Reality Check on "Health For All": Decision-Makers, Democratization and Ethnic Conflict in Burundi’s Primary Care Institutional Culture

by

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REALITY CHECK ON “HEALTH FOR ALL”: DECISION-MAKERS, DEMOCRATIZATION AND ETHNIC CONFLICT IN BURUNDI’S PRIMARY CARE INSTITUTIONAL CULTURE

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(ABSTRACT)

This research examines the relationships among Ministry of Health (MOH) decision-makers, the MOH, and structural forces shaping the evolution of Burundi’s primary health care delivery. While WHO’s goal of Health for All has shaped health strategies in Sub-Saharan Africa, how primary health care (PHC) is formulated and implemented over time is relatively unknown. Using a realist perspective that allows human agency to come through, multiple methods -- including in-depth interviews with senior MOH decision-makers (>90,000 word data base), content analysis, participant observation and policy document reviews -- were employed to assess the interaction between decision-makers’ PHC beliefs, the Ministry’s PHC approach and the structural factors in a Sub-Saharan African nation, Burundi. Field work was undertaken during a two and a half year period. Findings indicate that Burundi’s history of
authoritarian rule and ethnic strife molded the country's PHC approach over
time. The 1988-1993 period characterized by government democratic
transition, also witnessed a major in the Ministry's approach shift towards
decentralization and community participation. Decision-makers' PHC beliefs
were strongly influenced by public health education, suggesting that long- and
short-term education and training are prudent strategies for promoting primary
health care in the Ministry of Health's organizational culture. Collectively, these
beliefs changed the top-down institutional approach to decision-making,
moving the MOH to a consensus building model in its approach to PHC
issues. Despite these changes, authoritarian organizational culture and ethnic
conflict conditioned decision-makers to implement their PHC beliefs cautiously
and indirectly. Advances in participatory approaches to health care planning
have been placed on hold given the surge in ethnic violence in 1996.
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I also express my sincerest thanks and acknowledgment to all the participants of the senior staff of Burundi’s Ministry of Health. Clearly, their high levels of dedication have been key factors in holding together health care delivery in Burundi under the most difficult circumstances. I wish to thank them all for their insight, willingness to discuss and share their points of view on
many, many issues and delicate subjects over the years. Without their confidence and candor, this study would not have been possible.

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Finally, and perhaps most important, I would like to thank my children Allison and Ben Whitney. They "put up" with their mom while she pushed through the data analysis and initial drafts. But more importantly, they each contributed in their own way to making life bearable during a stressful time. They ensured that I had my own "reality check" on what should be a priority.
DEDICATION

I dedicate this work to my mother, Virginia Timberlake, who passed away prior to my finishing the study. She not only started me as a child on a journey to Africa, but serves as a role model in how to affect change through inquisitiveness, strength, and humility.
# GLOSSARY

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ABBUBEF</td>
<td>Burundi Association for Family Well Being</td>
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<td>CAM</td>
<td>Carte d'Assurance Maladie</td>
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<td>CD</td>
<td>Community Development</td>
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<td>CHW</td>
<td>Community Health Worker</td>
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<td>CPHC</td>
<td>Comprehensive Primary Care</td>
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<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
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<td>DHS</td>
<td>Demographic and Health Survey</td>
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<td>EPI</td>
<td>Expanded Program for Immunization</td>
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<tr>
<td>FRODEBU</td>
<td>Democratic Front of Burundi</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<tr>
<td>GNP</td>
<td>Gross National Product</td>
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<tr>
<td>GOBI</td>
<td>Growth Monitoring, Oral Rehydration, Breast Feeding and Immunization</td>
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<tr>
<td>GRB</td>
<td>Government of the Republic of Burundi</td>
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<td>HFA</td>
<td>Health for All</td>
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<td>ILO</td>
<td>International Labor Organization</td>
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<td>IMF</td>
<td>International Monetary Fund</td>
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<td>INR</td>
<td>Bureau of Intelligence and Research</td>
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<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
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<td>NPR</td>
<td>National Public Radio</td>
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<td>PAHO</td>
<td>Pan American Health Organization</td>
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<tr>
<td>PALIPAHUTU</td>
<td>People's Liberation Party</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<tr>
<td>PNLS</td>
<td>Programme Nationale pour la Lutte Contre le Sida</td>
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<tr>
<td>PVO</td>
<td>Private and Voluntary Organization</td>
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<td>SAP</td>
<td>Structural Adjustment Program</td>
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<td>SPHC</td>
<td>Selective Primary Health Care</td>
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<tr>
<td>STD</td>
<td>Sexually Transmitted Disease</td>
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<tr>
<td>TMP</td>
<td>Traditional Medical Practitioner</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children's Education Fund</td>
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<tr>
<td>UPRONA</td>
<td>Union pour le Progrès Nationale</td>
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<tr>
<td>USAID</td>
<td>United State Agency for International Development</td>
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<tr>
<td>VHC</td>
<td>Village Health Committee</td>
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<td>WHO</td>
<td>World Health Organization</td>
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I. Introduction

A. Introduction

In 1978, the World Health Organization's goal of Health for All (HFA) by the Year 2000 marked the beginning of health reform and a mass mobilization of resources for primary health care (PHC) throughout the world. HFA had particular ramifications for Sub-Saharan Africa, a region with some of the highest maternal and child mortality rates in the world. Eighteen years later, both donors and African Health Ministries are beginning to assess the successes and failures of PHC given the day-to-day realities in which policies are made and strategies implemented. Some countries have made significant strides in reorienting their health systems to address more appropriately the public health problems facing their nations. Others countries have made limited progress. Obviously, a variety of factors affect PHC approaches from one country to another. There will always be differences among nations in, for example, the capacity of individuals and institutions, and the role of the state and other societal forces in developing and implementing primary health care. Eighteen years of PHC experience in Africa now provides enough history to begin to make a cumulative assessment. This study, based on the primary care experience in one African country, Burundi, provides the foundation for just such an assessment.
Research within the mainstream positivist tradition is oriented to 'what' is happening, with less attention to 'why.' Most often, the why can only be deciphered through an in-depth exploration of how something happens. 'How,' in other words, refers to process. Understanding process takes time consuming field work. It requires longitudinal analysis which is a luxury in a world where time is money and research is costly. It is perhaps not surprising, therefore, that there have been limited efforts in this area. Health research in Africa is a good example of how most research is oriented to assessing disease or program-related outcomes. This is not a criticism. Knowledge of outcomes regarding health status, or program and project interventions can improve social well-being. However, such research paints only one side of the picture. It tells us what is happening, for example, in morbidity and mortality rates in HIV/AIDS and whether prevention and control efforts are having an impact. Outcome-oriented research does not tell us how persons, institutions and structures of society interact to produce a given social action, the premise of realist studies. Such knowledge is key in health for explaining social action, be it an AIDS prevention program, or, understanding primary health care. Unraveling 'process' in health makes us better prepared to orient our strategies to the realities operating in a given society. As the review of the literature will show, this is a particular concern as we move closer to the year 2000 and the goal of Health for All.
This thesis is about unraveling such a process. It takes an in-depth look at the evolution of primary care in one Sub-Saharan African county, Burundi. It is a descriptive analysis of the process of PHC development over a fairly long period, from Burundi’s independence in 1962 to 1993. It is based on the view that PHC is socially produced, and it considers PHC as the outcome of the interaction among individuals, institutions, and social forces operating in the country.

One might question whether research in a small and fairly unknown country like Burundi can offer us much understanding PHC development. Nonetheless, Burundi is of interest for several reasons. First, it was one of the few African nations to make good progress in reorienting its delivery system to a primary care approach, particularly from 1988 to 1993. This research captures this period in detail and provides an analysis of the interactions that occurred among individuals, institutions, and political processes that moved Burundi’s PHC approach forward. As one example, the study shows what can happen when a Minister of Health has a vision for his nation’s primary health care system, and takes specific actions to move that vision forward. In doing so, a process of institutional change begins.

Burundi is also of interest because the democratization process sweeping across many Sub-Saharan African nations, has brought about
dramatic changes in Burundi's political processes and society. As this study will indicate, democratization clearly set the stage for greater openness to a participatory approach in the health sector. However, democratic transitions are fragile as, of course, is democracy itself. Burundi's history of ethnic conflict between Hutu and Tutsi brought about by favoritism under Belgian colonial rule, played a strong role in shaping its PHC approach.

Finally, the research also shows that the concepts of decentralization and community participation, both critical to democratization and PHC, are terms that carried different meanings for different administrators. Ambiguous meanings are only some of the challenges faced in implementing decentralization and community participation. The process of change unleashed by attempts to realize these concepts prove potentially threatening since they implied changes in power relationships within state structures and between the state and its citizens.

This research serves as what I trust will be an appropriate example of the need for flexibility in extensive field research. My original intent was to assess PHC as a social action by focusing on how decision-makers' belief systems in non-governmental organizations (NGOs) influenced the approach of their respective organizations. When I arrived in Burundi, though, I found few NGOs in the country because most had been 'kicked out' for political reasons.
In a sense, the Ministry of Health was the only 'game' in town. As such, I was obliged to change the original focus of my research from NGOs to the state's role in primary care. Little did I know that I would be studying a process during a period of significant political and societal transition in Burundi. With hindsight, I realize that my original research proposal presented the social production of health as fairly conflict free. As this research will show, I was watching a unique process unfold that allowed me to document the relationships among health decision-makers, their personal experiences, factors of institutional culture, and an amalgam of variables molding health policy.

Inductive theory building or explanations of a phenomenon are often at the crux of qualitative or ethnographic studies. This research serves as an example of such an approach. It was not until I analyzed several sources of information that the full picture began to emerge about the relationships among decision-makers, the MOH, and structural forces operating in Burundi. My field experience and data analysis also showed the need to examine the role of democratization in Africa, a process I had not originally considered.

Given the multiple layers of analysis -- the individual, organizational, national, and global -- the study is long on description. It may be criticized for a lack of generalizability, a research goal important to the positivist tradition.
However, because its focus is on the explanation of process, generalizing its results is not my intent. Description, based upon careful qualitative analysis over several years, afforded deeper insight into the process of PHC development in Burundi than any logical positivist method could possibly have provided.

B. Problem Statement

This thesis explains the evolution of primary health care (PHC) in Burundi. It will show how PHC is the product of social action. Using a realist perspective, PHC derives from the complex interaction between Ministry of Health (MOH) decision-makers, their institution (MOH) and structures operating in Burundi's society. A key premise of this approach is that decision-makers' beliefs about PHC play a role in orienting the strategies used by the Ministry of Health. To understand this complex set of relationships, I classified and compared decision-maker belief systems and the MOH primary care approach. In-depth interviews in French, averaging two hours each, were held with twelve senior members of the MOH staff to assess their vision of primary care, life history factors influencing beliefs, vision achievement, and factors impeding or promoting vision achievement. These structured interviews were audio-recorded, then transcribed into English, to create a 98,316 word data-base that was analyzed through content analysis. Other methodological approaches were also employed. Participant observation in the health sector over a two
and a half year period informed much of the present study. Government
documents were also assessed for objectives and strategies that defined
Burundi's primary care approach.

Five research questions guide this research. Although they are
explained more fully in Chapter IV, I list them briefly here to set the stage for this
thesis.

1. What was Burundi's Ministry of Health's primary health care
approach between 1960-1993?

2. What are the primary health care belief systems of key decision-
makers in the Ministry of Health?

3. What factors influenced decision-makers' belief system?

4. What is the role of Ministry of Health decision-makers in policy
making?

5. What factors promoted or impeded decision-makers' belief system
achievement?

C. Organization of Dissertation

The research is presented in eight chapters. My contention in this
chapter is that logical positivism offers answers to only one part of the research
picture. Stand up, knock down, hypothesis testing -- long the backbone of
natural science inquiry as well as logical positivism in the social sciences --
may be too confining to examine in dynamic social settings like that in Burundi. This chapter also introduces the problem to be addressed by this study: to explain primary health care as a social process that is mediated by decision-makers, the Ministry of Health, and the structures within Burundi’s society.

Chapter II presents the literature review. It targets several conceptual areas that form the theoretical context of this study. It begins with the selective vs. comprehensive PHC debate that originated in the 1980s, and shows that such a debate is still relevant today. The review suggests that the selective vs. comprehensive debate is tied to the social production of PHC. The democratization in Africa literature reveals that unlike in Latin America, democratization is a new trend. Only since the late 1980s has the literature been grappling with the factors influencing democratization. The literature review also points out significant gaps that exist, particularly in field based studies, research in Francophone Africa, and investigations that assess the impact of democratization on the health sector. Linked to both the PHC and democratization literature are the concepts of community participation and decentralization. Both literatures are reviewed and their implications for the health sector are identified. The second chapter also addresses recent research on institutional culture. I sketch out the theoretical outlines of the interplay between individuals and a given organization. This literature shows that primary health care is best understood as a social action that is linked to
political, social and economic institutions operating within specific organizations and societies. Finally, the second chapter reviews the literature on the methodological approaches used in this study. These include ethnography, realism, and content analysis.

The research setting is laid out in Chapter III. This chapter is critical since it presents the political, social, and economic factors that interacted with primary health care in Burundi. The chapter further illustrates that Burundi's tragic history of ethnic conflict continues to mold present events, and will do so for the foreseeable future.

Chapter IV describes the methods used in the research. It begins by presenting the five research questions that guided the study. The methods for each question are then presented. I identify the data sources, which include structured interviews, government policy documents and documentation of the evolution of events and ideas within the MOH. This chapter illustrates the need for a variety of methodological approaches under complex research conditions.

The evolution of the Ministry of Health's PHC approach is explained in Chapter V. Three distinct periods emerged since independence and both the MOH policy document and interview findings enabled me to identify each
period. I chart the evolution of the MOH primary care approach from the 1960s to 1993.

The sixth chapter classifies decision-makers' belief systems and documents the role of life history in shaping beliefs. In this chapter, decision-makers' belief systems are grouped along the PHC typology presented in Chapter IV. Among the twelve decision-makers, four groups are apparent and are named according to the belief systems they reflect: the Progressives, the Non-Risk Takers, the Fence Sitters and the Conservatives. Factors influencing a decision-maker's belief system are identified. Results show that common life-history experiences exist among the different groups. Finally, I elaborate upon the relationships between what decision-makers believe primary health care entails and their life histories.

Chapter VII points out the gaps that exist between what decision-makers believed a PHC system should entail, and the actual MOH approach. This chapter begins with a presentation of decision-makers' influence on the MOH approach, including MOH policy development. This is followed by an identification of the factors that promote or impede the achievement of their beliefs in the MOH context. Two key differences -- the level of community participation and the degree of decentralization in MOH decision-making -- are presented.
Finally, the principal findings of this research are summarized in Chapter VIII. I conclude that democratic transitions have transformed the way African governments and civil society interact. The conditions of 1978 (when 178 countries signed the Health for All accord) and the 1990s have drastically changed, as the case of Burundi illustrates. Given the effects of democratic reforms and the back-tracking by some regimes, it is time to reevaluate PHC strategies in Africa, particularly as they relate to community participation and decentralization. The content analysis shows that we cannot assume that key concepts like community participation and decentralization hold the same meanings among bureaucrats in a public agency. My findings also show that decision-makers who have public health training are more likely to support more democratic and participatory approaches to PHC than those who do not. Public health training seems to be such a powerful force in PHC that it may have actually ameliorated some of the ethnic-driven tensions that continue to undermine Burundi’s government. By 1993, the favorable predisposition of public health training among key decision-makers had begun to transform the institutional culture of the MOH.

D. Research Significance

This study is significant in several ways. First, it is one of the first field-based studies that addresses the role of democratization in the health sector, in general, and specifically in primary care delivery. Second, it adds to the
literature on democratic trends in Francophone Africa, a cultural realm with little documentation on democracy. Third, little if any research has examined the influence of life-history factors on shaping decision-makers' vision of primary care. If public or non-profit agencies wish to promote a primary health care approach, then sharing similar visions of what PHC entails is one necessary piece of the puzzle in moving policy and program strategies forward. Promoting a common vision as well as understanding the human, institutional and structural factors that produce PHC will offer a reality check on the potential success of PHC policies and strategies. Despite the recent (1996) outbreak of ethnic violence in Burundi, this work will serve as a metric against which democratization of the culture of primary care can be assessed in the 21st century in Sub-Saharan Africa.
II. **Related Literature Review**

This research explains the evolution of primary health care in Burundi. It situates this evolution by analyzing the interrelationship between the belief systems of key decision-makers who influence primary health care policy and strategies, and the approach adopted and used by their organization, Burundi’s Ministry of Health. Its premise is that primary health care policy is socially produced and not simply the result of public administration. By clarifying the process of interaction among the individuals, institutions, and structures involved in developing and implementing Burundi’s primary care approach, we can better understand the workings of an essential public service in a developing African nation.

Because PHC is a social action, a variety of pertinent concepts must ground this assertion. In this literature review, I shall attempt to move well beyond the bio-medical or traditional public health fields. Beginning with the primary health care literature, this review will illustrate that a variety of theories and approaches must be used to explain the complex interface between the concept and delivery of primary health care. Some of these theories and approaches are politically charged because they conceptualize primary care as a process in which decision-making and power conflict with the state’s approach. As such, primary care can not be abstracted as an innocuous
strategy whereby health is merely "delivered" to a population. In its most engaging form, primary care entails strong community involvement and consensus, actions which are in direct contrast to the modus operandi of the majority of authoritarian regimes in Africa. To ensure that these actions are fully understood, this chapter will also draw on the democratization and governance literatures because they pertain to trends sweeping across Africa. This study also draws briefly on the literature relating to the study of institutional culture. As understandings change within an organization - such as the adoption of a primary care approach - a process of organizational change is unleashed. Institutional change is thus a variable itself. Finally, a short review of two pertinent literatures on the contributing methodologies of this research are presented. The first is realism which is used to explain the process of the evolution of primary care in Burundi. Ethnography and content analysis lay the second methodological foundation for this work.

A. Primary Health Care in Africa

1. Overview - Alma Ata and Beyond

The thrust to promote PHC in Africa must first be traced to Alma Ata in 1978. Although experiments in PHC programs existed on a limited basis prior to Alma Ata, this WHO conference proved a major force in the push to reorient curative-based health care delivery to primary-based care (Bossert and Parker, 1984; Zein and Kloos, 1988; Decosas, 1990; Scarpaci, 1991). The declaration
of Alma Ata declared primary care to be the key to health for all and to form an "integral part of both a country's health system...and of the overall social and economic development of the community" (WHO, 1981, p.32). The essential elements of primary health care are: health education, promotion of food supply and nutrition, adequate supply of safe water, basic sanitation, maternal and child health care including family planning, immunization, prevention of locally endemic diseases appropriate treatment of common diseases and injuries, and provision of essential drugs (WHO, 1981). While the Alma Ata Declaration was agreed upon by almost all nations present at the conference, the ability to implement the strategy proves difficult. There is much controversy about what the essence of PHC should really be about (Decosas, 1990; Bossert, 1990). Although the focus of this literature review is confined to PHC in Sub-Saharan Africa, the question of how PHC is defined in the literature remains a critical point of departure, and can be generalized in part to other parts of Africa as well as Latin America.

2. The Selective vs. Comprehensive Debate

A major debate in primary health planning is over Comprehensive PHC (CPHC) vs. Selective PHC (SPHC). CPHC, modeled after Alma Ata guidelines, occurs through direct community participation and is integrated into all aspects of social and economic development (Banerji, 1984). SPHC targets the few diseases that "are responsible for the greatest mortality and morbidity in less
developed areas for which interventions of proved efficacy exist" (Walsh and Warren, 1980, p.146). SPHC is thought to be the only viable alternative due to a lack of both human and monetary resources in developing countries (Walsh and Warren, 1980). However, CPHC proponents criticize SPHC for simply delivering PHC as a commodity to the consumer. Furthermore, as implemented, SPHC lacked community participation, an element considered imperative to successful health-care strategies (Banerji, 1984). Unger and Killingsworth (1986) criticize the SPHC adoption for its strong reliance on political and economically determined factors. They argue that decision-makers trained in public health have a greater likelihood of implementing SPHC than those who do not.

Radical CPHC promoters are strongly critical of SPHC's benign exercise in supply and demand. This group, whose philosophical origins lie in Nicaragua, Chile, and Cuba, argue that PHC is an ideology whose commitment is to restructure inegalitarian societies politically through a shift in wealth and power (Hegghougan, 1984; Stark, 1985; and Feinsilver, 1993). These critics believe that selective strategies will not improve health in the developing world, since the roots of ill health lie in poverty (Banjeri, 1984). Selective approaches are also criticized for setting priorities about disease that take a "technocratic approach to complex political problems" (Turshen, 1989, p. 254).
The controversy surrounding the conceptualization and operationalization of PHC often produces conflict among various contingents in a given country. While this dissertation defines the differences between the two strategies, it does not provide an understanding of where such beliefs originate. The following sections explain PHC strategies by outlining the features of the social production of health and the perspective that primary care is a cultural system.

3. The Social Organization of PHC in Africa

To begin to understand the social organization of PHC in Africa, a holistic view, incorporating both rural and urban health care developments, is warranted. To date, a major influence in the evolution of PHC in Africa is the bio-medical model imposed since colonial times. Since independence health care has been concentrated in towns and cities, relying on curative hospital-based care (Doyal and Pennell, 1981; Turshen, 1984; Harpman, et al. 1988). Health care in rural areas has traditionally been delivered in clinics staffed by nurses. Access to biomedical care is severely restricted from the majority of rural Africans (Good, 1987). For example, in Burkina Faso, only 45% of the rural population lives within ten kilometers of a health facility (Turshen, 1989).

Several factors explain this African urban-rural health care pattern of inequity. Health care systems created during colonial times served the elite
European class (Doyal and Pennell, 1981; Turshen, 1984; Zein and Kloos, 1988). With independence, leadership passed to a new elite class that trained under colonial tutorship. This class perpetuated a two-tiered health care system through state and dominant economic policies. In addition, the number of trained doctors and nurses remained inadequate to meet the health needs of most countries. The majority still prefer to practice in urban centers where most goods are readily available, work-settings more closely reflect their medical education, and living conditions are better (WHO, 1981). The ability to retain staff in remote posts is difficult due to rural living hardships, a lack of medical supplies, and a general perception of rural "backwardness" (Ofosu-Amaah, 1983).

Appreciation of rural health care has increased among African nations over the years, who now realize the need of a healthy population to carry out industrial and agricultural production effectively (Doyal and Pennell, 1981). In other words, health is often defined in purely economic terms, i.e., as increasing capacity to work (Brown, 1982) which, in turn, will increase economic development potential. However, an intriguing point is that both governments on both the left and right seek healthy and productive labor forces to ensure social reproduction (Scarpaci, 1991).
The result of the above definition, especially among donor agencies, is the view that disease causation and high population levels are linked to poverty. This, in a sense, blames the victim for poor health and legitimizes the inequalities of capitalism rather than explaining poverty as a result of capitalism (Navarro, 1984; McKinlay, 1984; Scarpaci, 1989). Health care approaches that result from this view are typified by low expenditure levels in order to ensure a minimum level of health care coverage, an emphasis on family planning efforts to "control" an ever increasing poor population, and curative care in which health care is delivered to a passive recipient.

Since Alma Ata in 1978 and the acceptance of the goal of "Health for All by the Year 2000," there has been increased awareness among African governments of the need for more appropriate health care measures to meet the developing world's population's health needs (Zein and Kloos, 1988). Most African health ministries remain poorly financed, highly centralized, and inefficient (WHO, 1984). Nevertheless, increased pressure exists for decentralization and training of lay people in simple primary care from not only donor agencies but from some indigenous rural populations as well (Bossert and Parker, 1984).¹ PVOs (Private and Voluntary Organizations) and NGOs (Non-Governmental Organizations) have been leaders in creating community-

¹Donor agencies have considerable influence in shaping health policies due to their level of financing. For example, 70% of Tanzania's health budget is financed by external donors (ILO, 1982). In other countries the percentage is even higher. (See Scarpaci and Irarrázaval, 1996 for Latin America.)
based care programs (Mburu, 1989). Operating with greater levels of autonomy and flexibility, these organizations are more responsive to local needs and have a higher success rate in community-based care programs. Within health ministries, efforts to decentralize and include more appropriate health strategies such as community-based care are on the increase. In most programs the emphasis is on health care delivered by a trained community health worker (CHW), supervised by a village health committee (VHC), with referrals of more severe health problems to the nearest health post (Smith, 1978; WHO, 1981). In the best-case scenario, the health needs of the rural population will be met because of a planning process that is informed from the bottom, and with the CHWs and VHCs expressing village health concerns to mid- and high-level ministry staff. In practice, however, a variety of problems prevail including insufficiently trained and poorly supervised or motivated CHWs, uninterested VHCs, ministry staff threatened by the village health systems, and difficulty in adopting a bottom-up planning process (Ofosu-Amaah, 1983; Zamen, 1984; Williams and Yumkella, 1986; Shepard and Benjamin, 1988). Nonetheless, several countries, including Tanzania and The Gambia, have made conscious efforts to restructure their ministries of health, and they have met with some successes (WHO, 1985; Turshen, 1989).

Several PHC programs have included traditional healers in their health care policies and programs (Dunlop, 1979; Ofosu-Amaah, 1983; WHO, 1986).
This has occurred because African health care practices are pluralistic (Ademuwagun et al., 1979; Good, 1987; Good, 1988). That is, a variety of health practices that co-exist in a society, ranging from the bio-medical approach to traditional healers. In most African countries, there is a higher level of confidence among users of traditional versus public provided services because the former is more culturally appropriate (USAID, 1992). The inclusion of traditional healers in a formal government or donor approach indicates a more holistic view of the health delivery system by decision-makers. The following section underscores the importance of this holistic view by conceptualizing health systems as cultural systems.

4. Health Systems as Cultural Systems

The present study uses a typology to understand and classify primary care beliefs and institutional approaches. This typology is based on the view of health systems as cultural systems. It is theoretically premised as one cognitive anthropology literature related to comparative studies of medical systems. This section explores that literature in more depth.

