

The Importance of Practical Norms in Government Health and Education Services in Togo

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1. Introduction

This report summarises the results of a socio-anthropological inquiry on the daily functioning of educational and health services in Togo. The study is part of a research programme entitled « Accountability Through Practical Norms: Civil Service Reform in Africa From Below » financed by the *British Academy-DFID Anti-Corruption Evidence Programme*. This anthropological research focuses on “practical norms” that regulate daily behaviours of civil servants, by comparing several French and English speaking countries in West and East Africa (Togo, Malawi, Niger, Sierra Leone, Senegal and Tanzania).

What does the notion of “practical norms” refer to? A significant number of studies on the working of public administrations and on the delivery of public goods and services in Africa and beyond have demonstrated that gaps between official norms (professional as well as bureaucratic) and state officials’ daily practices are widespread. These gaps do not occur randomly, and do not necessarily mirror inadequate training (state officials would ignore the canons of their respective professions). Nor are they systematically deviant behaviours dictated by personal interests (state officials would be corrupt). They are in their turn inspired by “practical norms”, i.e. modes of regulation other than official rules, results of *bricolage* and hybridization of official, social, and professional norms. One could even see them as “normed practices”, deliberately but sometimes unconsciously implemented by state officials and shared within a specific professional body, an administrative space, or even becoming part of the bureaucratic culture of a given country. In Olivier de Sardan’s terms, “practical norms are the latent regulations of the practices of civil servants when these do not follow official regulations” (Olivier de Sardan 2015: 21).

To make things clear at the outset, let us anticipate some examples that will be treated further in the present report. In Togo, public servants ordinarily take leave of absence from work for social reasons or to pursue other income generating jobs. At the same time, superior authorities rarely punish this absenteeism. Taking French leave is a *general bureaucratic “practical norm”*: we observed it both in the health and education sectors. In contrast, the informal practice of filling partograms after delivery, widely shared in Togo as well as in other West African countries, illustrates a *professional specific practical norm*. Finally, one can find some *location specific practical norms*. This is the case of the rural maternity, which has designed a night shift organisation that deviates from official regulations to compensate for the lack of staff.

Some of these “practical norms” can play a negative role and contribute to the malfunctioning of public services; others, on the contrary, can play a positive role: they can make up for the lack of material or human resources, or represent responses and attempts to adapt public policies or abstract procedures to daily realities in the

field. Admittedly, some of the observed practices can be seen to easily fit into the category of daily petty corruption, whereas others, though irregular, do not relate to the world of corrupting exchanges. By the way, our qualitative and non-normative approach does not reduce these deviations uniquely to their legal dimension.

Moreover, amongst the “non-compliant” behaviours (Olivier de Sardan 2001) identified, some undoubtedly appear innovative and facilitate the delivery of public services despite the multiple hindrances and obstacles. They can constitute the point of departure for conceiving reforms closer to real practices and to African administrative contexts.

1.1 Research methodology

The study was conducted in urban and semi-urban areas.

In the health service, we focused on two health services: in the urban area, Lomé-commune health circle’s district n° 3 hospital. This caters to a population of approximately 187 573 inhabitants with five public health services and nine recognized private services; in the rural area, to the Tchamba prefectural hospital. This covers a population of 30 878 inhabitants. At the time of the inquiry, the corresponding health district consisted of 18 health services.

In the education service, inquiries were conducted in primary schools in Lomé Golfe and Maritime educational zones. At the core of these two regional directorates that count a total of 2240 public primary schools, we chose 20 institutions (16 public and 4 private). These included some institutions that exist since at least 10 years in the neighbourhoods of urban Tsévié, rural Davié, semi-urban Adétikipe and urban Lomé.

In the two cases, we gathered a corpus of qualitative data based on semi-directive interviews and focus group discussions, observations *in situ* (participant and non-participant observation) and documentary research.

In the health service, we conducted 57 semi-directive interviews and 3 focus groups in gynaecology/maternity and paediatrics departments. The focus groups had 27 participants (health officials, association of health professionals and officials from the Health Ministry’s decentralized services). Systematic observations were made in the care units and hospitals, during monitoring and round-the-clock services and external consultations.

Table 1. Empirical corpus on Health Service

Strategic Group	Number of interviews
Birth attendants/Matrons	5
Institutional actors (DRS, DPS, health district officials)	7
Anaesthetists-Intensive care specialists	1
Medical assistants (senior health technicians)	10
Caregivers	2
Nurses	3
Doctors	3
Psycho-social mediators	1
Resource persons	10
Midwives	15
Total	57

We studied education services mainly through focus groups discussions, 15 in all, with targeted groups ranging from school principals, teachers, and parents. 18 individual interviews with school principals and teachers allowed us to clarify certain themes.

Table 2. Empirical corpus on Education Service

Strategic Group	Number of interviews	Nature of interviews	Number of participants
Institution heads	14	Individuals	14
	1	Group	7
Teachers	7	Group	24
	4	Individuals	3
Parents	7	Group	36
	33	-	84

In order to grasp the different practical norms functioning in the health and education services, we privileged two approaches: the first focused on the general working of the structures examined, or their daily governance in some ways; the second centred on observations and interviews on the application of some recent reforms and public servants' reactions and adaptation to these initiatives. In fact, gaps and discrepancies are particularly discernible in the implementation phase of a programme or a public policy. Hence, we have chosen to focus our investigations on some recent reforms. For the health sector, our case studies focused on free maternal health care policy, focused antenatal care, HIV prevention of mother-to-child transmission and the partogram. As for the education sector, we focused on the effects of free primary education policy, and the policy of automatic promotion in primary schools.

2. Common trends in the delivery of Health and Education services

2.1 Free access policies with no real accompanying measures

During the first decade of the 21st century, Togo like other states of West Africa adopted policies aimed at promoting free access to basic health and education services, particularly for more disadvantaged groups.

Thus, although the question of free education had been announced since the 1975 Education reform and reiterated in article 35 of the 1992 Togolese constitution, the Togo state implemented free schooling for the new school-year 2008-2009 only in the wake of the global policy of Education for All (EFA, 2000).

The law on free schooling followed a political decision and was not part of an education plan. Moreover, it was applied without any preliminary studies and without involving the teaching corps in its implementation.

“The decision was not well-thought-out. The State had neither deliberated on the expenses involved, nor arranged for alternative sources to finance free schooling. The State made no review of the prevailing conditions of education, nor did it evaluate the need per region before inaugurating the law on free public primary schooling.” (Parent, private secular school, West Lomé, September 2017).

One of the consequences of this policy was to increase the number of pupils in primary schools. This jumped from 776 396 in 2008 to 1 064 334 in 2016¹, without the State building more schools or training and recruiting the necessary teachers to face this new school expansion. Furthermore, annual State subsidies around 90 000 FCFA were inadequate to run a school during the academic year. They arrived late, because of delays in disbursements.

In the eyes of educationists – teachers and parents – free schooling indicates a State withdrawal from this service. Some feel that “free schooling exists only in name, in reality school is not free. The State can’t manage to shoulder free schooling” (Parents from a private secular school, West-Lomé, September 2017).

Maternal and child health service were equally affected by free healthcare policies during the years 2000. Introduced in 2011, the “Accelerated campaign to reduce maternal mortality in Africa” (CARMMA)² stipulated that the costs of deliveries by Caesarean section had to be shared by the State and the user. Before this reform, the cost of a Caesarean varied from 50 000 to 65 000 CFA francs depending on the health service. After the reform, all the public health services converged around 30 000 CFA

1 Source: Reconstituted Data of Statistics Directory, MEPSFR.

2 This followed a commitment made by the African Union’s Health ministers to battle maternal and infant mortality in their respective countries during the fourth session held in May 2009 at Addis-Ababa in Ethiopia.

francs. The State subsidizes two thirds of the fees and the user pays 10 000 CFA francs. These same principles apply to the treatment of malaria: quick diagnostic tests (TDR) and the Coartem are henceforth free, whereas the artemether is subsidised.

According to health officials and users, these two reforms are beneficial from every point of view - both for access to health services and for reducing maternal and newborn morbidity. Aboubakari et al. (2014) and Balaka et al. (2015) confirm these advantages, particularly in the case of the Caesarean in Togo. But these reforms have affected the economy of health services and according to the medical personnel constitute one of the bottlenecks in their functioning. Thus,

“Resources for self-financing of health services are diminishing; malaria and caesareans, which constitute the main sources of finance for hospitals, bring no more money into their tills since patients don’t have to pay” (Health official, field inquiry).

The State is late in paying its part for Caesareans, to compensate for the missing amount in health services. In one of the structures studied,

“In 2015, we did around 142 Caesareans; so, if the State allocated 20 000 CFA francs, we would have 142 multiplied by 20 000. Except that in fact, the State never allocated the 20 000 CFA francs that year. In 2016, we did 156 caesareans. To date, the State still hasn’t allocated its part. As we talk, the funds for Caesareans done in 2014 have just been disbursed” (head of a health institution).

In the case of some inputs like the artemether, the State henceforth obliges health services to limit the price of the vial to 180 francs. Before the reform, hospitals used their discretion to fix the resale price and thus reaped the benefits; bought at 110 CFA francs, the medicine was resold to patients at 300 CFA francs. It was the same for TDR and Coartem that were previously bought, but are now free. The State even provides medical tests’ inputs and Coartem molecules for health services.

The diminution of income in health services affects the hospital’s drugstore supplies and the payment of the numerous health workers whose salary comes from the institutions’ own budget ³.

Thus, policies of free access, thoughtlessly applied, have exacerbated dysfunctions in the health and education systems, aggravated the lack of human and material resources and fostered informal privatisation of schools or hospitals (as we shall see

³ These problems are not unique to Togo. The application of free access policies and subsidies has invited studies in different West African countries like Burkina Faso (Yaogo, Kagambega and Dabiré 2014: 87-99) and Mali (Koné 2014 : 101-113). Recent works have also underlined the impacts of free access reforms and subsidies on health services (Diarra 2011 ; Ousséini 2011 : 19-45 ; Kafando, Mazou, Kouanda, and Ridde 2011).

below).

2.2 Inadequate material resources

In Togo, public services in the Education and Health sector are characterised by penury. This is particularly extreme at the level of school institutions. According to a national study conducted by the World Bank in 2013, 75.7% of classrooms do not possess the minimum material necessary for teaching (blackboard, chalk, pens, notebooks), whereas 85.6% of school institutions were deprived of minimum infrastructures like functioning toilets, electricity, or good conditions of visibility of blackboards (World Bank 2013a: 22-23). Five years later, our field inquiry confirms these data, as shown in the table comparing data from the Ministry of Primary Education Official Statistics directory and that produced by our own observations on the field.

