Chad's experience can contribute to understanding problems of reform in poor and troubled Third World countries.

Context for Reform in Chad

Chad, a landlocked country, varies in topography from desert to heavily wooded savannah, from the middle of the Sahara to the outskirts of the Congo basin. Historically, Chad had been the center of trade, pilgrim, and slaving routes going north and south, east and west. As a result, the country boasts an extraordinary variety of ethnic groups, 110 by one conservative estimate.² In the north, the primary occupation has been herding livestock. In the south, agriculture predominates with a very few industries based on agricultural production (cotton processing, sugar refining, cigarettes).

Chad was the "Cinderella colony" of French Africa, a Cinderella who has yet to meet her Prince Charming. What little investment has gone into the country has been concentrated in the south, known to the colonizer as *le Tchad utile*, useful Chad. The country has been particularly handicapped by its poor road system, which imposes high internal transportation costs (when transport is even possible). Since Chad is 1500 kilometers from the nearest port, imports are expensive and exports must be priced to include high transport costs.

Following independence in 1960, Chad was ruled by an increasingly arbitrary regime dominated by southerners. The first revolts broke out in 1965, beginning a period of bloody civil strife and foreign intervention that ravaged the country for the next two decades and that has not completely ended. This violent period laid bare in dramatic form some of the underlying structure of Chadian political life. It demonstrated the fragility of large, formal structures of rule and social organization, which were undercut by a multiplicity of shifting factional alliances and feuds. Although region, religion, mode of livelihood, or ethnicity might at one moment describe a particular factional lineup, it would not likely explain the participants' motivations. Virtually none of the 110 or so ethnic groups is itself homogeneous or solidaristic. Parochial loyalties and antagonisms divide tiny villages among the animist/Christian Sara, while the Saharan Toubou must come close to world records for harsh individualism.

Fixed political ideology has been virtually absent from politics. When proclaimed, it would be used to provide a facade for factional rearrangement or for brokering an alliance of convenience with a group of foreigners who might take that sort of thing seriously.

Factionalism and short-run calculations dominated and exacerbated the civil wars, which were fought with unstable coalitions, often more jealous of their partners than of the opposition.³ The so-called Transitional Government of National Unity (GUNT), which was cobbled together by various outside interests in 1979, proved unable to devise a central process for governing the country. Everything had to be divided according to the shifting weight of factional interests. The GUNT lost the capital to Hissène Habré's forces in 1982 in good part because each of the armed factions making up the GUNT waited for the others to commit their troops to battle in the expectation that it could preserve its forces intact and emerge the ultimate winner over its coalition partners. The social scientist will find Chad a challenging laboratory for the study of collective choice, free riders, and prisoner's dilemmas.

Factionalism is a common enough feature of politics in African and other states. In some cases—Senegal is a good instance—factions are based on well-established patron-client relationships, with their own, well-understood rules of distribution, deference, loyalty, and defection. Although factional competition is intense, it follows predictable forms anchored in social structures common to most of the population. For all the swirl of political wheeling and dealing and the rise and fall of political *clan* leaders, the system itself is metastable and provides a high degree of predictability for those who participate in it.⁴ No such certainty is available to those who must play Chadian politics. The Chadian political system provides no such common social base or set of stable expectations on which trust can be established. The violent reversals of Chad's recent past inspire the adventuresome few to redefine the rules to fit their advantage, and persuade the prudent many to confide fully only in the smallest circle of friends, while keeping open multiple links to possible patrons who might provide a secure lifeline should things turn nasty.

Instability and factionalism have been increased by outside powers backing "their own" Chadian clients, and sometimes playing one against another. At one time or other, France, the United States, Egypt, Libya, Nigeria, Zaire, Congo-Brazzaville, Gabon, Sudan, Iraq, and Saudi Arabia have provided significant support for one or more Chadian factions. This has left a legacy for entrepreneurial Chadians of looking outside the country's borders for economic and other resources to profit themselves and their clients and close allies. Multiple backers are to be preferred, of course, so that one can be played off against another. Such a legacy inevitably affects the way foreign aid is understood by members of the current Chadian government.

Hissène Habré, who had built an effective fighting force largely on the basis of personal loyalty to himself and a core group of skilled commanders (and with quiet help from France and the United States), proved at first to be a surprisingly effective political leader. By the end of 1985, his government had reestablished civil order over most of the country. He combined military pressure on opposition factions with a policy of "national reconciliation," which distributed political plums to those who submitted to his leadership. Habré seized the high ground

of national unity by leading a national effort to chase the Libyans and their remaining Chadian clients out of their last positions in northern Chad. Although he was overthrown in December 1990 by ethnically based factions of his original military coalition dissatisfied with their share of power, Habré left behind a recognizable and functioning state apparatus.⁵

Chad is an exceptionally poor country, even when the rains come and the locusts stay away. Chadian government finances are in a perpetually parlous state of deficit (see Table 1). Well over half of all public expenses, on and off budget, goes for the war and other security purposes. The collapse of Chad's cotton economy, thanks to maladministration and a catastrophic fall in world prices, has deprived the government of 25 percent of its domestic income and sharply cut export earnings. (In 1986-87, Chad lost nearly \$1 on every kilo of cotton it sold.)

Since the mid-1980s, Chad has got by with more than a little help from its friends. As the World Bank has noted, "foreign aid is the most important "sector" of the Chadian economy, since it represents more than two and a half times the quantity of receipts from exports."⁶ In addition to substantial military aid, both France and the United States have provided direct budgetary aid to prevent total collapse. The World Bank and various European donors have put together a rescue package for the cotton industry, and the International Monetary Fund has negotiated a standby arrangement to reestablish some sort of budgetary order.