A cultural view of health care systems recognizes that all societies have formed some way of treating disease based on the beliefs and practices of that society (Fabrega, 1972; Kleinman, 1973; Fabrega, 1977; Kleinman, 1980; Douglas, 1986; Good, 1987). The specific ways of defining and dealing with
disease reflect sub-cultures which hold their own knowledge system, perceptions, values and beliefs (Kleinman, 1980). Sub-cultures do not necessarily have specific boundaries. Taken together, they form a holistic cultural system which interacts through patients seeking alternative healing strategies (e.g. bio-medical, popular, folk, or traditional), and the collaboration of providers and institutions. For example, in Africa it is quite common for persons who search for a specific health problem's cure to interact with a variety of sub-cultures. In Kenya, Good (1987) observed that patients suffering from chronic stomach ailments, who found no cure from bio-medical therapies, often turned to TMPs (Traditional Medical Practitioners). In previous research I found in rural villagers in Senegal that failure to find a cure in one sub-culture would provoke contact with another, or else, contact with another practitioner within the same sub-culture. This illustrates that health care systems are culturally pluralistic, reflecting the variety of socially organized responses to disease within a given society (Kleinman, 1980; Kleinman et al. 1978; Timberlake, 1989).

The health as a cultural system perspective sets the stage for viewing PHC as a complex socially constructed process. With primary care as a complex entity, the present study draws on a variety of theoretical underpinnings from political theory to cultural anthropology. Using primary care as a cultural system provides a classificatory base for unraveling the
complexities of decision-makers' belief systems about primary care and the MOH's primary care approach. The following section describes some of the scholarly work in this area.

5. PHC as a Cultural System

A variety of perspectives conceptualize and operationalize PHC. The majority are technically oriented, focusing on areas such as program implementation, appropriate healing therapies (e.g., which drugs or immunizations), and administrative strategies. These foci are criticized as being ethnocentric due to their focus on the bio-medical paradigm and their exclusion of other health frameworks within a given local setting (Kleinman, 1980). Several social science sub-disciplines, notably medical geography, medical anthropology and medical sociology, have generated a more holistic account of health systems. This literature provides a rich explanation of the interactions between social and cultural forces and health care systems (Meade, Florin and Gesler, 1988; Good, 1988; Scarpaci, 1988,1989). Such information is imperative for discerning how and why different components of health systems behave the way they do, which is key to understanding the process of PHC.

While a fair amount of literature exists on health as a cultural system, a direct focus on PHC, conceptualized as a specific cultural system within a
broader system does not exist. Nevertheless, the literature does describe the attributes of PHC sub-cultures due to their relation to the broader health care system. In Figure 1, Kleinman (1980) has portrayed a structural model of the health systems which can be used to study health care delivery in a variety of contexts. He notes that it is particularly valuable for research in developing societies because of its ability to encompass both "high order, literate (or classical) and low-order, oral (or folk healing traditions)" (Kleinman, 1980, p.49). This model, along with a similar model elaborated by Good (1987) are used in Chapter IV of this study as stepping stones to classify different belief systems and approaches to PHC within Burundi’s health system.

Kleinman defines three interrelated parts that make up the local health care system (Kleinman, 1980): the popular, professional and folk sectors. The popular sector encompasses the largest portion, containing several levels of analysis from the individual to community-based beliefs and practices relating to illness and health. It represents the influence of non-professionals, non-specialists or lay people in health decision management. The popular sector is where a strategy of action to address an illness is first initiated depending upon the cultural practices operating for the individual and related persons who influence therapy choice. On the one hand, the professional sector consists of organized health practitioners such as bio-medical practitioners, chiropractors, and homeopaths. The folk sector, on the other hand, is made up of non-
professional, non-bureaucratic health practitioners whose beliefs can be quite varied depending upon the particular local health care system under study.
Figure II - 1. LOCAL HEALTH CARE SYSTEMS AND THEIR INTERNAL STRUCTURES in *Patients and Healers in the Context of Culture*, by A. Kleinman, 1980, Berkeley: University of California Press, p. 50.
In *Ethnomedical Systems in Africa*, Good (1987), has elaborated a similar model. However, he defines the professional sector as the biomedical sector, and the folk sector as the traditional sector. Good employed his model to depict an ethnomedical system of health care: "total medical resources available to and utilized by a community or society, including popular, traditional and biomedical forms of therapy" (Good, 1987, p. 22). As a culturally focused methodology, an ethnomedical system describes health care delivery structures as "socially constructed systems of meaning, values, norms, and interpersonal relations" (Good, 1987, p.22). Conceptualizing health care delivery as an ethnomedical system allows for a holistic account of all "knowledge, resources, organizational patterns, behaviors, and strategies (traditional, indigenous, scientific, imported) that are utilized by a community to promote the individual and collective well-being of its members" (Good, 1987, p.23).

As a cultural or ethnomedical system, PHC is made up of a variety of interconnected sub-cultures which can be contrasted by their different practices and belief systems. The PHC literature explains the differences among PHC programs as derivatives of the debate over curative vs. preventive, and, community vs. more autocratic-based PHC program design. Analyzing health as a cultural perspective provides a base for classifying differences in beliefs and approaches among individuals and the institution researched in this study.
The social production of health literature gives a foundation from which to understand these differences manifest themselves in a health delivery system.

Within the explanation of the social production of health lies the emerging field of the geography of health (Kearns, 1993). The present study relates to this new literature because of its focus on explanation of health and place. The geography of health's origins are in the field of medical geography which has traditionally explained spatial relationships in health and disease (Meade et al, 1988). One of the criticisms of medical geography is that its studies often lack a theoretical base (Kearns, 1993). The discipline is criticized as too pragmatic and limited to disease mapping, central place theory, or other spatial analytic techniques. Kearns and Gesler (forthcoming) argue that medical geography's reliance on quantitative and formal survey based methods have caused the sub-discipline to ignore more nuanced geographies of health. The latter are primarily based on ethnographic and interpretive methodologies. They argue that more recent works have tried to connect theories of health and place by using more theoretically informed views of society and space. Early attempts to bring theory to medical geography focused on human agency through reflections on society and space, and a political economy approach centered on institutional and economic structures (Scarpaci and Kearns, 1996). These pioneering works on the structure/agency dualism were introduced in the 1980s and remain a relevant theoretical base.
for the study of health and place today (Kearns and Gesler, forthcoming), and will be used in this research.

Now that we are almost 20 years beyond Alma Ata, the optimism of the late 1970s and 1980s over the future success of primary care and Health for All has waned. The specific challenges of developing PHC policies and strategies that integrate community participation and decentralization in authoritarian African governments proved more difficult than initially anticipated. An anecdotal analysis of the majority of primary care approaches implemented in the 1980s indicates that few nations enlisted true community involvement, and that the majority using highly selective PHC interventions (Rhodes, 1994). For example, a recent PAHO paper on “Health for All” argued that one of the reasons for the failures of the HFA concept and strategy, is that it ran counter to the political context of authoritarian governments (PAHO, 1995). Such experience may indicate that the successful promotion of PHC policies and strategies is linked to the progress in democratic transitions sweeping the continent since 1990. This is of particular importance to this study, as Burundi was undergoing its own democratic transition during this research. The following section on democracy and governance in Africa presents an overview of political reform in Africa, as well as its implications for the health sector.
B. Democracy and Governance in Africa

Few health program decision-makers have recognized that political systems define how much citizens are encouraged or discouraged to participate in health systems (Walt, 1994; Turshen, 1989). The recent wave of political reform in Africa is only just beginning to call attention to these links. Participatory approach arguments by those considered ‘radicals’ ten years ago, appear less controversial in this new environment where democratization is in vogue. With democratization still a new phenomenon, there is no specific literature assessing the impact of democratic trends on primary health care. However, the nascent literature on democratic transitions in Africa sets the stage for further reflection on this subject. This section reviews the literature on democracy and governance in Africa.

Unlike Latin America where a literature on social movements, the state and democratic transition is well developed (Scarpaci, 1991), Africa’s experience with a democratization is new. The year 1990 marked the beginning of a burgeoning literature and scholarly conferences on democracy and governance in Africa. As 30 years of single party authoritarian rule began to fall, beginning with the Benin National Conference in 1990, a new era characterized by democratization and liberalization was born (Martin, 1994; Rasheed, 1995; Clark, 1994). By 1993, a Carter Center publication called Africa Demos, was founded to analyze the profound changes that democratic
trends are bringing to African political systems. The publication described the following: out of 51 Sub-Saharan African countries, 15 were considered “democratic,” 7 were under a “directed democracy” regime, and 24 were in transition to democracy, with “various degrees of commitment” (Martin, 1994). By 1994, parliamentary or multi-party elections had taken place in 37 of the 51 (Rasheed, 1995).

In the early 1990s, this new optimistic era was given a variety of names such as “second independence” or “second liberation” (Le Marchand, 1992; Ake, 1996). However, many now agree that while there appears to be a global consensus on the desirability of democratic development, the road to democratic governance is far from clear (Rasheed, 1995; Clark, 1995). For example, the history of the last few years indicates that elections are often over-emphasized and misleading indicators that a democratic process is underway (Chege, 1995). As Renée Le Marchand, a well known Africanist and political scientist notes, “In Africa the demise of authoritarian rule has been greeted with a mixture of euphoria and apprehension. The initial burst of popular enthusiasm ignited by the flame of democratization is giving way to a growing realization among Africans that, as one wag put it, ‘at the end of the light is the tunnel’” (Le Marchand, 1992 p.82).
With little known and much to understand about these rapid and sometimes tentative sociopolitical developments, a proliferation of conferences, literatures and publications have materialized on the subject of African democratization. As a new area of scholarly research, the major challenge is to be able to interpret the issues and theoretical stances as well as fill in remaining gaps in our knowledge of this topic.

The following section reviews the salient points of this literature. It lays a foundation for understanding the on-going debate on the origins of democratic trends in Africa, definitions of democracy, new developments of democratization and research gaps on the subject. Moreover, it will try to tie the links between democratic trends and the health sector, through their manifestations in community participation and decentralization in health care (which are more fully described in section C).

1. Origins of democratic processes in Africa

The predecessors to the literature on changing power structures and the emergence of democracy in Africa were early critiques of authoritarian (civilian or military) single-party rule. These works centered on African political systems characterized by political repression, human rights abuses, nepotism and economic and financial mismanagement (Martin, 1994). It was not until 1986 that one of the first collections of essays on pluralism and democracy in Africa
was produced. This collection was perceived as a bold step when no other authors had broached the topic.

One of the major debates in the democratization literature is over the origins of the democratic transition. Whether the demand for democratization in Africa has been internally or externally driven is a point of contention. In a very broad sense, the collapse of communism in the USSR and Eastern Europe revealed what was possible from a people’s movement (Doro, 1995). Others have gone further to postulate that the end of the Cold War has changed the environment in conditions of donor influence. Both Western and Eastern powers propped up undemocratic African regimes with monetary and military assistance out of geopolitical concern (Rasheed, 1995). With the question of Cold War rivalry no longer an issue, donors were more willing to assess realistically the impact of corruption, human rights abuses, and lack of participation of marginalized populations in governance.

Proponents of the externally driven argument look to the World Bank and other donor’s political conditionalities ² for development aid as an incentive for moving African states to undertake democratic reforms. Decades of changing development paradigms ranging from basic human needs to economic development, promoted a view that political reform and political institutions were a “realm apart from the economic systems” with which the donors were

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² The term 'conditionalities' is commonly used in the literature and among donors to refer to the prerequisites prior to disbursement of project funds or other donor aid.
concerned (Barkan, 1990, p. 76). In 1989, the World Bank made a strong shift in stance, with its document, “Sub-Saharan Africa: From Crisis to Sustainable Growth,” and promoted political reform as a prerequisite for donor aid (World Bank, 1989). The argument was made that while there were other structural factors that caused Africa’s failures to achieve economic development, years of poor governance were also responsible for Africa’s economic stagnation and decline (Ake, 1996). The document suggested that democratic reform equaled good governance, since democratic systems forge accountability through greater participation of the people in government (World Bank, 1989).

France and other donors, including the U.S., jumped on the band wagon. They often used a carrot-and-stick approach with political reform provisions attached to project funding. Among the donors, the U.S. government took the lead in backing up its conditionalities with project funding targeting democratic reform (USAID, 1992). This is evidenced by a major increase in U.S. foreign aid for political reform in Sub-Saharan Africa, which rose from $5.3 million in 1990 to $120 million in 1994 (Doro, 1995). With increased pressures for reform tied to donor aid, debt burdened authoritarian regimes had no choice but to accept these conditions and institute many political reforms, most visible among them, elections. Proponents of the external forces argument claim that one-man or one-party rule in Africa would not have made concessions without this pressure (INR, 1994).
Counter arguments to the external-forces perspective come from those who believe that demands for political reform come from internal forces. What are termed "popular movements" in the literature (as opposed to the well-developed "social movements" literature on democracy in Latin America), examine the role civil society has played in demanding change. One argument is that a new generation of civic leaders has grown up in a post-independence era, and are weary of corruption and economic decline (Rasheed, 1995). Francophone Africa took the lead in popular movements in the late 1980s with significant demonstrations and civil unrest in Mali and Benin. These West African nations protested a lack of influence of civil society in decision-making under authoritarian regimes that provided diminishing government resources.

Given the role that civil society has been forced to play in encouraging democratic trends in the literature, it is interesting that how civil society is defined remains controversial and is often questioned as a generator of democratic change within Africa. Chabal (1986) defines civil society as anything that is not of the state. This includes the disenfranchised as well as politicians, professionals, intellectuals, and the military. However, Bratton (1994) uses more analytically-based terms to differentiate ‘civil society’ from ‘political society’ and the ‘army’. The contention is that civil society consists of persons outside of the political arena. The military stands on its own, as it
operates under its own set of rules and objectives which are quite different from those of civil society. This latter definition may prove more useful for this study, as each entity has different motivations and agendas in its relationships with the state.

A significant part of the democratization literature documents the struggle of civil society in its demand for more just and democratic process. The presence and maintenance of authoritarian regimes is equated with a weak civil society (Rasheed, 1995; Ake, 1994). Years of autocratic or dictatorial military states that repressed and discouraged dissent in civil society were challenged by civic organizations (Le Marchand, 1992). Trade unions, religious organizations, and students, among others, are noted in the literature as playing a key role in spearheading and channeling popular dissent in some countries, and for providing the platform for a critique of authoritarianism and the need to restructure (Rasheed, 1995). These studies analyze the role that class has played, yet show that the middle or elite class, other than the ruling party, is a fairly new phenomenon in Africa (Fatton, 1992). Several studies look at the ways a political elite class is co-opted by the state. In countries where there is a limited or growing private sector, political elites are strongly tied to either state-run enterprises (through employment) or the advantages of linkages to the state in the private sector (through rent-seeking behaviors) (Clark, 1994).
Another development in the literature is the analysis of demands by ethnic groups for power-sharing, political freedom, and political autonomy. Reprisals against these groups have often spurred large scale insurrection, as witnessed in Burundi, Rwanda, Zaire, and the Sudan. The question of ethnic conflict and civil society's role in promoting dissent is a complex issue in Africa and cannot easily be analyzed as in the basis of western, class-based pluralist arguments (Adekanye, 1995).

Bratton (1994) argues that democratic trends would never have come so far so fast in Africa if there wasn't a convergence between the internal and external influences. Bratten contends that popular movements combined with donor pressures, have created an enabling environment that is producing some dramatic outcomes in several countries. Indeed, it is likely that both internal and external forces are at play, as the case of Burundi will show.

2. Definition of Democracy

Another thrust of the African development literature is on defining the democratic process. This is an outgrowth to what is deemed as too much emphasis by donors on elections as the only condition for foreign assistance. Elections prove to be only one indicator among many of the existence of pluralism in a given society.
Two journals have taken the lead in defining democratic transitions. In the *Journal of Democracy*, one of the editors compared evidence from all Third World countries and find the following features of the democratic process:

...as a system of government with three essential features: (1) *meaningful, extensive, and peaceful competition* among individuals and organized groups for all effective positions of government through regular free and fair elections; (2) *highly inclusive and genuinely independent political participation* in the section of leaders and policies, such that no significant adult group is excluded; (3) a *high level of civil and political liberties* - freedom of speech, religion, opinion, and information; freedom of peaceable assembly; freedom to form and join organizations; and equal protection and due process under the impartial rule of law - sufficient to ensure integrity of political competition and participation and the accountability of rulers to the people (*Journal of Democracy* 1990, 1).

The Carter Center of Emory University in Atlanta, meanwhile, in its *Africa Demos* journal, defines several "Phases of Transition to Democracy," as a mode of analysis for societies engaged in political transitions. According to *Africa Demos*, the phases in the transition to democracy include:

*Decay* (the government loses capacity to govern); *mobilization* (demands for change arise from various units within the society); *decision* (leaders respond and begin to construct modes of accountability); *formulation* (procedures are established for the transition to democratic structures and practice); *elections* (which must be judged "free and fair"); *handover* (transfer of power to those who won the elections); *legitimization* (process reflecting acceptance of the new structures); *consolidation* (sustained acceptance
reflected in widespread respect for the system over an extended period of time) (*Africa Demos*, 1990).

Both of the above schema have been adopted and refined by a variety of authors. They have identified specific levels of each dimension and undertaken empirical comparative research to analyze democratic reform (Hadenius, 1992; Doro, 1995). Their definitions are useful for understanding Burundi's evolution in democratic reform and will be examined in Chapter III.

3. Impediments to Democratic Transitions

Transitions to democracy are far from a linear process (Ake, 1996). More than one African country has derailed or taken significant steps backwards in the process. There is a significant focus in the literature to explain such phenomena. Western theories of pluralism and elitism have been applied. Although they are considered as inappropriate or ethnocentric by some (for imposing Western constructs to describe conditions with dynamics quite different from the West), some scholars find that pluralist and elitist theories well explain power sharing and policy making.

The pluralist perspective is prevalent in U.S. government documents that promote democratization (USAID, 1992). A normative assumption of pluralism as the means for successful governance pervades. One of the impediments to fostering democracy is the donor communities' failure to understand fully the
dynamics of Africa's democratic transition in terms other than the pluralist traditions of the West (Rasheed, 1995). For example, Ake (1994) argues that there is a dichotomy between the perceptions and expectations of democracy of African political elites and the masses. Political elites view democracy as a means for maintaining or attaining power. The masses look to democratization as liberation and as a means to ensure economic and social justice deprived them by past repressive regimes. A similar argument is put forth by Ambrose (1995). He posits that Africa's push for democracy is led by political elites who, although they may defend human rights, are still promoting their own top-down oriented agenda. For Ambrose, then, true reform can only come from the oppressed people themselves. In his most recent work, Ambrose illustrates how African elites have marginalized the continent's role in development through confusing development agendas, and maintaining inherited authoritarian systems of colonial rule, rather than transforming governance to a condition where public policy is an "expression of democratic will and connects again with social needs" (Ambrose, 1995, p. 39).

Nwokedi (1995), concurs with Ambrose based on his examination of the success of democratic transitions in Benin, Cameroon, Cote d'Ivoire, Congo, Gabon, Kenya, Niger, Nigeria, Mali, Togo, Zaire, and Zambia. His conclusion supports the elitism perspective. Specifically, "the type of the modality of democratic transition invariably determines the outcome of the democratization
process, all things being equal: democratization from above will tend to lead to partial transition while the opposite, democratization from below will tend to lead to full transition" (Nwokedi, 1995, p. 3).

Finally, The World Bank's Structural Adjustment Program (SAP), is cited as another impediment to democracy in the literature. Several scholars accuse SAP of pitting civil society against the state as resources become more rationed, and the African states are forced to reduce their welfare role (Ake, 1996, Adekanye 1995). Some argue that threatened by an increasingly hostile civil society against devaluation and withdrawal of state subsidies, many state heads have responded by intensifying control and repression (Nwokedi, 1995). This argument is clearly contrary to the World Bank and IMF's intentions, where democratic reform should enhance opportunities for economic development. This latter argument forms the base for political prerequisites/preconditions that are imposed by the donor community. Section 4 of this chapter fleshes out this debate.

SAPs are also linked with an increase in the role of the military and ethnic conflict. Citing that the role of the military has been a long neglected research area, Adekanye (1995) offers an argument assessing debt, military expenditure and the rise in ethnic conflict in several countries in Sub-Saharan Africa. Debt levels in Africa tripled from $55.6 billion in 1980 to $171 billion in
1990. Of interest to this study is the inclusion of Burundi as an example of the interaction between debt, increased military expenditure and ethnic conflict. In 1980, Burundi’s debt was $166 million and represented 22% of the country’s GNP. By 1990, the nation’s debt burden had increased by 479% to $961 million, representing 82.3% of Burundi’s GNP. Adekanye argues that with such fiscal burden, and the attendant increase in the scarcity of government resources, conflict over the control of scarce resources is exacerbated. As the state becomes destabilized by opposing ethnic groups, there is an increase in military expenditure to maintain control over a demanding population, adding to the debt pressures of the state. Adekanye finds that the debt burden of many African countries can be traced directly to military origins. He believes there is a reflexive interaction among ethnic conflict, increase in defense and security expenditures and authoritarian measures, and the implementation of SAPs. This interaction provides a sharp contradiction to the intent of SAPs. As we shall see in Chapter III (political history), the generic features of Adekanye’s explanation of this interaction hold true for Burundi.

4. Development then Democracy? Or Democracy then Development?

Another debate in the democratization literature is whether democratization is a pre-condition for development or vice versa. Again, the western pluralist tradition holds for both arguments. The first tenet views democracy as opening avenues for economic development through fuller
participation of all populations in a nation's economy (Clark, 1994). The assumption is that a pluralist society becomes an economically healthy society. Pluralism, therefore, allows greater participation of all groups in political as well as economic life. The second tenet holds that an increased degree of industrialization and urbanization of a country brings about an overall transformation of society. Such transformation in turn gives rise to political change towards a democratic system (Hadenius, 1992). This later argument follows the lines of modernization theory, whereby a society's old school perceptions and behaviors are eroded and new patterns of socialization and economic behavior appear (Rostow, 1962). With greater education, persons are more open and have deeper insight into political issues, and therefore positively challenge political powers for representation.

In the health sector, such an argument is fruitful. The comprehensive approach to primary health care views health as a coalescing force among communities so that they gain empowerment over decisions that affect their lives. If PHC is to play a role in the development process of a nation, popular movements with health-related objectives as a coalescing force could prove an impetus for democracy. This issue of empowerment remains relevant to date. A PAHO conference in June 1996 addressed the renewal of the "Health for All" goal and questioned whether the original 1978 objectives of social mobilization
around health remained valid given the history of PHC under authoritarian governments during the past 18 years (PAHO, 1996).

5. Research Gaps in the African Democratization Literatures

As a new area of scholarly endeavor, there is little systematic reference to democratization in Africa. Because this research area is still in its infancy, therefore, there are bound to be areas of omission or limited foci in the literature. One such gap in Africa's democratization literature is a dearth of analysis of the experience of Francophone countries (with the exception of Senegal, Cameroon and Zaire) (Martin, 1994). In contrast, English-speaking countries such as Botswana, Ghana, Kenya, Nigeria, Uganda, and Zambia are extensively researched. Although there is a rapidly growing body of theoretical literature on political reform, there are very few studies that have documented democratic transition based on extensive field work. Finally, while ethnic conflict appears pervasive on the African continent, there is little understanding of its long-term implications for the democratic process. One question that comes to mind is how newly democratically elected governments have fared in translating pluralist orientations into the reform of their economic and social policies. Furthermore, have democratic trends in previously authoritarian political systems made progress towards the “Health for All” goal?
These gaps in the literature suggest that the present research is of potential value if it can enhance our understanding of democratic transition in several ways. First, there are few studies documenting the democratic transition of Burundi, a French-speaking nation. Second, only limited research has documented the impact of democratization on the health sector's ability to promote a primary care approach based on participatory values. My extensive field work and involvement with decision-makers in Burundi's health sector provides a new perspective into how political liberalization affects both the individuals who influence primary health care policies and the actual approach of a nation. Such information will be valuable to all donors, policy makers, and other government officials operating within political transitions. It will also benefit those who must make decisions regarding how the demands of its citizenry should be integrated into health-care planning and what sorts of strategies might prove most effective in doing so.

C. Decentralization & Community Participation in Health

The concepts of decentralization and participation provide a critical yet common link between primary health care and democratization. The strong emphasis of the primary care approach is to orient a delivery system to offer care at the lowest level with full community participation (WHO, 1982; PAHO, 1995). Therefore, without some level of decentralization, community participation can be highly difficult. The extent of decentralization depends on
the type of government in place (Walt 1994; Conyers, 1986). While there are
few if any studies to document this assertion, it would appear that the success
of primary care is more easily promoted in political systems with a democratic
base which allow or encourage community participation in decisions related to
citizen well-being. In Africa, both "decentralization" and "community
participation" are words that are easily thrown around without much definition in
the policies and strategies of many developing nations (Walt 1994). As I will
indicate in the section below, interpretations of these terms are as varied as
the strategies used to implement them.

1. Decentralization

Decentralization is a vague term often applied to primary health care and
other public services. It is often expected to provide a panacea for improving
the effectiveness and efficiency with which services are delivered (Conyers,
1986; Mills et al, 1990). A closer look at the literature shows that in fact, a
variety of definitions exist. Scarpaci (1991) has defined two approaches to
decentralization in his study of SAP in the Southern Core (Argentina, Chile and
Uruguay). The first implies retrenchment in publicly provided services to
reduce governmental subsidy combined with the movement towards
privatization. The second implies the direct involvement of the community in
decision-making regarding their health care needs and services. This latter
definition is also stated by Conyers (1986), who makes a distinction between “Top-down vs. Bottom-up” objectives (see below).

Rondinelli (1981, p. 137), provides a broad management definition of decentralization. It is the transfer of “authority to plan, make decisions and manage public functions from a higher level of government to any individual, organization or agency at a lower level.” Later, Rondinelli (1983) delineated four types of decentralization that reflect the degree to which local bodies have discretion over decision-making. The four include deconcentration, devolution, delegation, and privatization.

Conyers (1986) argues that both centralization and decentralization are processes of change on a continuum. Moreover, she noted that confusion is added because there is often a simultaneous occurrence of centralization and decentralization in a given country or sector, there are often a number of different and conflicting objectives. A useful distinction is made between managerial objectives and political objectives, top-down vs. bottom-up objectives, and explicit vs. implicit objectives.

Managerial decentralization refers to a process that focuses on improving provision of services by better planning and program implementation. It considers local needs and conditions and seeks to improve
coordination among agencies at the regional or local level, and reduces delays in decision-making by promoting flexibility in administration and mobilizing resources. In this explanation, the change in power relationships involved in decentralization is not acknowledged. This is a common approach used in the health sector in Africa, and in particular, Burundi, where decentralization is promoted by donors and governments, without addressing the implications of such decisions for the individuals who hold the power over resources.