Table 3: Overview of ratios of pupils/teachers, pupils/classrooms, pupils/sitting space, textbooks/pupils

Ratios	Statistics Directory		Field data	
	Lomé-Golfe	Maritime	Lomé-Golfe	Maritime
Ratio pupils/teacher	60	44	70*	82*
Ratio pupils/classroom	59	44	81	90
Ratio textbooks /pupil	0,6	0,6	0,12**	0,12**
Ratio maths textbooks/pupil	0,6	0,5	1	1
Ratio pupils/sitting space	1	0,87	1,5	2

Source: MEPSFP, 2016 ; field inquiry 2017.

*Ratios can go up to 152 pupils per teacher in a class twinned due to lack of teachers (case of EPP Davié-rails in Maritime).

**Generally, school principals declare 10 to 11 books for a total of 80-90 pupils.

Regarding textbooks/pupil ratios, official data indicates a ratio of 0.6, which corresponds to 1,2 textbooks for 2 pupils, whereas our field data gives a ratio of 0.12, corresponding to 1 textbook for 8 pupils. As far as the pupils/maths textbook ratios are concerned, field data presents a better situation (ratio=1, or 1 textbook per pupil) in relation to official data (ratio=0.6 or 1 textbook for 2 pupils). Lastly, as far as the pupils/seats ratio is concerned, official figures indicate one seat for each pupil (2 per bench) whereas on the field, we generally found 3 pupils per bench in Lomé-Golfe and 4 pupils per bench in Maritime.

Globally, we systematically came up against large numbers on the field, often due to grouping of several classes to make up for a lack of classrooms and teachers. Thus,

“In classrooms, 4, even 5 of our children are seated on a bench and there are no aisles in the classes because the benches are placed against each other so that all the pupils of grouped classes may be seated. In these conditions, pupils develop some harmful practices. For instance, a pupil can go to sleep under the bench and at times he goes to sleep during the class without the teacher even noticing” (Group of parents from a Primary Public School of West Lomé inspection, September 2017).

In some institutions investigated, the parents of newly enrolled pupils are even obliged to make table-benches so as to find a seat for their children. Thus, because of lack of regular maintenance, buildings deteriorate quickly and are sometimes abandoned. This negatively impacts the pupils and teachers’ school life, and makes public spaces more insecure, as illustrated by the Aflao-Totsi public school case. Here, because of a flood, classroom blocks were abandoned for years. Slush and mildew covered nearly the entire school courtyard. The plot reserved for kindergarten teaching has actually become a zone for neighbourhood drug addicts who come there after school hours. The deterioration of this institution has led pupils’ parents to call it (kindergarten) “ghetto” or even (primary school) “amphibians”.

The same inquiry conducted in 2013 by the World Bank on the Togolese health system gives far better indicators for services. Thus, 44% of the health services possessed the major tracer drugs, whilst 64.7% had minimal equipment.⁴ The contrast appeared stronger in health infrastructures: if, on an average, 60.8% of the institutions (public as well as private, urban as well as rural) had electricity, water and latrines, rural public health services were 2.8 times less well-equipped than urban. (World Bank 2013b: 37)

By contrast, diametrically opposed situations were revealed in our field inquiry, since the urban service suffered from lack of equipment and infrastructures. In the city, all the health workers interviewed invariably mentioned the material difficulties they faced daily. Besides, as we shall see below, several practical norms that emerge in the urban environment have a “palliative” dimension, and seem to aim at circumventing these difficulties.

As far as the semi-urban health service is concerned, it is less exposed to material difficulties than the urban hospital: hospital rooms and furnished offices remain unoccupied (health workers’ occupy only one of the offices), brand-new hand-lamps lie around unused in health workers’ office corners since there are many more

⁴ Thermometer, stethoscope, sphygmomanometer, weighing scale, refrigerator and material for sterilisation (World Bank 2013b: 46).

available, the operation room is well-equipped and carefully maintained, etc. Before we left the field, the hospital administration handed over another delivery kit to the maternity, even though the old one was still working and being used.

On the contrary, in the city, half the working material used was practically broken down, insufficient or non-existent. A health worker informed us that “no working material functions at 50%, all function at 30 to 40%”. In most of the consulting offices we visited, the required hand-lamps for gynaecological consultations were either non-existent or broken down. Taking the example of the operating block, we noted that apart from it being the only one in the district, its operating table was neither movable nor adjustable to the size and convenience of the surgeon. It was maintained at a standard level because it was old and the system of adjustment was completely rusted. It is therefore up to the surgeon to “make do” by standing on a chair or bending to operate. The same applies to surgery boxes. A health worker complained that “the hysterectomy box has only 4 clamps, nothing more. Besides that, a dissector, a surgical blade, that’s all, there isn’t even a spacer”. He also mentioned the existence of one single heart monitor shared by the operating block and the recovery room. The latter, with only 4 beds can receive only 4 patients at a time.

2.3 Search for financial resources to supplement the State budget

Both in the Health and Education sector, even if the amounts required are not comparable, the slowness and inadequacy of State budgets along with the counterproductive effects of free access policies, have induced the institutions studied to develop strategies in their search for additional income. Here, we will refer only to practices destined to fill up the hospital or school coffers, whereas the practices dealing with the forms of supplementary individual payments will be discussed later, under the section of informal privatisation.

2.3.1 Recourse to patrons in rural health institutions

The functioning of the semi-urban site is sporadically supported by patrons (second generation diaspora or those holding important administrative or political posts in Lomé). They financed the building of referral services, ophthalmology and maternity services. They have also provided the working material (echography, X-Ray machine, trolleys, hospital beds etc.).

These patrons are sometimes driven by competition: the construction of the maternity was evidently a patron’s response to a competitor who had funded the hospital’s referral services. This rivalry is even greater when taunts are slung by one

native of the neighbourhood to another. As a national newspaper reported in 2011, a native boasted about the works he had done in the neighbourhood to his “brother”, who, he emphasized, had not even “built a hut” for the village. Nearly all the private patrons of this health service are members of the political party in power. Beyond the stakes of social recognition, the donations made by patrons thus fit into a logic of political clientelism: by investing in the health service, they expect a return for themselves or for their party in the legislative or even presidential elections. Moreover, it explains why most of the donations are made in the name of the party or under the patronage of the Head of State. The greater the popularity and reputation of the party in a neighbourhood, the better the chances of promotion for natives in exchange for their contributions.

2.3.2 The contribution of the pharmaceutical and banking sector to urban health institutions

In the urban area, the health services studied benefited equally from support and aid of pharmaceutical representatives, associations, NGOs and some local banking structures. These sporadic contributions remain comparatively weak in semi-urban areas and are destined only to specific health care units.

The logics of funders of this health service also differ. During the first phase of our field work in the urban structure, a local bank decided to renovate a health service building, on the condition that the service transfer its account to the bank. The offer would have come from a high bank official whose children habitually consult the doctors in this health service.

Equally, depending on each official’s or unit head’s relations, pharmaceutical representatives or medical delegates are invited to aid services or care units by offering equipment (refrigerators, fans, air conditioners, microwaves etc.). In the hospital’s paediatrics department, it is they who have built and maintained the service’s emergency kit by subscribing 10 000 CFA francs each month. In exchange, these pharmaceutical representatives expect health workers to prescribe their drug molecules to patients.

2.3.3 Informal payments imposed on users

« Bogus prescriptions »

During the inquiry in the health sector, we discovered an informal system based on “supplementary or bogus prescriptions”. On admission to a care service, users normally pay a consultation fees (depending on the health service and the services they seek) that gives them the right to some consumables directly provided by the

health service (gloves, cotton, alcohol, etc.). All the same, sometimes health workers prescribe them anyway, thus forcing patients to pay twice for material normally included in the consultation fees.

Of course, this practice is contrary to the rules and to the spirit of the reform introducing free access to care. Caregivers justify it by offering two arguments that question the central administration. On the one hand, the latter provides stocks that prove to be insufficient. In order to avoid a rupture before the next monthly supply, hospitals prefer to prescribe them to patients. On the other hand, according to health workers, getting consumables from the central administration is a long and fastidious process. The cumbersome procedures that can last one or two days can lead some health workers to ask users to buy the required consumables.

Convinced that users will pay care providers for these consumables, health service administrations supply them piecemeal so as to economize their stock and raise money for their own drugstores.

Incidental school expenses

In order to run the school (renovate the building, purchase equipment etc.) school principals are forced to take recourse to contributions from the same parents whose school fees was waived. Indeed, the policy of free schooling has paradoxically increased parents' burden in terms of educational expenses per child. Parents' contributions are considered "incidental expenses", as with free schooling, their contributions for building and school equipment are henceforth prohibited by the State. In fact, since the first complaints by the Parent-Teacher Associations (PTA) about "incidental expenses" practiced by some schools despite the law on free schooling, the government diffused a memorandum to all institutions banning all parallel contributions not previously authorised (memorandum N°1891 MEPS/CAB/SG/DAF, 09 July 2014).

But even if several school principals baulk at asking for financial contributions from parents, it is the latter who, in the light of some obvious dysfunctions of institutions, themselves take initiatives to finance schools through donations. Parents make financial contributions that exceed the annual school fees. In a primary public school of West Lomé inspection, one of them declared:

"Since two years, parents of children in the kindergarten contribute 10 000 FCFA per child to cover the expenses of cleaning ladies and the guardian recruited by the PTA. In the primary classes, parents give 1000 F per child to repair the roofs of school buildings that are run down, to set up a fence and install electricity in classrooms. The electricity counter cost parents 160 000 F. They paid the school watchman 15000F CFA per month for six months. At each new school year, the PTA goes around to the parents for voluntary donations from 1000F to 5000 CFA" (Interview of a group of

parents, West Lomé inspection Sept. 2017).

Because of the precarious teaching conditions, 'incidental expenses' become a routine in schools. In several institutions observed, children bring 50 to 100 FCFA per day to buy chalk or brooms. According to a parent questioned in a school of West Lomé inspection,

"We are tired of expenses here, expenses there. It makes one think fees is better than all the expenses created by free schooling. Everything leads to the conclusion that free schooling turns out more expensive. To avoid all this inconvenience, it would be better to reinstate school fees so that we are not harassed".

3. Practical norms in the health sector

3.1 Management of human resources

Subjected to a structural constraint – an insufficient number of caregivers of all categories – the management of human resources in Togolese health administration appears first and foremost as ineffective and incoherent: health workers are concentrated in the capital and urban centres of southern regions, precarious employees (contractual and voluntary) constitute the majority, acts reserved for medical personnel are accomplished by the paramedical corps, etc. We have here a fertile field for understanding practical norms used by civil servants in the everyday.

In Togo, besides the medical personnel (general physicians and specialists) and paramedical employees (nurses with state degrees, midwives, state auxiliary and permanent midwives etc.), there are community health workers along with medical assistants, this latter status being a Togolese specificity.