The net effect of all of this, however, is that the Chadian people and the Chadian civilian administration are faced with the prospect of a long period of even greater financial stringency than that which has obtained in the past. Pressure is on to reduce public employment, since civil service wages make up over 50 percent of nonmilitary expenditure, despite the fact that by most measures the country is seriously underadministered. Most civil servants are poorly paid; the average Chadian civil servant is paid 30,000 CFA a month (approximately U.S. \$100)—except for the month when the salary is "donated" to the war effort, and the one or two months when it just is not paid.⁷ Any new governmental enterprises must be made to pay for themselves in hard cash, first by generating new resources either internally or from outside donors, and second by making certain that recurrent operational costs do not become another drag on the regular budget.

The health system was in shambles in 1982 when Hissène Habré began to restore central government rule. More than half the country's hospitals, clinics, medical supplies and equipment had been destroyed. Doctors and nurses, most of whom belonged to southern ethnic groups, had fled into exile or been killed.

The rehabilitation of this health system was slow and depended on massive infusions of aid from outside donors, governments, international organizations, and private voluntary organizations. For example, the European Economic Community contributed U.S. \$9 million over three years to permit the Belgian-based Médecins sans Frontières (MSF) to rebuild facilities and train health personnel in the nine northern prefectures. In 1985, this outside aid for the health sector amounted to more than U.S. \$12 million, approximately seven times the amount appropriated by the government itself for its health activities.

In addition, religious and voluntary groups support a large share of the health activities, particularly in the southern part of the country. The financing of these

Protestant and Catholic facilities, which account for one-quarter of the country's facilities, is not computed in national aid figures (see Table 2).

Although most facilities had been rehabilitated by 1985, they were scarcely in adequate condition to provide basic health services and were chronically short of trained staff. Some public hospitals lacked basic equipment such as beds and x-ray machines, while facilities at all levels were without routine essentials such as soap.

The number of health personnel was woefully inadequate. In 1985, there were only seventy-five Chadian physicians backed up by an equal number of expatriates to serve nearly five million people. Lacking trained administrative personnel, the Ministry of Public Health assigned nearly one-third of its Chadian physicians to administrative duties, leaving the actual delivery of health care in the hands of expatriate doctors, Chadian nurses, and lesser-trained personnel. As a result, the health system was administered by physicians who were not, as a rule, experienced as administrators, while health facilities were shorthanded.

How well the ministry was meeting health needs could only be estimated because reliable data and a reliable information system were lacking. Nevertheless, the estimates produced alarming statistics: an infant mortality rate over 200 per 1,000 births (compared to 93 in Egypt and 72 in Kenya⁸); a maternal mortality rate of 786 per 100,000 births; high numbers of cases of tetanus, measles, and polio—diseases all preventable by immunization.

The economic and political situation in Chad in 1985, thus, seemed to orient the government less toward reform than toward simply rebuilding an economy and a state apparatus devastated by twenty years of civil war. Neither the government as a whole, nor the individuals who were employed by it, enjoyed the margin of security or of resources which are often thought to be necessary to bring about planned change.

Opportunities for Reform in the Health Sector and Chad's Response

The disappearance of central government and the destruction of facilities and personnel during the civil war had created a vacuum in the health sector, a vacuum which the rehabilitation of buildings and the reassignment of personnel only partially filled. Needed still were the means of organizing and monitoring the system.

To organize, or reorganize, or reform a health system, theoretically an infinite number of choices exist, but those most relevant to Third World countries can be grouped by four types of action, none of them necessarily exclusive:

1. **No reform:** Restore the system that existed before the war.
2. **Economic reform:** Institute a system of financing which would require patients to pay for use of the system and thereby provide the financial support which the central government was unable to provide.
3. **Health services organization reform:** Reorganize the health services system by giving primacy to primary health care at the expense of hospital (secondary) care. To carry out such a program would require training

village health care workers, organizing their supervision by nurses, and emphasizing public education.

4. Administrative reform: Reorganize the administrative structure of the health system to assert central control consonant with the assertion of central control by the government as a whole. Conversely or simultaneously, decentralize control in the provinces by giving more resources and responsibility to district doctors.

The first option, to restore, meant rehabilitating a system inherited from the French, a system geared toward infectious disease control (the *Grandes Endémies* approach standard throughout France's colonies) through top-down organization and geared toward high technology. Even in the 1970s, Chad continued to be dependent on technical assistance through expatriate personnel and funding of programs, projects, and administration. After 1983, as calm returned to Chad, restoration became the key word in the Ministry of Public Health.

To restore the health system to where it was before the breakdown of central government rule presented two dilemmas. The first raised the question, restore the health system to what period? To 1965, when civil unrest first began? To 1975, when the Southern-dominated Tombalbaye government was overthrown? To 1978, when the government of unity broke down completely? Or to 1979, when major battles between government factions raged in the streets of the capital? The second dilemma was to know what to restore, since most records had been lost and most personnel dispersed. Thus, any policy of restoration could be ambiguously interpreted; this left a broad scope for policy innovation and conflict.

A policy of restoration was politically advantageous to ministry leaders. They could make extensive demands for resources, whether to the Council of Ministers or to the president or to outside donors, with the straightforward plea for the equivalent of emergency aid to rebuild a war-torn infrastructure. It would be a hardhearted Chadian or outsider who could argue that Chad should do without the minimal health services which had existed before the "events" (as the war was euphemistically called).

Restoration rhetoric underlay most of the ministry's activities during the mid-eighties: the MSF's task was to "rebuild" the health facilities destroyed in the war and to retrain doctors and nurses to run the facilities. Appeals went out to the World Health Organization (WHO) and Swiss Cooperation for assistance to "rebuild" the nursing school.