The political objectives of decentralization are less easy to identify, because they are not as overtly stated as the more innocuous managerial objectives. These objectives treat decentralization as a political issue. They address the role of conflict, not only among different levels of the political and administrative hierarchy, but among different interest groups. As Conyers (1986) notes, managerial objectives are usually motivated by political objectives, and they may at times be in conflict. Managerial objectives also portray explicit objectives, i.e., those that are stated in public policy. Political objectives typify implicit objectives. They reflect the views that underlie individuals or interest groups, but may not be publicly stated. Most often in the implementation of decentralization, it is the un-stated political objectives which address change in power relationships that derail what might normally be perceived as a "rational" process (Walt, 1994).
The terms ‘top-down’ and ‘bottom-up’ are often used to describe decentralization objectives (Rondinelli, 1983; Cernea 1981, Korton 1984). However, decentralization is likely to be viewed differently from various levels of the system (Conyers, 1986). For government bureaucrats, bottom-up decentralization most commonly implies the local levels of government. Instituting a bottom-up approach in a highly centralized hierarchy is a major challenge. However, outside formal bureaucracies, bottom-up implies a step beyond this definition and connotes grassroots participation where input and involvement come from meaningful popular participation, usually outside formal programs. Many critics are skeptical of the ability of conventional decentralization programs to achieve community-led initiatives because the explicit and implicit objectives of these programs are so conflicting (Hyden, 1989). To understand the origins of this criticism, one must look to the literature on community development and participation for insight.

2. Community Participation

The schools of thought regarding community participation in health originate in the literature on community development. How the “community” is defined poses the greatest problem among practitioners and theorists. A similar definitional problem exists with the selective vs. comprehensive primary health care debate in the PHC literature. There is debate over the meaning of
conventional vs. transformative community development practices (Midgley, 1986).

These definitional problems are important because, like PHC, how community development is defined influences the kinds of approaches employed. The conventional definition casts community development (CD) as a non-partisan process whereby people improve their social and economic well being by cooperating with government authorities. Because of its emphasis on state cooperation, conventional CD is organized in a top-down manner, with directives originating from government planners (Korten, 1984).

Advocates of transformational CD offer a drastically different view. It is a process to aid the people to understand and confront the forces which exploit and oppress them from their full participation in political and economic processes (Frank, 1966; Friere, 1970; Galjart, 1976). In this view the "arm of the state" has either reached too far in directing the lives of community members, or has too little influence in providing services to a community (Midgley, 1986; Loney, 1983). Politics and conflict are accepted as inevitable in the development process (Timmel and Hope, 1984).

In the late 1970s, community development practitioners and theorists finally had an impact on mainstream development agencies and to a more
limited extent, government ministries. Agencies such as the World Bank, USAID, UNICEF had operated for years under a philosophy that for development to occur, development programs need only to be delivered to rural populations with little, if any input from the local population (Korten, 1983; Uphoff and Esman, 1984). With the purported success of small-scale programs undertaken within the NGO/PVO community, mainstream agencies jumped on the bandwagon mandating the participation of local populations--especially women--in rural development efforts (USAID, 1982; Gran, 1983). The extent to which community participation occurs, however, is often questionable. A major problem lies in the incompatibility in the modes of operation of bureaucratic mainstream donor agencies and community groups involved in program implementation (Korten, 1983; Nash, Dandler and Hopkins, 1976). Participatory approaches require more time for program implementation (Cerna, 1981). Such a time consuming process in which results can only occur over a long period exceeds the schedules of bureaucracies which demand tangible goal attainment over shorter periods (Ickis, 1983; Timberlake, 1989). Moreover, for government ministries already strapped by limited human resources, such an approach is extremely management and personnel intensive. Quantifying participation is difficult, posing problems in gauging the progress made towards meeting program goals (Korten, 1984). In addition, a fundamental conflict exists when development agencies that have traditionally operated in a top-down decision-
making mode are expected to involve local populations in program design, implementation and evaluation (Morss and Gow, 1985). Thus, only "lip-service" is given to community participation in program design and implementation (Midgely, 1986).

Given the reluctant acceptance of community participation in the late 1970s by top-down development agencies, many of the attempts to fund bottom-up approaches were put on the back burner by the late 1980s. In health, selective approaches to primary care that focused on immunization and family planning were strongly backed by USAID, and The World Bank (Turshen, 1989; Walt, 1994). However, the new wave of tentative democratization, pushed by either internal or external forces, shows a greater understanding of the importance of political systems in achieving development objectives.

Health services decentralization has been at the top of the list of priorities for many health ministries in Africa. Most central-level African health ministries retain control over policy making, health legislation and budgets. Day-to-day program implementation matters are usually delegated to the regional level (Walt, 1994). Devolution of decision-making authority over program resources threatens central level program directors, especially in Africa where resources are already scarce. Learned behaviors of authoritarian regimes make it difficult to change decision-makers who have experience with
only centralized management. Likewise, community participation in health did not contribute as much as was envisioned for primary care. It also ran counter to the political context of authoritarian governments. Where community participation has been used, it has taken a very diluted form. UNICEF's Bamako Initiative, a health strategy targeting community involvement in drugs and health center management, for example, involves the community at several levels throughout its implementation in African countries (UNICEF, 1993). Moreover, a recent evaluation of Health For All shows that during the last 17 years, "community participation was not utilized as conceived: democratizing national life and individual activity" (PAHO, 1995, p. 22).

D. Institutional Theory- Institutions as Cultural Systems

Understanding how a given phenomena becomes institutionalized within an organization over time (e.g., related to this research the question of PHC, democratization, or community participation) can be explained through the literature on institutional theory. In contemporary institutional theory, Scott (1995) gives a broad definition of institutions as "cognitive, normative, and regulative structures and activities that provide stability and meaning to social behavior" (p. 33). Institutions operate at multiple levels and are transported by different carriers-cultures, structures and routines. He further notes the relationship between institutions and individuals since institutions incorporate
both cognitive constructions and normative rules which serve as regulative processes that carry out and shape social behavior.

Institutional theory provides a broad range of explanations for why institutions operate in the way they do. Essentially, the literature defines three basic pillars with various levels of emphasis: regulative, normative and cognitive.

Regulative theories emphasize how institutions constrain and regularize behavior through rule-setting, monitoring or sanctioning activities. One example of such a view is economic based arguments which show how rule systems are used to preserve order. This regulative emphasis of institutions allows for an explanation of the role of the state as rule maker and enforcer. Economic sanctions applied to one country or another prove an good example of intention to regulate political institutions through economic actions. Often the primary mechanism for control lying at the base of this argument is coercion or punishment (North, 1990).

Normative-based theories emphasize the role of values and norms in defining behavior. This reasoning, which originated with early sociologists such as Parsons, Durkheim, and Selznick, explains social behavior as modified, constrained or empowered by normative rules. Role theory (Berger
and Luckmann, 1967), a significant contribution to the normative pillar, explains behavior as governed by roles which are derived from expected norms and values of a given context. Roles are therefore not arbitrary, but are selected, interpreted and adapted to a given situation. Roles chosen begin to have patterns that characterize the goals, attitudes or behaviors of a particular situation, organization or institutional context (Searing, 1991).

Cognitive theories use a cognitive anthropological approach to explaining institutions. This pillar stresses how the nature of social reality is derived from meaning attributed to different stimuli within the environment (Berger and Luckmann, 1967). Symbols such as words, signs and gestures are given meaning based on meaning ascribed from previous encounters. As social actions are produced and repeated, similar meanings are derived across individuals and groups which create the process of institutionalization. Thus, rather than stress the role of norms and rules, the cognitive approach emphasizes shared knowledge and belief systems ascribed to given phenomena.

One of the most significant contributions of the institutional analysis literature to the present study lies in what are termed neo-institutional views linking institutions, organizations and individual behavior (Scott, 1995). These more recent arguments suggest that the cultural and normative frameworks
that operate in the environment of organizations or organizational structures, have an importance apart or regardless of the impact on individual behavior. Linked to this theory is the concept of “organizational field” as an intermediate system that mediates between societal structure and the individual. The field is defined as the application of a specific complex of institutional rules that define and control activity within organizational fields (Scott, 1995). However, fields have their own distinctive worlds which operate under different rules with different logic and players. It is the organization’s structural features, such as its political structure, that affect its processes and outcomes. In the present study, the definition and implementation of primary health care as a social action is linked to political, social and economic institutions operating within society and specific organizations.

Summing up, then, the literature shows that defining and implementing PHC and its related concepts of decentralization and of community participation, is a integrative process that is based on how individuals and institutions define the different concepts and the political and institutional systems in which they operate. With the increase in democratic systems in African countries, decision-makers and scholars alike are just beginning to realize that the highly centralized and authoritarian regimes of the 1970s and 1980s did not provide the best context for initiating such reforms (PAHO, 1995). Accordingly, this finding is critical for this research. Understanding the
evolution of primary care in Burundi requires a broad as well as African contextual understanding of the relationship between primary health care, democratization and related concepts of community participation and decentralization. Combined with a realist perspective, this literature review will set the stage for a case-study approach.

E. Contributing Methodologies/The Realist Perspective and Ethnographic Research

This section will identify the explanatory framework used in this research. The approach here does not follow the positivist practice of theory testing. There are no hypotheses to “falsify” under Karl Popper’s “falsificationist” premise. Nor is there an attempt to assemble large data sets to confirm or refute a specific theory. The issue of validity (am I assessing what I set out to study) is more important than reliability (can I reduce health planning to an empirical model which can then be generalized). The research is not focused on outcomes of health indicators or health policy. Instead, its focus is on explaining a process, which can be defined as “A flow of events or actions which produces, reproduces or transforms a system or structure” (Johnston et al., 1994, p. 477). In the present study, the flow of events to be studied is the interaction among individuals, institutions and structures. The system produced is primary care. The approach taken is that of a realist. Its methods are qualitatively based and rely heavily on the ethnographic tradition.
1. The Realist Perspective

The realist approach blends well with understanding social action as a process. Both realist- and process-oriented approaches seek to give an explanatory account of how something happens (as opposed to predicting what will happen, an outcome oriented approach). Realism marks a clear departure from the positivist approach and the latter's quest for order and patterns through the evaluation of empirical regularities (Johnston, 1994). The realist perspective is more concerned with what causes a given phenomenon to happen rather than how many times it happens (Keat and Urry, 1975; Sayer, 1985). However, it is noted that in the past there has been much misunderstanding over the debate between realists and positivists (Gottdiener, 1985).

The perspective of open system lays an important ontological foundation of realism. In positivism the presumption is made that the world is made up of events - which are the empirical observations of science. BasuKar (1975, 1979), in his description of realism, calls it a “multi-tiered conception of reality.” Thus, rather than viewing the world as made-up only of individual events, the world is seen as differentiated and stratified by mechanisms and structures. Structures have internal relations with set ways of acting. Structures also have causal powers that are catalyzed through mechanisms.
According to Sayer (1985), realism is based on the premise that social action is the result of the interactions among human agency, institutions and structures. The challenge for the realist philosopher is to discover the mechanisms which link the interactions. Identifying mechanisms and structures is far from easy. As Keat and Urry state, the realist approach is not about showing instances of well established regularities, but is more about discovering knowledge about the underlying connections between structures and mechanisms. In doing so, we begin to postulate about "unobservable entities and processes that are unfamiliar to us; but it is only by doing this that we get beyond the 'mere appearance of things,' to their natures and essences" (Keat and Urry, 1975, p.4).

Key to the open system and the interaction between human agency, institutions and structures, is the question of time/space in which the interaction occurs, thus the concept of spatiality. For example, Sayer uses the example of gun powder, as it contains the ability to explode. However, its ability to explode or fully exercise its intrinsic nature depends on the presence of other conditions such as a spark (mechanisms). Thus space is critical to how the structure will act. In a closed system, space is considered indifferent or constant. In an open system, space is in constant flux due to how different structures relate and react (Sayer, 1984). It is in this vein that realism is at times linked with structuration theory. However, in realism, the role of human
agency is key and differentiates it from structuralist theories. Human agency can be defined as not only the intentions people have in doing things, but their capability to make a difference (Thompson, 1984).

The realist approach is most developed within the Marxist paradigm. However, not all realist studies are Marxist, as the present and other research illustrates (Klak, 1987). In the Marxist context, the realist perspective has been useful in explaining the deeper social forces affecting surface events and identify how they mediate structures. As shown earlier, the realist perspective has equally been used in medical geography in the 1980s to bring theory into a discipline that tended to be void of a theoretical underpinnings (Kearns and Gesler, forthcoming).

One of the challenges of the realist perspective is that there is no “cook book” approach to send the researcher off in search of answers or explanations. In order to make more sense of the abstraction of realist theory as it relates to the present research, the following are defined. Human agency reflects the decision-makers involved in primary health care, including their beliefs about PHC and their capacity to influence the PHC process. Institutions can be defined as the organizations in which they operate, in this case, the Ministry of Health. Structures refer to the forces that structure society such as political systems, economies, social norms, among others.
2. Ethnographic Research

Theory, method and research design are inextricably linked in any study. A theory about a given object shapes the research problems to be studied and the manner of this investigation (Ellen, 1984). This is particularly true in anthropology where the subject of study is culture. Ethnography provides a means for understanding culture. Ethnography forms an integral part of anthropological research but it is a minor practice in other social science fields such as sociology and geography. The term ethnography has come to encompass a variety of definitions and practices. In its broadest sense it implies extensive field work using participant observation in which the researcher is actively engaged in the subject’s daily activities (Johnson and Smith, 1986). Descriptions of its distinctive features have ranged from "the elicitation of cultural knowledge" (Spradley, 1980); "the detailed investigation of patterns of social interaction" (Gumperz, 1981); --[to]--"holistic analysis of societies" (Lutz, 1981) (cited in Hammersley and Atkinson, 1983, p.1). The term ethnography is further confused due to its various descriptive uses such as a finished product (i.e., a written account of a particular population’s culture and social organization), a research procedure, or its wider use as an academic subject (Ellen, 1984). The following section will expand on the main features of ethnographic research, including it strengths and weaknesses as a mode of inquiry.
Ethnographic research has evolved in part as a reaction to the positivists paradigm of understanding the world through quantitative methods, an emphasis on theory testing, and an over-riding search for universal laws (Hammersley and Atkinson, 1983). In the research process, positivism places much emphasis on the ability to test and falsify theories. Researchers attempt to collect data unobtrusively to avoid subject contamination. The social world is thus understood from the outside, with meaning ascribed from the researcher’s point of view to actions of individuals or groups operating in a given context. However, ethnographers who operate under naturalistic philosophies criticize positivists for operating under artificial research conditions with structured interviews and survey methodologies (Ellen, 1984; Hammersley and Atkinson, 1983). They believe that social phenomena can only be understood in their natural state. Moreover, and perhaps most central to their argument, is the view that causal relationships cannot automatically be assumed among variables in the social world. This is based on the belief that human actions are infused with social meanings rather than operating under a system of universal laws. In other words, each individual ascribes his/her own meaning to a particular event or stimuli (Blumer, 1969). Therefore, the use of standardized methods can barely reflect or measure the full meaning ascribed by all the subjects under study.
For the ethnographer, the means of understanding social phenomena is through direct participation in the subject's world. In most cases the ethnographer approaches the subject's reality without imposing a prior knowledge and preconstructed hypotheses. This is not to say that ethnography is devoid of theory. To be sure, the researcher is usually informed by specific theories. Instead, using this inductive approach allows for the significance of events to be determined from the participant's point of view. The role of the ethnographer, albeit no easy task, is to interpret these meanings and reconstruct the social reality of subjects under study.

A major criticism of the ethnographic approach by quantitative researchers is that subjectivity overrides or interferes with analysis (Ellen, 1984). As active participants in the research process, validity is in jeopardy due to researcher influence on the subject in the field. Moreover, credibility of the researchers is of prime importance, for without credibility, access to delicate matters is impossible. Ethnographers must further realize that even their research methodology is politically mediated (Van Maanen, 1988). Access to one group of informants may preclude access to another because of political differences or a perceived association of overt power to represent one group over another. In the present study, where tensions prevail between the two ethnic groups, I was critically aware of how political factors mediated the research. This tale unfolds in the chapters ahead.
Ethnographers retort that such criticisms miss the point about researcher involvement in data collection. Hammersley and Atkinson (1983) argue that social science research in itself is based upon the notion of reflexivity. In other words, social researchers, be they quantitative or qualitatively oriented, are in fact part of the world. It is difficult for a researcher not to influence the subjects under study in some way. Therefore, as an accepted fact, the researcher should use this knowledge to her advantage. As Hammersley and Atkinson observe, "How people respond to the presence of the researcher may be as informative as how they react to other situations" (Hammersley and Atkinson, 1983, p.15).

The primary strength of ethnography is its descriptive account of the cultural context under study. Such an in-depth account is rarely possible by other research methods. Some would argue that the ability to validate such an account through replicability is impossible. The ethnographer's reply is that ethnographic studies usually entail a variety of data sources and triangulation methods to ensure validity of responses (Hammersly and Atkinson, 1983). In the end, the crucial validation depends on how well the study reflects the everyday social reality of the subjects in question.

An ethnographic approach proved valuable in this study for a variety of reasons. Ethnographic methods provided a means for a holistic study of the
research setting. It allowed for comparative methods of classification to understand the everyday social reality of the subjects under study. As the following chapter will show, Burundi is an extremely complex and conflict-ridden country. It is a country where suspicion among nationals, let alone foreigners, is the norm. My teasing out the particularities of social relations in Burundi required time and direct participation to gain credibility as a foreign consultant among Hutu and Tutsi. Direct participation was essential to grasp the full social reality facing the individuals and institutions involved in this study. It gave me an understanding of how meaning is ascribed to different phenomena.

3. Content Analysis

A content analysis of interview transcriptions provided a third methodological base for this study. Content analysis can be applied to any form of communication. It is of particular use in qualitative studies where the question of “who said what, why, and with what effect?” is of importance (Babbie, 1992, p. 312). Perhaps the biggest concern in the content analysis literature is over the question of validity and reliability. To recall, validity is the degree to which a measure reflects the concept it is intended to measure. Put differently, it seeks to determine whether we have really measured what we set out to do. Reliability assesses whether or not findings can be replicated. In other words, if we were to repeat the study, would we get the same findings.
again (Bohrnstedt and Knoke, 1982). Positivist traditions put much emphasis on reliability. Both are important concerns in field work. However, in the use of qualitative research techniques, reliability is understood to be compromised (Babbie, 1992). Trade-offs are clear: qualitative research ensures greater emphasis on the validity of a few variables and observations, while logical positivism is concerned less with accuracy of measurement but is easy to apply to many observations (reliability is high). The point of qualitative research is to gain an in-depth and personal knowledge of the subject that would not otherwise be feasible under quantitative approaches. Thus such research does not seek high levels of generalizability (Babbie, 1992). Jackson (1987) notes that in field work, reliability should not even be considered an issue because nothing ever remains the same. Although this may be an extreme position, he believes that in field work both the subject and the researcher are changed by their own encounter as well as previous encounters. I also share this perspective.

Jackson's and other field researchers focusing on a few number of observations underscore validity as important to content analysis. How the researcher ascribes meanings to concepts is methodologically problematic (Scarpaci, 1993). How we ascribe meaning to concepts is highly influenced by the meaning we derive from our own cultures and experiences. In other words,
we understand other people and their expressions based on how we can relate it to our own experience and self understanding (Jackson, 1987).

Other scholars agree that field work allows for superior validity as compared to standardized survey and experiments. Babbie (1992) argues that the depth of meaning in concepts can only be tapped through field work. Content analysis, an unobtrusive method, allows for the understanding of how different words and concepts are used by the different subjects under study. But the contextual meaning of these words and concepts is critical. The specific methods used in this case involve isolating key concepts for the research, and counting not only how many times a word is used (manifest content), but also the meaning that is ascribed to it by the individual (latent content). This method was used to classify meanings given to key concepts used by decision-makers in this research. It affords an ability to ascertain the concreteness with which certain concepts are used therefore increasing the level of validity.

Other terms that warrant definition in this study and are related to validity and reliability are manifest and latent content. **Manifest content** is the apparent or surface level of communication, often associated with the ‘conventional’ or ‘dictionary’ meanings. One disadvantage of manifest content is that it may not give the full meaning of the word used. **Latent content** is defined as the
underlying meaning and often depends on judgments on the part of the reader. Its advantage is that it offers greater in-depth knowledge. However, it compromises reliability because it forgoes large numbers of observations. Where possible, it is recommended that both be used to make comparisons in interpretations.

F. Summary

This literature review has laid the foundation for understanding primary health care as the result of social action. With a research focus on the process of primary care development, the review included a variety of perspectives ranging from political science to anthropology to explain this process. The primary health care literature is currently embroiled in a debate over how PHC is defined. The definition of PHC, be it comprehensive or selective, influences the kind of delivery approach used in primary care programs. The literature on the social production of health points to the origins of the selective/comprehensive debate and the prevailing ideologies of how health is conceived. This section gave an historical account of the social forces that promoted curative over primary approaches in Africa and the evolution of primary care practices to this day. The literature on health and primary care as cultural system lays the foundation for studying health systems holistically; that is, as ethnomedical systems where a variety of beliefs and health-seeking
practices are held by both users and providers. In turn, this provides a useful means for classifying the health belief systems in the present research.

With almost twenty years of experience in trying to attain the Health for All goal in Africa, there is a nascent awareness of the links between primary health care and political systems. Health ministries have evolved and are not operating under the same contexts as they were in 1978. The literature shows that democratization is having a profound effect on reorganizing social, political and economic life in Sub-Saharan Africa. Nonetheless, much remains to be explored. Both civil society and the state are in transition with the decline in authoritarian rule. New roles for civil society's participation in political processes are emerging. The democratization literature shows Western explanations of the role of pluralism in democracy may or may not be valid in a country where the dynamics of ethnicity and the role of the military differ from the experience in the West. As a new area of scholarly inquiry, my review of the literature shows that significant gaps exist. Specifically, little is known about democratic trends in Francophone Africa, as the majority of the literature targets English-speaking countries. More germane to this study, there is limited field-based research and little knowledge of how democratic transitions affect specific sectors such as health care.
Introducing democratic reform often requires both decentralization and community participation in decision-making. Both concepts are directly relevant to the successful implementation of primary care. The literature review shows that both concepts have been insufficiently integrated into health care delivery. Much of this stems from a lack of understanding and definition of both concepts in policies and strategies. However, the literature also shows that there is a growing awareness that many governments' inability to progress is also due to the incompatibility of health-care reforms under centralized authoritarian rule. This notion is crucial to this study, which examines the process of primary care development in Burundi, a country undergoing significant democratic reforms during the research period.

Finally, a review of the methodological base for this study identified how a realist approach provides an appropriate philosophical foundation for explaining the evolution of PHC in Burundi. With its focus on how human agency, institutions and structures mediate social action, it builds a broad foundation for explaining PHC as a process. I argue that undertaking the research ethnographically was appropriate because method and theory are inextricably linked. Participant observation and a variety of data sources are critical for deciphering the meaning and the research context in a country where suspicion and distrust are the norm.
As this case study unfolds, I will show that the lack of progress in community participation and decentralization derives from structural variables outside the Ministry's realm of influence. In light of that finding, I will show that it is unrealistic to expect a few policy makers and health planners to overcome these obstacles. This argument is further explored in the final chapter where I use a realist perspective to show how the relationships among decision-makers (human agency), the Ministry of Health (institutional culture), and contextual factors (structures) shaped Burundi's primary care approach (social action).

This research will show that both micro and macro influences mediate the ability of the MOH to institutionalize the democratic process of primary care and resource allocation (Figure II-2). Such influences support neo-institutional views linking institutions, organizations and individual behaviors. I aim to show that cultural and normative frameworks operating within the environment of the MOH organizational structure are highly dictated by outside influences. As such, these frameworks are important regardless of the impact on individual beliefs within the organization. In a sense, the MOH is one “organizational field” among many that operate as an intermediate system mediating between societal structure and individual decision makers. Figure II - 2 summarizes some of these macro and micro influences as they relate to the democratization of primary care and resource allocation.
Macro Processes

IMF/World Bank/Government in Power/Political Parties

- Fiscal Austerity
- Authoritarian Regimes
- Societal Level Ethnic Prejudice
- Decentralization
- Community Participation

Democratization of Primary Care/Resource Allocation

- Family
- Education/Training
- Learned Bureaucratic Behaviors
- Personal Experience with Ethnic Conflict
- Field Experience

Micro Influences

Figure II - 2 Macro and Micro Factors Mediating the Democratization of Primary Care
III. Research Setting

To the outsider, especially the Westerner, Burundi is inconsequential. Most people have never heard of it. For American politicians, it holds no strategic geopolitical or economic interest. It is not an “Egypt,” receiving the majority of the U.S. foreign aid budget due to its strategic location. Nor is it a fledgling former Soviet client state trying to emerge into the global marketplace. It lacks the oil and clout that Nigeria wields, and is not the eastern African political and economic power of Kenya. Instead, it is just another poor African country facing development challenges.

To the insider, however, Burundi is unique. Its physical beauty and panoramic vistas surpass many on the continent. This striking natural beauty, however, masks an equally striking, yet tragic political history. Its recent history will shape Burundi’s future development. This chapter summarizes the country’s defining features, and places particular emphasis on those related to this research.
A. Physical Setting and Natural Resources

Burundi is a small mountainous country with a land area of 27,834 square kilometers (about the size of Maryland). The country is bordered by Zaire to the West, Rwanda to the north, and Tanzania to the east (Figure III - 1.) Burundi is marked by three diverse ecological zones: the plain along the eastern shore of Lake Tanganyika and the Central Rusizi River Valley north of the lake; the high, cooler central plateau containing the Zaire-Nile Divide, with mountain peaks over 2,200 meters; and finally, the eastern lowlands which slope down from the central plateau to Tanzania.

With increasing population growth and deforestation, erosion poses serious problems. Continuous cropping and an increase in the planting of tubers and root crops are draining soil fertility. These crops are popular since they produce good yields in poor soils and are carbohydrates which are considered by the population to "fill the belly." Twenty-five percent of the land is under cultivation, 60 percent is used for pasture and the remainder is covered by limited forests and steep mountainous inclines.

There are significant deposits of gold, nickel, vanadium, cassiterite, and other minerals, but these are not mined to a significant degree. Unfortunately for Burundi, low world prices make the exploitation of these minerals unattractive.
Figure III - 1. Map of Burundi (Burundi Country Report, Department of State)
Lake Tanganyika is no longer a major resource because fish catches have declined dramatically due to over-fishing in past years (USAID, 1992).