Community health workers (*Agents de Santé Communautaire*) are an outcome of community health policies linked to the Bamako Initiative. Barely trained to serve as intermediaries between populations and health workers, they are affiliated to the Department of Community Health and Senior Persons under the General direction of Health Action (Health Ministry 2015 a).

As for the medical assistants, they form a category of intermediary workers between doctors and nurses. This professional category was introduced by decree n° 72-181 on 5 September 1972 creating a School of medical assistants (EAM) at the University of Benin (actual University of Lomé). It aimed to train students in the exercise of the medical profession over a period of three years to counter the lack of doctors in the health system at the time. These assistants were above all destined to serve in rural areas, but over the years they became an important element in the organization of care in Togo. Although they are neither doctors nor nurses, they work *de facto* as doctors.

3.1.1 An unequal and incoherent distribution of human resources

The Togolese health system suffers as a whole from insufficient direct care providers. In 2014, Togo counted 13 855 workers, of which 10 391 – 75% – in the public sector and 3464 – 25% – in the private sector (Health Ministry 2015 a).

At a national level, according to PDGRHS 2016-2020, “the analysis of the distribution of human resources for health reveals a concentration of health personnel in urban areas at the cost of rural areas: 77.5% against 24.5%, whereas the rural population represents about 61% of the country’s total population” (Health Ministry 2015a: 18).

To understand what this imbalance between cities and the countryside signifies in terms of capacities of delivering health care, one could refer to the personnel of the health service studied. As shown in Table 4, the health worker/population ratio is broadly close to OMS norms in the case of Lomé hospital; on the contrary, in hospitals in rural areas, the health personnel (doctors, midwives, and nurses) is confronted with a population pool that is ten times higher.

Table 4. Comparison of personnel/population ratio of two health services and OMS norms

Category of worker	Ratios (health worker /population)		OMS Norms
	Urban area	Semi-urban area	
Doctor	1/11723	1/150202	1/10 000
Midwife	1/6252	1/50067	1/4 000
Nurse	1/3410	1/37551	1/ 4 000

Source: Inquiry data

Similar inequalities can be observed on the regional level, where the only region Lomé-Commune has around 34% of the total workforce. The northern regions of the country (Centrales, Kara and Savanes) receive only 36% of the caregivers, all categories included. (Health Ministry 2015 a)

It may also be noted that the administrative personnel represent 55.61% of the Togolese health service, whereas current norms require that they do not exceed a third of the personnel. (Health ministry 2015a)

Finally, recourse to contract workers⁵, trainees or voluntary workers who have a particularly precarious status, is common practice. In the two health services studied, there were more contract workers than officials. At the time of the inquiry, the semi-urban service counted 48 contract workers in a total workforce of 82 workers. A recent report of the Health Ministry evaluated the total number of contract workers at 5 441, or 43 % of the health personnel, whereas officials would be only 4 865 or 40 % of the personnel. Furthermore, voluntary workers and trainees represent 17% of the workforce of the health administration. Once again, we find non-official

⁵ Hospitals and some health structures (National Institute of Hygiene, National Centre of Blood Transfusion, National Centre of Orthopaedic etc.) are authorised to recruit contract workers and pay them from their own budgets with the agreement of the supervising ministry. It is the same for the Management committees (COGES), municipalities, and NGO's project programmes, technical and financial partners, etc. Cf. decree n° 90-191/PR, 26 Dec. 1990 relating to the organisation of hospital institutions of the Togo Republic.

personnel especially in the urban areas (72%) and in the capital and its hinterland (67%) (Health Ministry 2015b).

For the present, competitive exams for medical and paramedical professions organised by the health administration do not permit either the recruitment of new officials or an increase in their number on the field. In fact, most of the officials who pass exams are already working in different health services as voluntary or contract workers and are waiting to be integrated into public service since several years. A health worker told us:

“When I was in the private, I passed the competitive exam for entry into public service as a doctor several times, but I never succeeded. I understood that to pass a health public service exam in Togo, one must be a volunteer or contract worker in a public health service. I became a contract worker in a health service, and in 2008 I passed the competitive exam and got through easily” (field inquiry).

A high-ranking official in the Health Ministry, commenting the results of the health officials’ competitive exam in 2016 observed:

“At least 30% or 40%, even more I would say, of those who have just been recruited were already on the field. This means that we haven’t done much; in declaring this result perhaps we have eased the health services who were paying the workers themselves, but in fact, there are not many changes, because those admitted were already on the field” (field inquiry).

3.1.2 All posts are not equal

As emphasized in the above lines, health workers avoid the country’s rural areas and northern regions. Such a negative *à priori* about these areas seems to be part of the bureaucratic culture of the sector studied, because it appears right at the start of the university studies. Indeed, a recent work on human resources in Health in Togo (Health Ministry 2015 b) reveals that a large percentage (36%) of students in their final year of study in medicine wish to be posted in the maritime region and 25% in the Plateaux region; thus, only a minority show interest in other regions (15% in the region of Kara, 13% in the Central region and 9 % in the region of Savanes).

These qualms depend on whether one belongs to the medical or paramedical corps but a common denominator is the search for good living and working conditions as well as parallel lucrative activities.

Paramedics fear that a posting in a backward region will no longer permit them to come back later to Lomé or any other big city; often, working in the bush implies a separation of couples or the family, or the impossibility of enrolling their children in good schools; in rural areas, professional opportunities or parallel activities are non-

existent; it is therefore more difficult to perfect their training; some categories like those of midwives even find that “in the bush, one loses ground”, given the fact that equipment available in rural health services does not match their skills.

The medical body is even more hesitant than paramedics about postings in rural areas. General practitioners particularly fear that they will have to abandon their specialization. Another important reason from our informers’ viewpoint that leads the medical body to remain at Lomé is the possibility of intervening in private health services (significantly greater in number at Lomé than in the hinterland) where they are clearly better paid than in the public structures. Lastly, working in the capital or its surroundings implies being close to the supervisory ministry, an advantage when administrative steps need to be taken:

“Imagine I have a file in the Health Ministry. I take my motorcycle and in 15 minutes I have deposited the file. But if I were somewhere in the hinterland, I would be forced to go through the hierarchy, which would probably take a lot more time, or I would be forced to send my file by a driver or wait for someone I know to come to Lomé and hand him over the file, with all the risks of losing the file” (field inquiry)

The same logic shapes a cartography of interesting jobs even in the interior of the city of Lomé, where certain districts or health services are particularly sought after for their reputation or because of an ongoing project of international cooperation. According to one of our interviewees

“District n° 3 seems to be favoured both by users and caregivers for the quality of its services in maternal and infantile health because meanwhile, the GTZ undertook a project in this service and furthermore, under Minister Suzanne AHO, this district’s hospital received a prize for the quality of its maternal and infantile care” (field inquiry).

Other health services in Lomé, like the CHU S.O., are on the contrary feared by health workers because of their reputation of being bad hospitals or “mortuaries”, and their bad working conditions, but also because of the total anonymity in which workers find themselves in these structures.

3.1.3 Constantly negotiated postings

There are two types of postings: general postings that are made at the end of the year on the demands of workers or on the Ministry’s initiative; and occasional postings that can be made at any time of the year following an appointment, a worker’s promotion, the return of workers who had gone for training, in response to a requirement, etc.

Postings are managed at three levels of the health pyramid: at the central level, at the regional level and at the district level. Postings on the initiative of the supervisory

ministry generally occur after consulting the official's hierarchy.

Criteria for health postings are mostly informal because there exists no official norm regulating them, contrary to some ministry departments like Defence. The Health Ministry follows general rules of the public service but without really applying them.

Transfers may take place because of conflicts, professional mistakes, or a worker's involvement in corrupt practices or wrongdoing, transfer being the main kind of punishment used in these cases. A health worker's demand for a posting is most frequently for reasons of rapprochement of couples, health problems, conflict with his boss or another worker etc. Special postings are generally made suddenly and in most cases are the result of a unilateral decision of the Ministry after agreement with other levels of the health pyramid.

Attempts and pleas to create "staff mobility guidelines" remain unsuccessful. This is due to several reasons. The most important and the most frequently mentioned in our interviews is the hostility of some high officials to a tool that would risk depriving them of a key resource in the maintenance of their clientele:

"Our plea collides with the inertia of some of our bosses who prefer continuing with the old system because it helps them. When you help someone stay in place, not be transferred or come back to Lomé, that person owes you, tomorrow you could ask them to return the service. But if there is a law, a guideline stating for instance that an official must be posted to the hinterland for 5 years for his first job, people will rarely break the rule and the Human Resource people will have a valid legal argument to refuse demands or interventions from so and so, and even from their bosses to keep their protégés in place" (field inquiry)

Thus, for the moment, in nearly all cases, unwanted postings trigger strategies aimed at cancelling them.

"My niece recently passed a competitive exam for health workers for the region of Kara. When the results were declared, she was informed that her regional service had sent her to a health service in Gerin-kouka in the prefecture of Dankpen. She called me for guidance and told me she felt like resigning and coming back to Lomé but I advised her to see the locality, check out if there was electricity, running water, and if there was at least a transport system, to join her post and then we would see what could be done later..." (field inquiry)

Virtually, every demand for a posting or every refusal of transfer must borrow political-administrative networks parallel to the formal path, in order to identify relatives, friends or acquaintances (PAC "*Parents, Amis et Connaissances*", according to the term used in francophone West Africa), who could intervene in their favour.

"You must succeed in getting your name removed from the list of postings before it is officially published. And even if it is published, you can manage, but it's more

complicated” (field inquiry).

Negotiating postings is thus a practical norm that is widespread and largely accepted, and favoured by a management of human resources pervious to “affairs” and interventionism. According to our informants, workers – and they do exist – who accept for postings to the hinterland or in the rural areas are those who have no connections or those whose negotiations did not succeed.

3.1.4 Braindrain and trainingism

Beyond the unequal redistribution across the entire territory, the flight of health workers to the private sector or to professions other than clinical medicine (public health and the medical delegation for instance) and above all to other countries constitutes a real bottleneck in the Togolese health system.

A recent report on the work market (Health Ministry 2015) indicated that 51% of the doctors preferred to work outside the health sector. The Development plan of Human Resources in Health (PDGRHS) highlights that 250 doctors – around 40% of doctors trained in Togo – have already emigrated (Health Ministry 2013a: 25). Finally, the Health Ministry (2015 a) admits that the public sector does not attract specialised doctors. This is confirmed by the absence of candidates to posts for specialists advertised in the different public service competitive exams. According to the report, only 1 paediatrician and 2 gynaecologists could be recruited in the 2013-14 competitive exam, although there were 7 and 10 posts to fill in respectively.