Not all of the restoration rhetoric actually meant restoration; innovation could be built into the new structure. The ministry by 1984 had already approved a project for the "restoration of health planning." When the HIID/USAID-funded team arrived on site in 1985, it was evident that this phrase was a euphemism for "creation of a statistics and planning unit in the ministry." Thus, the option of restoration was attractive to policymakers throughout the ministry. It could bring in new resources to be used for purposes which went beyond narrow meanings of restoration, thanks to the ambiguity of the term.

Economic reform was a second direction to take. The financing of health facilities and health care in Chad was handled through the ministry except for those facilities supported by religious groups. Health personnel were employed

by the ministry. Physicians and nurses were not allowed to engage in private practice, at least not formally, and they were not supposed to charge fees for services rendered as state employees, nor for the drugs distributed free to the facilities. However, traditional healers who practiced outside public or private health facilities did charge fees, and some supervisory doctors did a lucrative abortion business, strictly against the law.

The financing available from Chadian and outside resources was clearly insufficient to support such a public system. The expenditure per capita was U.S. \$0.30.⁹ To obtain funds for facilities, the government asked them to charge 100 CFA (U.S. \$0.30) per visit. These fees, when they were collected, were sent to the treasury where they were never again seen by the Health Ministry. Thus, incentives were slim for this type of financing. Little was collected and none of whatever was passed on to the treasury returned to finance health services.

Reform of health financing is simply a facet of the increasing vogue for economic reform of Third World countries.¹⁰ These proposals usually take the form of proposals for user fees which may be acceptable in some countries.¹¹ USAID, during this period, supported a project in self-financing of medications in one town in Chad, putting pressure on Chadian officials to think about alternative means of financing.

The prevailing philosophy of leading ministry officials was that health care in Chad should be free and available to all. In fact, the private practice of medicine was forbidden. All Chadian physicians (who comprised the leadership in the ministry apart from the minister and the deputy minister) had been trained abroad, often in Eastern Europe, an experience which impressed them with the ability of government to furnish health care with little or no self-financing. There was even a slight sense that for government *not* to provide health care would make Chad a second-rate country.

Another reason for rejecting self-financing schemes was their impracticality in Chadian social structure. A health worker may be a civil servant in the eyes of the government, but in the eyes of his family he is a financial resource in case of need. Thus, any health worker would be hard pressed to collect fees from members of his family and friends. Even in the ostensibly nonpaying system, such family demands were a constant source of difficulty for health workers. One visitor to the national public pharmacy spent a morning observing drugs dispensed in exchange for favors previously rendered or to meet family obligations. A fee system would not be politically popular and would be extremely difficult to administer in the Chadian social context. Given these constraints, it is not surprising that ministry officials never seriously considered economic reform except for the single project of pharmaceutical self-financing, which USAID insisted on funding in one town and which ended two years later with no sign that it would be tried in other regions. It was clear that if any economic reform were undertaken, it would be only as a result of strong external pressure and strong external funding.

The third option for reform was to recast the health services system itself by emphasizing primary care over secondary and tertiary care. In public health parlance, primary care meant preventive, diagnostic, and treatment care delivered at the site of first contact in a situation where the care-givers were integral members of the community with which they worked. In the international sphere,

primary care began to take on a broader meaning particularly after the WHO Conference at Alma-Ata in 1978 which declared:

Primary Health Care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford.¹²

Putting this definition into operation has proved difficult. The conference specified eight elements necessary for primary care including nutrition, sanitation, maternal and child health care, and disease control, with communities expected to plan their own primary care activities.

In fact, what primary care began to mean through the work of WHO was the delivery of health services by indigenous village health workers (as opposed to doctors and nurses). This development was influenced by the experience of China during the Cultural Revolution when it had trained one million "barefoot doctors" to serve as community workers and sanitation experts, and to provide a minimum of medical care.¹³ Unfortunately, this experience has not been successfully replicated elsewhere (and subsequent inquiry suggests that its success in China was limited). The Chinese tried with little success to export their methods to Tanzania. India has been no more successful, despite attempts to place community health volunteers in 600,000 villages.¹⁴ A USAID-funded project to place village health workers in Niger fell far short of its goals, while a USAID-funded project in Mali incurred recurrent costs which went far beyond what local communities were willing to support.¹⁵

Nevertheless, the goal of training village health workers is still espoused by WHO. Thus, WHO provided Chad with funds for training village health workers and encouraged the ministry to set up a separate administrative division called "Primary Health Care."

Most ministry officials agreed, in principle, with the notion of promoting primary health care, but reacted with skepticism to giving prominence to a new type of health worker with no clear relationship to other health workers. However, as long as WHO provided the funds and clearly was not going to provide those same funds for other purposes, the Chadians were willing to accommodate a small program. At no time did they envision a massive community program. This was a reform which was acceptable so long as outsiders paid for it. The only officials who openly espoused the reform were those whose administrative positions gave them responsibility for the program. This was a reform with the potential to change entirely the face of health services delivery in Chad, but ministry officials, in treating it as just another incremental program, were able to limit its effects.

The fourth option was to reform the administrative structure itself. This became the ministry's major reform activity in two sequential parts: first, to restructure the ministry itself, and second, as a result, to develop a statistics and planning unit.

The Chadian administrative system is based on the Napoleonic model of a centralized bureaucracy, hierarchical in nature, with the central government represented outside the capital by a prefect responsible for all aspects of the administration in his region. The system is a direct descendant of the colonial

civil bureaucracy. Before the "events," the Health Ministry had followed a military model developed by the French technical advisers who, like their colonial predecessors, were themselves mainly military physicians.¹⁶ The bureaucracy they dominated and endowed was called the *Grandes Endémies*. It was organized with mobile teams which spread across the countryside striking down infectious disease wherever it arose. Permanent officers were posted in the "Secteurs" which did not correspond with the geographic lines of the prefectures. The agency was heavily staffed by French physicians and at one time was considered to have an effective disease prevention program. Divisions of the ministry other than the *Grandes Endémies*, such as sanitation, health facilities, and training, lacked enthusiastic French support and thus garnered relatively few resources in personnel and financing.

