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Health district governance and power relations in Burkina Faso

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Abstract
Introduction: The pluralistic nature of the governance of the health system with the multiplicity of actors disrupts power relations. Since the adoption of the Bamako Initiative in 1987 in Burkina Faso, we have noted the presence of community representatives in the decision-making space of health districts. They participate alongside government representatives in the decision-making process. This article aims to analyze the influence of the different actors involved in the governance of a health district in Burkina Faso.
Methodology: A total of 32 people were included in the study. These people were divided into three main groups: members of the district team (n=9), managers of the government's deconcentrated technical services (n=8) and community representatives (n=15). The data was collected through individual interviews. The content analysis method was used. NVIVO software was used for data processing.
Results: The results indicate that community representatives have little influence in the decision-making process at the health district level. Indeed, all the resources that allow actors to influence exchanges are beyond their reach. Language skills, expertise, and economic capital are the main resources that are mobilized in this space. They are easily mobilized in interactions by both health district officials and community representatives. As a result, the views of the communities are poorly taken into account in the governance of health districts in Burkina Faso.
Conclusion: The article notes that mastery of the language of communication, economic situation, and expertise on health issues give more scope for action to health district officials than to communities.

Keywords: governance, health district, health system, power relations, Burkina Faso

Introduction

The search for performance has been a major preoccupation of health system managers for several years (Murray *et al*., 1999) [35]. The objective is to make health care structures more responsive, efficient and sensitive to the needs of communities (Kruk & Freedman, 2008) [24]. Numerous institutional arrangements have been put in place to facilitate access to the decision-making space of the health system by other actors in addition to health professionals (Rathnayake *et al*., 2021) [40]. Since the adoption of the Bamako Initiative, the notion of governance has appeared in the discourse on the health system (Gilson & Mills, 1995; Haddad *et al*., 2006). Indeed, in the face of difficulties related to human resources in health, the quality of care, working conditions, and the inadequacy and quality of equipment in health care facilities, urgent reforms of management and administration were essential to give health care systems a boost (Leighton, 1995) [27].

The concept of governance, which is widely used in the field of research, reflects in many ways the transformations that mark the exercise of power in contemporary societies (Chevallier, 2003; Contandriopoulos, 2008) [8, 10]. A polysemous term, it can cover several meanings and describe variable phenomena depending on the field of research and the actors who use it. The literature informs us that the use of the concept of governance refers to three strong ideas. First, it notes that the space of responsibility expands and goes beyond existing structures. New organizations, based on their roles in the health system, need to enter the decision-making space. It requires thinking about and implementing mechanisms for coordinating autonomous and interdependent actors (Le Galès, 2019) [25]. Secondly, governance is not a simple way of making decisions in positions of authority for a use of resources. It remains a management device of several processes to achieve expected results (Seppey, 2017; Turcotte & Bastien, 2011) [42, 46]. The management body has an obligation to produce change. It will be evaluated on the basis and quality of the changes rather than on the number of activities carried out. Better coordination of the actions of all actors involved is an essential component of governance. Third, governance is generally associated with the notion of performance (Sicotte *et al*., 1998) [43]. The stated objective is to have health care structures that offer quality services at costs that are accessible to all and that meet the needs of communities. In order to properly assess governance, it is necessary to implement new tools for an optimal assessment of performance (Abelson & Eyles, 2002; Smith, 2005) [44, 2].

In response to the enormous challenges of health, new techniques of government have been imposed in the health sector (Hatchuel, 2000) [19]. They are characterized by the involvement of various actors in decision-making processes. Health professionals are forced to accept community representatives in decision-making bodies. From now on, the representatives of the State no longer have a monopoly on decision-making power.

The new form of governance indicates that consensual solutions, based on the agreement of the different actors, will be preferred to authoritarian formulas. All decisions must be the result of negotiations and compromises, taking into account the points of view of the stakeholders (Chevallier, 2003) [8]. State representatives must be willing to discuss on an equal footing with partners. Governance is a pluralist and interactive approach to collective action (Pinson, 2015) [38]. It means that no single actor can control the decision-making processes; taking into account the complexity of the problems and the existence of multiple powers, it is a matter of coordinating their action and obtaining their cooperation (Moreau, 2001) [33]. It manifests itself in "horizontal forms of interaction between actors who have conflicting interests but who are sufficiently independent of each other" (Pitseys, 2010) [39].