Leave to participate in seminars and workshops (that bring useful attestations for career advancement and significant daily allowances) constitutes another form of temporary but recurrent “escape” from the job. The multiplication of training workshops and “trainingism” (Ridde 2012) this engenders constitute a bottleneck that strangles the functioning of health services. During our inquiry, we could observe that the only doctor in the semi-urban health service left the hospital several times each week for these trainings.

3.1.5 Valorisation of subaltern positions or the “push upwards” of health agents

In the two health services observed, lower level health workers regularly perform their supervisor’s activities: nurses provide consultation instead of doctors or birth attendants undertake activities theoretically reserved to midwives. These practices are often justified by the unavailability of personnel or by the “ambition” of certain caregivers:

“There are doctors, there are services where one practically never sees the doctor and therefore it’s the nurse who does everything. If he’s in this situation, he considers

himself the doctor and he does what the doctor does" (field Inquiry).

"The nurse is trained to administer care, nonetheless when for example a nurse is (...) in a peripheral care unit (*Unité de soins périphérique*) or a social-medical center (*Centre Médico-Social*) where there is no doctor, the nurse acts as doctor, he consults and does everything. But in the big centres, ambition pushes the nurse to replace the doctor when he's not there (...). If the doctor doesn't assert himself, the nurse does the work instead" (field inquiry).

Heads of health services tend to trivialize such well-known practices. They are exacerbated by the attitude of doctors themselves, who tend to delegate their tasks to nurses.

"Nowadays, we begin by delegating tasks to our subalterns, we give them protocols to follow. You yourself will see that the doctor cannot take more than thirty people and in this situation the nurse takes over. It isn't that he replaces the doctor, but it is the doctor who himself defines the protocol to be followed. So the nurses, the subalterns follow these protocols until the doctor himself is free to takeover" (field inquiry).

Even if at the start, this "push upwards" is initiated by superiors (doctors, midwives, etc.), our observations reveal that this delegation of tasks is not adequately directed or supervised. Over time, it becomes uncontrolled then uncontrollable and later becomes part of the routine, because

"(...) Constant delegation of tasks leads people to end up confusing their qualifications. Occasionally one delegates, but the person to whom you delegate, if you don't follow him or don't direct him, he can even surpass you and step on your toes" (field inquiry).

The phenomenon becomes more problematic in the case of medical assistants. According to norms that organise this intermediary professional category, assistants must exercise in general medicine. But in the hospitals and CHR where we conducted our studies, these officials intervene openly as trained specialists "on the job" without any formal authorisation and with the knowledge of the health authorities. As this medical assistant admitted:

"Here I am doing surgical interventions, Caesareans and other gynaecological actions since ten years or so, but actually, I have no paper, attestation, degree or even certificate that authorises me to do so or confirms that I have the required skills to do so. When I left the Training school in 1997 I had no idea about Caesareans. I had some knowledge of general medicine. But when I was posted to this place where I am even today, I was transferred to gynaecology. Gradually, the doctor-gynaecologists held my hand and taught me the tips and tricks of doing Caesareans on the ground." When they thought I was capable enough, they began letting me do simple surgical actions. Then, I myself engaged in research; fortunately, today one can find everything on Internet" (field inquiry).

But in case of a medical error or the death of a patient, if “the victim’s family realizes that the person who has operated has no formal qualification, it can cost us a lot – deplores a medical assistant (...) The hospital or administration (...) say nothing, they employ us instead of the theoretically qualified personnel. Besides, we are not paid as specialists; they cover us and back us in case of a quibble, but it is not certain that they will be strong enough to back us if we’re in a big mess, since in the given medical legislation, we have no right to be doing what we do every day” (field inquiry).

3.1.6 Managing working time and care

It is at this level than one can observe some site-specific workplace norms. Certainly, as in other administrative services of the country, a majority of health officials come late to work and do not respect the official rule that demands their presence at work from 7 a.m. to noon and from 2.30 p.m. to 5.30 p.m. But the gap with regard to official norms is more striking in the city than in the semi-urban area.

Absenteeism is also high. According to a 2013 inquiry into public and private institutions, during a surprise visit 40% of the personnel were absent on an average, and 35% of the absences had not been approved by the hierarchy. The problem was more striking in private and urban services than in public or rural services (World Bank 2013b: 7)

In the urban areas, the practical norm shared by caregivers and hospital users organises the former’s working hours not according to formal administrative rules but depending on the situation and the number of patients to be treated daily. Arriving late at work, caregivers most often consult uninterruptedly until they have no more clients. Thus, if at 11 a.m. there are no more patients, the health worker can go back home, considering that his day is over. Users having grasped how this health service centre functions come only in the morning. On the other hand, in the semi urban area, rules are more-or-less respected. Even if officials arrive late, they all stop at noon and generally return to work around 3 p.m. or sometimes at 4 p.m. and finish around 6 p.m.

Each healthcare service and care unit organizes the management of care according to the available human resources. In the urban hospital, maternity care is ensured by an operating block team (gynaecologist-obstetrician, operating-room nurse, emergency anaesthetist and a nurse) and a maternity team (two midwives and a birth attendant). These officials spend the night at the hospital.

In the rural hospital, care is ensured by a maternity team composed of a midwife or a state auxiliary birth attendant, a permanent birth attendant or a matron and an operating block team (a high-skilled health technician commonly called medical

assistant acting as gynaecologist-obstetrician, an operating-room nurse, an emergency anaesthetist - and a nurse). Some members of the operating block team, especially the medical assistant and the emergency-anaesthetist do not spend the night in the hospital. They remain at home and are contacted only when a case requiring surgical intervention comes up.

This discrepancy with the official norm is justified by the fact that there is only one operating-block team in this health service. The members of this team rarely take vacation or even leave. A member of this team told us that since the last 17 years he took leave only once, and then the operating block was shut down during his absence.

According to health officials, the Health Ministry does not want to set up other teams, because there is a regional hospital 40 km. away, where emergency cases can be sent. However, this health service is a prefectoral hospital that covers peripheral care units (USP) located within a radius of 100 km. On the other hand, the organisation of such a care service is less expensive and complies with a need to rationalise health service expenditure.

3.2 Relations with patients and care delivery

3.2.1 "PAM" and "Gombo"

As has been observed in other African countries (Masquelier 2001, Ouattara 2002, Jaffré and Olivier de Sardan 2003, Hahonou 2015), health care delivery in Togo is not free from practices deviating from official norms (bureaucratic and deontological). Some of them can be linked to the universe of "petty corruption". Officially condemned but accepted in day-to-day practices in numerous occasions of interaction between caregivers and patients, they, along with other behaviours, tricks, know-how and arrangements, form part of the professional culture of caregivers of all categories.

During our observations and interactions with caregivers and users, we could identify a corpus of practices amongst health officials. They shared a concern to generate additional income - unfair, even illegal -, sometimes in exchange of a favour to the user, sometimes in the form of a simple extortion. These practices are often at the cost of a public service and /or users of health services, but they can sometimes contribute to a proper functioning of services. Depending on the context and the actors involved, they can thus appear "palliative" or purely transgressive.

The sale of medicines by health workers is no doubt the most widespread and common practice. Nurses can recommend their purchase on the pretext of helping patients. A need is created through a cleverly incomplete prescription: the patient

who has already bought prescribed medicines and products discovers that it was also necessary to buy scissors and a thermometer; the official can “help him out” thus saving him further journeys. Or “an artificial shortage of supplies is created, so that one can say that this product is not in the pharmacy” as one health official explained. One can also “inflate” prescriptions to force users to buy medicines they do not need. In this manner, personal stocks are sold. These have been built from a parallel market of samples given by medical representatives, but also through diversions from the health service drugstore and even by stealing medicines from other patients:

“Even nursing students have begun doing it - affirmed a midwife (...). There was one in the recovery room, the parent had brought Perfalgan because the child was getting fever, the guy said he wanted to make a transfusion and told the parent to leave. Having left, the parent remembered that she had forgotten her cell phone, and came back, realized that there is no Perfalgan in the tube hanging on the pole (...) The student had kept that Perfalgan in his bag to resell it to a third person”

Other practices range from commissions for services rendered and misappropriation: in order to make patients pay an amount inferior to the care they have received, a smaller number of hospitalized days are mentioned on the hospital’s discharge form (called Exeat). Following the same logic, medical intervention fees can be reduced after negotiation. But this fees is collected directly by the caregiver who does not register the patient: “A curettage is proposed at 20 000 FCFA. You do that, you don’t register the person and you keep the 20 000!” Obviously, patients who would have paid the caregiver directly receive more attention than those who have gone normally to the cashier. In other cases, the patient is victim of a racket or “over-billing”:

“If the health worker has to perform four MVA (Manual vacuum aspiration) in the care unit, he would perhaps ask one of the patients to go and pay at the cash desk, then the other three will hand over the fees directly so depending on the context this can be more expensive or equal to the normal price, but never less expensive than the normal price” (field inquiry).

In the Togolese hospital world, this set of informal but well-regulated practices falls under two emic categories, PAM” and “Gombo”.

PAM (Programme of Aid to patients, “*Programme d’aide aux malades*” in French) is an acronym that ironically diverts the UNO’s Food Aid Programme (PAM in French). For health workers it indicates practices, which, though deviating from the formal rules, are perceived as positive. In fact, their declared aim is to help users in difficulty: it saves patients and their families journeys to the city to buy medicines by selling them on the spot at a slightly lower price than the market rate or the hospital’s drugstore. It allows patients to buy medicines on credit, reduces the cost of hospitalization or medical actions, etc. As this health official explained,

“For example, you find yourself in a situation where a medicine has been prescribed to a patient: it’s night, the drugstore is far off, he has come to see you to ask where he can find all these medicines and you, you have this medicine in stock, you suggest you sell it to him at a lower price than that of the drugstore because you have perhaps bought it in the black market or a medical representative has given you a sample, so you sell him this” (field inquiry).

The notion of PAM therefore refers to small arrangements, legitimised by an element of compassion (Blundo and Olivier de Sardan 2006b) and mutually profitable both for the caregiver and the patient.

As for the “Gombo”, this expression of Ivoirian origin means a “personal work (paid personally) by caregivers, within the structure and outside it, to gain ‘something’” an addition to the salary, considered not as “theft nor a lack of professional conscience”, but “simply the search for better living conditions” (Koné 2003: 257-258). In the context of the professional culture of Togo’s medical body, the initial meaning has been transformed to characterize any illegal or non-compliant practice conceived for the health worker’s personal advantage at the expenses of the user and/or the health service. In other words, the “gombo”, to use the formula employed by a midwife, would be “a complication of PAM”, its darker dimension in some way, both illegal and morally reprehensible since it deals with a “commercial” and “business” dimension of the caregiver’s profession.