With the restoration of ministry activities after 1982, officials had at least five objectives for administrative reform. The first and most important was to strengthen the central ministry to make the power of the central government felt in the regions. Ideally, this would include control over personnel and resources. This objective was part of the whole government's need to reassert central control after years of anarchy. Just how to accomplish this administratively was not clear, but it would involve, among other things, creating regional representatives, a better trained (more competent) central bureaucracy, and the means to gather and process information so the ministry could plan, monitor, and supervise what was going on in the country.

A second objective was to coordinate relations between staff and line agencies, in this case between programs which were created at the ministry and the facilities in which the programs were supposed to operate. Another way of describing this is the problem of coordinating the activities of nationwide vertical programs, such as maternal and child health, with the activities of individual clinics and medical centers. This is a problem which has bedeviled public health officials in all places at all times. In essence, the question boils down to whether you organize by geographic area or by function. New York City, the world's first major public health department, struggled with this issue for more than forty years.¹⁷

Lest this objective seem an elevated philosophical one, it should be noted that the way an issue such as this tends to get resolved has less to do with the philosophy of administration than with a necessity of self-preservation, which we propose as a third objective. For any individual actor in the Chadian Health Ministry, the objective was to enhance his personal survival and secondarily to enhance any agency in which he had a major role. Since the assignment of roles could easily change under the reorganization, and since it was not necessarily clear who, if anyone, would reassign roles (whether the director general, the highest ranking professional, or the deputy minister, or the minister), negotiations became highly complex. The director general had a particular interest in consolidating the power of his office, but in this objective he could not absolutely count on the support of his political superiors in the ministry, nor necessarily on his inferiors, the directors of divisions/agencies who wanted to retain their autonomy.

The fourth objective was, paradoxically, to strengthen regional administration, to make the regions more capable of solving their own health problems. This was

not as much in conflict with centralization as it seemed. The regions had developed a good deal of autonomy thanks to the civil war. For many years, they had been operating without benefit of central government. For example, when a ministry delegation traveled to health facilities outside the capital in 1986, health workers commented that it was the first time they had received a government delegation. However, the autonomy afforded by the lack of central government had also created independently operating personnel, often oblivious to what was going on in the next village or health facility. Hence the need for central government to establish a regional medical officer, called at first "medical prefect," whose task was to coordinate health activities in his prefecture.

The fifth and final objective for some ministry personnel was to decrease the influence of foreign, particularly French, personnel. Residuals of Chad's colonial past, of Chad's impoverished status, and of its intermittent wars, French advisers had a place of honor at the minister's side and all the way down through the hierarchy. Sentiment at this state of affairs ranged from outraged anticolonialism to simple pecuniary interest in controlling the funds the French provided. No one was ready to bite the hand that feeds, but certain Chadians, galled by their semicolonial status, did think it time to limit the amount of poking the fingers of that hand could do.

If those were the five primary objectives of reform, one should not lose sight of an objective frequently cited, the need to "rationalize" the administration. When closely scrutinized, "rationalize" itself turned out to be a rationalization for any of the five other objectives which were not as easily enunciated in polite discourse.

Administrative Reform: Decisions and Implementation: Two Cases

Organizational Reform

The first action was to restructure the ministry. The discussion on administrative reorganization dragged on from 1984 until April 1986 when changes were finally approved by the Council of Ministers. The Chadian description of this process was "créer un nouvel organigramme," that is, to create a new organization chart. The intensity of the debates suggested that much more than a drawing was at stake. The major controversial issue became the number and character of each of the ministry's major agencies, and what the responsibilities of each would be.

The director general preferred as few such agencies as possible, since that would simplify the task of coordination and, fortuitously, consolidate his power. He wanted also to break up or at least submerge the *Grandes Endémies* in a larger agency, particularly if the director of that agency were one who were closely tied to him. Arrayed against this viewpoint were certain directors who already controlled agencies and wanted to maintain the status quo, if not increase their holdings. Two other important actors were the French advisers, whose extensive investment in the ministry made changes in the administrative structure no trivial matter, and the WHO, which had published recommendations for how Third World health agencies should be organized, including suggestions for assuring the visibility of primary care by giving it its own agency.

The second issue was the creation of the "medical prefects" who were to coordinate health activities in their localities. The Ministry of the Interior had objected to their denomination as "prefects" since there could be only one prefect in each region and he was the representative of the Ministry of the Interior. This objection was easily met by rebaptizing the physicians "Médecins Chefs de Préfecture" (MCPs). However, there remained much ambiguity about their roles. The director general wanted them directly under his authority, a kind of local health czar. The directors of agencies wanted them to be subordinate to their agencies and the programs they directed. Most donors favored the creation of the MCPs but were inclined to take no position on administrative relations, except for the French advisers who wanted to be sure the MCPs did not usurp the authority of the Grandes Endémies' regional agents, the Médecins Chefs de Secteur.

The third issue was whether to move the statistics and planning unit, which had been buried in the agency for training and education, up to become part of the director general's office. The director general favored this proposal because this unit, funded and promoted by USAID, would give him the means to monitor and survey activities of the whole ministry, as well as give him the tools to do some orderly planning. Few other ministry staff saw the potential of such an agency. In fact, no one else seemed to care except for the director of the training and education agency, who was known to be unhappy about the dismemberment of his agency. (His discomfort was resolved when he was rewarded with a major post with the political party and relieved of having to deal with the health bureaucracy.)