The pluralistic nature of the governance of the health system with the multiplicity of actors disrupts power relations (Lemieux, 1967) [28]. Indeed, as Dahl (2005) [12] pointed out, pluralistic situations make it very unlikely that a single actor or organization will have unilateral and hard-line domination. The influence of other actors no longer resides in titles or positions in the decision-making space, but depends on the actors' ability to mobilize in their favor the resources that have been dispersed in the health system (Abélès, 2008; Ciavolella & Wittersheim, 2016). Power relations will be determined by the ability to mobilize adequate resources according to the given situations. Power in these circumstances is not linked to a function or a title but remains "a relationship and not an attribute of the actors" (Crozier & Friedberg, 1977) [11]. This indicates that each group of actors must organize itself in order to acquire the necessary resources to enable it to influence the others in negotiations for decision-making. In the space of the health district, there are many resources that give the different actors greater capacity to influence (Lemieux, 2001) [29]. Everything will depend on the strategies put in place and the capacities of the different actors. This article aims to analyze the power relations in the health districts in Burkina Faso. It focuses on the interactions between community representatives and state representatives. The article will first list the power resources available in the health district. Secondly, it will analyze the capacities and conditions of resource mobilization by the actors to dominate decision-making situations.

Methodology

Setting of the study

The study took place in the Tenkodogo health district, in the Centre-East health region of Burkina Faso. It involved the governance bodies of the health district. The 2016 general population and housing census estimated the district's population at 274,735, with an average household size of six persons. The main ethnic groups inhabiting the area are the Bissa, Mossi, Peulh and Yanas. The religions practiced are Islam, Christianity, and animism. According to 2013 school statistics, the primary school enrollment rate was 82% in 2018.

Study Participants and Data Collection

The study participants fall into three main groups. The first group is composed of members of the district management team (DMT). They are all health workers of different profiles. All 9 members of the DST were included. The DST team was composed of 6 men and 3 women. The second group was made up of officials from the government's deconcentrated technical services. Eight of the 10 officials involved in the district were interviewed. The two who were not included were absent at the time of data collection. Finally, the third group is made up of community representatives who sit on the CoGes. Finally, in the third group, 15 people were included. These people are members of the CoGes. Three members were chosen from each of the five CoGes in the study area. A total of 15 community representatives participated in the study.

Data processing and analysis

The content analysis method was used (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005). All interviews and focus groups were recorded and transcribed. We used two types of encoding: inductive encoding and deductive encoding (Wong, 2008). Indeed, from the note-taking and interview summaries, a certain number of words or phrases were deemed important either because of their frequency or because they are relevant. From the corpus, a code book (a list of expressions or words that were used for encoding the interviews) was designed. Then, we proceeded to the systematic reading of all the interviews and all the passages that contained these elements were identified and marked with a distinctive sign. The second approach, inductive encoding, consisted in identifying, during the readings, new passages or interesting words that had not been previously selected. Once identified, these new elements were also marked with another sign in order to differentiate them from the first. Following this exercise, the corpus of analysis was constituted, composed essentially of a series of themes. To achieve this, we used the NVIVO 12 software from QSR International (Krippendorff, 2012; Mouricou, 2010) [23, 24].

Results

Management practices and decision-making processes

The first level of community involvement in decision-making is at the level of the CSPS. The structure in charge of managing this entity is the CoGes, which brings together health workers and community representatives. Decisions are made on the management of drugs, allocation of resources, organization of care, maintenance of equipment, recruitment and management of temporary staff. The results of the surveys reveal two major findings. The first is that instead of the chairperson of the CoGes chairing the meetings, the Head Nurse (ICP) is responsible for this task in all the CoGes observed. Meetings are usually held in the office of the PHN, who

remains seated at his or her desk while the CoMC members face him or her, seated on a bench or in chairs. This attitude reminds us that the ICP does not behave as a member of the CoGes but rather as the primary manager of the CSPS. This seems important to note insofar as these facts are likely to have any effect in the decision-making process. The other important fact to note in the decision-making process at the CSPS level concerns the definition of the meeting agenda. This is an important step in that it is around the items on the agenda that the discussions will take place. Generally, those who choose the agenda of the meetings have the advantage of having a head start on the others in the exchanges because "by defining a problem, one also defines the relevance of the expertise, know-how and possibilities of action available to the various actors interested in this problem" (Tang, 2013, p. 119). When we know that in the current practice of CoGes meetings, meeting agendas are not communicated in advance to participants, it remains that those in charge of choosing the agenda have the opportunity to better prepare themselves with a view to having their opinions prevail in the discussions. For example, they can seek out the necessary information to support their arguments during the discussions. It is still the KPIs that decide what items to put on the agenda of the meetings, as one CoGes chair explained:

"*It is the nurse who convenes the meeting. As he is the one who knows the problems of the CSPS well, he is the one who decides what we will discuss. When we arrive, he takes the floor to indicate the points to be discussed and then he asks if anyone wants to talk about anything else. That's how things are done. It's true that I'm the president of the CoGes, but to tell the truth, I don't understand much about the functioning of the health services, so I can't decide on something without the nurse's opinion. Even in training, that's what they tell us. Everything we have to do, the nurse has to give his opinion because he knows more than all of us" (President of the CoGes of the village of Salou).*

We also note that the subjects discussed mainly revolve around the sale of medicines and the management of the resulting resources, the expenses incurred, the organization of vaccination campaigns and, at times, difficulties concerning the relationship between nurses and patients. It often happens that subjects concerning the renovation or construction of a new building are discussed during these meetings. This was the case during a meeting of the CoGes of the CSPS Kallou where it was question of putting in place a strategy to mobilize resources in order to re-roof the housing of the itinerant health agent (AIS). Indeed, when it rains, his house is flooded and he was forced to move last year. The CoGes is thus obliged to contribute everything in order to find him a house in good condition. However, the funds from the sale of medicines are not sufficient to undertake the work and ensure the regular supply of medicines to the pharmaceutical warehouse. It is therefore necessary to find other means to carry out this activity, which seems almost impossible according to the members of the CoGes because the population is no longer willing to participate in the contributions or to give their time to take part in the work of common interest.

It was noted that many topics of interest to the population are rarely discussed in CoGes meetings. This is the case for the issue of care for the indigent. Indeed, the Ministry of Health of Burkina Faso wanted 5% of the resources generated by the sale of medicines to be used by the CoGes to take care of the needy in the health area. This issue is rarely discussed within the CoGes, whose main objective is oriented towards hoarding rather than finding solutions to the health problems of the populations (Hoffman, 2012). This is one of the reasons that could explain the growing disinterest of the populations in the activities of the CoGes.

Observation of CoGes meetings shows that the most common decision-making mechanism is consensus. This is a process by which participants reach agreement on a proposal without resorting to a vote. The exchanges and the various speeches end up bringing the positions of the stakeholders closer together and finally a solution is found that takes into account the expectations of all the participants. As some authors have noted (Brinkerhoff, 2004; Brinkerhoff & Bossert, 2014), consensus is the most widely used decision-making method in African societies, where voting was introduced by colonization in the administrative spheres. In many traditional political circles, the quest for consensus in decision making is still the norm. At the CoGes level, the practice of voting is almost non-existent as one PCI points out:

"Voting..., no, not at all. In any case, since I have been in office, I have never had a case where a vote was taken to make a decision within a CoGes. Whatever the difficulties, we end up agreeing" (Head nurse of a CSPS in Kalou).

Indeed, the observations made during the activities of the various CoGes visited confirm this state of affairs. Whatever the nature of the decision, it is generated by a consensus. This should not lead one to believe that all the participants' views converge in the same direction all the time. At a meeting of Cellou's CoGes, the deliberation on the need to raise the salary of the laborer was the subject of a lengthy discussion among the CoGes members. There were two opposing camps: the first, represented by the chairman, was in favor, while the second, which did not see the need, was led by an auditor. The exchanges lasted for about an hour before reaching a decision that followed a proposal from the ICP, which in substance stressed a reconsideration of its workload accompanied by an increase in its bonus. Also, it was noted that the nurses let in most cases, the other members of the office discuss among themselves without taking sides. But the proposals around which the unanimity is made come from them. It is understandable that this is a strategy used by the health staff to give the impression to the community members that their opinion counts in the decisions. The examples that were observed show that the nurses' proposals are generally endorsed by the other members. In sharing this observation with one office chair, he commented:

"You know except for the nurse, we other members have the same level. We know that there are things we don't understand. So, when the nurse explains and makes a proposal, we understand and we accept his proposal. As the nurse knows many things more than we do, when he speaks, we can't discuss too much" (CoGes23).