The origins of PAM and “gombo” are always linked by our informants to the severe social, political and economic crisis that rocked the country at the start of the 1990s and culminated in 1992 in a ‘general and unlimited strike’ lasting nearly nine months. During this period, hospitals slowed down, health workers received no salary, stocks of products and medicines were depleted, and prevailing insecurity convinced a good number of officials to migrate to adjoining countries. It was in this context of crisis that health workers would have sought to ensure the availability of the most basic medicines and at prices within the reach of users:

“If one went and got (medicines) and added a little profit, it allowed us to travel, live, survive while waiting for the salaries. And that’s how this story began becoming what you call PAM and Gombo” (field inquiry).

“I remember that the head of the service was obliged to assemble all the midwives and inform them of the situation of penury. He said: “Will we stop operating, caring for or delivering women because we don’t have the material?” He then heard our suggestions about what we all knew already (she was talking of the practices of PAM and Gombo” (field inquiry).

Linked to the necessity of ensuring continued public service despite the political and institutional crisis, these practices found themselves legitimised in the eyes of caregivers and users. All the same, they survived the period of crisis and crystallised

to the point of becoming regular.

On the one hand, far from being isolated activities of some black sheep, PAM and “gombo” constitute regulated practices, organized and accepted within a given service. The benefits they bring are redistributed in conformity with the hierarchical organisation of the service, which diminishes the risks of creating dissent within the group:

“We work in a team and if most of the time some people tell themselves that they don’t want to get involved, others don’t accept it, but whether you like it or not, you are in the team, you are told you have to do the Gombo. If you refuse, you’re considered a threat. And so, it becomes an obligation. Besides, on the morrow of a night shift, the receipts are shared and you are forced to take your part” (field inquiry).

On the other hand, the terms are even integrated in the professional jargon, which adds neologisms like “*pammer*” and “*gombotiser*”:

“I often heard people say when after delivery a woman has to have stitches, she will be ‘gombotised’. This means that they perform the action using the tools of the service or its material but without declaring it to the cashier”.

In the eyes of our informants, PAM and “gombo” are rooted in the cash circulation in health services since the Bamako initiative instituted the practice of self-financing by users: “a fried fish is left beside a cat and the cat asked not to touch it. The temptation is huge”, admits a health worker. Hence, procuring supplementary financial resources, either from the user or the health service is a practice that is legitimized by the gap between financial resources produced by health workers in the health services and the salaries paid to them:

“If someone helps you to raise money, one must learn to share the profits with that person, otherwise you force him to cheat you. When they (health services) began to sell products in the Bamako Initiative framework, ideally it would be simple to institute a small benefit to pacify caregivers working to fill up the tills of health services” (field inquiry).

Another factor evoked is the large number of precarious personnel. The health services function thanks to contract workers, but also and above all, thanks to voluntary workers. Most often, the latter are health workers who have finished their training and are waiting for a job. In order not to lose touch, they agree to work as voluntary workers. In most cases, health services do not have a budget even for their travel. Consequently, the latter turn to PAM and Gombo to survive, or it’s their superiors who pay them with illegal incomes. Finally, the poor organisation of health services would explain why these practices endure. The absence of a reception service that informs and orients users on the procedures to be followed and the modalities of payment, or the chronically low stocks of specialized medicines in

hospital drugstores represent favourable contexts for PAM and “gombo” to flourish.

« In health workers’ jargon, when you do the gombo and you are caught, it is said that the gombo has boiled in the fire until the froth spilled over into the fire” a health worker laughingly tells us. But what happens to agents who have “gombotised” patients? During the inquiry, cases were cited of offenders who were fired, but the main punishment consists of a posting that physically removes the official from the scene of offence. If the punishments are therefore not totally non-existent, they nonetheless have little impact because of political interventionism or the ambiguous position of the supervisory ministry:

“One midwife refused to return the money and the doctor had to turn to the authorities. The reaction of the authorities discouraged him. The doctor said, if I as head find something malfunctioning in my department I punish the person, I report it to you, you don’t support me, and you send the message to the offender that she is right, where does one go?” (Head of a maternity).

Three examples of reforms in the field of maternal and infantile health are presented here through a discussion of specific tools and procedures, which after being tested in other contexts were popularized in West Africa. Observing the implementation of these models will permit us to understand how the norms they disseminate are short-circuited or replaced by practical norms produced by the professional circle of maternity officials.

3.2.2 Focused Antenatal Care (FANC)

Antenatal care exists in Togo since a long time. To avoid complications, every pregnant woman must have antenatal consultations before the end of her pregnancy. Before 2000, a monthly follow-up was based on a rigidly applied standard protocol. In 2005, focused antenatal care (FANC) was introduced to correct errors in earlier procedures. It worked on the principle that each woman was henceforth an isolated case and the protocol was to be consequently adapted. Whereas earlier antenatal care was completed in a few minutes, the reform extended the consultation, which now lasted at least 20 minutes, according to our informants. CPNR henceforth took account of the pregnant woman’s social and family environment as well as her psychological state and included a dozen para-clinical examinations among with an HIV test.

To counter this constraint both in the urban and semi-urban areas, maternity staff has decided to dramatically limit the number of daily consultations on new cases. In the urban health service, for instance, only seven new pregnancies are accepted per day. This has resulted in increased waiting times for pregnant women who are forced to return to the maternity ward the next day in the hope of a consultation. Besides,

FANC standardised application protocols are implemented only in the first consultation. From the second, FANC becomes a pure formality and often takes less than five minutes.

While midwives blame the chronic lack of time for this situation, it must be recalled that since 2005, refresher courses for midwives were rare. It is true that midwife students or auxiliary birth assistants just out of training schools are increasingly initiated to FANC. It is equally true that supervisions are an occasion for re-training, as some authorities suggest. But in fact, there is no doubt that supervisions take the form of tests rather than instructive exchanges with health workers (Tepper, Moss & Duffy, 2011 and Bamaberger & Bachaech 2006). Furthermore, beginner midwives are not expected to contradict senior midwives whose professional culture inclines them to consider standardised tools of monitoring pregnancy as time-consuming administrative paperwork rather than a helpful procedure.

3.2.3 Prevention of mother to child transmission (PTME)

Introduced in maternal and child health in Togo around 2002, the Prevention of mother to child transmission (PMTCT) is a set of arrangements and techniques aimed at preventing risks of HIV transmission from mothers to children. Its implementation starts with the first Focused Antenatal Care consultation, ending with delivery in case of HIV negative women, or at least one year after delivery in case of HIV positive women. The norms of this reform recommend at least three detection tests for pregnant women before delivery: two tests during the FANC and a last test in the labour room. The aim is to avoid a contamination of the new-born and health workers during the delivery.

In the maternity department of the urban health service, the third test is not performed in the labour room for women who showed the first two tests as negative. On the contrary, in the semi-urban area, the first two tests are not systematically performed, because in the rural areas, women come for consultations only when the pregnancy “starts showing”, that is around the fifth month: “coming to the health centre when her stomach is not visible, it’s wanting to show people that one is pregnant and that can prove to be dangerous for one’s baby” (field inquiry). Besides, coming to the hospital earlier creates anticipated expenses: “one prefers to come when the pregnancy is drawing to an end to spend once and for all. » (field inquiry) Moreover, women do not keep the appointments, so that officials manage to do only one or two tests. Thus, in the semi-urban maternity department, the practical norm is performing a detection test either in FANC or in the delivery room or in the postpartum care room instead of performing the three recommended tests. This location specific practical norm is a maternity staff response to cope with the difficulties raised by the local socio-cultural context.

3.2.4 Partogram

Conceived in the United States by Friedman in 1954, the partogram is a document that health workers use to keep track of the anthropometric parameters of a parturient from labour to delivery. This standardised tool is widespread in Africa⁶ and is considered to prevent risks of maternal mortality. In Togo, a first version of this tool was introduced in 1995, then revised by the WHO in 2001 (Health Ministry 2002 : 20).

Yet, according to the practical norm in force, the partogram is in most cases filled in at the end of the delivery, before staff meetings or supervisions, as was observed throughout the inquiry. According to a quantitative study dealing with four maternities of Lomé (Adama-Hondegla & al. 2014), amongst the 496 deliveries performed by 43 different midwives, only 186 (37,50 %) benefitted from a partogram. Nearly all these partograms (95,16%) were completed after the delivery and presented several problems: critical data like medication, the characteristics of amniotic fluid, uterine contractions, the falling curve of the mobile foetal, the pulse, the proteinuria, artery tension and temperature were badly noted.

The partogram is apparently better implemented in smaller structures like Medico-Social Centres (CMS) than in hospitals, CHU or CHR, the former having fewer cases to treat. During the interviews and focus groups, maternity staff and their superiors recognized this existing situation, without for all that questioning the use of the partogram. Multiple reasons were advanced by the caregivers:

a) WHO modifications in drawing up a partogram require that it be “opened” from 4 centimetres dilation of the cervix. Midwives would therefore not have enough time to progressively fill in this document, as one midwife explained:

“We were trained to open the partogram when we begin the diagnostic of labour, even if the woman is at two centimetres. You really don’t have the time to follow the labour with the partogram. But with the modification of the partogram by the WHO, they say you must open the partogram at four centimetres. Or, we know that with multiparous women, in the active phase the labour evolves quickly. The woman whom I admit at 3 cm of cervical dilation, I wait for 4 cm to open the partogram. Perhaps after one or two hours during which I do other things, she is completely dilated and has delivered, while I haven’t finished the partogram I began. So the partogram will be traced after delivery, and it is of no further use for monitoring the delivery” (Field work).

b) The heavy workload and the inadequacy of human resources do not encourage a

⁶ See Diakit  2008 for Mali. For Niger, see Olivier de Sardan, Diarra and Moha 2017.

parallel follow-up of several pregnancies:

“One can’t leave the woman who is completely dilated to go and track the others’ partograms and one is forced to do the delivery and finish the partogram after the delivery. If there were more of us, some could draw up the case and others take care of the deliveries” (Field inquiry).

c) The absence of adequate working material – especially monitors – is frequently evoked by the caregivers.

“I find that what creates a problem is how to chronometer the uterine contractions. I think that’s the core of the problem because it is difficult to chronometer and see in 10 minutes for example the number of contractions as well as their duration. I think it’s noting the constants that is a problem” (Field inquiry).

d) Other health workers do not fill in the partogram simply because they do not know how to do it; they are afraid of revealing their ignorance and exposing themselves to criticism from staff and supervisors. They prefer not to learn about the tool, leaving other colleagues or the staff to do it before the supervisions. Scarcity of trainings in filling up partograms was frequently evoked in our interviews.

Finally, a retrospective completion of the partogram permits the insertion of “good” parameters. In fact, this tool for monitoring the delivery is also an instrument for evaluating midwives’ performances and skills. To deal with audits or judicial inquiries in case of death of a pregnant woman or a newborn, the cases can be forged.