The resolution of these questions was worked out in the back rooms, in ministry staff meetings, and ultimately in the Council of Ministers, but not until they had been remanded to lower levels several times. As in all such political compromises, there was something for everybody. Every director got an agency. Primary care had its own agency. The "preventive medicine" agency included all the former Grandes Endémies activities. In addition, it was given management of the special programs such as maternal and child health, nutrition, and vaccination. To give the agency line authority, rural clinics were placed under its supervision while urban clinics, infirmaries, and hospitals were placed under another agency, Hospitals and Urban Medicine. With this splintering of the health facilities, attempts to coordinate line and staff agencies appeared frustrated.

The law gave the MCPs authority over local health services, but since facilities and programs were administered through agencies, and since the relationship between the MCPs and the agencies was not spelled out (in the new organization chart both MCPs and agencies depended on the director general but no lines connected them), the extent of their authority remained murky. The one concession to the director general's interests was the transfer of statistics and planning to his office.

These compromises maintained the independent position of certain agency directors (and even added one), maintained intact the elements of the French-sponsored activities, gave visibility to the WHO-sponsored programs of primary care, and gave the director general his own statistics unit. This result can be seen as typical of bureaucratic infighting, with the agency heads and foreign donors succeeding in protecting their pet projects. The French preserved their Grandes

Endémies structure, yet henceforth their influence in the ministry as a whole could be balanced by the American-supported statistics unit.

Creation of the Statistics and Planning Unit

Although the creation of a statistics and planning unit was originally proposed by a donor, USAID, its implementation became possible because some ministry officials, at least, could benefit from espousing it. The very establishment of this unit gave the director general some of the means to assert central control over the regions, to put in place a regional representative of central authority, to increase the resources available to his office, and finally, to assess resources and plan for their deployment.

The notion of a strong Bureau de Statistiques, Planification, et Etudes (BSPE) had been around since the mid-1970s when it had been particularly promoted by USAID representatives in Chad as in other African countries. By 1983, USAID had revived the idea which met with favor from the director general, and they had funded a two-year project for the restoration of health planning.

When the three-person, USAID-funded HIID team assembled in N'Djamena in October 1985, it found that the ministry lacked the means to gather data on even the simplest activities. It could not report accurately the number of public health facilities in the country, much less the number of private ones. The five agencies trying to gather some data did so with duplicative and less than optimal results.

With the HIID team helpfully pointing out these lacunae, the ministry moved to establish the Commission on the Health Information System (CSIS). Commission members included all agency and program directors as well as donor representatives. Thus, the debate on administrative reform could also be played out in the debate on the information system. The director general asked the BSPE to serve as secretary to the commission, but since the BSPE had no bureau chief and only a modestly trained staff of three, the secretarial work as well as the more directive work of option papers fell in the hands of the HIID team. This additional bureaucratic capacity was essential to the planning process.

The option paper for restructuring the health information system, which the HIID team prepared in May 1986 after much consultation with ministry officials, was circulated to the director general and members of the commission in June 1986. It took account of the needs for data voiced by agency and program directors, the need to minimize administrative burdens of regional and local personnel, and the limited resources available at the ministerial level.

During the next few weeks, a member of the HIID team met individually with the director general and members of the commission to evaluate what options were likely to be chosen, and to see where compromises could be made. As positions were clarified, they were communicated to others to see if agreement could be reached. By the day of the commission meeting on June 30, it was obvious that there was a consensus to scrap the old system and to build a greatly simplified new one.

Three decisions had to be made that morning as the commission assembled in the ministry meeting room with its droning fans and creaking chairs. The first was to select the sources of data to be used in the information system. Many of

the directors had earlier insisted that much of the information they needed could be acquired only through surveys of particular populations for particular health problems—for example, malnutrition. Others who recognized the ministry's limited resources felt that it would not be possible to build a capacity for surveys simultaneously with building a routine reporting system. Since a routine reporting system was needed to monitor the activities of the health facilities as well as to assess health needs, the commission decided that the ministry's major source of data for the next few years would be routine reports provided by all health facilities, both public and voluntary/private.

The second decision was to choose the types of reports required. The directors of Administration and of Hospitals and Urban Medicine wanted an annual inventory of all health facilities with information about their personnel, facilities, and equipment. The primary care aficionados wanted this inventory to include information about village health workers, village health committees, and population size. When an inventory was eventually agreed to all these indicators were included, although much doubt was expressed about the reliability of population data and the probability of succeeding in getting facilities to fill out such a form annually.

The old system had required each facility to report monthly on its activities and on the health problems it had treated. Everyone agreed that one of the major reasons this system had not worked before was that the reports were too long, too complicated, and no one did anything with them anyway. As a result, the commission decided that all health facilities would still be required to fill out monthly reports but that less information would be required; that the reporting of health problems would be limited to those problems that nurses even in the simplest clinics were capable of recognizing correctly; and finally, that clinics would receive feedback from their reports.

This agreement to simplify reporting requirements did not sit well with the preventive medicine agency epidemiologists, who feared losing information about (and control over) various diseases running loose in the country. Therefore, the commission decided that health facilities which had greater diagnostic ability (and which were equipped with laboratories) would serve as "sentinel sites" to report on supplementary diagnoses and activities.

Finally, the commission decided to ask a limited number of facilities with good diagnostic capability and access to a radio, telephone, or telegraph to report weekly on a few important infectious diseases against which the preventive medicine division might have to take immediate action. Thus, in all, four routine reports were chosen, with the stipulation that they be the *only* reports used by *all* ministry agencies and programs.

The third and most important decision in terms of administrative reform was how and through whom the data were to be transmitted, and who was to receive and process them. Knowledge is power, as everyone knows. Those in the ministry who until now had been collecting their own data, however badly, were still reluctant to see them going to anyone else. The director general, who had been dissatisfied with previous information efforts, particularly those run by the French, saw an opportunity to revamp information flow and to centralize it within the BSPE, now under his direction. Before the commission meeting, he had conveyed his preference to the directors with the rationale that since the

HIID project would provide two personal computers for the BSPE, the data should be centralized where the computers were. The agency and program directors agreed to this plan only after the director general had reassured them that the BSPE thereby undertook an obligation to provide feedback to the directors and to generate special reports when requested. But they remained skeptical and later, on several occasions, tried to circumvent the new system.