B. Population Characteristics

In its last census in 1990, Burundi was estimated to have around 5.3 million people (GRB, 1992). Bujumbura, the capital city, is where this research took place. It has an estimated population of 300,000 persons, and is situated at the northern end of Lake Tanganyika where the coastal plain meets the central Rusizi River Valley, not far from the Zaire border. Forty-three percent of Burundi’s population is under the age of 15. Burundi’s limited physical size and average population density of 207 people per square kilometer make it the second most densely populated country in Africa (after Rwanda). If one compares the ratio of people to cultivated land area, the density is 536 people per square kilometer. The average land area cultivated to support a farm family is extremely small, only .9 hectares. Population densities are highest in the central plateau region, where farmers routinely plant crops on hillsides with slopes exceeding 30 percent (USAID, 1992). Population densities are lower in the south, mainly due to poor soil conditions. Burundi’s population growth rate is estimated at 2.8 percent per year and its total fertility rate is seven children per woman (GRB, 1993). Until 1993, Burundi was able to maintain its level of food self-sufficiency. However, population growth combined with limited areas for cultivation posed considerable challenges in maintaining food security for
farm families and the nation as a whole. (DHS, 1988). At present, ethnic conflict and the resulting displacement of persons has brought about major problems in ensuring adequate caloric and nutritional intake.

Burundi is unlike the majority of African nations in that only 6% percent of the population resides in urban areas. Three fourths of urban dwellers reside in Bujumbura, the only major city in the country. Only two other towns in the country have populations of 20 to 25 thousand (Gitega and Ngozi). Several reasons account for the low level of urbanization. Up until the time of this research, few off-farm economic opportunities existed. However, pressures to migrate off the farm were beginning to mount with the decrease in arable land area. Also, colonial and post-colonial bans on rural migration to the cities was another inhibiting factor (Bidou, 1989). Moreover, Burundi's history of ethnic strife created a fear of ethnic violence in the city (USAID, 1992).

C. Socio-Economic Characteristics

The country is made up of two major ethnic groups: the Hutu, estimated to comprise about 84%, of the nation's population, and the Tutsi, which comprise about 15%. The remaining 1% are the Twa, also known throughout this part of Africa as the "Pygmies." No official census has documented ethnicity, because asking such a question is extremely sensitive. (See
following section on Political Setting.) Hutu and Tutsi speak a single language, Kirundi, and share a common culture.

Religion plays a strong role in the lives of most Barundi. Sixty-seven percent of the population is Catholic, and 32% practice traditional or indigenous religions. Only one percent of the population is Muslim. For Catholics, Church doctrine plays a strong role in Burundi values. For example, open discussion of family planning is constrained because of Catholic mores.

As a highly rural society, Barundi\(^1\) traditionally live together in dispersed houses on what is termed in French as ‘collines’ or hillside communities. The collines function like a village. People of one ‘colline’ share significant social and economic relationships, even if they are from different ethnic groups. Tutsi traditionally were herders, and therefore provided meat and milk. Hutu worked largely as farmers and produced grains, beans, or tubers that form the staples of the Burundian diet. Many claim that colonial rule altered these social relationships and made ethnic status a group rather than individual identity (Des Forges, 1994; Gahama, 1991). In this sense the group identity and rivalry that is so much a part of Burundi’s recent history developed because the

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\(^{1}\)Barundi (bā’ rūn dē), spoken with an accent on the first syllable, is the term used to describe Burundi nationals.
Belgians gave preference to the Tutsi in education, economic resources, employment, and political power during colonization (Gahama, 1983).

Burundi was under German colonization from 1889 to 1918, and under Belgian rule from 1918 until independence in 1962. Perhaps what characterized the Belgian period most was the continuous reorganization of previously independent chiefdoms, in the name of administrative efficiency. Belgian colonists wanted to ensure their ability to rule over the country. This meant endowing privileges over certain chiefdoms to ensure their rule over others. Le Marchand (1992) argues that these moves put previously independent chiefs under the jurisdiction of ‘favored’ kingdoms. Rural unrest began even during this period as one prince’s kingdom jostled for position over another. Additionally, some of the origins of Hutu/Tutsi rivalries can be traced to the administrative reorganization policies of 1929.

Burundi is often referred to as an “enclave,” A French word for a landlocked territory (Chretien et al. 1989; USAID, 1992). More importantly, though, the word characterizes the country’s historic physical, social, economic, and intellectual isolation from the rest of the world. Under Belgian rule, very few Burundians were sent for training, unlike the French, who took great pride in promoting their own culture to their colonies. After 35 years of independence,
Burundi is just beginning to form a critical mass of university educated
decision-makers to run its historically military dominated country.

Per capita income is approximately $208. However, this figure fails to
indicate the disparity in the distribution of income. The GDP was estimated at
$1.1 billion in 1990 and is derived primarily from food crops and a single
agricultural export crop, coffee (World Bank, 1993). Even though most of their
lands are devoted to production of food crops, farm families generally produce
one export crop to ensure cash returns.

Burundi has a very small private sector. In 1990, small and medium
enterprises that characterized the private sector accounted for 20% of GDP
(USAID, 1992). Given its subsistence agrarian base and pastoralism,
commercial activities were not given high status and were perceived as an
activity of foreigners (Belgian, Indian and limited Greek communities). With
Burundi's own experimentation in structural adjustment since 1988, there is a
growing interest in private business. People are beginning to realize that the
government cannot continue to be the country's primary employer. There is a
growing sense that Burundi must join the global economy if it is to survive. One
of the major challenges to the development of a private sector is the lack of
qualified human resources. There are extremely few individuals trained in
accounting, marketing or management (USAID, 1992). By 1993, a few
Burundian enterprises were beginning to develop and they were notably dominated by the well educated Tutsi minority.

D. Health Status and Delivery System

An in-depth description of the evolution of the Burundian health delivery system can be found in Chapter V. This section provides an overview of the health sector in 1993.

Basic health indicators for Burundi show that it has high child (173/1000) and infant (110/1000) mortality rates. Average life expectancy is 38.5 years at birth and is very low compared to an average 55 for low-income countries (DHS, 1988).

Mortality data are considered unreliable since questions about death are taboo within a society founded on suspicion. Morbidity data from 1990 indicate that malaria was the leading cause of morbidity, followed by intestinal worms, acute respiratory infection, and diarrhea (MOH, 1990).

Government spending on health slightly increased from 4.2 percent of the national public budget between 1983-1987, to 4.6 percent from 1988-1992 (GRB, 1993). Health is delivered primarily through government facilities. There are few private clinics in the capital and a limited number of church-related
health clinics in the rural areas. This concurs with the lack of private-sector initiative and represents the outcome of laws which previously required doctors to remain in the public service due to a shortage of physicians. NGOs played a greater role in health until 1986-87 when the Bagaza regime perceived them as a threat, believing that NGOs could be used to mobilize the masses who might claim their rights within society (Sindayigaya, 1991).

Barundi enjoy fairly good geographic access to government health care facilities (80% of the population is within a five kilometer radius of a health center). However, foot paths that must be traversed through the steep hillsides and mountainous peaks make these figures a bit misleading. Moreover, Barundi lack confidence in health facilities, partly because of a history of drug shortages and poor provider/client relationships. As a result, there is a strong alliance between Barundi and traditional practitioners, who are often the first point of health-care reference for the population.

By 1993 the government health system was operating under a somewhat decentralized delivery system, and was organized into 15 medical provinces that correspond to the country’s 15 administrative provinces. Medical provinces are under the direction of a Provincial Medical Head. Each province was further divided into sectors that had between five and nine health centers. Each health center, in turn, is staffed by a nurse and possibly other para-
professional health staff. By this period the country had started its own medical school at the University of Burundi, and had two nursing schools. Disparities between client/provider ratios were beginning to narrow, but the country still lacked an adequate number of physicians and specialists. In 1987 it was estimated that there was one health center for every 30,000 to 40,000 inhabitants. By 1992 there was one health center for every 20,000 (MOH, 1993). By 1992 there was one doctor (including expatriate doctors) for every 15,988 inhabitants, and one Medical Technician (equivalent to a nurse) for every 13,000 persons (MOH, 1993).

E. Political Setting

Understanding Burundi's political past is imperative for appreciating any aspect of Burundi's present situation, as its ethnic rifts run deep and have long roots. As noted in the previous section, Hutu and Tutsi lived peacefully together for almost 400 years (Gahama, 1983). Both groups were ruled by a king. Status often depended on an individual's relationship to the ruler, who favored Hutu or Tutsi depending on his own interests (Des Forges, 1994). It was during the colonial period that ethnic divisions became more sharply defined.

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2Burundi's political history is a challenge to understand for a variety of reasons. Little documentation of the country's "real" history exists, since freedom of the press was unheard of until the early 1990s, and many accounts are biased to one ethnic group's view over another. Therefore, I am greatly indebted to Allison Des Forges, a historian, expert on Rwanda and Burundi, for a well laid out account in the May 1994 issue of Current History entitled "Burundi: Failed Coup d'état or Creeping Coup d'etat." Des Forges serves on the board of Human Rights Watch/Africa and has chaired the International Commission of Inquiry into Human Rights Abuses in Burundi.
when the Belgian colonialists reorganized the existing administrative system and systematically eliminated Hutu from positions of power. Because of their tall and thin appearance, the Belgian colonialists believed the Tutsi to be “whites in black skin” (Gahama, 1991). Very much like themselves, the Belgians thought the Tutsi must be superior to the Hutu, and therefore accorded them access to higher education and a limited number of salaried jobs. By independence in 1962, the Tutsi population was well engrained in more powerful roles, fed by European assurances of their superiority as “natural and right” (Des Forges, 1994, 205).

With Burundi’s own government established at Independence, a new government ruled by a prime minister and a national assembly, and the traditional system ruler (at this point a Prince named Mwambutsa) operated at the same time. Burundi’s first ethnic conflict arose in 1965 when Mwambutsa, who usually played an arbitrating role between the two ethnic groups, refused to accept a Hutu prime minister. As tensions rose, a small group of Hutu soldiers tried an unsuccessful coup d’etat and followed-up with attacks that fatally wounded around 500 Tutsi. The army retaliated by killing an estimated 2,500 to 5,000 Hutu. Moreover, these attacks targeted a first generation of Hutu leaders and tried to purge all Hutu army officers. The army, led entirely by Tutsi commanders, took on the major role in Burundi’s political life, a role that it
continues until today. In 1966, the monarchy was overthrown by Captain Michel Micombero, and a military-dominated republic was established (Des Forges, 1994).

In 1972 conflict escalated again when Hutu rose up against the Tutsi in Bujumbura and several smaller towns. Initially, several thousand people were killed. However, the army once again retaliated with a forceful repression. Over several months more than 100,000 Hutu were killed, including all with higher education and students at institutions of higher learning\(^3\). Any Hutu leader or potential leader was eliminated to ensure continued Tutsi domination. At this point, several thousand Hutu fled the country. As Des Forges (1994, 204) notes in her account of that period, “The army employed some new methods, such as helicopter attacks, but resorted once again to using civilian bands to extend its range, sometimes inciting them in radio broadcasts to attack Hutu in their vicinity.” The carnage that took place is well etched into every Burundian’s memory who lived during that period.

In 1976 a second coup d’etat took place and Colonel Jean-Baptiste Bagaza took power from Micombero. Again, the military continued to dominate. However, Bagaza proclaimed that as in pre-colonial times, Tutsi and Hutu were

\(^3\)For a personal account of this see related account in respondent profile section of Chapter IV.
the same, and that national unity was always the case in Burundi. Bagaza co-opted a few Hutu to serve in the government and, worked extremely hard to undermine a reviving Hutu opposition. Under Bagaza’s 11-year rule, Burundi’s isolation was maintained and then increased. In 1985, Bagaza extended his persecution beyond several religious organizations to include the members of the Catholic church and clergy for having pro-Hutu sentiments. This proved to be a major miscalculation as over two-thirds of Burundi’s population were Catholics.

Dissatisfied with the situation, Major Pierre Buyoya, led a successful coup d’etat in 1987, and replaced Bagaza. Buyoya ruled through a Military Committee for National Salvation, made up entirely of Tutsi. Only token Hutu were given a few positions of power. Des Forges (1994) notes that for the first time even the Tutsi dominated Catholic clergy, an important force within the community, took a strong position against the government’s anti-Hutu actions.

In 1988, for the third time in less than 25 years, another massacre erupted in two northern communes where a Hutu uprising began. Twenty thousand people died after months of tension evoked by secret meetings among both ethnic groups who prepared and circulated lists of victims to be
killed (Hakizimana, 1992).\textsuperscript{4} Remembering full well what had occurred 1972, Hutu cut off access to the area by destroying bridges and barricading roads to keep the military out (Chretien et al., 1990). Attacks began when Hutu killed a Tutsi trader and politician, and moved forward killing 100 more Tutsi. With the remaining Tutsi population fleeing, the military was able to make easy warfare against the Hutu. The event is of critical importance because it traumatized a new generation of Burundians from both ethnic groups by “reenacting the horrors of 1972” (Des Forges, 1994, 204).

Perhaps for the first time, in 1989 international pressure was brought on the government to begin to rectify disparities in ethnic representation in Burundi’s government. Buyoya, seeking reconciliation with the Hutu, chose Adrian Sibomana, a Hutu, to serve as prime minister. In addition, half of his cabinet was changed to Hutu. This set the stage for what has been termed “ethnic arithmetic” by Africanist Rene Le Marchand (1992). Several Hutu governors were appointed and Hutu were recruited into the civil service. In education, more Hutu were admitted to secondary schools as a result of secondary school exams being administered more fairly.

\textsuperscript{4}Hakizimana is a Hutu journalist in exile. In his book Burundi: le non dit or “Burundi: the unspoken,” he recounts his version of the events leading up to 1988, and provides a testimony of his own incarceration and exile. The book appeared in local bookstores in Bujumbura in early 1993, indicating a greater freedom of press and that the government was serious about its democratic reforms.
While progress appeared on the surface, some felt it was not strong or fast enough. In November 1991, the Hutu People's Liberation Party (PALIPAHUTU), an underground group thought to be operating outside of the country, attacked several military targets in three provinces, including Bujumbura. At that time, I was living in a neighborhood situated between two military camps on the outskirts of Bujumbura. My family spent three days enclosed in a hallway as the bullets whirled around our house. By the end of the fighting, the government estimated 551 people killed, but outside observers estimated 3,000. One change between the 1991 uprisings and previous ones was that the army behaved more than ever as a force of order for the nation. Any abuses came under strong and quick criticism. However, there were still known instances of disobeyed orders and continued killing by subordinates (Le Marchand, 1992).

External pressure on the government for power sharing continued. The United States played a lead role among the donor community in supporting democratization efforts. It sponsored conferences with military leaders on the role of democracy and the military, and it funded projects to support legal reform and NGOs. A new constitution was passed in 1992 and a multi-party system replaced the single party system. 'National Unity' became the number one proclaimed objective of the government. Dialogues were carried out
among political and intellectual leaders and banners traversed main thoroughfares, stating *Oublions notre passé* (Let us forget our past).

I believed that unless the country was ready to honestly confront and reconcile its past, hostilities would remain. With its history of conflict, there was probably not one Barundi family -- Hutu or Tutsi -- that had not lost a family member in previous attacks. 'Forgetting' the past seemed to me an avoidance of root issues which revolved around power and sharing of resources.

Elections were scheduled for June of 1993, and for the first time a democratic election process was allowed. UPRONA (*Union pour le Progres Nationale*), the previous state party, felt that with Buyoya’s popularity, they would win. The major contender, the Democratic Front of Burundi (*Front Democratique du Burundi*, commonly known as FRODEBU) represented the majority of Hutu and was led by a young banker named Melchior Ndadaye. The campaign was a test of the seriousness of the government about promoting democratic processes. Political rallies and mass mobilization of the population were carried out throughout the country. I had never seen Hutu react with such spontaneity. They broke into dance in the streets when their charismatic leader passed by. This was totally uncharacteristic. I felt that because Hutu had tasted a sense of unconstrained expression of joy and
freedom, it would be difficult for them to return to any kind of previous
oppressive control.

Several days after the June, 1993 elections, (which were considered fair
by internal and foreign observers), official results were disclosed. Ndadaye
had won, taking 65% of the vote. Tutsi were stunned. By the late afternoon
when the results were declared, I had not fully appreciated the tensions among
the Tutsi. The next morning when I returned to work, I saw that Tutsi local
employees of the USAID mission\(^5\) had arrived at work exhausted yet relieved.
As Ndadaye had been painted by UPRONA as a radical Hutu, none had slept
the entire night, believing they would be killed in their homes in retaliation for
past massacres. Hutu celebrations were very tempered, as it was clear
tensions were running high and no one really knew how the military would
react. The military's chief of staff promptly acknowledged the FRODEBU victory
on the country's only television station, a government-run service. Meetings
were held at all military bases to sensitize officers of the national and
international ramifications of a coup d'état (Des Forges, 1994). The country's
democratic initiative had gained the attention and confidence of its donors, and
foreign aid was greatly needed to bring Burundi from its history of isolation into

\(^5\)The USAID mission, with its strong focus on democratic initiative, tried to support its own
affirmative action by hiring as many qualified Hutu as possible. In the offices where Hutu
and Tutsi staff mixed, tensions were often evident, particularly during the election period.
a global economy. On a national level a coup d'etat would surely incite a major revolution and begin another era of serious ethnic conflict.

Legislative elections were held three weeks later and, once again, FRODEBU candidates took a majority lead with 71% of the ballots cast. On July 2, officers organized a coup d'etat, but it was thwarted. The five high-ranking officers (including the former head of Buyoya’s cabinet) behind the coup d'etat were jailed. Ndadaye was well aware that his greatest challenge was to ensure that the army serve the elected government and population. Therefore, he split the national police from the army and made the police a separate force under a different ministry. He also issued a plan for more balanced ethnic representation in the military forces.

Ndadaye also had to prove that he was not elected as a radical who would pull all powers from the Tutsi. Instead, he stood for national unity. He formed a government with FRODEBU which held thirteen of twenty-three posts, and he set six aside for UPRONA. In his savvy to appease the opposition, nine of the twenty-three ministerial posts were given to Tutsi. Moreover, he chose a Tutsi woman as Prime Minister, a staunch member of UPRONA, and notably, a renowned economist.
Tutsi fears of an all-out Hutu retaliation were alayed somewhat. However, at lower levels of the government system, many Tutsi government officials lost employment as FRODEBU members were appointed as provincial governors and administrators. The reality of a reverse "affirmative action" and competition with Hutu for salaried positions proved difficult for many Tutsi to accept.

In the meantime, the government took a strong stance at promoting repatriation of the 200,000 Hutu in exile. To complicate matters and increase tensions, most refugees (some having been gone since 1972) returned to find their homes and lands had been taken over by Tutsi. Even though commissions were set up to settle land disputes, tensions increased as apparent bias in decisions taken proliferated (Des Forges, 1994). By August and September, small conflicts, exemplified by arson or attacks on individuals, made the government look unstable and ineffective.

By October, 1993 rumors of a pending coup d'état were running rampant. Because of its authoritarian past, Barundi lived in secrecy and thrived on rumors. In turn, rumors often begot rumors, and everyone believed different ones. On October 20, I awoke around 4:00 AM to the sound of canon fire. The phone lines were dead, and where one usually heard people scurrying down the streets to the central market, there was complete silence. By 8:00 AM the
radio was playing only classical music, a sure sign that something drastic had occurred.

It was later learned that rebellious junior military officers had arrived around 2 AM at the presidential palace and began shooting. Fire was returned. As Des Forges (1994, 206) described it:

During a lull in the fighting Ndadaye left the palace in an armored vehicle and headed for the military camp that housed the presidential guard. There, in the presence of many senior officers, the chief of staff, Jean Bikamagu, handed Ndadaye over to the insurgent troops. Several hours later, Ndadaye was killed, as were four other high officials (Des Forges, 1994, 206).

The four casualties included the President and Vice-president of the National Assembly, both successors to the Presidency under the New Constitution.

On the morning of October 20, 1993, there appeared to be confusion among the military patrolling the capital. Most units did not know whose side they were on because it was unclear who was in control of the country. By noon it was common knowledge that a coup d'état initiated by junior officers was complete and senior officers were forced to comply.6

6Burundi's military has a history of junior officers seizing power from senior officers. Micombero, Bagaza, and Buyoya were all junior officers at the time they seized power. I was informed that one reason for this was as senior officers gained their elite status, they became more disengaged from junior staff. Many of them, established and became preoccupied with businesses on the side of their "primary" military activities. By alienating themselves from junior staff, they in a sense set themselves up for such outcomes.
The extent of internal feelings among the population is, again, well illustrated by Des Forges: "When one policewoman in the capital first heard the shooting, she started to vomit, knowing where it might lead" (Ibid. p. 206). As predicted, Hutu in the countryside understood the meaning of radio silence in the early morning hours. Upon hearing that Ndadaye was assassinated, their revenge began. To date, no coup d'etat had ever ended with an assassination of the leader in power. Previous coup d'etats involved Tutsi taking power from Tutsi, where the deposed were jailed and then exiled from the country. With the memory of 1972 and 1988 and the military's predisposition to genocide, roads to the interior were blocked by huge tree trunks and boulders. By the afternoon of October 21, revenge against the Tutsi community had already begun with executions. Radio Rwanda began broadcasts inciting Hutu to attack Tutsi.

The military eventually broke through the barricades and descended forcefully upon the Hutu communities, sometimes with the aid of the police or Tutsi civilians. Homes on both sides were destroyed and food and other property pillaged. By October 23 the coup d'etat had collapsed and was

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7In Rwanda, the Hutu majority holds power, but is known for discrimination and human rights violations against Tutsi.
renounced by the Military Chief of Staff. The remaining civil government staff took refuge in the French Embassy, and operated from there for several weeks.

The situation turned into a paradox; the military disavowed its governmental control, and the government was paralyzed by fear of the military. In the interior of the country, local governments fell into chaos and mayhem as killings among officials and the local population continued, including four governors. I remember one instance recounted by a U.S. Embassy security officer who made a tour of the interior to report on how bad the situation had become. The group of foreign officials accompanying him were taken to a secondary school where in the previous week, over 70 Tutsi school children and their teacher had been locked in a classroom which was then set afire. The charred stench-ridden bodies laid inside the building, untouched for several days after the incident.

As the level of violence on both sides became known throughout the country, people began to flee. Some crossed the borders to Zaire, Rwanda and Tanzania. Others fled to different refuge camps within Burundi. An estimated 300,000 people were displaced and 100,000 people were killed in that initial period. Conditions in the camps were abhorrent and many people succumbed to disease, exposure, or both. As the rainy season approached,
the government realized it would face widespread famine if people could not return to work their fields.

Analysts of the event believe that the role of the coup d'etat was to derail the democratic process which had begun (Le Marchand, 1994; Des Forges, 1994). The coup d'etat led by army officers, the murder of the three individuals who had the constitutional right to hold power, and the subsequent returning of power to a government paralyzed by fear, ensured that chaos would prevail. This strongly suggested that the present government was not up to the job. With such evidence, Tutsi could argue for a constitutional amendment that would begin to shift the powers. In the long term, perhaps even the international community would believe that Burundi was not ready for a democracy and, therefore, reduce the external driven pressures on the country (Adekanye, 1995).

The detailed account of the political setting ends here, since the research time-frame of this study ended in November of 1993, shortly after the coup d'etat. What has gone on to the present in Burundi is increasing pressure and success from Tutsi opposition to regain positions of authority in both the National Assembly and the cabinet. Bands of Tutsi youths have staged rampages and the popular neighborhoods of the capital have been "ethnicized," with Hutu fleeing to the hillsides outside of the city. More recently
three Swiss Red Cross staff were ambushed and killed in June, 1996 while taking food and medical supplies to remote areas. Robert Krueger, the ex-American ambassador to Burundi who was pulled out by the U.S. State Department in early 1996 for outspokenness, declared that Burundi is in a "slow genocide" whereby between 100 to 150 people are killed each week.  

Living under such continuous tensions, one becomes psychologically immune and somewhat accepting of the abhorrent violence, perhaps only as a means for survival. Today, it is difficult to say who is right and who is wrong. Radical groups on both sides continue to commit serious human rights violations in retaliation for acts of violence to one side or the other. Hundreds of horrifying human rights violations are extensively documented and reported by Amnesty International (1995) and Doctors Without Borders - USA (Medecins Sans Frontieres-USA) (1995).

National Public Radio (NPR) broadcast a two day report on Burundi’s ethnic conflict in early June, 1996. It was clear that violence is escalating and many people fear a full-blown genocide like that of Rwanda. Interviews with Tutsi and Hutu gave a picture of the situation. Tutsi, who now hold the greatest power in the government, were outraged with the media and the West for

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8Krueger's outspoken role in eliciting a reaction to the conflict from the State Department was the subject of an article in the Washington Post, May 7, 1996.
implying the need for United Nations Peace Keeping Forces to keep the country from falling apart. Surely, U.N. forces (which no country appears willing to supply) might disrupt the Tutsi renewed domination. However, interviews with Hutu in a refugee camp on the outskirts of Bujumbura implored the NPR interviewer to assist in bringing some kind of outside assistance, as there would otherwise be no hope.

The most recent update from Burundi is a coup d’etat which occurred on July 24, 1996. This was precipitated by the killing of 300 Tutsi in a refugee camp by Hutu rebels. At the funeral, the Hutu President was forced to flee by helicopter after Tutsi funeral goers threw stones and cow dung and his Tutsi cabinet members did nothing to stop the insults. Retired Major Pierre Buyoya has taken over until a new government can be formed.

F. Summary

Burundi’s tragic political history continues to shape the country’s prospects for the future. While many are ready to ‘write off’ such a country, the progress and achievements made between 1989-1993 showed glimmers of hope for both Hutu and Tutsi. Peaceful coexistence was a tentative but distinct possibility. For the first time, progress had been made in several sectors and the economy was showing signs of improvement. The health sector made major strides during this period. The country was increasingly seeking
political, social, and economic ties within its own regions of central and east
Africa, and with developed nations.

The definition of democratic transitions by Africa Demos, cited in Chapter
II, is particularly useful for understanding how far Burundi had come in a very
short time. The government never lost its capacity to govern in 1988 when the
pressure for reforms began. However, it was destabilized by Hutu uprisings.
Burundi entered the transition process in the mobilization stage. Demands for
change came from internal (Hutu rebellions and to some extent Catholic
sympathizers, and debt burden) and external (World Bank/IMF Structural
Adjustment and donor conditionalities) forces. Buyoya made the decision to
respond, evidenced by discussions and formulation of plans (national
referendum, new constitution). Elections were held, and judged free and fair.
Initial legitimization occurred with military acceptance of the new government.
However, consolidation never took place, and widespread respect for the
system was never gained. In hindsight the limited period (1990-1993) for such
drastic reforms was much too fast to ensure far-reaching support.