4. Practical norms in the educational sector

4.1 Precarious and low-skilled human resources

Currently, entry into the primary school teaching body in Togo requires a two-year degree after the baccalaureate, along with a pedagogical diploma from the Teachers Training Institute (*Ecole Normale* for Teachers: ENI) or from any other State recognized pedagogical institution. But many primary school teachers have no pedagogical training. According to the Statistical Directory (MESP, 2016), only 35% of primary school teachers have received a professional training in an ENI. The remainder of the primary school teachers in Togo hold no professional qualifications, being recruited either directly through competitive exams to compensate a deficit in the field, or by a simple review of their case. This is so in several private institutions.

Most of the teachers who have not been trained in the ENI benefitted from an “initial refresher training” after joining their posts. Continuous training of teachers is also offered through practices that are not regulated by any official text: other than the direct follow-up of teaching by heads of institutions and school supervisions, “education boards” are set up every three months by pedagogical inspectors. These are free occasional trainings provided by the councillors and school inspectors in which teachers of all sectors – public and private –, participate: “through these boards, the inspectors train us in the teaching of a discipline: how to prepare fact sheets, how to teach, how to evaluate” (Director of a primary public school, West Lomé inspection, September 2017).

Despite all this, a recent study revealed that only 2,5% of second and third-grade primary school teachers have sufficient mastery of French and mathematics⁷. There are still some teachers who have been recruited with just a primary school certificate (CEPD, *Certificat d'études du premier degré*), even if this category is disappearing, or with a First Cycle Certificate (BEPC, *Brevet d'Études du Premier Cycle*). The former begin as monitors, the latter as assistant training teachers. Promotion from one grade to another takes place through professional exams like the Certificate of Aptitude to Monitoring (CAM), the Basic Teaching Ability Certificate (CEAP, *Certificat élémentaire d'aptitude pédagogique*), and the Teaching Ability Certificate (CAP, *Certificat d'aptitude pédagogique*). Thus, teachers recruited with a CEPD level, pass CAM, CEAP then CAP; the holders of BEPC pass CEAP and CAP; holders of high school diploma only have to pass CAP.

As far as teachers' status is concerned, the State recognizes four categories: official teachers, auxiliary teachers, benevolent teachers and community teachers.

Teachers freshly out of ENI work for five years before being confirmed as officials.

⁷ World Bank 2013a: 16.

Auxiliaries are trainees who can get tenure after a pedagogical evaluation but their salary is lower than that of officials. As for benevolent teachers, lack of qualification prevents them from occupying the post of auxiliaries and they must make do with 5000 to 10 000 FCFA per month,⁸ sometimes even accepting payment in kind, while hoping to become officials one day. Finally, there are “community teachers financed by the community but [zero chances] of integration into public service” (World Bank 2013a: 8).

The current policy is to gradually remove the last three positions. Indeed, a revision of the texts relating to the specific status of teachers would potentially allow all non-permanent teachers to be regularized and re-absorbed in public service. Despite promises made by the supervisory ministry, these precarious positions still exist in primary schools in Togo. In 2013, a World Bank study was made on a sample of 716 teachers, of which 40% were benevolent and 20,3% auxiliaries. Recently estimated at more than 5000⁹ on a national scale, more than a dozen benevolent teachers were identified by our inquiry just in the prefecture of Zio and in some schools of West Lomé inspection.

In all the public schools investigated, there was a lack of teachers because they had been transferred and not been replaced or they had retired. Heads of institutions are forced to recruit voluntary teachers to compensate for the slow response of authorities in filling up vacant posts.

Thus, the future of the voluntary teachers, who are demotivated and provide mediocre teaching remains uncertain; in the recruitment exam held in August 2017, “of the 1420 [voluntary teachers] registered, only 218 were admitted. 1202 failed but could not understand why; for the simple reason that they had no idea of their chances.”¹⁰ For the moment, the requirements of the education sector, estimated in February 2018 at “13 000 teachers for primary and secondary school, and 267 for vocational teaching as well as the building of 7459 classrooms”¹¹ present an enormous challenge to the central administration.

4.2 Internal governance of educational institutions

Contrary to the results of the study on the health sector, the inquiry in the educational sector could not obtain systematic and sufficient data on practical norms

⁸ Sources: World Bank, 2013a : 8 ; <https://www.togotopinfos.com/2016/12/28/le-concours-national-de-recrutement-ouvert-aux-enseignants-volontaires-ages-de-45-ans/>

⁹ <http://news.lomechrono.com/?idnews=827876&t=les-enseignants-volontaires,-les-oublies-du-gouvernement>

¹⁰ (<https://www.togobreakingnews.info/index.php/rubriques/education/item/1984-les-enseignants-volontaires-du-togo-crient-leur-detresse>).

¹¹ <http://news.icilome.com/?idnews=844029&t=education-un-besoin-de-7-459-salles-de-classe-dans-le-pays>.

ruling the internal governance of educational administrations. Nonetheless, the focus groups and even the final validation workshop (Lomé, 24 November 2017), revealed that teaching personnel lengthily evoked red tape causing delayed transfers and appointments, and miscommunication with the hierarchy.

Monitoring of teachers and their pedagogical and administrative control is firstly ensured by the school principal who also has teaching responsibilities and simultaneously represents the school before the parents and the academic inspection. At a higher level, the progress of the school's pedagogical activities is supervised by pedagogical councillors and inspectors. With them, we could evoke the delicate question of the teaching body's professional misconducts and the eventual penalties enforced, even if it was impossible to determine their frequency.

On the pedagogical level, misconducts can include: unprepared lessons, poorly maintained registers, unassigned or uncorrected homework, etc.; on the administrative level: coming to school sloppily dressed or drunk, frequently arriving late or taking French leave¹² (absences at the end of the month to withdraw one's salary in the administrative capital are authorised), using the telephone in class; on a criminal level: abusive exploitation of pupils in extra-school tasks (working in the field, extraction and transport of sand, grinding and transport of gravel, making bricks), bodily harm by inflicting punishment and lastly what the interviewees termed "guilty relations", or sexual relations with pupils; sometimes, this violence "can kill", in case of "pregnancy and attempted termination by abortion and death" (director, Lomé, September 2017).

What about penalties? The question being delicate, answers were evasive or referred to applicable laws¹³. Still, their content indicated that the range of expected penalties is rarely applied formally. School principals admit to a "social" management of professional mistakes. At least for minor errors, they seek to find solutions so as to "reason" with the teacher (sometimes even through the intermediary of a colleague), on the principle that "firstly, these could have been errors, but if it recurs, it becomes a mistake". In case of a relapse, the file is conveyed to the pedagogical councillor, then to the inspection and finally to the ministry: "at our level here - admitted a principal - we can impose no penalties".

¹² On absenteeism, a quantitative inquiry of 2013 showed that "21% of Togolese teachers were absent from school whilst 15% were at school but not in the class" (World Bank 2013a: 9). Nevertheless, this absenteeism rate is the lowest in West Africa.

¹³ Depending on the seriousness of the act, penalties scheduled are: warning, blame, transfer, suspension cannot exceed a month, removal from promotion lists or delay in promotion, loss of seniority in scale, downgrading, temporary removal from post, dismissal with suspension of retirement benefits (MEPDD, 1983).

4.3 An avalanche of reforms and their painstaking application

4.3.1 Policy of free education

We have already mentioned the policy of free schooling in public schools, perceived by officials and parents as a form of State withdrawal from the education sector. Some strategies were instituted by managers and teachers to enable the school to continue functioning. Other than the recourse to “incidental expenses” imposed on families (cf. above) to compensate for the lack of schools and teaching personnel, several grades are regrouped in the same class (CP, CE and CM) (*class twinning*) or classes from different schools are merged. However, assembling students of different grades in the same class and keeping them during fixed class hours while following the programme is a complex and difficult task. It calls for sufficiently qualified, motivated and devoted teachers.

In this context, the majority of teachers do not succeed in following the programme and delays are frequent. Some then decide to neglect some educational activities such as practical works or disciplines like recitation, sports, singing, drawing or national languages; others prefer to “muddle through the classes”, or skim over some lessons so as to finish the programme, even if this implies a superficial or incomplete treatment; others organise remedial classes, calling pupils early in the morning at 6.30 a.m., keeping them later in the morning, as well as using Wednesday afternoons or Saturday mornings.

Formally banned by the State, these practically compulsory refresher courses form one of the sources of supplementary income for teachers, especially in the secular private sector where they make up for low salaries. Such a system is taken over by businessmen in search of commercial gain. Instituted as compulsory in the secular private sector, these refresher courses have come to be known under various names in public primary schools: “refresher classes”, “capacity building course”, or “remedial courses”. This polysemy translates the suspicious attitude and fear of public primary school actors regarding educational authorities who prohibit them officially. Thus, all together, the falling level of students, the inadequacy of teachers and the search for supplementary revenues have made refresher classes a routine. These classes become practically compulsory in fourth and fifth grades to prepare for the primary school certificate exam.

4.3.2 Automatic success

Since 2013, primary education is organised in three sub-cycles, each of which lasts two years: the first groups preparatory classes (CP1 and CP2), the second elementary classes (CE1 and CE2) and the third middle classes (CM1 and CM2). To reduce school failure and not extend the students’ stay in the cycle, the passage from first to second year of each sub-cycle is automatic. “Failure can only occur at the end of the

sub-cycle”¹⁴.

The application of this measure has raised problems linked to students’ performance because of a lack of effective application of intended measures of remediation for students in trouble: “students whose performances do not come up to expectations will benefit from refresher courses during or at the end of the academic year, at specific moments”.¹⁵ This policy is strongly criticised by educational actors, for it contributes to lowering the students’ levels.

“Because of the policy of automatic promotion, children stop learning. They don’t do their homework because they know that at the end of the year, they won’t fail”. (Director of a primary public school, West Lomé, September 2017).

“Some parents even keep their children at home for domestic tasks, because in their viewpoint, even if the child doesn’t come to class, he will automatically pass.” (Teacher of a primary public school, West-Lomé, 2017).

In this context, some directors invent strategies to make the weakest students repeat the class by putting their names on the list of dropouts or absentees, thus avoiding sanctions by the inspection.

4.3.3 The suppression of physical punishment

Since 2009, Togo has formally prohibited all forms of physical punishment or forced exploitation of pupils’ labour.¹⁶ Ministerial authority thus reacted to repeated complaints from parents, associations for child rights, and NGOs working in the education sector. This law was publicized widely and is broadly followed in Togo’s educational institutions. The suppression of physical punishment was especially supported by international NGOs (UNESCO, Plan Togo international, Børnfonden), which piloted several non-violent educational programmes in Togo proposing alternative measures to physical punishment in agreement with pedagogical inspectors.

