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Local Perspectives on the Legitimacy of Health Institutions in Manantali, Mali

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Pardo and Prato (2019: 9) have discussed the importance of understanding the everyday practices around government legitimacy and the processes that contribute to legitimation and delegitimation. Reciprocal trust is crucial in creating credibility, as citizens constantly assess the actions and motivations of government actors (Pardo and Prato 2019: 11). This piece focuses on the legitimacy of everyday practices in health care in the area of the Manantali dam in Western Mali. It focuses on two aspects: 1) performance legitimacy, the ability to offer effective and quality services, and 2) process legitimacy, agreed rules of procedure for acceptable action (OECD 2010: 23).

Legitimacy and Health Care in Mali

When Mali became independent in 1960, its socialist government put in place a system of public hospitals and practitioners meant to serve all its people. For about ten years, the new government benefited from international assistance (Mariko 1993: 247), but afterwards, contributions to the national budget for health steadily decreased, and the state was unable to fund adequately all levels of the national health system (Coulibaly and Diarra 1993). Most small town and rural health centres lacked personnel, equipment and drugs. In this context, medical personnel often indulged in dishonest and sometimes harmful behaviour along the lines described by Pardo (2004, 2022) and Prato (2022). Coulibaly and Diarra (1993: 234) noted corruption, theft and other illegal practices. Agents often asked for money for care that should have been free or charged for extras beyond posted fees (Tinta 1993: 223). Physicians and other health professionals, then universally employed by the state, also illegitimately saw private patients. In 1986, patients spent an estimated US$ 1.597 million on private clandestine medicine (Coulibaly and Diarra 1993: 243). Through the 1980s, Mali's national health care system, with little trust between providers and users, lacked both performance and process legitimacy.

Then, structural adjustment programs pushed the Malian state to disengage from health service provision. Private medical practice was legalized in 1983. The government monopoly on the import and distribution of pharmaceuticals was ended in 1991. These changes did not directly improve health services, so policy makers began to look at other options, including cost recovery, health insurance, mutual insurance associations, and the use of generic drugs (Coulibaly and Diarra 1993: 240).

Since then, the key institution in the health care system has become the *Centre de Santé Communautaire* (CSCOM, Community Health Centre), in which user fees from patients generate funds to cover operating costs, including salaries. The idea was first piloted in a spontaneous neighbourhood in Mali's capital as an experiment that involved Tiéman Diarra as implementor and researcher. The first CSCOM was opened there in March 1989 (Diarra 2012). By 2001, there were 350 CSCOMs (Balique et al. 2001), by 2011, 1086 (Mali 2014: 20).

The formation of a CSCOM starts with the establishment of a community-based non-profit *Association de Santé Communautaire* (ASACO, Community Health Association), which first launches and then manages the CSCOM. Although private not-for-profit institutions, ASACOs and CSCOMs are under the supervision of the state, which verifies respect for four essential conditions: ASACO respect for democratic rules, legitimacy of the CSCOM director's authority and decisions, not-for-profit status, and accounting transparency (Balique et al. 2001: 38-9). As more communities wanted CSCOMs, the government established rules for their creation as an integral part of the national health system with different tiers of care. A convention of mutual assistance between the government and the ASACO-CSCOM jointly established the roles and obligations of the partners. Government funding to equip new CSCOMs and aid in recruiting personnel is available; some also get assistance from NGO programs.

The community-run ASACO has conferred transparency on CSCOM operations and is a key guarantee of their process legitimacy. In contrast, the performance legitimacy of CSCOMs is fragile. Many CSCOMs have insufficient income to sustain them (Konaté and Kanté 2005: 137). The number of visits may not cover costs (Balique et al. 2001), although sometimes the deficit is made up by drug sales (Konaté and Kanté 2005: 144-5). Nevertheless, residents sometimes complained that the supply of essential medications was not reliable (Konaté and Kanté 2005: 143). The financial problems were compounded by lack of qualified personnel, low use of service, inadequate infrastructure and equipment, and poor performance (Coulibaly et al. 2020: 2).

For advanced care, people usually move into the public system. Most prefectures in Mali have public referral hospitals; public hospitals in regional capitals treat more complex cases. The capital, Bamako, houses five public hospitals and government research institutes for public health, blood transfusions, child survival and sickle cell disease (Mali 2014: 19). Private options are also available, mostly in major cities.

These tiers of care build on the CSCOMs, now the-state recognized backbone of Mali's health system and the first level of contact for health services.