Ethnic conflict forms the primary character of Burundi’s history. However,
the political history of Burundi shows that ethnic conflict has evolved. There are
many differences between 1972, when Hutu were totally disenfranchised and
the target of the massacres, and today, where equal numbers of victims exist
on both sides. Moreover, Hutu have gained representation within the
government and they are trying to hold on to it. Today, many civilian Tutsi
realize that power sharing is inevitable if Burundi is to join the rest of the world.
It is Burundi’s army and radical factions on both sides that pose major
problems for the country’s leaders. Moving the army to understand its role in a
democratic system to protect all citizens will be a formidable challenge. It will
take years to overcome the major step backward in the democratic process
with the 1993 assassination of Mechior Ndadaye.

This research setting forms a very important stage for understanding the
goals of this study. No aspect of Burundi can be understood without an
appreciation of the country’s political history. As this research will indicate,
ethnic strife and democratic transition played a significant role in shaping
Burundi’s primary care approach. Both individuals and public institutions
involved in the health sector have been inextricably affected by these events. In
the next chapter I lay out the methods of this research, which provide the
foundation for this study.
IV. A Realist Approach to Explaining Primary Health Care in Burundi

A. Introduction: How I came to work and live in Burundi

My two and a half years in Burundi stemmed from two events. I had prepared a dissertation research proposal to study the role of decision-makers in developing a primary care approach in Africa. Because my family's trip to Africa was contingent upon the country to which my spouse would be assigned, the exact African country where we would live was not known when I wrote the proposal. My interest in PHC came from a belief that it could serve as a window for development efforts. This belief was based on my seven years' experience in Senegal, Africa, working and living at a grassroots level and using an integrated approach to community development. Around the time that I completed my proposal, my spouse was offered a job in Burundi to lead a University of Arkansas team in a USAID farming systems project. My intent was to find a job within the health sector so that I could gain direct experience and knowledge, and hopefully an entree to the people who could provide the best insight into my research problem.

With hindsight, I was extremely fortunate to be in the right place at the right time. I arrived in Burundi in April 1991 to find the USAID mission in Bujumbura exploring the possibility of increasing its presence in Burundi's
health sector. The USAID mission gave Burundi limited support for its health sector in family planning, child survival and AIDS prevention. Due to this limited presence, the mission had no personnel with a direct health background. I was offered a position to develop a new and expanded health program and assist in managing on-going activities. Within three months of arrival, I was at work and directly involved with the key decision-makers in the Ministry’s programs and the donor community.

My work brought me into daily contact with individuals at all levels of Burundi’s health delivery system. However, the majority, of these contacts were with the central level Ministry. My initial role was to assess the present needs of the health sector and identify who in the donor community was contributing. My charge was to analyze the gaps in health care delivery. The main focus of my work during the following period was to develop a $50 million ten-year project targeting family planning, child survival, and the institutional strengthening of Burundi’s Ministry of Health. The project also contained an element to support NGOs in AIDS prevention, family planning, and child survival. Because of such a broad ranged multi-million dollar project, my work involved extensive proposal writing, fielding and supervision of teams from health consulting firms, and most importantly, constant and close collaboration with the principal decision-makers in Burundi’s health system.
One of the highlights of this position was my insistence that the project establish a true partnership with the Ministry's staff. The Ministry seemed to be both highly surprised by and appreciative of this approach as they had never worked with a donor in such a manner before. For instance, the Ministry was highly critical of Belgian and French cooperation for bringing their project proposals to the Ministry as "fait accompli," with little or no input from Ministry officials. The USAID mission director informed me that in his twenty years with USAID, he had never seen project development occur in such a positive way. Project development meetings were chaired by the Ministry's Director of Planning, rather than myself, and individuals from every Ministry office touched by project interventions contributed to developing goals, objectives and intervention strategies.

I mention the partnership process because it is germane to this research for several reasons. First, the approach used conveyed my own personal ethics of project development. Second, I believe it played an extremely important role in giving me credibility among my Ministry colleagues, a critical factor for in-field work (Van Maanen 1988; Jackson, 1987). Burundi is not a place where trust and confidence is gained easily. As a landlocked mountainous country with an already infamous political history, Burundi do not look outward, but inward. Third, foreign assistance, while needed, is looked upon with suspicion. Gaining the trust of the Burundi not only facilitated my
own daily work, but allowed me the entrée needed for gaining honest and in-depth responses during the research interviews. Such candid responses were clearly important for understanding the complexities of developing primary care vis-à-vis the dynamics in the tension laden country.

Table IV - 1 Observation Methods (Jackson, 1987)

<table>
<thead>
<tr>
<th>Method</th>
<th>Attributes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disengaged</td>
<td>Complete observer:</td>
</tr>
<tr>
<td></td>
<td>• Participant does not know he/she is observed.</td>
</tr>
<tr>
<td></td>
<td>Observer participant:</td>
</tr>
<tr>
<td></td>
<td>• Participant may or may not know he/she is observed.</td>
</tr>
<tr>
<td></td>
<td>• Observer does not do what they do.</td>
</tr>
<tr>
<td>Engaged</td>
<td>Participant observer:</td>
</tr>
<tr>
<td></td>
<td>• Observer takes part what participant(s) do.</td>
</tr>
<tr>
<td></td>
<td>• Participants know the observer is observing.</td>
</tr>
<tr>
<td></td>
<td>Complete participant:</td>
</tr>
<tr>
<td></td>
<td>• Observer is fully &quot;undercover&quot; and takes part in participants' activities, but they do not know his/her observation/research.</td>
</tr>
</tbody>
</table>

Thus this research is informed by my two and a half years as an engaged participant observer. There are many ways to undertake participant observation, ranging from the disengaged to the fully engaged (Table IV - 1). During my entire stay in Burundi, MOH staff, including the Minister, were aware I was doing a Ph.D. dissertation on the health sector. They realized I was there as a professional, representing the USAID mission in health, but they also

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knew and appreciated the fact that I took a keener and more personal interest in the sector due to my research.

B. Research Questions

This study was guided by five research questions that directed the analysis of the interaction between decision-makers and Burundi’s primary care approach. They are listed and explained as follows:

1. What was Burundi’s Ministry of Health primary health care approach between 1960-1993? Classify the approaches by specific periods.

Justification

Classificatory schemes of health systems by both medical and social scientists have generally focused on epidemiological and ecological aspects of disease. The former group classifies disease system according to genetic, environmental, host, disease agent criteria by the latter (Kleinman, 1973). Treating health care systems as cultural systems is a fairly recent development. Since PHC planning as a concerted global effort is still in its infancy, an understanding of the differences among PHC approaches is just beginning to develop. Knowing the nature of PHC as a cultural system begins with a classificatory process based on commonalities and differences among those who implement PHC programs. Thus, analyzing the development of
PHC delivery in one particular organization serves as a key mechanism for PHC praxis. Setting up a relevant classificatory system serves as an initial step in theory construction of PHC as a system of ideas and beliefs about health; a matter I return to in my concluding chapter.

2. **What are the primary health care belief systems of key decision-makers in the Ministry of Health?**

**Justification**

To date, a study of decision-makers as key actors in PHC design and implementation has not been undertaken. There exists little knowledge of who exactly these people are, the range of PHC beliefs they hold, and how they have come to acquire these beliefs. More specifically, in the health field there is little examination to date of how an individual's life history affects his or her belief system. If health care is to be viewed from a cultural system perspective, decision-makers constitute the human agency that influences PHC actions. The structural forces within a particular culture that influence decision-maker beliefs can only be understood through a comparative and classificatory process of the beliefs which decision-makers hold. This is an important initial step in explaining how ideas, meanings, and beliefs about health and disease are formed within a given cultural system.
3. What factors influenced decision-makers’ belief systems?

Classifying decision-makers’ belief systems is useful to this study, as it allows for a comparison of the similarities and differences between the micro (individual’s belief systems) and the macro (the Ministry’s approach). If the assumption holds that decision-makers have an important role in shaping the primary care approach of the organization, then documenting how decision-makers come to acquire a certain belief system forms the cornerstone for explaining why one kind of primary care based system is adopted rather than another.

4. What is the role of Ministry of Health decision-makers in policy decision-making?

This study assumes that decision-makers within the Ministry of Health have a major influence on shaping the Ministry’s primary care approach. Therefore, it is critical for the research to establish whether decision-makers interviewed, do in fact play a decisive role in orienting the Ministry’s approach. Clearly, all decision-makers will not have the same level of influence.

5. What factors promoted or impeded decision-makers’ belief system achievement?

Since Alma Ata and subsequent practical experience with PHC delivery, PHC approaches have evolved and at times meshed. As stated earlier, much
of the design process of PHC programs is due to decision-makers and organizations involved in its delivery. To date, little is understood about the interaction between the two. Such knowledge is of prime importance in realist studies (Sayer, 1984). It affords an understanding of how interaction between human agency (decision-makers) and institutions (mechanisms), and culture (structures) mediates primary health care (social action).

C. Methods Used

1. Research Questions 1 and 2: Classifying Decision-Maker PHC Beliefs and the MOH PHC Approach

Research questions 1 and 2 both rely on the same classificatory method. This method may be defined as follows:

In order to view the social construction of primary health care, one has to be able to provide some way of measuring both an organization’s vision of PHC as well as the vision of those individuals who operate within the organization. This is of particular importance if the assumption is made that the individuals within an organization play a role in the development of an organization’s approach.
Figure IV - 1 presents a typology for identifying and classifying the
Ministry of Health's primary care approach over time and its key decision

The typology reflects four key dimensions of PHC programs as gleaned
from the literature. The X-axis represents a continuum of how programs are
administered. It ranges from those that are community based, relying heavily
on a bottom up approach to PHC implementation, to those heavily centralized,
using a top-down administrative approach. The Y-axis indicates a range of
program philosophies, from curative-based care to preventive approaches.

Policy statements adopted by a government agency reflect the
orientations which guide program implementers in their day-to-day or future
actions. Policy statements also reflect what a government is willing to be held
accountable for to its citizens and benefactors. In this research, MOH policy
documents and implementation strategies serve as one measure of the
Ministry's PHC approach, because both the policy and strategy chosen should
reflect the formally articulated PHC belief system of the organization. It should
also be noted that the articulation of policy does not always translate into the
application of policy. Such instances related to primary care will be noted in
this research.
Figure IV-1. Typology of Primary Care Approaches
<table>
<thead>
<tr>
<th>Community Development</th>
<th>Authoritarian</th>
<th>Curative</th>
<th>Preventive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collective decision-making by debate</td>
<td>Centralized authoritarian decision-making</td>
<td>Physicians and nurses dominate</td>
<td>Nurse or CHW dominates</td>
</tr>
<tr>
<td>Cooperation in relationship with public</td>
<td>Domination in relationships with public</td>
<td>Centrally located</td>
<td>Traditionally healers included</td>
</tr>
<tr>
<td>Collective responsibility</td>
<td>Individual responsibility stressed greatly</td>
<td>Clinic based</td>
<td>More remote village outreach</td>
</tr>
<tr>
<td>Program &quot;open&quot; to its environment</td>
<td>Program &quot;closed&quot; to its environment</td>
<td>Emphasis on drug therapy</td>
<td>Primary emphasis on preventive measures: immunization, sanitation, health education, nutrition, simple curative care</td>
</tr>
<tr>
<td>Collective values</td>
<td>Individual values</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health viewed holistically (i.e., integrated in community development activities)</td>
<td>Health care is &quot;delivered&quot;</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Interview data with key decision-makers were also used to supplement policy documents. Questions were asked regarding recollection of the evolution of the Ministry's PHC from the independence period. This is of particular importance for charting a PHC development over time in a setting in which policy documents were not evenly available. Possible indicators for measures within each Quadrant appear in Table IV - 2. Although the list is not exhaustive, it does provide a departure point for exploring these ideas.

The PHC approach represented by Quadrant 1 of Figure IV - 2 espouses the philosophy that health is to be delivered to the consumer through pro-curative care measures relying on the medical profession in a very centralized decision making process. Programs in which decisions and resources filter down from hospital centers to rural clinics which remain curative based. For example, a child with diarrhea in a rural clinic would be given an antibiotic treatment (if available), with no consultation with the mother to explain how she can prevent diarrheal disease in her child. Health decision-makers are expected to be educated strictly as medical doctors.

Quadrant 2 represents an approach whereby PHC programs are curative based yet are primarily administered by the community. For example, USAID has used this approach in organizing its village "health hut" program in Senegal where community members were trained to treat common ailments
primarily through drug therapy (Gray, 1986). Little emphasis was placed on health education. Decision-makers within Quadrant 2 are expected to be trained within the bio-medical tradition, and with some public health background. They have a somewhat “liberal” view of the role of the medical profession in health care delivery, as noted by their “acceptance” of para-professionals in health care delivery.

Quadrant 3 represents the view that health is a right of all individuals and must be viewed holistically. Health can only be improved by promoting better living conditions, by improving water and sanitation practices, good nutrition, and high levels of literacy among other factors, in addition to improved delivery of medical services. The major thrust of this Quadrant is its mandate of community participation in organizing for, implementing and evaluating health care. As this Quadrant is the most grassroots oriented, decision-makers involved in this approach are expected to be community activists, with or without a health education, and to collaborate with PVOs, NGOs or other organizations with similar PHC philosophies. Decision-makers involved are expected to come from a variety of backgrounds such as geography, sociology, anthropology, and public health, to religious affiliation or political activism.

Finally, Quadrant 4 represents organizational approaches and decision-maker belief systems with PHC programs that are preventive-based, yet deliver
health care based on decisions from the top. Currently, this is a common approach of mainstream development organizations as it maintains centralized bureaucratic decision-making processes while implementing preventive-based care (an integral element of the WHO Year 2000 mandate). UNICEF’s GOBI (Growth Monitoring, Oral Rehydration, Breast Feeding and Immunization) program serves as an excellent example of a preventive program whose support is delivered to recipients who have no say in how the program is delivered. Decision-makers involved in this Quadrant are likely to have a public health background.

The MOH’s organizational history was reconstructed to understand the development of primary health care within the MOH to its present state. This was undertaken through an historical analysis of government documents and interviews with the twelve key decision makers within the organization. An identification of relationships among historical events, influence of individual, or other determining factors informed an explanation of important variables that influenced Burundi’s primary care approach.

For the purposes of this study, decision-makers were broadly defined as persons who had direct influence on program design, implementation and policy decision-making. Those included ranged from individuals who were program directors to ministers.
2. Research Question 3: Identify Factors Influencing Decision-Maker's Belief System Achievement

Decision-makers were interviewed to assess a variety of attributes such as educational background, past health program experiences, views on societal organization, and other matters. Once individuals responded to a question regarding their own vision of what a PHC approach should be, they were asked if there were any specific factors in their lives that might have shaped that view. Responses were then categorized to assess the kinds and frequency of factors.

3. Research Question 4: What is the role of MOH decision-makers in policy decision-making?

Policy as a guide in the MOH is a fairly recent development in Burundi's MOH. Thus, the assumption could not be made that all decision-makers were aware of a specific policy process or that they were even involved in policy development. I asked specific interview questions to first understand each individual's perception of the MOH policy development process and whether or not they felt they had influenced policy decisions (See Research Questionnaire in Appendix 1).
4. Research Question 5: What factors promoted or impeded decision-makers’ belief system achievement?

Analysis of the MOH’s approach and decision-makers' belief systems from data gathered in objectives one and two indicated the extent to which the MOH organization approach and beliefs concurred.

Observations and interviews with MOH decision-makers allowed for the reconstruction of the extent to which decision-makers have influenced the Ministry’s approach to PHC. I inquired about the tensions among decision-makers and between decision-maker and organization to understand the reason for, and evolution of, the conflict. The question also allowed me to determine whether tension is a source of innovation.

D. Data Sources

A triangulation of three data sources were used for providing information for this research. Sources included:

1. Structured Interviews
2. Government Policy Documents
3. Documentation of Evolution of Events/Ideas within the MOH
1. Structured Interview

Structured interviews were used to elicit information on three objectives defined in section A of this chapter. Information gathered in the interview included an assessment of:

- Decision-maker's biographical data
- Decision-maker's vision of PHC
- Factors contributing to decision-maker's PHC vision
- Factors contributing to and/or impeding, vision achievement
- Individual's perception of her/his influence in the health policy process
- The historical development of the health system

The structured interview questionnaire is included in Appendix 1. I conducted the interviews in French. The interviews were later translated into English by a professional translator in Dakar, Senegal.

The interview data base for this research comprises 98,316 words. Content analysis was performed using key word analysis with Qualitative Cyberquest, a software package developed by Dr. John Dickey, of the Department of Urban Affairs and Planning at Virginia Tech, for content analysis.
and theory building. Content analysis was broken down into three steps. First, a matrix of responses was employed to pull key responses that were directly related to the research questions. These matrices are presented in Appendix 2. Second, word frequencies were run on the entire data set to assess the most commonly used words (manifest content). Third, from the most commonly used words, nine words that were related to measures of PHC on the typology were analyzed in depth for their overt and possibly hidden (latent content) meaning. This form of analysis allowed me to classify decision-makers in terms of the typology outlined above.

Sample Selection

The sample consisted of twelve key decision-makers within the Ministry of Health. One of the twelve had recently left the Ministry to become Director of a family planning NGO, but remained closely linked to the MOH in her professional duties.

The decision-makers chosen had to have held a leadership position (i.e., program/project/departmental directorship or ministerial advisor, or minister) within the MOH and be available and willing to participate in the study. The latter criterion was of particular significance given that the interviews were carried out shortly after the October 13, 1993 coup d'état during which the first democratically elected Hutu president had been assassinated by the Tutsi-
dominated army. The sampling universe of senior level decision-makers constitutes about 26 persons in the central MOH, if all project directors are included. Therefore, roughly fifty percent of MOH senior decision-makers participated in the study. All individuals who were asked to participate accepted. For some of the MOH staff, the ensuing chaos was a period of “down” time as top decision-makers of the Ministry tried to assess the implications of the crisis. It was during this time that the Hutu rural population blocked the military’s access to the interior and began retaliating by going on rampages and by launching fatal attacks on the rural Tutsi. Organizing for this emergency was an extremely complicated and seemingly impossible challenge given the Ministry of Health’s role in providing health care to the population, and the prevalence of ethnic divisions existing between Tutsi dominated health providers and majority Hutu consumers of care.

The MOH organization chart in Appendix 3 shows the positions of the twelve respondents within the ministerial hierarchy. This is the adopted organizational chart of the MOH, and therefore, reflects the Ministry’s conceptualization of functional roles. As noted in the chart, the Ministry is divided into technical health-care functions on the left (under Direction Generale de la Sante), with the logistical/financial support functions on the right (under Direction Generale de la Logistique Sanitaire). All of the respondents fall under the technical side of the Ministry. Each position included in the
interview sample is marked with a star. Due to the circumstances of the coup d’état, some high level persons were inaccessible. For example, the newly appointed Hutu Minister under the new government was in exile in Rwanda, and therefore could not be interviewed.

Impact of Interview timing

As noted above, the interviews were carried out just after the October 13, 1993 coup d’état when the country was in considerable upheaval. The long-term ramifications of this event, coupled with the assassination of the country’s first democratically elected president, were unknown at the time. In many ways, the timing of the interviews (although not intended) coincided with a dramatic situation which engendered greater respondent reflection on the ramifications of Burundi’s political situation. Also, as noted in the introduction to this chapter, I had worked side by side with the majority of the individuals during the previous two and a half year period and had gained their trust. This likely allowed for more candid reflections that would not have otherwise been possible; especially given the “closed” context of Burundi’s society.

Respondent candor in the interviews is reflected through a willingness to criticize the system in the context of a confidential interview. Under normal circumstances, criticisms of the regime in power are rarely openly discussed because they led to political ostracizing and outright persecution under past
regimes. That I was a foreigner also gave me a bit of detachment (and them a sense of security) which may have helped gain honest responses.

Sample Characteristics of Respondents

Biographical Characteristics

Appendix 4 summarizes the biographical characteristics of the 12 respondents. These characteristics are further broken down in the following sample description.

Burundi is one of the few countries in Africa in which it is considered taboo to ask direct questions about a person’s ethnicity. While this contrasts the norms of other African nations where a person’s ethnicity is stated with pride, it is, nevertheless, understandable considering that ethnicity is directly related to conflict and death. It should be noted that Burundi are very aware of who comes from what background. In the interview, a direct question of ethnic origin was not asked of respondents because it would be culturally insensitive. However, my familiarity with the respondents over time, allowed me to identify their ethnic background. True to the predominating power relationships within the country, Tutsi made up 75% of the sample while Hutu, representing the majority population, made up only 25%.
The age of the sample is relatively young for persons with senior level decision-making capacities within a Ministry. Three quarters of the respondents were between the age of 31 and 40, 17% between 41 and 50, and 8% (one person) between 51 and 60. The young age is not surprising as the sample is reflective of the entire public service of Burundi. As noted in Chapter III, Burundi's history of ethnic conflict in the early 1970's played a major role in wiping out an educated work force that today would be in its late forties to fifties.

Male respondents out numbered female (5:1). This is similar to the male to female ratios of other Ministries within the public service in general. In general Barundi women hold a very low profile in professional or business related careers.

Similar to many health ministries in Africa, all respondents were trained as medical doctors indicating that Burundi's MOH senior level decision-making staff is physician dominated. Of significance, however, is that all of the respondents had either an MPH (50%) or had undertaken short-term public health training either locally or in a foreign country (the other 50%). This is a good indication that Burundi's MOH had begun to understand the role public health could play in addressing the country's health problems.
The breakdown of rural to urban experience among respondents shows fifty-five percent had a broad range of both rural and urban work experience. Thirty-six percent had primarily urban-based experience - defined as working in Bujumbura. Nine percent had come from primarily rural experience, having recently been brought into the central level administration.

Sixty-four percent had carried out the function of Provincial Medical Head at some point in their career while 36% had not. Experience as the Medical Head of a province within a country gives an appreciation of the entire delivery system and the realities facing staff in the field. By viewing a delivery system in its three component parts (center, intermediate and peripheral levels), Provincial Medical Heads were in charge of the intermediate level.

The formal level of decision making within the MOH hierarchy shows how much an individual official is or was potentially able to influence decision-making. Of respondents interviewed, 17% (or two individuals) had previously served as ministers of health. One of these respondents stepped down from his post only two months prior to the interview, and after a five year tenure as minister. Fifty-eight percent were either current members or past members of the Ministerial cabinet, the top collective decision-making body of the Ministry. The remaining twenty-five percent were program directors who were not
implicated at the top level, but were nevertheless involved in certain policy commissions related to their specific domains.

Finally, the sample is broken down by percentage of respondents who had a direct advisory role to the minister. This function is reserved for persons who had either previously held senior positions or recently returned from long-term training and had special skills to offer while waiting for their permanent senior position to open up within the Ministry. An average of five or six persons would serve in this position at any given time. Advisors are often given specific "dossiers" or files to assist the minister in his duties (e.g., investigating health insurance options, or more mundane individual case management matters). Advisors are not cabinet members and therefore cannot vote on program or policy issues that come up within the cabinet. They are included in this study because all had recently held key decision-making positions in the Ministry. Forty-two percent of respondents served in this category either in the past or present while the remaining fifty-eight percent held specific directorship positions.

To summarize, the sample was made up of fairly young (31-40), predominately male doctors with some public health training. Additionally, the majority of interviewers had "come up" through the system by working in rural and regional posts prior to beginning their work at the health center. All were
involved in ministerial level policy design or decision-making in either present
or past positions.

**Respondent Profiles**

The following section presents a brief profile of the respondents. The
intention is not only to include biographical data obtained in the interviews, but
to give a glimpse of each individual's character. The latter is based on the rich
experience I had collaborating with each individual over a two and a half year
period. Some of the profiles are more extensive than others, reflecting an in-
depth knowledge and insights gained through friendships. The profiles also
reveal the cultural environment in which the individuals lived, worked or studied,
which should assist the reader in further understanding the Burundi context. In
addition to these profiles, Appendix 5 provides a vignette of what a typical day
for respondents might entail in order to portray the environment in which they
lived and worked. All names in this research are pseudonyms to ensure
confidentiality and anonymity. Profiles are offered in no particular order.

**Allen**

Allen was a highly respected individual within the Ministry of Health due
to his seriousness, fairness and dedication. Under the one party system of
UPRONA, Allen was one of the few Hutu who held a position of leadership and
proved very influential in convincing rural Hutu populations of the need for their
participation in certain government goals. Moreover, he was often called upon
to smooth over conflicts between Tutsi dominated local government
administrators and the Hutu majority local population. Essentially, he had
earned the trust of the local population not only because he was a Hutu, but,
because of his fairness in dealing with issues at hand. He was a fairly small
man with a quiet strength and self confidence that was evident every time he
spoke.

Like many of those interviewed, Allen held a medical degree from the
University of Burundi. After graduating from medical school, he was posted in a
rural hospital as head of Internal Medicine. One of his main functions was to
perform surgery and he hoped to specialize in that field. During this period he
participated in several short-term training programs in public health. One
specific training in community health held in Lome, Togo, played a major
influence in developing an interest and reorienting his path to a public health
career. He later undertook his MPH in France, and began to focus on the
control and prevention of AIDS, a disease whose ramifications were only just
becoming known in Burundi. Upon his return from France and up until the time
of this research, he served as the Director of the Office for the Prevention and
Control of AIDS and STDs (PNLS- French acronym). As a strongly respected
individual among both the Hutu and Tutsi populations within the community,
Allen was very instrumental in getting the conservative government finally to
recognize and take steps to address one of the highest HIV prevalence rates in Africa.

At the time of this research, Allen was one of the most published staff members within the Ministry of Health due to his research contributions and presentations on HIV/AIDS in Burundi at a variety of international conferences. As Director of PNLS, he operated somewhat autonomously and was sometimes criticized for this. Allen was convinced that AIDS was an extremely serious problem to be addressed and his program actions could not always wait for the full blessings of the Ministry's heavy bureaucratic structure. Moreover, unlike most programs within the Ministry, PNLS had significant control over much of its own resources which came from a variety of donors willing to support AIDS programming.

At the time of the interview Allen was playing a key leadership role in the Ministry's "Emergency Team" to coordinate relief and health care efforts during the crisis. In addition to this and his role as director of PNLS, he also was a short-term consultant to UNICEF where he formulated the National AIDS Policy and elaborated a protocol to study AIDS among teenagers between 10 and 19 years of age.
Interestingly, the problem of ethnicity prevailed even among the most respected Hutu. I later learned that as the regime crisis continued into 1994, even Allen feared for his safety and left the country for several months.