Today, the crisis of primary education has reanimated a debate that seemed to have been closed: parents, sometimes even teachers or school directors condemn the abandon of the “stick” at school and hold it responsible for the degradation of teaching conditions and learning: “It is with a stick that one educates a child”, we were frequently told during the inquiry. Accustomed to resorting to threats of physical violence to hold student’ attention and impose discipline, and with no real training in managing a class by any other means than the whip, teachers admit to

¹⁴ Art. 2, decree n° 080/MEPSA/CAB/SG, 10 Oct. 2012.

¹⁵ Art. 3 decree n° 080/MEPSA/CAB/SG, 10 Oct. 2012.

¹⁶ Cf. Circular note of Ministry of primary and secondary teaching (circular N°694/MEPSA/CAB/SG), 16 March 2009.

being overwhelmed by the hundreds of students in class:

“Even beating is banned, and I tell myself, in our time, without the stick, you couldn’t advance. In any case, that’s my viewpoint, me, I advanced with the stick. (...) Nowadays, with its ban, children don’t learn any more, they know we won’t hit them, we won’t punish them in any way. So, they are free to an extent that I don’t even know how to explain this, what! They do nothing, it’s you the teacher who will do everything in their place”.

For the parents’ too this measure appears incomprehensible. They admit to hitting their children at home when this becomes necessary and confess to having been disciplined by the fear of a possible physical punishment:

“It’s really painful that education has become an object of distraction. One says this today, one doesn’t stop to see the consequences and one jumps to something else. There are too many decisions that one wants to apply at the same time and it’s inexplicable. Our children today are scared of nothing. You say they must not fail, and you suppress the only means the teacher has of applying pressure. Exactly what level do you want them to have?” (Parent of a primary public school of West-Lomé inspection, September 2017).

4.4 Informal privatisation of the educational sector

Studying other administrations in West Africa (Blundo 2006, Blundo and Olivier de Sardan 2006a), we showed that in contexts of structural deprivation of the public service, officials react to the material penury that threatens their daily life and mortgages their capacity to provide public service, not by inaction but by inventing alternative sources of financing. In chapter 2, we mentioned the “incidental expenses” families must pay the school. Here, we examine the series of initiatives taken by principals and some teachers, which present as many practical norms adopted to ensure the survival of the educational institution.

4.4.1 Principals financing the school

School principals are increasingly led to finance some activities “from their own pocket”, as they say. A director of Zio-sud inspection for example explained that on her arrival in 2011 at her post, she discovered that she was all alone and there were no classrooms! The buildings of the educational sector she was supposed to administer had not yet been constructed. She had to undertake the construction of classrooms herself in *apatam* (a kind of shack) and try to work with the system of twinning classes while waiting for State funds. These forms of self-financing seem to have become the daily fare of heads of institutions:

“I was at home in the middle of vacations when I received a call informing me that one of my buildings had lost its roof because of the wind. I rushed immediately to school and indeed confirmed the damage. Quick action had to be taken to avoid the theft of the tin sheets and wood. I called the carpenters to save what could be saved. At the end of their work, they estimated their labour as 15 000 FCFA. Incapable of paying them this amount, I negotiated and at the end of much pleading, they agreed to take 5000 F CFA. I then appealed to the inspection but until now there has been no reaction, although the new academic year begins in a few days” (Interview of a public school principal, West-Lomé inspection, September 2017).

4.4.2 Pre-financing the new academic year

Delay of State funds leads some principals to pre-finance the new academic year by the purchase of pedagogical and didactic materials essential to begin classes. With the reception of these funds in April, towards the end of the second semester, these principals recover the funds in the form of reimbursements. Other directors pre-finance the new academic year by sacrificing their bonus for they know that State funds will not suffice to resolve their school’s problems.

4.4.3 Support of pupils’ by principals and teachers

Today, the number of children registered in preparatory classes (CP) without any civil-status documents (birth certificate) and waiting to be regularised is increasingly high. The misunderstanding around free access liberates some parents even from some of their basic duties: we met principals who paid to get their students’ birth certificates so that they could pass the CEPD exam, and who were never reimbursed by parents.

When school principals are asked why they choose to spend their own money in such situations, they answer that as heads of families it is sometimes difficult for them to remain inactive, especially if the student is brilliant. Others confess to having clothed and fed some particularly poor students:

“Children arrive dressed in a way it is hard to describe. Sometimes, we are forced to get clothes made for them because the state of their dress makes them uncomfortable, and if the child remains like that till the end of the year, he can’t produce a good result, because he feels inappropriate and stressed. When you send him to the blackboard for instance, he begins to walk sideways because he doesn’t want others to see that his underpants are torn (...). Other children come to school with no money and without having eaten at home. When one sees this, one is forced to put one’s hand in one’s own pocket” (Interview of a public school principal of West-Lomé inspection, September 2017).

Whether moved by compassion, altruism, a sense of public service or ambition, these practical norms represent a certain degree of “informal privatisation” of the Togolese public school. By proclaiming free public schooling but giving educational institutions ridiculous funds far too late, the State subjects its officials to a classic situation of a double bind: they must provide results without for all that possessing the necessary means to achieve them. But the equally classic strategy adopted in this kind of situation, intrinsically produces ambiguities, since it contributes to blurring the boundary between private and public money, between personal and collective interest.

Conclusion: gazing into the mirror, thinking reforms “from below”

At the end of the inquiry, we organised sessions to reconstitute the main results to the actors of the services studied (senior officers from Ministries, agents of decentralized administrative levels, NGO representatives and parents' associations, etc.). These day-long meetings aimed partly to win official confirmation of our observations and analyses. We began with the hypothesis that sharing the data that emerged from the field inquiry and our reading of their daily normal and commonplace practices would provide an occasion for the people we interviewed to “look at themselves in the mirror” and react. We hoped in this way to trigger a debate on the conception and feasibility of reforms from the perspective of actors' experiences and sensitivity to local contexts of production of public services.

Each restitution workshop reproduced the same structure: during the morning after presenting the research questions and methodology adopted, we discussed the general context of service deliveries (health care and education) going on to expose the routine behaviours and practical norms we had identified; after a pause for lunch, participants were divided into working groups to answer three questions: 1) *Which practical norms can be added to those identified and described?* 2) *Which practical norms can be improved and generalized?* 3) *Which practical norms must on the contrary be abandoned or contested?*

The organisation of these workshops was itself an occasion for understanding the bureaucratic cultures of health and education administrations from another angle. In the two cases, we came up against the delays in the decision-making chain, due partly to its strongly centralized structure. In the two cases, we were obliged to postpone the workshops repeatedly; in the two cases, even on the eve of the workshop we had no idea of the number of participants in the event.

These problems were particularly acute for the workshop destined to health officials. Planned as a two and a half-day seminar to be held at the beginning of July 2017, the seminar finally took place on 29 September 2017, after having been postponed twice and in a reduced version of a one-day workshop. The administrative procedures involved were heavy, time-consuming and more complex than those for authorisation to do the research: they can be quantified in 53 emails, 5 meetings between the Health Ministry officials and research team (one outside Lomé) along with a great number of telephone calls.

In principle, the organisation of an event by external actors like a meeting or a workshop involving health officials, must be supported by a Health Ministry department. Its head must draw up the invitations that are submitted to the Health Minister himself for his signature. In principle again, these formalities do not take more than a maximum two weeks. Our experience showed us that they take much

longer and the procedures mentioned above may not be respected.

Our partner in the Ministry was the Department of Child and Maternal Health (DSMI), which was the first to support the organisation of a restitution session at the end of a meeting held on 9 May 2017. The DSMI then wished the team members to present the project of organizing the restitution workshop to the General Direction of Studies of Health Planning and Information on 2 August 2017. Coming out of this meeting, the DSMI head told us that she preferred the Head of Studies to supervise the event's organisation. Some hours later, we were told to address ourselves to a third partner, the General Direction of Sanitary Action (DGAS), to draw up the invitations. On 3 August, the research assistant had to meet the DGAS director, but the latter sent him back for he was not accompanied by a DSMI delegation.

We came back to the DSMI and fixed a new calendar for the workshop (6, 7 and 8 September 2017). These dates did not work since at the beginning of September we had no idea which department would send the invitation. Finally, a fourth administrative structure, the Head of institutions of Health Care (DES), agreed to support the restitution workshop now planned for 20, 21 and 22 September 2017. But the DSMI had not conveyed the file required to draw up the invitations within the necessary time limit. So, the research team had to make another file. Once again, the workshop was postponed, this time to 29 September 2017.

Until 25 September, the letters were still with the Minister's cabinet for signature and had therefore not been sent to the participants. We convinced the head of DGAS to do it instead. Finally, we had to personally call the participants individually to inform them that they were invited to a workshop but would be receiving the invitations later. Contacting these officials was also a headache, given the lack of data listing the current health officials and administration managers.

These repeated delays reveal the problems of coordination between ministerial services and an excessively centralized decision-making process. The progression of workshops itself confirmed other dimensions of the administrative culture observed on the field. This report showed that comparatively, the problems in the management of working hours (delays, absences) were more pronounced in the health sector than in schools. We noted the same difference while holding the workshops: whilst educational actors arrived punctually at 7.30 a.m. and attended all the programmes regularly, the health workers' audience reproduced all the "practical norms" in force in hospitals. Rare were those participants who were punctual; the seminar began an hour and a half late with constant interruptions because of noisy entrances of latecomers. Some even arrived at lunchtime...

At the end of the day, we had to comply with another well-known practical norm, disseminated across Africa with the collusion of donors, according to which all participation in a workshop or seminar must be rewarded by "incentives". This

consists of a grant of a daily allowance and substantial fuel costs. Whilst the education officials did not demand these allowances (locally termed « practical measures ») as a condition of participation in the workshop and discovered them with some surprise, health officials negotiated the rates beforehand, judging them initially to be insufficient and “un-motivating”. In the evening, the distribution of the daily allowances threatened to degenerate into a real sprint as participants pushed to get their due for themselves as well as for their drivers, contrary to what had been fixed earlier.

Differences clearly appeared as well in the discussion on practical norms, even if the officials from the two sectors were unanimous about the general dissatisfaction of public service officials and about the need to revalorise public service. Indeed, as our study has shown, working conditions are so difficult that solutions must be found to counter the discouragement of officials. In the contrary case, the latter will continue to seek informal sources of motivation, which could injure the administration or users. For example, postings in difficult areas should be accompanied by an ad hoc salary bonus.

All the same, the remarks and reactions of teachers demonstrated a clear hostility to practical norms while recognizing their pervasiveness in everyday school life. They unanimously condemned the hasty and non-concerted important reforms like the end of tuition fees, the automatic advance in sub-cycles and the ban on physical punishment. Reforms of this scale would have required accompanying measures on a financial and pedagogical level as well as a truly decentralized administrative environment.