Observation of the meetings shows that in the decision-making process within the CoGes, the nurses' opinions are predominant. The consensus that seems to guide the decision-making mechanism hides in fact a disproportionate distribution of resources to be mobilized in the exchanges. Knowledge of the texts gives the nurses a large advantage over the members of the CoGes, who find themselves obliged to ratify proposals whose ins and outs they do not in fact master. There are situations where the CoGes meetings do not exceed thirty minutes. These are situations where the nurses who lead the meetings make proposals directly and ask for the opinions of the other participants. In these circumstances, the others remain silent and often end up accepting the proposal out of spite with uncertain conviction. In fact, many members of the community who sit in the CoGes do not have the cognitive means to analyze the nurses' proposals and make counter-proposals with solid arguments. The influence capacities of some community representatives are very weak. Indeed, their relatively low level of education does not facilitate their access to the contents of the legislative and regulatory texts that govern the functioning of health services. All decisions that must be made in the context of the management of the CSPS must comply with the provisions in force.

The second level of community participation in decision-making at the health district level is the District Health Council (DHC). Unlike the CoGes, this body is located at the provincial level and brings together several categories of actors from both the public administration and civil society. The themes that are also debated there are different from those addressed in the CoGes. Compared to the CoGes, the CSD deals with issues of design, planning, resource mobilization, and management of both human and material resources. The CSD is placed under the direct authority of the provincial public administration, whose first official is the de facto president of this management body. It is the chief district medical officer who provides the general secretariat, while the other actors are members. The texts creating the district health council are not precise about its real powers. It should be noted that its opinions are not binding on the health district. In practice, it could be said that it remains an advisory rather than a deliberative body. An ethnography of the meetings of this body reveals a total domination of the CoGes representatives by the other actors. Indeed, when observing the interactions, we discover that the CoGes presidents interact very little with the other actors. Generally sitting at the back of the meeting room among themselves, they hardly intervene in the exchanges. Those who did agree to speak at times were content to thank the authorities for having associated them with this meeting. Their interventions are rarely related to the issues on the agenda. During the SSC meeting, twelve CoGes members were present and we noted that they were seated on the same side. Only three of them spoke at the insistence of the chair. The first, after thanking the authorities, focused his intervention on the fact that the CSPS in his zone had a problem of insufficient human resources because a nurse who had passed a professional competition had left without being replaced. The staff is reduced to two agents, which naturally increases the waiting time. The second mentioned the case of households that had not received impregnated mosquito nets during the previous campaign (which took place a few weeks before the CSD meeting). Finally, the last speaker raised the problem of physical access to the CSPS in case of rain for a large part of the population in his area due to the presence of many low-lying areas that make travel almost impossible in some places. The agenda of the said meeting was the adoption of the 2014 action plan. We note that the interventions of the community representatives were not related to the topics on the agenda of the meeting. This situation could be explained by a lack of information on the importance of this document, but also by their weak capacity to grasp the scope and implications of such a document for the proper functioning of health services and the communities in the district area.

The context in which SSC meetings are organized leaves very little room for real involvement of CoGes members in the exchanges. Indeed, the meeting is held in French, which remains the official working language in Burkina. However, most CoGes members have a low level of education. This limits their participation in the exchanges. It was observed that after the various presentations, a summary was made in Mooré so that the members could understand the content of the exchanges. Is this sufficient? Involvement implies first of all the ability to communicate with others in order to influence the exchanges in one's favor through the strength of one's arguments. How can one have one's opinions taken into account if one is not able to present them? This is where linguistic capital becomes an essential element in the participation process.

As with the CoGes, the decision-making process is based on consensus. During the meeting devoted to the adoption of the action plan, after the presentation of the highlights by the district team, there were some questions of clarification. Then, the High Commissioner who chaired the meeting asked the room if they had any objections to applauding the adoption of the document. This was done. The document that was adopted was not reviewed in its entirety. Apart from those who drafted it, the other participants did not have access to the document. It was validated on the basis of the synthesis that was presented. Some participants complained about this, such as the mayor of a rural commune:

"I think it is urgent to review the process of adoption of this document which, in my opinion, must take into account the concerns of the community. It is mandatory to send this document in advance to all participants, which will allow them to examine it in depth and make the necessary comments. If you come to the meeting to hear presentations and adopt the district's action plan, that's not participation. The terms of reference and operation of the DSC need to be reviewed. As it is designed, it does not allow for real involvement of communities in the management of the district" (Mayor 2).