The Preventive Medicine Agency held out that it should receive the weekly telegram simultaneously with the BSPE so that it could immediately take whatever action was needed. Thus, the weekly telegram was the one exception to the pattern of transmission. All the other reports were transmitted by the health facility to the MCP who, in turn, transmitted them to the BSPE for processing and analysis. Agency directors would become dependent on the BSPE for information about activities in the regions.

During the next year, the ministry increased the BSPE staff to eight members and appointed a bureau chief. The HIID team installed computers, trained staff, designed new forms for the monthly reports and annual inventory, and trained the BSPE staff to organize seminars throughout the country for MCPs and local personnel on how to use the new system. By the end of 1988, 88 percent of all health facilities were participating in the monthly reporting system and had managed to send to the BSPE 86 percent of the reports expected during the previous year. This was a remarkable achievement considering the difficult local work conditions and the previous history of poor communications.

Let us now turn to how actors and administrative relations were affected by the burgeoning information system. The major change was in the flow of information and in the consequential change of administrative relationships, much as had been intended by the reform. The MCPs found themselves with the authority to train and supervise nurses and to tell them how to manage information in their clinics. They could stop in the BSPE offices when they were in the capital to review the activities in their region and to assess needs. This information gave them an advantage in negotiating with the Administration and Finance agency for personnel or with the Preventive Medicine Agency for preventive programs. In fact, only one or two of the more energetic and dedicated MCPs took advantage of the new situation. For the others, using this tool to improve their professional performance was less important than other considerations.

The director general benefited from having information about health facilities, personnel, and activities available at any time. When donors presented proposals to develop new facilities, he could marshal lists of current facilities and more easily turn donors toward projects he favored. He could keep an eye on the activities of programs, agencies, and the MCPs.

The high point of the BSPE's early career was reached when a meningitis epidemic swept N'Djamena in March 1988 (in public health, administrative triumphs tend to accompany epidemiologic disasters). The BSPE became the nerve center for directing the successful fight against the epidemic, maintaining daily counts of cases (something which the Preventive Medicine Agency would have done previously), and coordinating the distribution of vaccines.

The new information system did not necessarily clarify administrative relationships. For example, the minister and deputy ministers, when they pleased,

would go directly to BSPE staff for information and special reports (which took priority over other activities) instead of passing through the director general. The new system also heightened tensions between donors, each in defense of his client agency as well as between the BSPE and other agencies and programs. To illustrate the first case there was the time the HIID team asked if the BSPE could use some empty ministry offices the French had just renovated to set up computers and train BSPE staff during the two months when their own offices were being renovated. The French adviser took this issue to the minister with the statement, "No American is going to use our offices." BSPE tensions with the vaccination program became evident during a vaccination campaign in late 1987, when the latter program set up its own data collection and analysis system. Meanwhile, preventive medicine eyed nervously the BSPE's activities during the meningitis epidemic, while some of the BSPE nervously eyed the HIID team. None of these tensions was serious enough to threaten the information system, but one could see the possibility that the agencies which had lost their data-gathering and controlling capacity when the system was formed were working to erode BSPE's control, or better yet, to contrive to establish their own parallel system, if possible with the help of outside donors.

The implementation of these administrative reforms sounds like the stuff of bureaucratic politics, with bureaucrats defending their turf or expanding it. In fact, the only ones playing a traditional bureaucratic politics game were those who were not part of the Chadian bureaucracy: the donors. They were playing it on behalf of their own bureaucracies back home. Within the Chadian bureaucracy there were other events which did not happen, which you would have expected to happen if everyone were happily being a classic bureaucrat. In the next section, we will examine these events or nonevents.

Bureaucratic Reform in Chad-Like Systems

The most telling nonevents were in the BSPE itself where staff stability and indigenous leadership remained in short supply despite the bureau's enlarged resources and responsibilities. It would be tempting to attribute this either to slow development or to incompetence, but that would be missing the effects of the factional system which creates incentives for actions that are often at variance with the bureaucratic interests that one expects to prevail in a bureaucratic politics model.

From an analytic point of view, bureaucratic politics is a subset of factional politics. In bureaucratic politics it is assumed that the faction is congruent with the bureau and that when a person leaves the bureau, his prime factional loyalties change. Such an arrangement can prevail when a person's objective interests— income, advancement—and psychic well-being—power, status—are tightly bound to the workplace and its success. Chadian factional life is more unbounded than this; where one stands depends only coincidentally on where one sits, because vital personal alliances extend outside bureaucratic structures. They persist when a civil servant changes his bureaucratic position or, as has too frequently been the case, when the bureaucratic and governmental structure collapses around him. Given Chad's recent history of uncertainty, betrayal, and distrust, holding on to as many bureaucratically unbounded alliances as one can find is perfectly rational.

The low level of financial rewards from bureaucratic work further militates against strong identification with the workplace. Thus, making money on the side by tutoring, double-dipping, fiddling the expense account, or cadging a plum like a personal vehicle or a trip abroad has more survival value than intense devotion to a bureaucratic mission.

The chief of the BSPE had been appointed when he returned from study in France, nearly a year after the bureau's creation. Although he and the director general were from the same small central ethnic group, which some said accounted for his receiving his post, the BSPE's chief's strategy seemed to be to increase his own margin of maneuver by building ties to as many sources as possible including the minister and the deputy-minister. The BSPE chief managed his staff with a very light touch because the staff also had patrons among higher officials. If affronted, even on minor disciplinary issues (such as regularly not showing up for work), they took their complaints to their patrons, who then leaned on the BSPE chief. Under such circumstances, the costs of hewing to bureaucratic norms of administration became high.