Health Care in Manantali in the Early 2000s

Although Manantali[1] is similar to many areas of rural Mali, it is different in one striking way. It is the site of a high dam, built in the mid-1980s to provide electricity and improve irrigation and navigation to the states of the OMVS (*Organisation pour la Mise en Valeur du Fleuve Sénégal*, Senegal River Basin Authority) at the time of dam construction: Mali, Mauritania and Senegal.[2] There has since been rapid change, including the construction of roads and new villages for the 8850 people displaced from the reservoir, most of whom now live downstream of the dam. The dam galvanized the growth of Manantali town, a small rural service centre with about 10,000 inhabitants in 2016. The area was also affected by significant national changes, not only structural adjustment, but also democratization, political decentralization, and

[1] The term Manantali refers to the dam, the town, and the wider area.
[2] Since then, Guinea has joined the organization.

associated development initiatives from the early 1990s onward. With decentralization, the area created two communes, Bamafele and Diokeli, each with an elected council and mayor.

The town of Manantali occupies an anomalous position. As part of the commune of Bamafele, it comprises approximately half its population, while the other half is dispersed among 25 villages. However, the land upon which the town is located is owned by the OMVS, which continues to support some of its infrastructure, including a health centre. Although the town is large and wealthier than the villages, the commune political centre is the village of Bamafele.

The information here comes from a study funded by the US National Science Foundation (BCS-1560543) in 2016-19 to understand the effects of resettlement, with special attention to those displaced from the reservoir in the mid-1980s. The research team followed a sample of 137 households, 108 resettlers and 29 hosts. In each, up to four members were interviewed; not all households had people in each category. Relevant here, male heads and one older woman were asked their responses to household illness and what health centres they used. Younger men and women were asked how they tended to their health and whether and where they sought modern health care. Qualitative information was also collected on Manantali's health institutions.

Before the resettlement in the mid-1980s, the area health institutions suffered from performance and process illegitimacy. The administrative centre of Bamafele had a 'rudimentary' health post staffed by a senior nurse and midwife (USAID 1984 Annex 7.7: 10). There was virtually no equipment; rarely were drugs available. In an isolated area, people said that they had to walk up to three days to get to decent health facilities.

Now, as in most of Mali, the provision of modern medicine is based on CSCOMs. The commune of Bamafele has three. The first, in Bamafele, the commune centre, was established in 1998 as a transformation of an older health post built by the resettlement project. A second CSCOM was created in 2003 in Marena, on the other side of the Bafing river, to serve the villages there. A third CSCOM was opened in Manantali town in 2021. Unlike the village CSCOMs, this one promised stable running water and electricity; it hoped to provide an operating room, x-ray and ultrasound machine. Bamafele also supervised a satellite health post in an upstream village, to serve the minority who lived there. In contrast, the more rural commune of Diokeli, with about the same population as Bamafele, has only one CSCOM, in the commune centre. All the CSCOMs are formally linked to the government referral hospital in the prefecture, Bafoulabe.

Manantali town also includes a health centre owned and staffed by the OMVS, known to residents as the 'hospital' of Manantali. Originally built to serve construction managers and workers, it continues to function and is open to all. This health centre has a working x-ray, an oxygen treatment room and four hospital rooms, as well as consultation rooms and offices for doctors and nurses. The OMVS also runs a smaller dispensary, which focuses on prenatal, infant and child care, family planning, routine vaccinations, and malnutrition. Although the OMVS health centres send patients to government referral hospitals, they are not formally integrated into the Malian public health care system.

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Health Care Options in Manantali

Manantali residents evaluated the legitimacy of their health care institutions using concrete criteria. People did not talk of dishonesty, favouritism, under-the-table payments or other evidence of process illegitimacy in the context of health care, although they often mentioned it in other domains. Therefore, this section focuses on performance legitimacy, as evaluated by availability, cost, effectiveness and quality of the health care institutions.

Available health care options included both traditional and modern medicine.[3] Both were practiced in Manantali. There were three traditional specialists in our sample; all claimed relatively successful practices. They treated mental illnesses, epilepsy, infertility, and diseases with supernatural causes. The sample also included a traditional bonesetter and several midwives. No one mentioned using traditional specialists in answer to the interview questions about provision of family health care. However, other information indicated that several people in the sample had been treated by them for mental illness and impotence.

By far, the most common use of traditional medicine was the home-based preparation of plants and leaves for teas or washing solutions. These medicines are based on gathered or cultivated plants, and their preparation is widely known and based on local knowledge passed down for generations. In answer to our questions about sources of health care, a substantial minority of women, both older and younger, and younger men said they used plant-based medicines exclusively. More commonly, all categories of individuals used both traditional medicines and the modern health system. Generally, they tried traditional medicines first, but if they did not work, they turned to modern health care, especially the CSCOM. Traditional health care, widely available, is often, but not always effective. In other words, it is legitimate but not for all health problems.