Jane

I remember meeting Jane for the first time when she was the Provincial Medical Head. I had long heard tales of a dynamic “power house” Provincial head who also happened to be the only female in this leadership position. My recollection is arriving at her office in the Provincial capital just before she did. As I waited outside, tall Tutsi women strolled by carrying clay pots of water upon their heads, babies on their backs, draped in their flowing ankle-length traditional garb. Within minutes, a short attractive woman wearing tinted aviator glasses, a leather jacket and khaki trousers arrived rapidly, and was conversing with two male nurses in white laboratory coats. This was Jane. The contrast between the women was striking. Even in urban Bujumbura, this kind of “western look” on a woman was rare.

Only in her early thirties, Jane’s reputation as a dynamo was well deserved. In contrast to the poised and reserved outward temperament of most Barundi, Jane’s ideas and her mouth were in a constant race to see which would win over the other. Her strong ideas erupted from her as soon as
they entered her mind, producing very animated and candid responses. Needless to say, the translation of her tapes proved very challenging.

At the very young age of five, she was sent by her family to live with Catholic sisters in a rural monastery because as a child, in Jane’s words, one could not be “brought up well in an urban environment...especially if you were a girl.” Her early life was full of study and prayer.

Her decision to pursue medicine came not from the love of it, but more from external societal pressures. She adored biology, but realized that to continue on, she would have to study outside of Burundi. This could never happen, because her parents feared she would never return. Moreover, it was well known that when it came time to grade exams at the University, the Faculty of Medicine was one of the few schools where merit, not ethnicity, determined one’s success. Each exam was graded anonymously. Jane decided she could not participate in the Faculty of Science, because it was a system which perpetuated her own society’s injustices. This proved the final push for Jane to pursue her career in medicine.

Jane’s initial introduction to public health came in medical school. Her education in curative medicine did not prepare her for the realities of the field. Public health in the Burundi medical school was taught by expatriate clinical
doctors who had neither the appreciation nor the understanding of what the
discipline was all about. It was later through short-term training programs both
inside and outside of Burundi, that Jane began to appreciate a community-
health approach.

Her first posting was in Pediatrics at what is considered “the people’s”
hospital, which provides curative care to those with little means. For someone
who was raised in an environment based on merit and charity, this first posting
proved an eye-opening experience. It had a major impact on understanding the
“delivery” of health care out of the classroom. She sighted the frustrations of
losing children to dehydration during measles epidemics, just after they were
beginning to improve. She found that the mothers would bring traditional
products in the night to give their children enemas, therefore inducing
dehydration. Realizing the major challenge before her, Jane was further struck
by how alone she was in her concern. The health personnel she worked with
had neither a sense of unity nor an interest in trying to educate the mothers.

At the time of her interview, Jane was posted as the Director of the Blood
Transfusion Center. With the prevalence of AIDS in Burundi and strong taboos
against giving blood, this position was providing Jane with another major
challenge.
Ned

Ned was a large, soft-spoken, yet talkative man in his late thirties. I initially met him outside of Burundi, while he was in Dakar, Senegal working on his MPH. I was in Dakar on some other business, but looked him up as I heard he would soon return. This initial contact seemed to facilitate a trusting relationship upon his return to Burundi.

While all of the persons interviewed are a part of Burundi’s intellectual elite, my conversations with Ned made me feel as if his thought process was working on a level with a vision a bit different and, perhaps, even beyond everyone else. I remember him sharing his initial frustrations with me upon his return. He had not been automatically included in the “inner circle” of decision-making in the Ministry. He felt he had much to contribute yet he was given only an advisory position while waiting for a cabinet post to open up. Shortly after his return, the cabinet was dealing with financing Burundi’s health sector, an area in which Ned had undertaken his masters degree research. Among cabinet members, there was no one who had any health financing expertise. Ned refused to share his research until he was assured a key position within the Ministry. Under an authoritarian regime, such antics or political positioning are rarely evident. Staff members generally feel that when the message for a posting comes from above, it is accepted with no questions asked. In Ned’s case, he was highly respected for his knowledge and contributions, but, there
were always latent undertones concerning his level of cooperation with the group.

Ned took his job as a doctor and health administrator very seriously. Raised in part by a grandmother who was a traditional healer, he perceived a career in health as a vocation. He undertook his training at the University of Burundi where he was part of the first graduating class of thirteen medical doctors. He then spent several of his initial years of service in rural hospitals.

Ned held himself to very high standards. He told me that during his years of medical school, he followed the established curriculum, but secretly went further by establishing his “own program” to prepare himself for any emergency he might face. He made extensive notebooks on different surgical actions to be mastered, many of them life-saving procedures. Basically, this typifies Ned’s character: he searches for excellence beyond what he finds in his own environment. Yet his feelings of superiority which this projected sometimes put his peers off.

At the time of the interview, Ned was in the very senior position of Director General of the Ministry. Since he was somewhat older than his colleagues, he had held a variety of directorship positions throughout his
career and willingly shared much insight on his vision of the evolution of the Ministry.

John

I had worked with John for over a two year period before I interviewed him for this research. Strangely enough, it was the interview that gave me my first look at who this man was and what he believed in. It altered my entire perception of him.

John was head of one of the Ministry’s most significant programs, family planning. Since the nation had one of Africa’s highest fertility rates and was one of its most densely populated countries, Burundi’s family planning program was a key priority of both government and donors. With such an important profile, one would expect a very dynamic communicator at the program’s helm. John, however, was extremely shy and unassuming about this responsibility, and sometimes appeared ill at ease discussing his job. He was severely crossed-eyed and this made me wonder if he was actually looking at or addressing me, or, perhaps someone else.

John did his medical training in Burundi yet never pursued a masters in public health. He did participate, however, in several international public health
conferences and short-term training programs in family planning, epidemiology, and management, among others.

He was most marked by an experience early on in his career as a government medical doctor when he was assigned to a Catholic diocese, community health care clinic, and hospital in the heart of Burundi. It was there, in a non-governmental setting, where John realized for the first time what true out-reach and community participation could be in health care delivery. He carried this orientation to other positions later in his career.

John served in a variety of posts with supervisory capacities for rural provinces, including provincial medical head. Due to his interest in family planning, he was later brought in to run the family planning program when Norton, the past program director, was named Minister of Health.

While known for being a bit authoritarian within his own program, John operated cautiously. Compared to some of the other individuals cited in this study (who led their programs with more risk taking and autonomy), John was very careful when making decisions, and most often chose to defer to the "higher authorities" on many matters. Family planning was a highly sensitive issue in a Catholic-dominated country where it was rumored that the ruling ethnic minority was hoping to limit the births of the majority. However, I often
wondered if his caution was based on the fact that his predecessor was now
the Minister who held a strong personal interest in John's program.

The interview for this research showed me a completely different side of
John. I found a person full of ideas which in our work setting, I had no inkling
that he had even considered. He expressed a strong vision of how things
should be, had a good sense of humor, and a candor and ability to be critical of
past and present conditions within his Ministry.

Martine

When I first met Martine she was Assistant Director of the Family
Planning Program. I found her to be an extremely serious, but willing
collaborator in work. However, I sensed she was constrained in her decision-
making power, as everything depended upon the Director. Martine exhibits a
typical Barundi female character: extremely stoic and polite, yet warm if real
alliances are formed over time.

Martine did her medical training in Burundi and did not have an
opportunity to do an MPH. She had, however, participated in many international
conferences and short-term training programs in family planning. One
program included a stay in India that had a major impact on widening her
vision of what was actually possible in a family planning program.
Since finishing her medical degree, her entire career has focused on obstetrics and gynecology in one form or another. She spent four years in obstetrics at the low-income hospital of Bujumbura. However, one of the experiences that had the most profound effect on her was when she worked as a consultation doctor and later as Director of the urban community-health center next to the hospital. As a female working in reproductive health, Martine found herself immersed in the importance of establishing good communication links with both the patients she served and with the support staff who continued to appall her with their lack of knowledge of the basics of care. She later directed the Sexually Transmitted Disease (STD) unit of the HIV/AIDS and STD Control and Prevention Program.

At the time of the interview, Martine was directing the newly formed IPPF (International Planned Parenthood Federation) affiliate, ABBUBEF (in English, the Barundi Association for Family Well Being) which served as the first family planning NGO in Burundi.\footnote{Even the name Association for Family Well Being indicates the level of uneasiness that the word family planning created in the Burundi context. Everyone knew it was a family planning association, however, decision-makers felt that Barundi society was not ready to deal with family planning so openly.} She and I had worked closely to define the new program’s goals and objectives and to develop a proposal for funding. While my previous experience with her showed that she was an extremely capable person, as director of her own NGO, I found she had gained her “own wings” to some extent, although she still had a government appointed-body as her
advisory board. All the same, Martine was able to reflect on the role of the MOH in the delivery of health in a way she previously was unable. For someone who was characteristically "politically correct" in her staff position in the MOH, her new autonomy allowed for a critical analysis that would not have been possible otherwise.

Chin

Among all of the people included in this study, I had the least contact with Chin. He was tall and in his early thirties. Like many of his colleagues, he received his medical degree from the University of Burundi. He later did an MPH at Tulane University in New Orleans, USA, and participated in a variety of public health related short-term training programs, ranging from disaster management to epidemiology. His MPH training at Tulane exposed him to people from all over the world and had allowed him to exchange ideas about the organization of primary health care.

Although Chin had extensive training in public health, his career in the Ministry focused on curative matters. He served several years as a hospital director in rural provinces. At the time of the interview he was in his third year

\footnote{Although the MOH policy document states the desire to create and support health related NGOs, the "arm of the state" (Midgley, 1988) was ever present in NGO advisory boards. It was often not clear where state influence ended and NGO autonomy began.}
as Director of Health Care where he organized curative care in hospitals and health centers and allocated personnel in the field based on population need.

My knowledge of Chin is based on one excursion where we visited an NGO health center in one of the low-income areas of Bujumbura. The center was unique because it offered both traditional and bio-medical approaches to medicine. It was an interesting set-up whereby those seeking the bio-medical approach would go to one side, while those seeking traditional treatment entered on the other side. I found Chin extremely candid. He acted in a comfortable, non-formal manner with the Catholic nun showing us the center, rather than exhibiting the typical "government official" approach. He seemed genuinely interested in the kind of alternative services offered.

During the interview for this research, I was impressed with the ease in which he articulated his knowledge and understanding of the Ministry's delivery system. He was also very forthright in his responses about political and ethnic conflicts.

Lawrence

Because I came from a donor organization, short trips to the provinces were usually not enough to overcome any preconceived ideas or biases about
foreign consultants. Lawrence, however, was one of the few provincial medical heads with whom I had the opportunity to become close friends.

During my time in the field Lawrence was one of the few provincial heads recognized for initiatives beyond those of his peers. In my last year with USAID, Lawrence was starting to be included in some of the Ministry’s two and three day retreats, far from Bujumbura, near the Tanzanian border. These retreats studied the implications of the Bamako Initiative which was being implemented as a pilot project. A few select technical assistants from the donor community were also invited to participate in these retreats. I was among them, and found that these were wonderful occasions for exchanging ideas. But when work was over, strong bonds were formed over lengthy informal exchanges on the health sector, Burundi’s politics (to a certain degree), or whatever subject was of interest. As the only female invited to the retreat, I often found myself surrounded by my male counterparts. We would get into animated discussions and drink bottles of warm beer (electricity was poor in the rural areas). In these settings, I learned a lot about the Barundi people as well as the informants that I interviewed.

It was also at these retreats that the role of ethnicity became more apparent. I was told that if you were ever invited to a Barundi wedding, you would be sure to know who was from which ethnic group. The two groups
rarely mix in these social situations. Tutsi eat and drink with Tutsi and Hutu eat and drink with Hutu. At the retreats, when the real drinking began, the separation was evident. This is how I came to know Lawrence and, for the first time, began to have an understanding of the real impact of ethnic genocide on an individual and on the country.

Lawrence was an extremely tall and handsome man. Because of his height and facial qualities, I assumed he was a Tutsi. Moreover, due to his good looks and reserved demeanor, I also assumed he was part of the elite class. At one of the retreats, I found Lawrence during the dinner hour eating by himself. I assumed because he was the only provincial level staff person there he felt he couldn’t really mix with those higher up than he. I sat at his table to get to know someone I knew less than the others. I was also interested in his epidemiological studies to understand the health status of his province. No other Provincial Medical Head had taken such steps.

Although we had met on several occasions before, this was the first in-depth conversation we had. Somehow the conversation shifted to his past, and how he became involved in medicine. The story which followed shaped my own perception. Lawrence spoke in a very quiet voice to ensure that he was not overheard as he recounted the following.
His tale began in 1972, a year well known part in Burundi’s history.

Fearing a Hutu uprising, the Tutsi government and army began an ethnic cleansing whereby Hutu in leadership positions were called by radio announcements to come to meetings at the stadiums in Bujumbura and the provincial capitals of their respective places of residence. Under an authoritarian regime, you obey without questioning. Upon arrival, all were shot by military firing squads. As word spread and anxieties increased, the military moved throughout the hillsides, and killed as many Hutu male school age children as possible, from around nine years of age on up. In other words, the intention was to eliminate an educated Hutu class that could threaten the future of the Tutsis. Lawrence was hidden while all of the sons on his hillside were killed. For several years he stayed at home, rather than returning to school where he would be found out. One day, the teacher of his small rural school came to his father to ask him why his son was not attending. His father feared for his son’s life if he were to return to school. Fortunately, the teacher was an understanding person and assured Lawrence’s safety at school. The teacher soon recognized Lawrence’s abilities and encouraged him to pursue a university education. At this point, Lawrence chose medicine in the belief that he might find himself a refugee at some point in his life. Being a doctor would ensure him employment wherever he ended up. Little did we know at the time of this conversation in 1992, that in 1995 he would have to flee to Zaire.
At the time of the interview, Lawrence was second in command at the Ministry. He also feared for his life. Due to the coup d'etat attempt and his new high level appointment, he felt extremely threatened and unsafe. A colleague of mine from the Centers for Disease Control and I kept Lawrence and his family in hiding, until the exact severity of the crisis became clear. Life was once again stressful. However, as a person with strong religious convictions, Lawrence felt that God had gotten him this far in life under adverse circumstances and he would somehow be provided for again. Lawrence is now living in exile in Belgium with his family.

Inn

Inn was a person I did not know well, even though we collaborated on several projects. Like many of his peers, he did his medical training at the University of Burundi, as part of the second group of medical degree graduates. Although he did not have an MPH, he was well traveled through participation in several public health training programs and conferences in Brussels, the US and Holland. He also participated in many of the primary care management and epidemiology short-term training programs offered within Burundi. He had extensive field experience as provincial medical head and director of a community health center in a rural area.

\[^3\] Just after the coup d'etat many foreigners, particularly in the American community took Hutu colleagues and friends into their homes in secrecy. Buyoya, the past president and his family, took refuge in the American Embassy.
Inn seemed more Westernized than many of his colleagues and also had a bit of an entrepreneurial spirit. He had worked as a private consultant for a few World Bank missions. With this experience and evidence that donors were willing to finance many studies in Burundi -- particularly those related to the impact of population growth -- Inn formed a small research consulting group to provide the expertise. All of the individuals were full-time staff members of either the University or other public service ministries.

During the time of the interview he was wearing several “hats.” He was Assistant Director of Hygiene in the Ministry, which provided the umbrella for all prevention and health education efforts. He also was the Project Director for an extremely innovative Dutch financed pilot project whose goal was to improve prevention through community health education with community groups. He also carried the lead role in his consulting firm, searching out prospective contracts and implementing studies among the donor community. There were frequent trips to Holland to deal with the home project office.

I found it interesting that given that he was in charge of the most innovative community oriented project of the MOH, he spoke differently about the political structures and their impact on the population. As he put it, being Hutu or Tutsi made no difference to a farmer. It was “we intellectuals who make an issue of it.” He also posited that the crisis would be over as soon as
it started. I am not quite sure where this vision came from; whether it was
denial by an elite Tutsi of the real situation facing his country or some other
factor.

Norton

I knew Norton as Minister of Health, a position he held for five years.
Obviously, access to the minister was limited, but, I made official calls on him
throughout my stay. I actually met him informally the first time, as I was looking
for a house to rent and the realtor showed us his newly constructed house.
Unfortunately, it bordered the president’s residence and military guards were
continually peering over the fence during our visit. In a country known for a
series of coup d’etats, it did not seem like the safest place to make a home for
my family.

Norton was extremely quiet and soft spoken. In a formal meeting, he
had a comportment of politeness and official protocol. His aides would slip
quietly in and out bringing papers or whispering messages in his ear. You
never could tell what he was really thinking. Moreover, he spoke so quietly, that
the USAID mission director (who was a fluent French speaker) and I would
spend the ride back to the office discussing whether we both understood the
same thing. However, Norton always reiterated government-stated priorities
and positions.
It was evident that Norton was highly respected among his staff and as a government cabinet member. He was a strong party member under UPRONA during the time of the one party system. Although he was a Hutu, he stayed loyal to the party after the first democratic elections, and became a Parliamentarian, representing UPRONA when he stepped down as minister in June of 1993. Norton was known as being fair and knowledgeable about the needs of the Ministry.

When I interviewed him during the crisis, he was at home, and very willingly participated in the study. I found him taking care of his three-year-old son while his wife was off at work. The boy played at our feet as Norton reflected and provided perceptive responses to the questions I asked. He was much less formal at home than at work and pleased to be asked to contribute to the study and have the opportunity to reflect on his five years as minister. At the end of the interview he asked how the other interviews had been. I told him that members of his staff recognized the key role he played in shaping the progress of Burundi’s primary care approach. He seemed pleased, but remained true to character, very humble, and gave his staff much of the credit.

David

David was the person with whom I had the most contact in the Ministry. He served as the point person for initiating donor activities. In his mid-thirties,
he had graduated from medical school at the University of Burundi, and was chosen by Norton to do an MPH at Emory University in Atlanta. Upon his return, he was named head of the newly formed Office of Planning and Supervision within the Ministry. As a person with an extremely dynamic personality, David began to build in a certain degree of planning functions in the Ministry, where few had previously existed. The Ministry's organization chart depicts the Office of Planning and Inspection at the same level as the Office for Management and Training of Personnel. Aside from the Minister himself, David was clearly “running the show” at the Ministry.

When a project or program had David's blessing, the ability to move forward quickly would be clear. A program without David’s blessing would be blocked eternally. Although he was stubborn, I found that he would accept new ideas in a matter of time.

David was extremely dedicated, as was most of the Ministry senior staff. It was quite usual to find him in his office well into the night. David managed the Ministry with a fairly authoritarian style that was not always appreciated by several people beneath him. His demeanor was not atypical of public servants. However, it was in direct contrast to promoting ideals of decentralization and increased communication. He set high standards for
himself, and expected others to do the same. He could be very personable, if your own credibility was established.

What I admired most in David was his strong independence and ability to say no to a donor when specific protocols were not respected, or if the donor projects clearly did not coincide or support the Ministry’s goals and objectives. Everyone was amused when he gave the World Bank an extremely hard time as they pushed their own agenda. David was willing to refuse funding rather than compromise the directions which he felt could provide the needed foundations for the Ministry.

My image of him to this day is working in his office. It is cluttered with piles of files to be addressed. He is sitting at his desk deep in conversation concerning Ministry business and pressing his fist into his right side with a chronic pain that was probably due to an ulcer.

**Bizi**

The best way to describe Bizi is someone from the “old school” whose position was based on links to those in power rather than for knowledge level and capabilities. As an ex-Minister of Health, his own days of power and control had passed on to a younger and more skilled generation. My major contact with Bizi was in his role as Project Director for the Ministry’s Expanded
Immunization Program (EPI). The program was a star performer in the Ministry, and produced some of the highest vaccine coverage rates among all sub-Saharan vaccination programs. This was based on years of training providers at the local level, and mobilizing communities to vaccinate their children. The actual management of the program's finances and material resources in recent years, however, was in a shambles. Bizi would come to meetings with his accountant and assistant, and be full of surprise and chastise his subordinates when answers to certain issues were not forthcoming. Unfortunately, he was unaware that this reflected badly on himself. The Ministry was well aware of the situation, and eventually placed him in an "advisory" position to the minister.

At the time of the interview, he was advising on "administrative services" in an office far removed from the mainstream Ministry. He made a bit of a fuss about being recorded, and he swore to me he had never let anyone record his voice before. All of this was to show his importance and that he was doing me a great favor. His responses were quite enlightening because he was one of the few individuals with the institutional memory of what health service delivery was like during the previous 30 years. Moreover, his own life history was of a different era than the majority of those in the study and therefore reflected a unique perspective.
Mark

Mark was another of the more "senior" members of the Ministry's staff. He was in his fifties, and had undertaken his medical degree in what was then Czechoslovakia. He later did an MPH in Belgium and returned to hold key positions at many levels of the system. When I first arrived in Burundi, he was General Director of Health for the Ministry; one of the most senior positions.

Mark was very personable and a bit less formal than many of his colleagues. Although very busy in his days as General Director, he was always willing to take the time to deal with whatever issue anyone brought to him. His years of experience at every level of the Ministry's delivery system were quite evident when you conversed with him, for he was very knowledgeable of the realities faced in the countryside as well as in the urban context. In this sense, he seemed much more seasoned than many of the young cadre who were holding high level positions after only a few years in the field.

At the time of the interview, Mark no longer held his post as General Director. He had been named as an advisor to the Minister but, I somehow felt that he too was being moved aside for the younger, more recently trained individuals. If business furniture is any indication of power, his run-down office suggested he held little power. The broken desk in his office was a contrast to
his previous office where he had a “salon” to discuss business with important individuals.

With his extensive experience in the health system since the 1960s, Mark was able share a lot of insight into the history of the development of primary care in the country.

2. Government Policy Documents

The second data source used in this research was government policy documents. These included the following:

- **Health Sector Policy 1988-1993**
- **Health Sector Policy 1993-97 (draft)**
- **Sixth Five Year Socio-Sanitary Health Development Plan (1993-97)**
- **Why a Directive National Health Plan for Burundi?**

The informational objectives from government documents were as follows:

- Identify the present and future formal policy orientations of the MOH;
• Along with the historical perspective of the health system gathered through structured interviews, trace the evolution of the health system over at least the past 15 years.

• Combined with information gathered from the interviews, identify particular policy objectives that were less successfully implemented.

3. Documentation of Evolution of Events/Ideas within the MOH

The third data source consists of a series of notes written by me and/or my colleagues during my work with the MOH over a two year period (1991-1993) in the capacity of managing USAID Burundi’s Health Portfolio. The notes deal with a variety of policy reform-related subjects with which the Ministry was grappling at the time, including national health insurance, decentralization, and others. The notes are reflective on the process of developing and/or integrating new policy directions. Essentially, they document the processes that were going on at that given time, and complement or reinforce the information gathered from the two previous data sources.

E. Summary

With the view of primary health care as the outcome of social action, this research does not take a rational policy approach to PHC. Burundi’s history of ethnic conflict and genocide created an environment in which government processes were moving towards a Western policy orientation. However, other
societal forces prevailed. The research methods used in this study incorporate a variety of information sources to reconstruct influential factors in the development of Burundi's primary care approach. The study's focus is on the interaction among Ministry of Health decision-makers, the Ministry's primary care approach and intervening mechanisms. It is guided by five research questions that describe and classify the evolution of the Ministry's PHC approach and the PHC belief systems of its key decision-makers. From there, the study seeks to understand the factors that have influenced decision-makers' vision of PHC. Whether or not the decision-makers had a role in the Ministry's approach is then established, since decision-makers' influence in MOH policy is critical to this study. Factors promoting or impeding decision-makers' achievement of their belief systems are then assessed.

To undertake this research, triangulation of a variety data sources was necessary. The study relies primarily on interviews with key decision-makers in the Ministry of Health and Ministry of Health policy documents. Field notes from two and a half years of participant observation while working with Ministry of Health staff were also used. One potential contribution of this study lies in the assessment of life history factors that influence an individual's belief system or vision of a given phenomenon, in this case primary health care. Triangulation of the data sources also allowed me to identify and compare
individuals' visions, factors that promoted or impeded the achievement of their vision, and the development of Burundi's primary care system over time.

This analysis provides critical information for understanding the gaps between what decision-makers believe about PHC and the practice of the organization in which they work; the Ministry of Health. Like many countries in Africa, Burundi's MOH and government are in a state of transition. Understanding the interaction between the micro (decision-maker) and the macro (institutional/structural) factors gives a clearer picture of the development of primary care.
V. Analysis of the Evolution of Primary Health Care in Burundi

Understanding the history of a given Ministry requires the use of a variety of inquiry methods. In Burundi, ten- and fifteen-year old policy documents are rare because sector-related policies are only beginning to play a role in orienting public services. If such documents exist, a lack of a record filing system or information control precludes access to them. I have visited many over-stuffed health ministry archives where documents are covered with mold and dust, and strewn about haphazardly. In a country plagued by a series of coup d'etats, maintaining evidence of the past was not a priority.

Complementary methods of inquiry to reconstruct the evolution of primary health-care in Burundi were required. Finding someone with an "institutional memory" of the health-care system can be quite helpful. In Burundi's case, ethnic conflict and a relatively short life expectancy (38 years for males) put the majority of interview respondents in their thirties. Nevertheless, several respondents provided a broader view of the evolution of Burundi's health system. In addition, the Health Sector Policy document for 1988-1993 carefully described the delivery system of the early 1980s.
This chapter summarizes the history of the Ministry of Health delivery system during three distinct time periods. The first two periods, (A) 1960s-1979 and (B) 1980-1987, rely on data gathered from respondent recollections of how the delivery system was organized in the past. Part (C), the period from 1988-1993 relies primarily on two data sources: interviews with decision-makers and the Ministry of Health’s policy document for that period. The discussion of 1988-1993 is divided into these respective sections since the policy document provides the stated intention of the Ministry, while the interview content reflects both policy intentions versus day-to-day reality. In addition, my own two and a half year experience of working with the Ministry provides insight into policy evolution.

A. 1960s-1979

Health care from 1960 to 1979 emphasized curative services. A highly centralized and authoritarian government system delivered care. Catholic missions during the colonial period served as the model for health care delivery. This entailed curative-based vertical programs administered primarily in hospitals and free of charge. Dispensaries were also a part of this system but, more often than not, lacked drugs to cure diseases. Therefore, the population sought care in hospitals. As one respondent noted, “Doctors were thought of as people who were supposed to cure, not tell people how to avoid disease.” Existing health centers were designed with two rooms for curative
visits. When preventive programs to control epidemics such as typhus and smallpox occurred, they were delivered in the open air. Evidence of the importance of prevention did not occur until the early 1980s when health centers were designed with a room for prevention activities.