BSPE staff also found means to opt out of the BSPE completely by obtaining fellowships abroad using their own patron-client networks. Even a much needed secretary, by using his patron-client network, secured a transfer back to his hometown. For an administrator in these circumstances, personal survival may have to take precedence over administrative reform, even reform that, in theory, should increase the power and rewards accruing to his bureaucratic unit.

Although the director general had lost most of the major points in the administrative reform, and although rumors abounded that he would lose his post, he survived. The secret of his survival lay not in his ability to manipulate the forces within the ministry but in his ties outside the ministry. These ties included having been part of the core group of loyalists that fought its way back to N'Djamena in 1982 with Hissène Habré and friendships with politically powerful individuals, not from his ethnic group, but with whom he had gone to school. The director general's survival, like his subordinates' advancement, depended little on bureaucratic performance.

Ministry business was often conducted on the basis of factional alliances, not bureaucratic position. Higher officials frequently blocked proposals or projects put forward by civil servants belonging to other factions, and called in extra-ministry allies to make their point stick. When carried to extremes, this behavior could cause all government business to come to a grinding halt, as when a very senior official insisted on running ministry funds through his personal account where they could be used to bankroll his political faction. An official in the ministry, explaining in late 1987 how factionalism dominated decisions, called the situation "GUNT II."

In the classic model of the civil service, loyalty is owed to the state. In the Chadian version of the civil service, loyalty to political allies must take precedence. Insofar as allies represent the formal state command hierarchy, business can be accomplished. But when the political allies and the state are no longer synonymous, government activity follows patterns bewildering to the outsider (and even occasionally to the insider). Contributing to the bewilderment is the presumption on the part of Chadian participants that others *must* be acting in accordance with

personal factional interests, even on those occasions when bureaucratic policy interests may be the motivation.

What conclusions are we to draw about the reform discussed in this paper? The bureaucratic lines were successfully rearranged; MCPs began to monitor their regions; the BSPE was established and has been more than trivially successful in producing reports and information useful to interested policymakers. At the same time, coordination remains a sometime thing; erratic decision making is a frequent occurrence, as are misallocations of resources and bureaucratic undiscipline. The reform may be justifiably seen as a triumph over the chaos of Chad's recent history. Even then, serious questions must be raised about the reform's sustainability after the HIID team leaves.

Grindle and Thomas usefully employ Hirschman's distinction between pressing and chosen reforms to analyze the problems these reforms encounter later.¹⁸ The reform leading to the creation of the BSPE would clearly fall within the category of chosen reform. As such, it does not benefit from the overwhelming pressures of circumstance that might continue to guarantee its survival against the disruptive effects of factional politics. The fact that reform occurred at all owes something to the pressures, at least in the form of resource enticements, provided by USAID, and the pressures exerted by the presence of the HIID team.

This would suggest that proposals for chosen reforms in countries with Chad-like characteristics must include plans to build in continuing pressures that may sustain the reform over time. These pressures could include plans for projects to last five to ten years rather than the two to three years of this project or to require that disbursements for further projects be made conditional upon maintenance of the earlier reform. Ultimately, of course, a reform will be sustained against lower-level factional pressures only if officials at the ministerial level or higher take a direct interest in these reforms.

To understand the effects of bureau and ministerial level factionalism should be the first assignment for those proposing reforms. In effect, something of a "political risk" and "political resource" analysis should be done at these subsystemic levels as part of the preparatory work. While no outside group is likely to penetrate the deepest mysteries of factional alignment, it should at least be possible to arrive at a realistic assessment of the internal factors affecting success and sustainability. Such work is touchy, but reformers should have some idea of what they are getting into. For administrative reforms such an analysis means understanding political factionalism in the bureaus where the reforms will take place.

Outsiders who would be reform-mongers in Chad-like bureaucratic systems might well pay attention to three additional lessons from the experience described above. First, since reform consumes both time and bureaucratic resources, a supplemental team, like the HIID team in Chad, may be required. However, it will prove useful only if it serves instrumental purposes of important officials. Second, adjustment policies that hold down civil-service salaries to present levels make the task of improving bureaucratic performance even harder, however imperative such policies may appear from a macroeconomic perspective. Such trade-offs should be debated and not decided on ideological grounds. Finally, major improvement in bureaucratic performance, and a fair prospect that reforms will be self-sustaining, will in the longer run depend on assuring

stability of the governmental system as a whole. Predictability and supervisory attention of senior officials who themselves have a stake in the performance and survival of the regime are essential. In the production of such a felicitous macrolevel environment, outsiders can provide modest help and encouragement, but they cannot hope to direct the process nor to control the prime variables that determine success or failure. ∞

Table 1 Chad Facts (estimates)

Population (est.1987) ¹	5.3 million
Gross Domestic Product (GDP), 1987 ²	U.S. \$729 million
GDP/capita, 1987 ²	U.S. \$138
External aid for all public activities (gifts and loans), 1987 ²	U.S. \$240 million
External aid as percent of GDP ²	32.9%
External aid for health activities, 1986 ³	U.S. \$16 million
Ministry of Public Health	
Average annual expenditures, 1983-85 ⁴	U.S. \$1.2-1.6 million
Personnel costs, 1986 ⁴	
Budgeted	U.S. \$3.2 million
Estimated allocation	U.S. \$1-2 million
Operating costs, 1986 ⁵	
Budgeted	U.S. \$1 million
Actual expenditures	U.S. \$250,000

¹ Government of Chad, Ministry of Planning and Cooperation, *Statistiques Démographiques du Tchad, 1985-86-87-88*.