The organizational reality of the CSDs creates obstacles that hinder the appropriate involvement of other actors in health governance. Indeed, they are in a situation where they cannot influence the health district team. The institutional context of their intervention does not give them the means to effectively contribute to the management of health issues. One prefect who participated in the meeting indicated that he had not received any documents or information on the responsibilities and functioning of the CSD. This puts him in a position where he cannot oppose anything. He was limited in his ability to act and had to be satisfied with ratifying choices that he could not criticize.

We note that the exchanges within the district's participatory bodies are not to the advantage of the community actors and other non-health actors. It is the health agents who actually influence the entire process of interaction. The decisions that are made are more in line with the expectations of the health staff. Participation as it is organized reduces the capacity of other actors to act. The exchanges take place in a framework where the resources that give the most influence are held by the health workers. It can be seen that in the governance of health districts as it currently takes place, power relations are to the advantage of health agents. What are the elements that give health agents the means to influence?

Power resources in the health district

Several power resources have been identified in the health district and are mobilized by health workers to dominate community representatives. These resources are presented below.

Language competence

Language competence is a resource that allows its holders to have influence over other individuals, especially those who do not possess it (Fairclough, 2013). Having access to information and mastering the channels of its dissemination offers major assets to individuals in their interactions with other group members. Mastering the language of exchange in the social field thus facilitates access to information but also and above all communication with other partners. To make oneself understood and to convince others, it is essential to know how to express one's ideas and arguments. Every organization has channels for communicating information and a language that allows actors to express themselves and understand each other. There is no doubt that mastering the language can increase the capacity for action, i.e., the possibility for individuals to exchange in a given context (Lussier, 2011) [30].

In the context of health district management, the language most used in exchanges is French. All documents and texts that govern the functioning of this organization are written in French. All official communication is done in French. This is what makes this language a de facto essential element for a real participation and involvement of the actors in the management activities and plays an important role in the balance of exchanges. It remains a characteristic of differentiation and access to the decision-making space. Knowing how to handle the French language opens the door to knowledge that is indispensable to the actors in the game of influences within the district. Those who have a better knowledge of the district's official operating procedures can use this advantage to make their opinions prevail in negotiations for decision-making. Information itself is a valuable resource in interactions among district stakeholders. One will be able to challenge an opinion if one has the information to convince the other actors. In the context of the Burkina Faso health system, information is available only in French. Thus, access to this information is mediated by the ability to use this language.

Language skills are a resource that is constantly mobilized in interactions within the district. First of all, within the CoGes, it was noted that it is the members who have a high level of education, and therefore an acceptable mastery of the French language, who are the most solicited and end up playing all the roles, like this member of a CoGes:

"I am an auditor in the office. But since I am the only one who can read and write, I am obliged to do all the work of the others. When there is something to do, the nurse calls on me. For example, every other day, the treasurer comes to me to help him update the various management documents. When the president has to go to the bank, I have to accompany him because he is illiterate. This is why, during meetings, when I say something, the other members don't dispute it. Because they trust me, they always support what I say. (CoGes12).

Members who do not have a good command of this language very often develop a feeling of inferiority towards others, which translates into attitudes of passivity and silence. By their silence they confirm the opinions of others. Their participation in meetings is limited to their physical presence; very few of them accept to speak. The absence of this linguistic competence among community actors places them in a situation of dependence and, above all, a lack of self-confidence that limits their involvement as desired. This is one of the reasons why many do not take their role in the management of the health system seriously, as the president of a CoGes explains:

"When people criticize us by saying that we can't change anything at the CSPS level, I think they are right. Among us members of the CoGes, no one can read, whereas everything that the CoGes has to do, we have to understand French. So it is difficult. We have to hand everything over to the nurse and follow what he or she says to do. Often, even if it's not good, since we are not able to know, we can't do anything. All the expenses that the CoGes makes, it is him who decides and we cannot contradict because we do not know if what he says is true or false. If there was someone among us who had been to school, he could verify things. But this is not the case. Our real problem is French" (CoGes21).

At the SSC meetings, despite the fact that the content of the various presentations was translated into the national language, there was little input from community actors. One EDC member gave the following explanation:

"I think it's not because the CoGes chairs don't have anything to say but, the problem is because they don't understand French. If you've noticed, those who can speak French don't hesitate to speak up" (Ecd3).

We note that linguistic competence facilitates the integration of the actor into the group and also allows him to build relationships, even to form coalitions. The absence of this ability among community representatives contributes to their isolation within the organization.