Although the majority of residents used modern medicine and the national health system, they had problems with its cost. Despite the fact that CSCOM fees are kept low, many people found it difficult to pay for consultations, treatment and medications. Although many brought ill family members to the CSCOM, about a quarter of household heads said that it was not easy to pay. They brought up the need to borrow money, to call upon migrant family members, to sell livestock, and to use savings. Some 18% of older women also brought up these problems, as well as the cost of transport to health centres.

Availability of both personnel and medicines at the CSCOMs was raised by some respondents. A few also had questions about quality of care. Several called into question the capability of the physician at Diokeli; more commonly, people complained that he was often absent. A few also complained about the absence of the physician at Marena. Several people also said that appropriate medications were not always available at the CSCOMs.

Both ASACOs and CSCOMs were aware of these problems in performance, but they did not always agree on what should be done and who should do it. CSCOM personnel presented lists of needs: unfilled positions, housing for the medical team, renovations to buildings and

[3] Malians of all social classes throughout the country mix modern and traditional medicine. Although individuals may reject one domain or the other, the legitimacy of both sorts of medicine is generally accepted, in contrast to other places (e.g. Sarfati 2022).

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equipment, improvements to the water supply, incinerators for medical waste, better transport for patients. Medical directors generally thought the ASACO boards could be more proactive and should manage their financial resources better. They also wanted ASACOs to find 'partners' who could aid with funds, particularly NGOs who might finance particular needs. In turn, ASACOs struggled to manage with restricted budgets, linked to the CSCOM income. Some said they faced difficulty in paying required salaries and the monthly electric bill and were not always up to date on employee insurance. Indeed, the Diokeli commune paid half the physician's salary to relieve pressure on the ASACO. In general, there was little money for improvements. ASACOs confirmed that there were sometimes shortages of essential medications.

Despite the problems, patients generally trusted the CSCOMs. Many young women went for regular prenatal consultations; a significant number delivered their babies there. A few mentioned regular treatment for chronic diseases. This was a significant change from what their life had been before the resettlement. Yet the basic legitimacy of the CSCOMs, a consistent level of quality care at a reasonable price, is not assured, because their economic fragility affects their performance.

People did not question the legitimacy of the system as a whole as much as the individual CSCOMs, clinics and hospitals. Often, they did not go to the CSCOM in their commune or to the closest one. They also did not go consistently to the same site for primary health care. For example, in the commune of Bamafele, which includes the OMVS facilities in Manantali, interviewees were almost as likely to use OMVS facilities as the Bamafele CSCOM. Twelve heads and six older women said the household used the Bamafele CSCOM, while eight heads and seven older women said household members went to both Manantali and Bamafele. The pattern was similar in Marena, the area of Bamafele commune across the river. Nine heads and seven older women said the household primarily used Marena CSCOM, but 12 heads and eight older women said they used Manantali, usually along with Marena, but a few times Manantali only. The upstream villages, a part of Bamafele, rarely if ever used its CSCOM, which was far away. Rather they used other CSCOMs upstream; if they needed more advanced care, they often went to the referral hospital in Kita, a neighbouring prefecture.

In Diokeli, people made different choices. Slightly less than half of heads and slightly more than half of older women used mainly the Diokeli CSCOM. A significant minority used Bamafele. Others used both Diokeli and Bamafele CSCOMs; more than half of them also sent people to Manantali. A few used Diokeli and Manantali only. For advanced care, a number went not only to Bafoulabe, but mentioned using the regional hospital at Kayes or getting care in Bamako.

Many residents chose the OMVS health services at Manantali for at least some of their care. Although not an official referral hospital, it served as such for many households. They often clarified that when something was complicated, they went directly to Manantali. People also believed that a physician would be more reliably present in Manantali, and several mentioned that its pharmacy was cheaper.

In light of these choices, it is worth asking how the presence of a better equipped CSCOM

at Manantali, opened after these data were collected, would affect how people evaluate their options. If this centre offers good quality and low prices, it may attract patients from existing CSCOMs. Those who already have problems facing costs may see their incomes further erode, making them more fragile.

Conclusion

The establishment of CSCOMs has done much to increase transparency, trust, and process legitimacy in health care at Manantali, but performance legitimacy remains fragile. The ASACOs that manage the CSCOMs often struggle to meet operating costs and find it even more difficult to maintain and upgrade equipment and locales. Thus, the viability of established CSCOMs may suffer as newer ones, better equipped with initial start-up funds, open. For example, the Diokeli CSCOM, already facing financial constraints and viewed as problematic by some patients, may lose even more clients. If the fall in income means that minimum services cannot be maintained, the commune could lose its only health centre. To be sure, patients could still use the abundant services in Bamafele, but this puts poorer patients at greater risk, as they are less likely to be able to afford transport there.

If the Malian government values the presence of universal basic health services, it needs to increase government support for CSCOMs in poorer areas to maintain performance legitimacy. For example, it should consider grants and funding for renewing equipment and structures and advanced training for personnel.

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