The administration of services took place at two levels: the center and the periphery. Central level teams were sent out to cover the entire country with their programs. Personnel were extremely limited and therefore concentrated in hospitals. Staff shortages were further compounded by the fact that medical doctors were trained in a clinical setting in Europe and were ill prepared for the health problems of Burundi. In addition, the delivery system was poorly managed by urban doctors put in administrative positions with no previous administration or field experience. The end result was unsatisfactorily delivered services due to a lack of adequate numbers of trained personnel, poor supervision of care in the periphery health centers and an extremely limited supply of drugs. Such a system had little to offer the population compared to the popular and culturally appropriate traditional medicine practiced by local healers.

In 1978 Burundi sent a delegation to the WHO Alma Ata conference and signed the Health For All declaration. As in many African nations, concrete
actions towards implementing a primary care strategy did not occur until the early 1980s.

It is worth noting that Ministry personnel were dominated almost entirely by the Tutsi, because the Belgians gave them educational opportunities during colonial times. The most significant event during the 1960-1978 period to have a major impact on the health sector (as well as all social, political and economic life) was the civil unrest of 1972. As Chapter III on Burundi’s history explained, the perceived threat of a Hutu uprising set the stage for the massacre of over 400,000 Hutu, and targeted the educated and young school-age Hutu of the country. With the continued domination of the Hutu majority by the Tutsi minority, the memory of this event perpetuated mistrust and hate among both populations. In the health sector, this had multiple implications for Burundi’s future organization of a primary care delivery system and provider/client relations for years to come.

B. 1980-1987

With the signing of Alma Ata and a stated worldwide commitment to primary care, much of donor assistance, particularly American, emphasized primary care. In the early 1980s Burundi became a recipient of US Government assistance to Africa through its Child Survival Program, a selective primary care approach focused on an Expanded Program for Immunization (EPI). EPI
marked the first major effort at disease prevention. Because a successful vaccination program requires education, communication and direct contact with the population, the program tried a decentralized approach to provide greater access to services. Hence, the Ministry awakened to not only the need for a greater number of health centers, but also to a delivery system that would allow the central level to supply materials and deliver services more easily to the periphery where 94% of the population resided.

Mobilizing the masses to immunize their children was fairly easy in a country in which authoritarian government leaders speak, the people obey. Barundi know full well that dissidence carries serious repercussions. The Ministry did, however, have to convince skeptical mothers about the merits of immunization after their children were taken with fever-related side effects. But, the ravages of childhood preventable diseases were well known to the people. It was a common saying in Kirundi, “Don’t count your children until measles has passed.” By 1987, Burundi had one of the highest vaccine coverage rates in Africa. EPI, a well funded, strongly vertical program, became the backbone of the Ministry’s prevention efforts. It continues to hold that role to this day.

Decentralization efforts during this 1980-1987 period were purely administrative. The country was divided into five medical regions which entailed regrouping three or four provinces. This division represented a new
intermediate level created to assist in overseeing central level programs which
were previously administered directly to the periphery. The exact role of the
medical regions was not clearly thought out and was more or less determined
by the needs of the EPI program in moving supplies and setting up the cold
chain (for constant refrigeration of vaccines).

Health centers were designed with a room devoted exclusively to
prevention activities, which at this point revolved around vaccination
administrations. The concept of health education was only just beginning, and
few efforts were expended other than informing mothers about vaccination.

Family planning became the second prevention focus of the Ministry’s
program in 1985. With arable land already a scarce resource and, a total
fertility rate of seven plus children per woman, it became increasingly clear to
some government officials that Burundi could not sustain more people. While
EPI met with much success, family planning became embroiled in social and
political controversy. As a predominately Roman Catholic population, the
Church played a strong role in the lives of Barundi.¹ But perhaps even more
startling was the prevailing idea that family planning was another strategy for
the government to reduce the numbers of the Hutu majority. Comments of one

¹In 1990 Pope John Paul II visited Burundi. Given the impact of demographic growth and
AIDS on the country, government officials and donors alike feared he would make strong
proclamations against the use of contraceptives. The Pope may have been well advised
on the polemic because the subject was not mentioned during his visit.
respondent who did his doctoral thesis in 1982 on family planning well illustrate the tensions surrounding the matter:

I had to do my thesis in secret and keep the Minister uninformed because family planning was forbidden at that time in the country. But, since the Minister understood the need for public health, he managed to introduce a family planning component at the Community Health Center, but he did not want people to talk about it to avoid problems. So when I told him that I wanted to write a paper on family planning he said to me: 'Listen, I do not want to have any trouble because many people will read your paper and chances are I will have trouble with the government.' I said to him: Listen, let me go ahead and write the paper. If there is any trouble about it we will explain because I do not see anything wrong with writing this paper.' But, some time later, the party UPRONA which was in power got together and decided that considering the demographic increase which had an impact on the economic and health development of the country, it was necessary to control births and they issued a declaration asking the government to apply this policy. The minister was very happy saying that we will be the first ones to write a paper relating to family planning.²

²Comment relates to response to interview question regarding the evolution of Burundi's primary care approach.
The above statement strongly illustrates how policy research and initiatives are influenced by political climate and a country's contextual factors. On an individual level, taking the risk of undertaking or disclosing such a controversial research agenda could mean the end of an individual’s career, or even life.

Community participation per se was rarely considered during this period. If it was brought up at all, it had to be couched in terms of the community using the health center, or, of mothers bringing their babies and children to participate in the vaccination program. Obviously, the underlying tensions between Hutu and Tutsi always preoccupied the government. Notably, in 1987 most of the Catholic Missions and other NGO-run health centers were shut down and their organizers expelled from the country. The Bagaza regime in power became increasingly threatened by a perceived mobilization of the masses, thought to be instigated by these non-government related leaders working at the grassroots level. By 1988, with an extremely limited private or NGO affiliated health sector, the Ministry’s delivery system provided the only major health care resource other than traditional healers.

C. 1988-1993

As noted earlier, the presentation of the 1988-1993 era is divided into two related subsections. The first presents the history of this time period
based on descriptions from the interviews. The second analyzes the specific policy focus of the Ministry by summarizing the Ministry’s five-year plan policy document. The 1988-1993 period is of central importance to this study as it is the basis of an in-depth view of the inter-relationship between the perceptions of individuals interviewed and the specific actions that were taken by the Ministry.

1. Interview Findings: Reconstructing Institutional History

The focus of the MOH shifted in 1988. Until then, military doctors with clinical backgrounds had dominated the top leadership position of the Ministry. With Pierre Buyoya as president, Norton was the first Minister of Health appointed who had a public health background. Norton’s vision of public health and his related actions gave a major impetus for moving the Ministry’s primary care approach forward.

The significance of this change is reflected in the following statements by Norton. They show how politics and power are intertwined with the promotion of a disease prevention/health promotion approach:

The policy at the Ministry then [prior to 1988], was not to train people in public health. Since the Minister was not trained in public health, he feared that if he sent people for training in public
health, one of them might be nominated in his place upon return. He was afraid to lose his seat. So he blocked people telling them
to go out and study surgery, gynecology, and other specialties.
But, I had a different approach because I was trained in public
health.

Realizing that the only way to have a long-term impact on Burundi’s
health status was through health promotion and a strong disease prevention
program, Norton set his initial sights on creating a public health team at the
center. Understanding the need to be “speaking the same language: public
health,” one of the first actions Norton took was gradually to replace his central
team of urban physicians with provincial medical heads who were first sent out
of the country for public health training. Norton noted that, “Since I was trained
in public health, I might have a hard time talking about public health to a
clinician, unless I sent them to study it first...They came back with a different
vision and were able to discuss it.”

By 1991 a critical mass of public health specialists had assumed senior
positions at the MOH. Significant funding was provided by several of the major
donors in the health sector (UNICEF, Belgian bi-lateral aid, and USAID) for
short-term public health training programs both in and outside of the country,
covering the maximum of MOH staff. Norton, reflecting on his tenure as
minister, observed: "There was a harmony in the organization of health care...The emphasis was placed on the improvement of human resources and...to my sense, this is the source of the results."

With the increased skills and appropriate knowledge of the central level team and more medically trained staff, efforts to decentralize the delivery system further increased. 'Health provinces' which previously grouped three to four administrative provinces, were now further divided to respond to the 15 administrative provinces of the country. Each province had its own provincial Medical Head to plan for the health needs and manage the service delivery of their respective province. Unfortunately, much of this administrative decentralization remained theoretical, since the provincial heads carried the responsibility for planning the health needs of their services, but had no funding to run their offices and no real decision-making authority over resource allocation, other than personnel.

During this period, a greater focus for the need for community participation surfaced than in the past. However, most references by top decision-makers to community participation in the health sector referred to a financial participation of the population through a national insurance scheme. Like in many African countries, the impact of structural adjustment programs (SAPs) on the health sector was beginning to be felt (Le Marchand, 1992). The
government increased its budget allocations for the purchase of drugs to keep up with inflation, but froze the allocation of the rest of the Ministry's budget. Norton was under major constraints to maintain the Ministry's policy of "social medicine" and respond to the increasing health needs of Burundi’s growing population.³

In response to population and fiscal pressures, Norton undertook two related initiatives. The first meant taking control of mismanaged curative care. Without including donor funding, the Ministry was allocating 80% of its budget to hospitals. Under Norton’s leadership, a system of autonomous hospital management was instituted. Hospitals in the urban capital received their allocated budgets. However, for the first time in the management of budgets, human and material resources were entirely under the discretion of each hospital. This new decentralized decision-making authority for curative care improved staff motivation, facility hygiene, management of material resources, and recovery of fees for all services administered.⁴

³The concept of social medicine is defined in the MOH policy document as "to provide equitable access to health services for the entire population." (MOH 1988, p.16, my translation)
⁴Before autonomous management, fee collection was haphazard. Thus, few individuals paid for services rendered during their stay. Under autonomous management, hospitals adopted a policy of no discharge without payment up front. In other words, there was strong incentive to pay on time, as each day spent in the facility would be added to one’s bill.
The second initiative was to establish a functioning cost-recovery program for the Ministry. With the institution of fee for service in the early 1980s, the government started a health insurance program (*La Mutuelle*) for public servants, thereby providing coverage for only a small minority and elite section of the population. Norton gained government approval for a national insurance system through the purchase of a national insurance card (*Carte d'Assurance Maladie*) available to all Barundi. However, making this insurance system operative with a population who traditionally lacked confidence in the government's health care system was challenging.

In addition to the *Carte d'Assurance Maladie*, in 1991 UNICEF promoted the Bamako Initiative with Burundi's government. The Bamako Initiative is a community participation model in the management and financing of primary care services. In the few countries where it has been initiated (Benin, Cameroon, Mali) it also gives communities a revolving fund for the purchase of essential drugs (UNICEF, 1992). Its successful implementation requires interested and well informed community health committees in health center management and financing, and health center staff who are open to improving services through community involvement.

The Ministry began implementation of a "pilot Burundian adaptation" of the Bamako Initiative (*l'adaptation de L'Initiative du Bamako au Burundi,* or
ABIB) in one remote province, Muyinga, bordering Tanzania. Muyinga, was politically calm and had a governor who was willing to experiment with the program. From the start, it was a very centralized effort. The provincial Medical Head had a limited understanding of the program. Most communications came from a few Bujumbura staff directly to the health centers in the province. Project initiators had no idea of the amount of 'sensitizing' that was necessary for health care professionals and political leaders to understand and embrace an unfamiliar and potentially threatening participatory approach. Village health committees knew little about their new role. Health center staff, who lived within a hierarchical society and strongly valued the powerful role they held within the community, showed little interest in promoting or maintaining the involvement of the health committees. In short, no one from either the Ministry or UNICEF ever questioned the appropriateness or feasibility of implementing such a model in a country where the community had never been asked its opinion and responded to authorities' orders out of fear of retribution.

Another early effort to decentralize prevention was the establishment of health/sanitation committees to oversee hygiene and sanitation within communities. While one would think local community members might serve on such committees, the usual authoritarian model prevailed. Committee members consisted of local authorities such as administrators, school teachers, or political figures who would carry provincial-level planning functions
and ensure the cooperation of the population in health and sanitation matters. In the end, this approach rapidly unraveled since the committee members had neither the commitment to perform the extra duties, nor an understanding of the importance of disease prevention. This example further illustrates the government's authoritarian mode of operating vis-à-vis the population before 1988.

Norton's tenure in the Ministry, though, marked an era of greater involvement of senior staff in program implementation and policy development decision-making. The ministerial cabinet met every Monday morning to consider important issues at hand. Specific policy reform issues such as decentralization and health financing were sent to different commissions whose members were appointed by the Minister based on their ability to contribute to the policy area. There was a strong sense of professionalism, whereby all participants knew they were valued for their contributions. A democratic process prevailed. Commissions would develop a policy statement to be reviewed by the ministerial cabinet and the minister. In this way, the ministry sought a broad range of expertise by including not only senior staff, but also program heads.

In mid-1993, the development of the new 1994-1999 policy statement was undertaken in a similar way. A policy commission oversaw the
development of the document. Specific sub-groups involving individuals from all levels of the Ministry developed sections of the document. As Chapter VII will indicate, decision-makers interviewed in this study all felt they had some influence on policy within the Ministry.


Written in June, 1988, the MOH Policy Statement (*Politique Sectorielle de la Santé*) was the first policy document ever developed by the Ministry of Health. The introduction includes a broad, yet clear statement how the newly formed government expected to reorient its health system over the next five years. The policy document is divided into five main sections: an introduction with a critical situation analysis, definition of objectives and strategies, an identification of means, and a conclusion. Through its introductory statements and critical (albeit sometimes politically motivated) analysis of the Ministry’s progress under previous regimes, the document also gives a succinct history of previous efforts to develop a primary care orientation.

The opening paragraph serves as the Ministry’s new mission statement:

The health policy of Burundi is focused on the principle of social and preventive medicine targeting the largest and most equitable access possible to health care in view of contributing to the improvement of the quality of life of all citizens in order to permit them to live an economically and
socially productive life. (MOH 1988, p. 3, my translation)

The introduction further states that the present document analyzes the inadequacies of the current health system which have contributed to "slowing down the health development of the population" (MOH, 1988). Therefore, the goal of the 1988-1993 document was to define the global objectives which would allow for the subsequent identification of strategies to be employed. However, the strategies would be implemented under a very clear:

multi-sectoral, community approach integrating curative and preventive health care and health promotion with particular emphasis on hygiene, in order to offer the population health care that is geographically, economically, and culturally accessible and acceptable (MOH, 1988, p 3, my translation).

These statements serve as a template for the MOH to install a community-based, integrated health system based on equity and appropriate delivery of care to its population.

**Criticisms of the past**

The second major section presents a strong critical analysis of the present situation. It targets the insufficiencies of previous regimes in the health sector and makes severe statements about lifting the sector from the lethargy
in which it was operating. One major shortcoming of previous regimes cited was their inability to focus clearly on the needs of their population. Specifically, the inability of previous governments to "define a clear health policy and integrate such a policy into the governments day-to-day actions has caused, for several years, certain areas to be ignored, while others were developed in an anarchical fashion, without coordination" (MOH, 1988, p. 4, my translation).

Given the above, the first major criticism of the orientation of past systems is the lack of previous emphasis on public health, which is cited as the "keystone of social medicine" (MOH, 1988, p.4). The document describes the previous system where few funds were allocated for public health activities and personnel training was oriented only towards curative medicine. The document further states that any kind of preventive approaches had only started in the 1980s and were primarily vertical programs working independently from one another. Even the Health Education Unit, which was formed in 1985, was allocated few resources and left alone to "improvise themes to be developed based on its own imagination" (MOH, 1988, p.4, my translation).

Any stated focus on preventive efforts is criticized as only "theoretical," pointing out that the urban population was favored over the rural (which represents 94% of the total population). In addition, 80% of the Ministry's resources were channeled to hospitals serving the urban population. One
specific study is mentioned and notes that 2,000 Burundi francs (approx. U.S. $10.00) per person were spent in urban areas on health while 47 Burundi francs (approx. 50 cents) per person were spent in rural areas.

With this "centralized focus" the issue of ineffective decentralization forms another major criticism of the document. All references to decentralization are referred to in administrative terms. In other words, if health care is to be delivered to the population, what is the most efficient geographical breakdown for the Ministry to provide and manage the human and material resources for the system? The situation found in 1988 is criticized for not making sufficient progress towards a decentralization scheme to create 15 "health provinces" whereby the Ministry's human and material resources would be managed at the provincial level. Not surprisingly, there are no criticisms made of past regimes' lack of involving the community in health care, which is another form of decentralization.

The "Critical Analysis" section cites other problems in the delivery system such as a lack of recognition of merit or integration of traditional medicine within the government's health sector. Moreover, this section finds fault with health-related NGOs because they are only in their "embryonic" stage and have not been supported by the government thus far. Conversely, the document notes the dependence of the health sector on external resources.
Among those cited are an over-reliance on external training institutions for doctors, the importation of drugs and medical supplies, and last but not least, donor funding for financing significant portions of the sector.

Finally, the historic lack of concerted efforts at planning is cited as the factor for why the health delivery system has encountered so many problems. Although an Office of Planning and Inspection was created in 1985, it is criticized for not fulfilling its mission. Thus, a renewed effort in planning and evaluation is emphasized for the future. This is important for two reasons. First, it coincides with the development of a planning focus in the health industry world-wide, indicating that Burundi was fairly progressive for a developing country at that time. Secondly, the criticism sets the stage for the ensuring the development of a more dynamic department of planning and evaluation of services within the Ministry, which later played a role in ensuring the implementation of the current policies and the design of future policy reforms.

**Charting New Courses: MOH General Objectives and Strategies 1988-1993**

Five general health status objectives were defined for the 1988-1993 period. They are listed in Table V - 1 as direct translations from the document. Under these general objectives, what are termed 'specific objectives' follow.
The document states that these are grouped and prioritized in “function with factors that would have an impact on improving the health of the population.”

What this means exactly is not clear.

**Table V - 1 MOH General Objectives (MOH, 1988)**

<table>
<thead>
<tr>
<th>General Objectives</th>
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<tbody>
<tr>
<td>1) Contribute to the increase in life expectancy of the population (46 for men and 49 for women in 1985);</td>
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<tr>
<td>2) Contribute to a decrease in infant and child morbidity and mortality (118 and 23 /1000 respectively);</td>
</tr>
<tr>
<td>3) Decrease maternal mortality (estimated at 400/100,000 births in 1986);</td>
</tr>
<tr>
<td>4) Reduce morbidity and mortality (estimated at 400/100,000 births in 1986);</td>
</tr>
<tr>
<td>5) Contribute to a reduction of demographic growth (2.96 % in 1986).</td>
</tr>
</tbody>
</table>

MOH specific objectives stand as follows:

‘Specific objectives’

1) Children 0 to 5 years:

   a) Reduce morbidity and mortality due to childhood diseases before 1992:

      - Reduce by 40 percent morbidity and mortality due to measles and polio by attaining a vaccine coverage of 80 percent in children under one year of age.
- Reduce mortality due to diarrhea by 17% in children under five years of age by treating at least 25% of cases with an effective oral rehydration therapy.

- Reduce mortality due to malaria in children under five years by the rapid treatment of fever.

- Reduce by 30% the frequency of severe and moderate malnutrition in children 12 to 24 months of age, over a period of five years, by reinforcing child surveillance.

- Reduce mortality due to pulmonary infections by 25% in children 0 to 5 years of age by improving the effectiveness of treatment.

b) Women of reproductive age (15 - 45 years)

Reduce maternal morbidity and mortality linked with childbirth by 20% before 1992:

- By decreasing the frequency of principal problems and subsequent complications linked with childbirth.

- By decreasing the severity and frequency of malaria attacks in pregnant women.

- By decreasing the prevalence of severe anemia in women by 5% in five years.

- By bringing 50% of women who have given childbirth to use an effective contraceptive method by the third postpartem month in five years.

- By increasing the contraceptive prevalence rate from 1.54 percent (December 1987) to 7%, especially among women who have already given birth.

- By decreasing neonatal tetanus by 40% by ensuring that 65 percent of women of reproductive age have completed tetanus vaccines.
c) The general population:

Reduce mortality and morbidity due to infectious diseases and parasites:

- malaria
- digestive related diseases (bacillary dysentery, cholera...)
- neonatal tetanus
- acute respiratory infection

I believe a major weakness of the document is that these broad objectives and many of the specific objectives have no target indicators. For example, under section a) on children, there is a sub-objective to reduce mortality due to malaria by 25% in children five and under. However, current mortality levels are not mentioned, as I am sure they were unknown at the time. Even now, mortality data are extremely difficult to obtain. Where the present indicators were known and target indicators were set, many of these were unrealistic. For example, reaching a contraceptive prevalence rate (CPR) of 7% in five years from the estimated CPR of 1.54 would be major achievement even in a country where family planning methods are less controversial than Burundi. In the developing world where prevalence rates prior to contraceptive use usually start from an extremely low level (less than 10), an increase of only one percent per year is considered a major success (Siedman and Horne, 1991).
Strategies

The objectives of the previous section signify the outcomes the Ministry wanted to achieve during the 1988 to 1993 time frame. The strategies used to reach those objectives prove of greater significance to this research than the outcomes themselves. Strategies should tell how something is to be accomplished and, the kind of approach taken to reach the objectives.

Seventeen strategies were broadly defined (Table V - 2). They were to be operationalized in: “a multi-sectoral, community approach that integrates prevention, curative and promotional health care in order to offer to the population care that is geographically, economically and culturally accessible” (MOH, 1988, p. 11, my translation).

Criticisms

As mentioned in the introduction to the MOH policy document, strategies should explain how the Ministry was to achieve its objectives. One of the major criticisms of this policy document is that it sets no policy priorities. All strategies appear to receive the same importance. This also corroborates Clark's observation that policy development in African country's post independence is characterized by an inclination to deal in the "comprehensive and total" (Clark, 1982, p. 123).
Another criticism of the document is that while it lays a broad foundation for a community-based delivery system, neither what that system reflects, nor how the Ministry will achieve the system (under decentralization) is defined in the document. Only one small reference is made that a policy should be elaborated to define how the population can contribute to the definition of its needs and management of its services. Clearly, more emphasis and greater strategy definition was placed on the population's participation in contributing to the financing of the health sector. Burundi's Ministry of Health typifies conventional approaches to community participation as noted in the literature review of this research. Although the MOH was probably one of the most progressive among government ministries in even considering a community participation approach, its primary motivations lay in ensuring the financing of its system (Midgley, 1984), rather than in permitting its citizens to have greater decision-making control in health delivery (Korton, 1984).

On a more positive note, the policy document marks a fairly challenging first effort for the Ministry. Some strategy areas are more developed than others. This gives a clear indication of how far the Ministry had moved in certain areas. During my two and a half year experience I found that the MOH staff recognized their weaknesses, which is a major first step in problem solving. However, staff often lacked the specific resources to define and find
### Table V-2. MOH Strategies

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>HOW DEFINED</th>
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<tbody>
<tr>
<td>1. Hygiene</td>
<td>Focus: Latrines, supply of clean water, promotion of cleanliness in the home, school, workplace and environment. How: Public hygiene assistants in each commune. Individuals chosen from the community to work with community and schools.</td>
</tr>
<tr>
<td>2. Prevention</td>
<td>Focus: Maternal and Child Health, accelerated vaccination strategy, nutrition education, promotion of breast feeding and deworming. How: Improve childbirth conditions of health centers, iron supplements for anemia, high risk pregnancy focus, family planning services, reproductive health education.</td>
</tr>
<tr>
<td>3. Family Planning</td>
<td>Focus: Reduction of population growth rate How: Extensive family planning services focused on sexuality and birth control, ensure a constant supply of contraceptives, training of personnel, establishment of ‘trusting’ client/provider relationships.</td>
</tr>
<tr>
<td>4. Health Education</td>
<td>Focus: Key element for ensuring success of curative and prevention How: Media, administrative and political meetings, formal and non-formal education, inter-personal communication mechanisms, inter-sectoral collaboration.</td>
</tr>
<tr>
<td>5. Social Medicine</td>
<td>Focus: Make health care accessible to everyone How: Construction of facilities in priority areas; Multi-disciplinary medical teams made available to the population; Health insurance card for financial access.</td>
</tr>
<tr>
<td>6. Service Decentralization</td>
<td>Focus: Begin administrative decentralization How: Create 14 &quot;health provinces&quot; divided into sectors with referral hospitals; Develop socio-sanitary committees for each commune Role of committee: a) elaborate policy objectives, plans and norms of the MOH; b) identify needs in order to adopt plans and government health policies; c) elaborate a policy for the population’s participation in the definition of its needs and the administration of its health structures; d) elaboration of a plan for allocating human resources” (MOH, p.17. my translation) Improve allocation of material and financial resources</td>
</tr>
<tr>
<td>7. Curative Medicine</td>
<td>Focus: Improve access and quality of curative services How: a) renovate health structures b) extension of hospitals c) construction of new health structures d) development of support services (e.g., medical laboratories, transfusion centers in provinces, etc.) and equipment.</td>
</tr>
<tr>
<td>8. Non profit and Private sector Health Care</td>
<td>Focus: State alone can no longer cover health needs of entire population. Therefore, encouragement of the ministry and other organizations to invest in health.</td>
</tr>
<tr>
<td>9. Drug Policy</td>
<td>Focus: Improve and implement essential drug policy. How: Improve: a) supply of drugs to the public sector; b) the national production of essential medicines; c) the encouragement of the private pharmacies.</td>
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<tr>
<td>STRATEGY</td>
<td>HOW DEFINED</td>
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| 10. Traditional Medicine | **Focus:** Ministry accepts traditional medicine but notes the identification of "good" vs. "chafatans" is a major problem.  
**How:** Association of "good" healer with doctors in order to enable the legal exercise of traditional medicine. Expected outcomes would be greater contact, experimentation and research that would ultimately establish correct dosages and standards of usage. |
| 11. Personnel | **Focus:** Ensure adequate quantity of technically competent personnel.  
**How:** 1) Create a National Commission to evaluate training programs to ensure appropriateness, given the population's health needs.  
2) Ensure adequate numbers of para-medical staff and specialists in surgery, gynecology, pediatrics, etc.  
3) Ensure equitable division of equipment, materials and personnel in all hospitals and rural health centers. |
| 12. Medical, Pharmacy and Dental Associations | **Focus:** Commitment to create medical related associations in order to reinforce communication among administrators, practitioners and the beneficiaries of care.  
**How:** Not defined. |
| 13. The Red Cross | **Focus:** Promote an active role for the Red Cross in assisting the MOH in fighting epidemics such as AIDS, dysentery, cholera, etc. and improving general hygiene of the population.  
**How:** Not defined. |
| 14. Inter-sectoral, regional and International Collaboration | **Focus:** Because health is complex and inter-related with other domains, promote collaboration among all sectors to define health policies and galvanize mobilization of resources.  
**How:** Create multi-sectoral commission to coordinate health related activities. To be successful, must meet following challenges:  
a) MOH must have real support of political-administrative authorities, especially in the periphery  
b) Ensure a good conceptual understanding and interest in inter-sectoral collaboration at all levels  
c) Clear understanding of the needs of each collective. |
| 15. Planning and Supervision | **Focus:** Improve the role of policy and planning within the MOH  
**How:** Develop a health information system to ensure knowledge of the epidemiological situation.  
Develop a system of integrated supervision to monitor program delivery |
| 16. Institutional Strengthening | **Focus:** The organization of the Ministry no longer corresponds with its functions. The MOH reorganization should target the following goals:  
a) ensure homogeneity and coordination in the functioning of structure;  
b) accoring and importance in planning;  
c) ensuring growth in planning and management by developing data collection and analysis capacities;  
d) coordinating donor assistance to ensure a more optimal use of health resources. |
<table>
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<th>STRATEGY</th>
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<tr>
<td>17. Financing Health</td>
<td>Focus: Primary care coverage objectives can only be obtained through a better</td>
</tr>
<tr>
<td>Services</td>
<td>organized health financing system</td>
</tr>
<tr>
<td></td>
<td>How: Three mechanisms for improving health sector financing:</td>
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<tr>
<td></td>
<td>a) Improve the allocation of present financial, human and material resources</td>
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<td></td>
<td>b) Find new financing mechanisms (e.g., health insurance card, encourage</td>
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<td></td>
<td>NGOs and private sector to establish centers and clinics)</td>
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<tr>
<td></td>
<td>c) Examine possibility of auto-financing of hospitals and health centers.</td>
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</table>
appropriate solutions. As such, the policy document gives indications of where the ministry's strengths and foci lay. For example, the family planning section is detailed in three and a half pages, while traditional medicine is covered by one short paragraph. Family planning was a major priority for the government and was highly controversial. The added length to present a 'rational' analysis for the need for promoting birth spacing and limiting population growth illustrates how controversial the subject was at the time. Family planning strategies are defined in greater detail, indicating that someone in the Ministry had thought long and hard, and had a plan in hand.