This is the case, in particular, when CSDs are held, where the layout of the actors in the meeting room reflects their capacity for action, their level of influence. Indeed, it is common to observe during meetings that the place where individuals are seated is not neutral. Generally, the first seats are reserved for the most important people, i.e. those who, by virtue of their title or social position, enjoy a certain audience with the other actors. This practice tends to be established as a norm, to the point that during any assembly, individuals tend to evaluate their power in the environment and settle accordingly. This was observed during the various meetings at the district level with the group of CoGes members, who tacitly consider themselves to be without any capacity to influence this space of interaction. To justify this behavior, they always invoke the fact that they do not have enough knowledge about the management of health issues, which they consider to be a domain reserved for insiders, for technicians. They confine themselves to positions of support, of second-tier actors, rather than as individuals with freedom of speech and position-taking. They judge the basis of influence of the actors within this organization by the level of possession of scientific and technical knowledge. They perceive the management of health issues as a matter for experts and, as such, they do not feel qualified to participate. Many of them feel that involving them in meetings is a privilege in the sense that they are aware and convinced that they cannot contribute relevant ideas better than those held by other actors who are considered more competent and capable. The lack of appropriate linguistic skills prevents access to technical and scientific knowledge, which in turn reduces the ability of certain actors to make their opinions prevail in exchanges. To be able to influence others, one must also be aware of the quality of the resources in one's possession and have sufficient means to mobilize them in social transactions. In interactions between district actors, linguistic competence seems to be an asset in positioning oneself within the decision-making space. The better one is able to handle the official language of exchange, the better one has access to information that increases one's possibilities of influencing others. This is one of the elements that underpins the power and supremacy of health workers over their partners from the community.

Indeed, in a general context of low level of schooling, such as what is observed in the rural areas of the country, individuals do not often make a difference between mastering the French language and possessing knowledge in a specific field. There is a tendency to confuse linguistic competence with the possession of certain skills. As a result, people who have an acceptable level of language handling are often socially considered as possessing certain modern knowledge. This is particularly true of people who can read and write in the villages. They enjoy the relative confidence of the population, even if this is not the only element that facilitates the establishment of trust between individuals. In situations of exchange other than traditional ones, and especially those that bring the group into contact with the outside world, literate people are often sought out to play the leading roles in the belief that they are better able to represent the group. The linguistic dynamism of the actors has the value of knowledge, and therefore of power. Indeed, knowledge, whether empirical or scientific, has been recognized by several authors as an important element of power. Whether it is modern or traditional knowledge, it constitutes a means of influence over the other members of the group. And access to knowledge is always dependent on the mastery of the language through the use of which competence is acquired and disseminated.

Linguistic competence also contributes to the foundation of legitimacy of actors. Indeed, as Resnick *et al*. (2010) pointed out, legitimacy is essential to the exercise of power, it is a willingness of others to accept influence (Johnson *et al*., 2006; Suddaby *et al*., 2017). The existence of resources alone is not enough, they must also be mobilizable, that is, recognized by others and appropriate to the context. In some cases, we observed that CoGes presidents who have a level of education recognized by the population as acceptable for leading this community organization were able to get the population to adhere to the activities of the CSPS. The communities recognize the qualities that encourage them to accompany them in their missions, as this respondent stated:

"It was when the current office was set up that the people began to get involved in the activities of the CoGes. It must be said that people did not trust those who were there at all, for two reasons. Among them, nobody attended. I can speak French better than many of them. So, the population wonders how people who did not go to school can manage the CSPS. The second thing is that among the members of the former office, there are at least three who do not have a good reputation in the village" (Enq23, 39).

Among the socially recognized qualities for leading CoGes, mastering the French language is an important one. People feel that without this skill, it will be difficult for people in this position to accomplish the tasks entrusted to them. During a focus group, when asked what qualities a CoGes member should have, the participants unanimously insisted on the level of education, which in their eyes seems to be the necessary means to exercise the function. The access to certain functions requires having certain qualities that can facilitate the establishment of relationships with others. Being a member of CoGes and having attended modern school is an asset for individuals in interactions within the health system.