On the contrary, health officials had a more nuanced, articulate gaze on their own routine and informal practices. With respect to practices close to petty corruption, such as the PAM and Gombo, participants of the workshop suggested they be formally regulated by allotting them specific slots in the week. During authorised hours, health officials would directly encash informal benefits. On the other hand, they would be expected to refund a percentage to the health service so as to contribute to the latter’s maintenance expenses. In the same spirit, instead of unsuccessfully contesting the favoured treatment of “relatives, friends and acquaintances” (PACS), for “Africa is social”, a working-group suggested officialising the practice by devoting a time-slot to PACS. Every exception to the new rule would, on the contrary, be strictly suppressed.

Participants also supported the idea of flexible working hours: permitting officials to come late, while inventing formulas allowing them to catch up with time lost. Participants of the health workshop also recognized the legitimacy of the practical norm, which consisted of “pushing upwards” subaltern posts. They even suggested that this tendency be formalized by creating other intermediary professional

categories besides medical assistants, to officially replace midwives or doctors. In other words, they supported the idea of a larger delegation of tasks in the health system.

Whether imposed by the lack of human resources and administrative means, by reforms un-adapted to local contexts or by the search for additional income, most behaviours and practices deviating from official rules identified in this study are routinized and often legitimate in the eyes of the officials. They thus form an integral part of health and education officials' professional culture in Togo. Our study, quite new in Togo (though it certainly needs to be developed), has shown that if official rules are too disconnected from their local contexts of application, informality takes over and becomes the new rule. How can we learn from practical norms to conceive official rules and regulations that are closer to contexts and therefore more efficient?

References

- Aboubakari, A.S. et al., 2014, "Influence, à court terme, de la subvention sur le profil épidémiologique, clinique et pronostique des grossesses et accouchements par césarienne au nord du Togo : étude comparative de 520 cas", *Journal de la recherche scientifique à l'université de Lomé (Togo)*, Série D, 16(2) : 363-369
- Balaka, B, et al., 2015, "Impact de la césarienne subventionnée sur l'asphyxie périnatale à l'hôpital de district de Bè" *Journal de la recherche scientifique à l'université de Lomé (Togo)*, Série D, 17(2) : 337-343
- Bamaberger, P., A., et Bachaech, S., B., 2006, "Abusive supervision and subordinate problem drinking: Taking resistance, stress and subordinate personality into account", *Human Relation*, Vol. 59, N° 6: 723-752.
- Blundo, Giorgio, 2006. "Dealing with the Local State: The Informal Privatization of Street-Level Bureaucracies in Senegal", *Development & Change*, 37(4): 799-819.
- Blundo, Giorgio and Jean-Pierre Olivier de Sardan, Eds. 2006a. *Everyday corruption and the State. Citizens and public officials in Africa*. London, Zed Books.
- Blundo, Giorgio and J.-P. Olivier de Sardan, 2006b. "The Popular Semiology of Corruption." In G. Blundo and J.-P. Olivier de Sardan (eds.) *Everyday Corruption and the State: Citizens and Public Officials in Africa*,. London: Zed Books: 110-134.
- Diarra, A., 2011, *La mise en œuvre de la politique d'exemption de paiement dans les districts sanitaires de Gaweye et de Say*, "Etudes et Travaux du Lasdel", N°96.
- Hahonou, Eric Komlavi, 2015. "Juggling with the norms. Informal payment and everyday governance of healthcare facilities in Niger", in T. De Herdt and J. P. Olivier de Sardan (eds.), *Real Governance and Practical Norms in Sub-Saharan Africa. The Game of the Rules*. London, New York, Routledge: 123-141.
- Jaffré, Yannick and Jean-Pierre Olivier de Sardan, Eds. 2003. *Une médecine inhospitalière. Les difficiles relations entre soignants et soignés dans cinq capitales d'Afrique de l'Ouest*. Paris, Karthala.
- Kafando, Y., Mazou B., Kouanda, S., Ridde, V., 2011, *Les retards de remboursements liés à la politique de gratuité des soins au Niger ont des effets néfastes sur la capacité financière des formations sanitaires*, "Etudes et Travaux du Lasdel", N°99.
- Koné, F., 2014, "Mise en place des gratuités des années 2000 au Mali", in Ridde, V., et Olivier de Sardan, J.-P., (eds.), *Une politique publique de santé et ses contradictions : La gratuité des soins au Burkina Faso, au Mali et au Niger*, Paris : Karthala : 101-113.
- Koné, M., 2003, "'Contexte' et 'gombo' dans les formations sanitaires" in Jaffré, Y. et Olivier de Sardan, J.P., (eds), *Une médecine inhospitalière. Les difficiles relations entre soignants et soignés dans cinq capitales d'Afrique de l'Ouest*, Paris : Karthala : 237-261.
- Masquelier, Adeline, 2001. "Behind the dispensary's prosperous facade: Imagining the state in rural Niger", *Public Culture* 13(2): 267-291.
- Olivier de Sardan, J.P., 2001, "La sage-femme et le douanier : cultures professionnelles locales et culture bureaucratique privatisée en Afrique de l'Ouest", *Autrepart*, n° 20 : 61-73.
- Olivier de Sardan, J.-P., 2008, "A la recherche des normes pratiques de la gouvernance réelle en Afrique", APP, Discussion Paper, n°5.
- Olivier de Sardan, J.-P., 2014, *La routine des comportements non-observants au sein des services publics nigériens. Connaître la culture bureaucratique pour la réformer de l'intérieur*, Rapport

réalisé pour le Haut-Commissariat à la Modernisation de l'Etat (HCME), Etudes et Travaux du Lasdel.

Olivier de Sardan, J.-P., 2015, "Practical norms. Informal regulations within public bureaucracies (in Africa and beyond)", in T. De Herdt and J. P. Olivier de Sardan (eds.), *Real Governance and Practical Norms in Sub-Saharan Africa. The Game of the Rules*. London, New York, Routledge.

Olivier de Sardan, J.P., Diarra A. & Moha, M., 2017, "Travelling models and the challenge of pragmatic contexts and practical norms: the case of maternal health", *Health Research Policy and Systems*, 15 (Suppl 1):60.

Ouattara, Fatoumata, 2002, "Gouvernances quotidiennes au coeur des structures de santé. Les cas d'Orodara et de Banfora, Burkina Faso", *Bulletin de l'APAD* (23-24).

Ousseini, A., 2011, Exemptions de paiement des soins en faveur des femmes et des enfants de moins de 5 ans, Mise en œuvre dans la région sanitaire de Dosso, Etudes et Travaux du Lasdel, N°92.

Ridde, V., 2012. "Réflexions sur les per diem dans les projets de développement en Afrique", *Bulletin de l'APAD*, (34-36).

Salissou, A. et al. 2012, "Efficacité et tolérance de l'association artemether lumefantrine dans le traitement du paludisme simple à Plasmodium falciparum au Niger", *Journal de la Recherche Scientifique*, (1)14.

Tepper, B., J., Moss, S., E., Duffy, M., K., 2011, "Predictors of abusive supervision: supervisor perceptions of deep-level dissimilarity, relationship conflict, and subordinate performance?", *Academy of Management Journal*, vol. 54, N° 2: 279-294.

World Bank, 2013a. *Togo. Indicateurs de prestation de services 2013. Rapport technique éducation, Service Delivery Indicators*, 58 p.

World Bank, 2013b. *Togo. Indicateurs de prestation de services 2013. Rapport technique santé, Service Delivery Indicators*, 69 p.

Yaogo, M., Kagambega, A., et Dabiré, D., 2014, "Emergence et formulation des exemptions de paiement des services liées au paludisme au Burkina Faso", in Ridde, V. et Olivier de Sardan, J.-P., (éds.), *Une politique publique de santé et ses contradictions : la gratuité des soins au Burkina Faso, au Mali et au Niger*, Paris : Karthala: 87-99.

Official sources

Ministère de la santé 2012 *Plan national de développement sanitaire du Togo : 2012-2015*

Ministère de la santé, 2013 a, *Rapport synthèse de l'analyse de la situation du personnel lié à la pratique sage-femme au Togo*, République Togolaise.

Ministère de la santé 2013 b, *Rapport de l'étude de cas sur la situation des personnels de la pratique sage-femme et planification familiale au Togo*, République Togolaise.

Ministère de la Santé, 2015 a, *Plan de développement des ressources humaines en santé (PDGRHS) 2016-2020*, République Togolaise.

Ministère de la santé, 2015 b, *Etude du marché de l'emploi du personnel de la santé au Togo : Analyse de la chaîne « formation-recrutement-déploiement »*, République Togolaise.

Ministère des Enseignements Primaire et Secondaire, 2014, *Annuaire National des Statistiques scolaires 2013-2014*, Lomé.

Ministère des Enseignements Primaire et Secondaire, 2015, *Annuaire National des Statistiques scolaires 2015-2016*, Lomé.

Ministère des Enseignements Primaire et Secondaire, *Note de service portant interdiction des cotisations parallèles sans autorisation dans l'enseignement primaire public*, 09 juillet 2014

République togolaise, 1975, Ordonnance N° 16 du 6 Mai 1975 sur la Réforme de l'Enseignement, Lomé, MENRS.

République togolaise, 1998, *Politique nationale du secteur de l'éducation et de la Formation*, Lomé, MENRS/METFPA

République Togolaise, 2005, *Plan d'Action Nationale de l'Education Pour Tous (PANEPT)*

République togolaise, 2010, *Plan Sectoriel de l'Education 2010-2020. Maximiser la contribution de l'éducation au développement économique et social du pays*, Lomé

République togolaise, 2012, *Stratégie de Croissance Accélérée et de la Promotion de l'Emploi*

République togolaise, 2014, *le Plan Sectoriel de l'Education 2014-2025. Amélioration de l'accès, de l'équité et de la qualité de l'éducation au Togo*, Lomé

République togolaise, *Journal officiel Togo Presse du 1^e juin 2015*, Lomé.

République togolaise, *Journal officiel Togo Presse du 30 mars 2015*, Lomé.

République Togolaise, Ministère des enseignements primaire, secondaire et de l'alphabétisation (MEPSA), *Projet Education et Renforcement Institutionnel (PERI), 2011, Manuel de procédures de gestion financière et de passation des marchés (volume 2 à l'usage des COGEP), Version finale*. Lomé.

République Togolaise, Ministère des enseignements primaire, secondaire et de l'alphabétisation (MEPSA), 2013, *Revue sectorielle du PSE. Rapport de performance du secteur de l'éducation entre 2010 et 2012*, Lomé.

République Togolaise/Pôle de Dakar (2013) : RESEN, *Diagnostic du système éducatif togolais pour la poursuite des efforts engagés vers la scolarisation primaire universelle et une meilleure adéquation formation-emploi*, UNESCO, Dakar.