² Government of Chad, Ministry of Planning and Cooperation, *Comptes Economiques: 1983-1988 -Document Provisoire- (Données recueillies au 31-12-87)*.

³ World Bank, *Tchad: Situation Economique et Priorités*, 18 June 1987.

⁴ Republique du Tchad, *Dotation de Fonctionnement des Pouvoirs Publiques*, 1986.

⁵ Government of Chad, Ministry of Public Health, *Rapport d'Activités, 1986*.

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Table 2 Chad Health Data

A. Health resources per 100,000 inhabitants, 1988

Physicians	2.13
Dentists	0.11
Qualified nurses	17.74
Pharmacists	0.34
Hospitals/med. centers	0.58
Dispensaries/clinics	5.90
Hospital beds and places for beds	74.00

B. Health facilities

	Public	Religious/ Voluntary/ Private	TOTAL
Hospital/med. center	24	7	31
Infirmiry/maternity	22	7	29
Dispensary/clinic	193	93	286
Health posts	3	32	35
Other	33	4	37
TOTAL	275	143	418

C. Death rates

Infant mortality estimate, 1987	210/1,000
Maternal mortality rate for births at N'Djamena hospital, 1986	786/100,000

D. New cases of selected health problems per 1,000 inhabitants as reported by 294 health facilities, July 1987-June 1988

HEALTH PROBLEM	AGE			
	0-11 Months	1-4 Years	5 Years and Up	All Ages
Fever	112	65	21	30
Cough of <2 weeks	168	61	15	27
Trauma	35	33	22	24
Diarrhea	179	69	9	23
Dysentery	21	22	7	10
Conjunctivitis	63	26	9	13
Skin infection	47	29	9	13
Otitis media/tonsil	43	25	8	11
Neonatal tetanus	5	—	—	—

Source: Government of Chad, Ministry of Health, Bureau of Statistics, Planning, and Studies

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Notes

- 1 For the "bureaucratic politics" model see Graham Allison, *Essence of Decision: Explaining the Cuban Missile Crisis* (Boston: Little Brown, 1971). Merilee S. Grindle and John W. Thomas use this concept in explaining the outcome of reforms in their paper, "The Political Economy of Policy Change in Developing Countries," Harvard Institute for International Development, Employment and Enterprise Analysis (E.E.P.A.) Discussion Paper No. 10, October 1987.
- 2 Jean Chapelle, *Le Peuple Tchadien: Ses Racines, Sa Vie Quotidienne et Ses Combats* (Paris: Editions l'Harmattan, 1980), 39.
- 3 Robert Buijtenhuijs, *Le Frolinat et Les Guerres Civiles du Tchad (1977-1984)* (Paris: Karthala, 1987).
- 4 William J. Foltz, "Social Structure and Political Behavior of Senegalese Elites," in *Friends, Followers and Factions: A Reader in Political Clientelism*, eds. Steffan W. Schmidt, James C. Scott, Carl Lande, and Laura Guasti (Berkeley: University of California Press, 1977), 242-49.
- 5 William J. Foltz, "Chad's Third Republic: Strengths, Problems, and Prospects," *CSIS Africa Notes* 77 (October 30, 1987).
- 6 World Bank, *Tchad: Situation Economique et Priorités (Projet)* (18 June 1987): 127.
- 7 It is commonly estimated that an African family of four requires 50,000 CFA a month to live with modest comfort in N'Djamena.
- 8 The source of the infant mortality rate for Chad is from estimates by Chadian and expatriate physicians of infant deaths in N'Djamena. No studies permitting a more accurate estimate have been undertaken in Chad in the 1980s. The source of the Egyptian and Kenyan rates is James P. Grant/UNICEF, *The State of the World's Children, 1987* (New York: Oxford University Press, 1987), 90. This source gives an infant mortality rate of 138 per 1,000 live births in Chad in 1985. No one in Chad could identify the source of this statistic, nor was anyone willing to attest to its reliability.
- 9 World Bank, *Tchad: Situation Economique et Priorités* Report No. 6785-ch (Washington, D.C., January 1988): 123.
- 10 See, for example, the volume of nine papers edited by D. Donaldson and D. Dunlop, "Financing Health Services in Developing Countries," *Soc. Sci. Med.* 22, no. 3 (April 1986): 313-85. Each paper develops and illustrates some of the issues in financing health services in particular countries.
- 11 Donald S. Shepard and Elisabeth R. Benjamin, "Mobilizing Resources for Health: The Role of User Fees in Developing Countries," Harvard Institute for International Development, Development Discussion Paper No. 234, September 1986.
- 12 World Health Organization, *Primary Health Care*, a joint report by the Director-General of the World Health Organization and the Executive Director of the United Nations Children's Fund (Geneva and New York, 1978), 2.

- 13 Victor W. Sidel, "The Role and Training of Medical Personnel," in *Public Health and the People's Republic of China*, eds. Myron E. Wegman, Tsung-Yi Lin, and Elizabeth Purcell (New York: Josiah Macy Foundation, 1973), 162.
- 14 Lincoln C. Chen, "Primary Health Care in Developing Countries: Overcoming Operational, Technical, and Social Barriers," *Lancet* (29 November 1986): 1264.
- 15 Clive S. Gray, "State-sponsored Primary Health Care in Africa: The Recurrent Cost of Performing Miracles," *Soc. Sci. Med.* 22, no. 3 (1986): 361-68.
- 16 The military model was the origin for the Public Health Service Corps in the United States, and it is not quite dead yet. During the 1980s, United States Surgeon General C. Everett Koop reinstated the policy of requiring Public Health Service Corps personnel to wear uniforms when on duty.
- 17 Herbert Kaufman, *The New York City Health Centers, Inter-University Case Program* (Indianapolis: Bobbs-Merrill, 1959).
- 18 Grindle and Thomas, "The Political Economy of Policy Change," 31.