Economic capital

Economic resources play an important role in the exchange between individuals. Most often, those who possess more of them tend to have a larger audience. They give certain individuals considerable social weight, that is, the ability to influence community decisions in the direction they wish or at least to benefit from a favorable opinion

within the group. Economic capital predisposes individuals to accept to entrust responsibilities to certain people rather than to others. Economic capital, i.e. professional activity, income or the possession of certain goods, participates in the social differentiation of actors but also in the legitimization of certain positions. Thus, the holders of certain economic goods have a certain influence on the management of common affairs by the fact that they voluntarily or involuntarily exercise an influence on the opinions of the other members of the group. They are said to be biased in favor of others (Baum, 2000). As pointed out, the position of individuals within a given social field depends on their social situation, i.e. the resources in their possession, which resources are invested with a certain value accepted and shared by the group members(Lynch *et al*., 2000).

It has been observed in some health areas where people who are in an acceptable economic position are considered credible by the majority of the population to hold certain positions within the group. Indeed, people who are materially and financially well off tend to be considered the most capable of leading others as this notable explains:

"I think that in order to be able to lead people, it is necessary to be free from want. I'm not saying you have to be very rich, but you have to be able to support yourself. In the village here, even if we don't say it, those who have a little bit of money are more respected than the others. When these people ask for things, many people in the village are willing to do so because tomorrow they may need the services of these people. But when you are poor, I am not sure that people will listen to you. When I said that the CoGes does not work because of the president, it is this idea that I wanted to explain. Before the CoGes was working well. People participated in the activities because of the outgoing president who is a rich merchant, well respected in all the villages" (Enq54, 67 years old).

Several factors may underlie this situation. First, these people are sources of help for others. In times of trouble, it is to these people that people in difficulty turn to seek financial or other assistance. In doing so, others tend to work to get closer to these wealthy people in the hope of benefiting from their support one day. This makes it easy for them to rally others to their cause. Secondly, it is clear that when it comes to managing public funds, people believe that those who are well off economically are better placed to hold these positions for the following reasons:

"When you put someone who has the means at the head of a CoGes, you can be sure that this person will not try to steal money. Also, there are times when the person in charge must have the means to do certain things such as travel to meetings in Tenkodogo. So if, for example, we put someone in charge who does not even have a bicycle, how will he get around? It is difficult" (Interview 12).

At the time of the renewal of the CoGes offices, it was noted in two health areas where the population massively participated in this activity that the people who were proposed were among the best endowed with material and financial resources in their village. This is the case of Mr. Jérémie Bambara. He is married and has eight children, the oldest of whom is a bank executive. He owns a large herd of cattle and sheep. He also owns a store selling cereals and two motorcycles. According to the people of the village, he is considered the richest man in the area. He is the one that the majority of the people present at the meeting wanted to place in the position of president of the CoGes. For reasons of availability, he refused the advance of the people. Most of the people who were interviewed on the day of the meeting felt that Jeremiah was the best person to lead the CoGes because of his influence in the village. His social position gives him important advantages in his relationships with community members and especially with health workers:

"If the president of CoGes is a poor guy, I am not sure, that the nurses will respect him. If it's someone like Jeremiah, they will take him seriously because they themselves may need him. Also, since he is well known in Tenkodogo, he has connections that will help him do the job well" (Enq26).

Economic status is an important element in the qualification criteria of individuals for the occupation of certain responsibilities at the local level. Economic power, because it allows individuals to control material and financial "zones of uncertainty" at the local level, grants them more influence over others. The empowerment resulting from economic power can have ramifications outside the health area, all of which increases the possibilities for individual intervention.

The desire to have someone with economic power lead the CoGes is seen as a sign of security or a guarantee for the good management of the resources that this structure will generate. Indeed, as some participants in the study pointed out, it is easier for someone who has the means to pay back the money embezzled than someone who has nothing. Regardless of what might happen in the management of resources, people believe that some people, because of their social status, are more capable than others. There is a greater tendency to entrust the management of CoGes to people with a minimum of economic power. In the local collective imagination, there is a great deal of suspicion about entrusting the management of resources to people who are financially deprived. It is felt that there is a high risk that these people will use them for their own needs. As a result, a significant portion of the population has little confidence in the institution, resulting in low participation in activities. This is the case with many CoGes today as one nurse notes:

"One of the major problems in the case of many CoGes is that the population does not trust the people in charge of this structure for several reasons. There are people among the members of the office who do not have a good reputation because of their past. They had to lead structures that did not work. But what I think is important is the status of these people. In many cases, they are people who are looking for themselves, as we say, they don't have the means. There are some among them who could be qualified as needy. And these are the people who have to manage the resources of the group. You understand that it is not easy. As a result, people think that these

people will take advantage of their position to use the money from the sale of medicines for their own benefit. It is complicated because those who are believed to be able to run the CoGes do not want to do so" (Inf7).
Economic capacity is an important resource in relation to the unpredictability of the behavior of CoGes members with respect to the financial resources to be managed. In the community, more credit seems to be given to people who occupy an important place in the chain of production and distribution of economic resources. They are thus favored with a prejudice against adopting behaviors that are contrary to the principles of good management. Based on who they are and what they possess, it is argued that they present socially acceptable arguments that guarantee the achievement of the group's interests. Therefore, they are legitimate to conduct activities on behalf of the community.

Expertise
Insofar as it implies the exploitation of uncertainties in relation to others, and insofar as its exercise is linked to negotiation and bargaining, power as conceived by the organizational approach raises the question of its links with the competence of the actors (March & Olsen, 2005). Indeed, it remains obvious that the level of possession of theoretical and practical knowledge relating to the problem to be solved within the group, offers more possibilities of intervention to certain actors. Their mastery of the problem to be solved makes the others dependent on them.
In fact, both in the CoGes and in the CSD meetings, we note that the other groups of actors feel limited in putting forward points of view contrary to those developed by the health agents. These meetings become spaces for ratifying decisions already made by the health staff. It is rare that the other actors bring elements *of contradiction to the discussions. A prefect, met after a CSD meeting, explains:*
"Things are done in such a way that everyone is competent in his or her field. So, when health issues are discussed, it is difficult for other members who are not from the health sector to contradict the specialists. What arguments could we have to do that. I think that when it comes to technical issues, it is those who have the expertise who can intervene, the others just listen. For example, when we are presented with an action plan that is developed on the basis of a directive from the Ministry of Health, you understand that it is not that we do not want to talk. No, not at all, but it is because we do not have the means to make our contributions. It would be the same for the others if we were to discuss issues related to the administration, it is the prefects who will discuss among themselves. It is normal that the opinions of the health agents dominate because they are the ones who have the competence to discuss health problems" (Prefect1).
Health workers generally use their expertise in the health field to influence other actors in interactions within the district. Thus, they are often not very receptive to the opinions and counterproposals made by other actors who are formally equipped with technical skills. One association leader explains:
"Many people act in the health field without being specialists. So when you are in a meeting with nurses and doctors, when they say something, people tend to trust them. Even if you say the opposite, it's not safe, that people will have a hard time listening to you. A lot of people think that people who are not trained in health care cannot solve health problems. Even nurses think that way. So when you have to discuss health issues with them, many of them feel they have nothing to learn from you. That's what makes collaboration often difficult" (RespAss3).
Expertise is only worthwhile if it is recognized by others. No matter how good you are at health issues, until you have a recognized health-related degree or designation, people will not agree with your ideas. They will prefer to follow the advice of those they believe have expertise in the field. It is a fact that collaboration in the health system is always to the advantage of health workers who constantly influence decisions in their favour. It has been widely believed and accepted that the management of health issues is primarily a technical matter and reserved for insiders. In this environment, medical expertise is above all others and empowers health workers. In most CoGes, decisions on all areas of activity are oriented toward nurses' proposals. As one CoGes chair stated:
"What do you want us to do, among us, no one went to school, so we don't understand anything in the business of running a CSPS. What the nurse says to do is what we do. He is the one who knows" (CoGes4).
The advantage that the nurse has over the other members of the CoGes comes partly from his technical capital, i.e. his knowledge of health and management issues. He remains the main actor in the functioning of the CSPS. It is through him that all the information from the district flows. Whether it is at the level of care or management of the CSPS, the knowledge that the ICP has makes them influential. One of the sources of their power comes from the expertise they have in the health field, compared to the members of the CoGes.

Conclusion
This article has examined the relationships between actors in the health district management space. We were interested in the capacity of influence of the different actors in the current interrelationships. To do this, the analysis focused on a certain locus of power to identify the resources at stake and their distribution among the individuals involved. Thus, it was noted that the mastery of the language of communication, the economic situation, and the expertise on health issues grant more possibilities of action to certain actors than to others. It appears that community representatives, because of a lack of sufficient resources that can be mobilized in the district's governance space, are unable to truly influence decision-making. The balance of power sought in the relationship between health workers and communities is slow to materialize in the management of the district health system.

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