In contrast, the sections concerning traditional medicine and health education receive little attention. Traditional medicine is accepted by the Ministry, as noted by the statement to study the possibilities for integrating biomedicine and traditional approaches. However, no specific strategy is defined. This suggests that the Ministry was not clear on just how this should be achieved. Likewise, health education, which should be the foundation of a preventive-based system, was not given the attention it warranted in the document. Even until 1993, the Health Education Unit (Éducation pour la Santé) remained particularly weak. Although the majority of Ministry decision-makers had public health training at this time, Ministry staff were doctor dominated. The necessary social science research and communication skills needed to develop an effective health education program were sorely lacking.
Identification of Means

A broad allocation of means for implementing the policy orientations are identified in this section of the policy document, as well as an initial estimation of the origins of these resources. Certain allocation objectives are listed for human and material resources, maintaining, renovating or building new infrastructure, service equipment, transportation. The most remarkable aspect of this section is the clarity of communication about budget allocations by program, donor assistance, and an identification of funding gaps.

Policy Document Concluding Remarks

The final section of the policy document contains a very striking conclusion that repeats the need to uncover the weaknesses and lethargy of past regimes and move forward. With the global objective of providing coherent well coordinated activities for all Barundi (i.e., to live a healthy and productive life), the conclusion invites its citizens and other partners (e.g., donors, NGO community) to work together to take responsibility for the health of the nation. With the “Ministry of Health as catalyst, all strategies would be implemented through an intersectoral, community-based approach integrating prevention, curative and promotional health activities in order to offer the population geographically, economically, and culturally accessible care” (MOH, 1988, p. 37, my translation).
D. MOH Institutional Culture

Like many ministries of health throughout Africa and the world, Burundi’s MOH was considered a weak cousin among the 16 government ministries. Poor management, weak leadership during the seventies and eighties, and an inability to address the complexity of health demands in a poor nation contributed to the perception. The Ministry’s two “big brothers” were the Ministry of Plan (MOP) (whose role was to coordinate the planning of all sectors in the country), and, the Ministry of Finance (MOF) (which held the purse strings and dictated the MOH budget). As indicated below, the MOH senior level was strongly dedicated to its mission. However, visits to the MOP and MOF showed a distinctly slick and “in control” of operations attitude, noted by a demeanor and dress of importance among senior staff and the proliferation of computers (unlike the MOH) in these Ministries. By 1991, the Ministry of Health had gained a bit more clout, due to improvement in budget management and knowledge of health needs. The MOH was learning not only to request, but to justify an increase in budget, and was granted an increase for prescription drug procurement.

The MOH institutional culture among senior decision-makers can be described as strongly serious and dedicated. This was typical of all ministries and perhaps engendered through the model of discipline and authoritarianism acquired under years of military leadership. It should be noted, however, that
the culture of decision-making was in transition during the 1988-1993 period. Several factors can be attributed to these. With greater knowledge of the country's epidemiological picture, due to an improved disease reporting system, planning began to take on a new role in the ministry. In addition, the first non-military Minister of Health with a public health background was appointed to lead the MOH in 1988. As later chapters will indicate, while still operating in an authoritarian context, his management style in the 1990s was one oriented to team problem solving and consensus building as policy issues developed.

Every Monday morning was set aside for cabinet, ensuring that both Minister and staff were up to date on progress on subjects to be addressed in that week and were able to report on progress on business from the previous week. In this sense, Burundi's MOH was fairly proactive for an African Ministry of Health. Cabinet members were "in the know" about Ministry operations. However, an obstacle to effective management in the MOH was lack of communication by program heads to their own subordinates. This is not atypical of authoritarian bureaucratic regimes where knowledge is used as a powerful tool. Thus, lack of knowledge of certain daily issues of importance, as well as macro policy directions were a major complaint of those lower in the ministry hierarchy.

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5See also the vignette on the daily life of a bureaucrat in Appendix 5.
E. Classifying the Evolution of Primary Care

From the early 1960s to 1993 the Ministry made significant strides in orienting its delivery system to meet the health needs of its population. By early 1993 Burundi was increasingly recognized as a success story in making significant headway in disease prevention, primarily due to the success of EPI. My own experience with the Ministry showed that unlike many other African countries, by 1993, the Ministry not only had a good understanding of the nation's epidemiological profile and its delivery system weaknesses, but was developing specific measures to rectify them. Much of that progress happened in a relatively short time (1988 to October, 1993).

Typology of MOH Approach

Figure V - 1 shows the typology of primary care approaches presented in Chapter IV which described the methods of this research. It depicts the evolution of health system from the 1960s to 1993, based on the data presented thus far. Major events which shaped the evolution of primary health care over the following years are summarized below. Words which relate to measures to classify the approaches on the typology are in italics.

1960s

Burundi emerged from colonialism with a curative care and hospital-based system that was delivered by a highly centralized and
authoritarian (military dominated) government system. The only prevention-oriented services which existed were those to fight epidemics. Therefore, Figure V - 1 situates the MOH in the 1960s in Quadrant 1.

1972

Civil unrest occurs after the ruling Tutsi minority perceive a threat of a Hutu majority uprising. An estimated 400,000 Hutu are massacred throughout the country. Mistrust and fear of retaliation permeate relations among the ethnically divided population.

1978

Burundi’s participation in Alma Ata triggers an awareness of ‘Health for All’ by top decision-makers.

1982

Influenced by Alma Ata and donor agendas, the Expanded Program for Immunization (EPI) is initiated marking one of the first major efforts at prevention within the country. Because Burundi is highly rural (over 94% of the population resides in rural areas), this program also highlighted the need to provide greater access to primary care. It marks an awakening to the idea of increasing the number of health centers. Shortly after, a family planning program was also
Figure V-1. Evolution of MOH PHC Approach
introduced. The Ministry was still operating in a *highly centralized*, authoritarian manner, but was moving down the curative/preventive care continuum with evidence of an increased focus on preventive, albeit a highly selective primary care approach. Ministers of Health are military doctors appointed by each successive military leader, who have taken power through military coup d'état.

1988

A military coup d'état overthrows military, leftist leader Jean Baptiste Bagaza, who increasingly isolated Burundi from the outside world. Pierre Buyoya, a junior military officer, declares himself president. Under Buyoya, many government reforms take place. One reform is a tentative push for more democratic institutions within the country and a focus on building national unity. Democratic elections resulted from these efforts. Within the health sector, for the first time a physician (Norton) with a public health background leads the Ministry. Norton's vision of public health and his related actions have a profound effect on moving the primary-care approach forward. Additionally, the Ministry's develops its first policy document that provides a clear orientation for a primary-care system with equitable access for all Barundi. It embraces community participation and multi-sectoral involvement in the health sector. Although service
delivery remains authoritarian, a new era of greater transparency of finances and team decision-making at the central level evolves.

1991

By 1991 the most senior decision-makers in the Ministry have public health backgrounds. UNICEF starts promoting the “Bamako Initiative,” targeting community participation in drug supply and health center management. In 1992 the MOH began to implement its own version of the Bamako Initiative as a pilot project.

Burundi is recognized among African countries as a ‘success story’ for its strong progress in prevention, noted by very high vaccine coverage. However, HIV/AIDS infection rates are among some of the highest in Africa (USAID, 1992).

1993

June: Burundi’s first democratic elections bring Mechiar Ndadaye to the presidency and a Hutu majority into power. As a member of the previous government, Norton steps down and a new minister of Health is appointed in August.
October: Military officers assassinate the newly elected president igniting a new era of ethnic conflict. Implementation of Ministry reforms comes to a halt and a period of crisis management prevails.

F. Summary

The present chapter analyzed the institutional dimensions of Burundi's health system development, by classifying the evolution of the Ministry of Health's PHC approach. Between the 1960s and 1993, Burundi's health care system evolved from a highly curative and authoritarian approach to more preventive care. Until 1988, when the Ministry's first health policy document was developed, the health sector operated without a broad guide to orient the delivery system. Accordingly, piecing together the evolution of primary care required several approaches.

In this chapter I used data from the 12 interviews with decision-makers to help fill in the gaps of the evolution of Burundi's health care approach up until 1988. With the advent of Norton's administration as Minister in 1988, the MOH policy statement (Politique Sectorielle de la Santé) charted a defined course. During its five-year existence, we can see an initial connection between normative statements (policy goals) and practice (program actions and health care outcomes). One such example, is Burundi's success in the Expanded Program for Immunization (EPI).
With this understanding of the development of the delivery system, we can now examine the human agency side of the delivery system. This includes the decision-makers who were responsible for its evolution from 1988 to 1992. The next chapter will explain the human agency focus and present an analysis of Ministry of Health senior decision-makers' belief systems and the factors which influenced them.
VI. Melding Individual Experience With The Burundi Framework

As a scholar with a background in sociology who has lived in a variety of countries in the developing world, gaining a full comprehension of the Burundi context was important to me. I had never lived anywhere before where acquiring an ‘insider’s’ understanding prompted a continuous reexamination of my own views about human behavior. A French sociologist (who spent over seven years working side by side with Burundian farmers) and I both agreed that the more information you were privy to regarding political and ethnic conflict in Burundi, the more difficult it was to comprehend that society. For instance, how could Barundi coexist peacefully one day, only to commit atrocities to each other the next day. The weight of history cannot be seen on the surface during peaceful times. Over time I realized that unbeknownst to the outsider, the scars of past atrocities were in the minds of every Burundian old enough to have witnessed past calamities. Like many conflict-ridden relationships, subjects that need to be talked about the most are those that are too threatening to mention. Thus, while no mention of ethnic conflict surfaces in daily pariance, an underlying tension exists.

This section will show that such a tension had major implications for the Ministry decision-makers who were trying to implement the primary care

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approach described in the previous chapter. This tension had implications for each decision-maker's own life history, their PHC belief system, and the extent to which they were willing to advocate a belief system.

A. Understanding and Classifying Decision-maker's Primary Care Belief Systems

Figure VI - 1 presents the range of primary care belief systems held by the respondents interviewed. I use the term 'vision' in the interview as it relates to what the individuals perceive as the ideal approach for primary care. An individual's 'vision' of PHC, or in other words, how he or she visualizes what PHC should be, is the articulation of their beliefs about PHC.

Individuals were classified based on how their interview responses compared to the measures on each continuum (X and Y axis) of the typology defined in Chapter IV. Responses were assessed by employing two content analysis methodologies that I designed. First, I examined specific interview questions and responses regarding an individual's vision of PHC to gain an initial orientation. However, the responses to a variety of questions regarding each individual's participation in the health sector were so rich that I pursued a
Figure VI-1. Decision-Maker Primary Care Beliefs
more detailed analysis. This assessment used word frequencies to ascertain the most commonly used words among individuals groups. From this frequency analysis, words related to the measures used in the typology were analyzed in greater depth to uncover their associations with other key words or phrases. This latter analysis provided strong support for not only placing individuals on the typology, but for situating individuals within groups with common belief systems about primary care.

Table VI - 1 shows the response frequencies for the entire data set for all words used more than five times. I ran frequencies at both a minimum of three and five words. The two lists were compared to see if there were any key words that appeared with one respondent or would be left out from another if the minimum number of word frequencies were chosen. A minimum frequency of five word usages appeared to be a good cut off point for words of importance without limiting one decision-maker's responses over another. Word frequencies included terms used in questions that I asked. However, questions were worded the same in each interview in order to maintain the same amount of key-word frequencies introduced into the interviews.

Among these key terms, nine words were chosen based on their relevance to an individual's belief system. In turn, these nine words were more
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Table VI - 1  Word Frequencies: Words stated minimum 5 times

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thoroughly analyzed for context and frequency. For example, as noted in the
literature review, ‘community participation’ has many meanings. While one
individual may have stated the words 18 times and another only eight, both the
quantity of and context in which the words were used helped me to
conceptualize an individual’s vision. For example, like many countries where
community participation is practiced, Burundi’s MOH never clarified its
interpretation of “community participation” (Korton, 1983). The country’s
historical context of uneven power relationships between the minority in power
and the majority population made this subject taboo. Thus, the Ministry never
investigated the conflict between using a community approach in health and
the potential incompatibility of such an approach with the dominant political
system. Even the UNICEF promoted ‘pilot’ Bamako Initiative project could not
overcome this problem (See Chapter V on the history of Burundi’s health
system). While analyzing these results I realized that for some decision-
makers, participation was only a matter of contributing to the finances of the
health sector, while for others, the emphasis was on participating in
management decision-making.

Analysis of the interview texts also showed that certain words of
importance to some decision-makers were not used by others. Therefore,
when certain words related to primary care were not used at all by some
individuals, I assumed that a concept inherent in the word was unimportant.
One example is the word ‘democratization.’ The term was not used by those with a conservative view about primary care, but rather by those with more progressive belief systems. By considering both the frequency and context of words used, the typology employed in this study proved highly illustrative of how commonly used words can hold a variety of meanings and nuances for each individual.

The nine most frequently used words related to primary health care in the analysis were: access(ibility), central, community, decentralization, democratization, insurance, management, participation, and population. Tables VI - 2 through VI - 10 indicate the frequencies and contexts of the nine words for each respondent.

Figure VI - 1 shows that all of the decision-makers fall within Quadrants 3 and 4, representing a primary-care focused approach. Among Quadrants 3 and 4, four distinct groups emerged from the analysis. I have labeled the four groups as follows. The five individuals on the far left Quadrant are called the Progressives. The three individuals closer to the right side of Quadrant 3 are named the Non-risk Takers. The two decision-makers along the center axis are called the Fence Sitters. Finally, the two decision-makers falling totally in

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*Conservative refers to more authoritarian top-down approaches to PHC. Progressive refers to community-consensus based PHC approaches.
Quadrant 4 are dubbed the Conservatives. These labels and meanings are explained more fully in the following section.

1. The Progressives

Quadrant 3’s over-all approach is typified by an emphasis on the necessity of a decentralized approach with community involvement in the management of health care. Decision-making would be undertaken as a team effort and consensus building.

The Progressives hold a holistic perception of the involvement of the community in health care. They emphasize the need to include the community in all stages of health care delivery, from the conceptualization to the management of a center. One progressive stated: “To me, I think that there are political declarations, which have their importance, in order to support the operational. But a political declaration is not enough. ‘Health care for all by the year 2000’...it’s very beautiful to say and the politicians like it...People have understood that primary health care cannot be executed without the participation of the population instead of thinking that ‘This is what should be given to the population without consulting them before and discussing with them.”
The Progressives also believe that outreach beyond the clinic is crucial. Frequently mentioned was the perception that the majority of factors that affect an individual's health are preventive and beyond the health center. Therefore, these individuals talk about a vision in which the community considers themselves as part of health. In this light, health education is key to promoting an individual's responsibility about his/her own health. Because health is viewed more holistically, several Progressives identify the need to deal with health issues facing the community in an integrated approach. Specifically cited was the need to involve and mobilize other sectors within the government (e.g., regional administrators) and local organizations, (e.g., churches).

Traditional practitioners form part of the progressive vision. Several stated that the government's health care system has much to learn from traditional practitioners in terms of undertaking appropriate case management given the values and the realities that face individuals in the community. One respondent observed that one of the reasons traditional practitioners are more accepted within the population is that they 'value' the cultural practices of the community.

The in-depth analysis for context of the nine words clearly differentiates the Progressives from the other groups. As noted in Table VI - 2, the analysis of the word 'community' indicates that all five Progressives used the word “community”
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in the context of community participation. They said that community was the most important component of primary care at least twice during the interview. This statement was made by only one of the Non-risk Takers, and once by each individual in the “fence-sitter” group, but it was not used at all by the conservatives. In addition, the need to understand community values was articulated most often by the Progressives, with one particular individual mentioning this need nine times. This idea was conveyed by one member of the Non-risk Takers, but by no one in the remaining two groups.

‘Population’ is a word used almost synonymously with ‘community.’ In English we talk about participation of the ‘community’ while in French participation of the ‘population’ is a term equally used. Table VI - 3 shows that the Progressives stated far more than the other groups that the population must participate in health. This group indicated the greatest awareness about the need to involve the population and understand its culture. Moreover, this group is set apart from the others in that none of its members talked about the population’s role in financing health. Reference was only made to the population’s financial access to health care.

Analysis of the word ‘participation’ alone yielded more pronounced differences. Participation of the ‘community’ or ‘population’ as necessary for PHC was stated a minimum of two and a maximum of six times by all members.
Figure VI - 2 Factors Influencing PHC Vision
Table VI-3. Population

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<td>health</td>
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<td>democratization</td>
<td>Martine</td>
<td>4</td>
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<tr>
<td>MOH progress: gives minimum level of care to population</td>
<td>Chin</td>
<td>1</td>
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<tr>
<td>Prevention equals education of population</td>
<td>Lawrence</td>
<td>2</td>
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<tr>
<td>Encourage population to take care of own health</td>
<td>Norton</td>
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<tr>
<td>Population must be convinced to move into action</td>
<td>David</td>
<td>3</td>
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<tr>
<td>Participation depends on political environment</td>
<td>Bill</td>
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<td>Decentralization should enable community participation</td>
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<td>&quot;population&quot;</td>
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<td>&quot;needs of&quot;</td>
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<td>&quot;Understand culture of&quot;</td>
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<td>&quot;How to involve&quot;</td>
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<td>&quot;Association of peripheral population is lacking/ need to feel implicated&quot;</td>
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<td>&quot;Present minister knows population&quot;</td>
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<td>&quot;Contributes cash- then money vanish&quot;</td>
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of the Progressives group (See Table VI - 4). The comment that PHC was applied without much participation was a criticism made by two Progressives. One went further to make a criticism that he or she had no idea of what the Ministry's community participation approach really entailed. In contrast to the remaining three groups (especially the conservatives), none of the Progressives referred to participation in a financial context.

There is a marked difference in how the question of the national insurance scheme (*Carte d'Assurance Maladie* or CAM) was mentioned by the Progressive group. Decision-makers who made reference to insurance did so in the context of insurance as a key primary care policy that ensures access to care for everyone. Other groups focused primarily on the "client/administrative" perspective of insurance scheme’s ability to finance health care.

Table VI - 5 shows that the words ‘democracy’ or ‘democratization’ were referred to most often by the Progressives. Several contexts were used, including: democratization as necessary for reaching the community in PHC; in reference to the difficulties of dialogue in a non-democratic process; and, conversely, in the ability to express oneself within democratic institutions. Neither democracy nor democratization was mentioned by the Conservatives. Of interest is a Non-Risk Taker who made the most references to democracy.
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<th>Fence Sitters</th>
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Subtotal by Group

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<td>Chin Lawrence</td>
<td>Norton David</td>
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<td>With democratic institutions people can express themselves</td>
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<td>Within democracy fundamental to listen to population</td>
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<td>Important for administration of finances and management of health</td>
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</table>

Subtotal by Group | 12 2 | 11 0 |
That respondent did so mostly in the managerial context of improving the administration of finances and management of health.

The word 'central' also had specific connotations for the Progressive group. As indicated in Table VI - 6, this was the one group that made consistent critical reference to central level Ministry efforts, particularly in the realm of decentralization. This group criticized the central level for being too centralized, having poor communication within itself or among other levels, having difficulty in getting organized, and for the need for it to be a “full partner” in the delivery system. Only one or two others from other groups made mild criticisms regarding the central level.

Finally, the Progressives reflected on decentralization as an element of primary care. Table VI - 7 indicates that certain individuals within the group noted the role of democratization for decentralization to be effective, or mentioned the ideas that the community's true participation is dependent upon decentralization. One individual stated numerous times that decentralization to date was purely theoretical.

2. The Non-risk Takers

The three individuals on the right side of Quadrant 3 form the Non-risk Takers. The group is given this name because they share many of the beliefs
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*Table VI - 7 Decentralization*
of the Progressives, but not at as strongly. Put another way, because they know the ramifications of holding and voicing liberal ideas in a conservative and authoritarian society, they are far less critical in their statements of the status quo than the Progressives. They also differ from the Progressives in their comments and beliefs about primary care in several ways. While all respondents agreed that community participation is a “must” in primary health care, the Non-risk Takers spoke of participation with a greater emphasis on the financial or physical maintenance of the health center, rather than empowering individuals and the community to take responsibility for their own health. Table VI - 4 notes that the Non-risk Takers refer less to ‘participation’ than the progressives. Moreover, while there is a focus on participation from the client perspective (e.g., need for participation in management, appropriateness given realities) there are fewer references in this sense than the Progressives. ‘Community’ is also referred to less by this group (20 times compared to 51 for the Progressives), although there are some references to the success of community participation only if there is a “good political” system in place or, a feeling that most decision-makers in the MOH system view the participation of the community in terms of financial or labor contributions.

Like the use of ‘community,’ the word ‘population’ is less frequently used by these individuals than the progressive group. However, when participation is used, there is limited reference to the context of encouraging the population
to become responsible for its own health and the importance of a direct dialog and contacts with the population. As shown in Table VI - 3, these additional orientations (which include some criticisms of inadequate community outreach to the population) distinguish this group from the Fence Sitters' belief system.

'Decentralization' and 'management' were also concerns of the Non-risk Takers but were stated less frequently than the Progressives (Tables VI - 7 and VI - 8). For the Non-risk Takers, most references to decentralization denote the problems or resistance to it. In the analysis of the word 'management', references were made to decentralization by citing the need for more autonomy and responsibility at the provincial level. Much of this vision stems from frustrations encountered while holding previous positions as Provincial Medical Heads with neither the authority to make decisions nor the resources to solve problems in the periphery.

3. The Fence Sitters

I assigned the name “Fence Sitters” to characterize the two respondents whose views fall between Quadrants 3 and 4. Although both have a strong public health orientation, their views about community participation are special. This group referred to the importance of the population’s participation in both the management and financing of health. However, further analysis of the
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words “population” and “community” (See Tables VI - 3 and VI - 4) indicate that this group placed a greater focus on financial and/or “in kind” participation than on management. They differentiate themselves from the Non-risk Takers through their stronger focus on financing the health system. The Fence Sitters differentiate themselves from the Conservatives by their limited, yet consistent references to a variety of measures that would place them in Quadrant 3. For example, unlike the Conservatives, this group referred to the role that democratization plays in promoting participation, and the importance of listening to people within a democracy. One respondent was particularly aligned with the Progressive group in stating that democratization is a necessity for reaching the community in primary care. This decision-maker, moreover, had a broader vision of community participation, stating that such an exercise was necessary for all sectors, not just health. Both individuals mentioned at least twice that trust and confidence are gained by planning services with the community. While these statements seem logical within a Western context, one needs to remember that they are bold statements for decision-makers who have only known extremely authoritarian regimes.

4. The Conservatives

The Conservatives represent Quadrant 4, and emphasize a more authoritarian approach in their primary care beliefs. Their emphasis on participation is clearly oriented to the financial contributions of the community in
the health sector. References made to encourage the population to take care
of its own health implied a financial or in kind contribution. Examples of
statements reflecting this belief include, "Free health care is an old practice" or
"It is the government's role to train and pay staff. Financial support and
material support should come from the population."

Only the conservatives did not refer to democracy or democratization
(Table VI - 5). This lack of reference indicates that the concept was not
important or perhaps even too threatening to their belief system. This contrasts
markedly with the Progressives.

The Conservatives did, however, speak about certain values regarding
the need for direct dialogue and good communication and contacts with the
population or community (See Tables VI - 2 and VI - 3). In addition, there is a
level of awareness regarding the need for geographic and financial access to
quality services (Table VI - 9). It was these references that led me to place the
Conservatives near the center of the continuum line of Quadrant 4.

B. How Life History Shapes PHC Vision to Life History

When I compared decision-makers' visions of primary care to life history
factors, some interesting similarities emerged. This information is useful for
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administrators who must orient an organization towards a particular primary care approach.

As was mentioned earlier, three Progressives had previous field experience in community-health programs. Additionally, these individuals cited the community experience as having a profound effect on their present vision of primary care. As well, it is these decision-makers who have the most forward looking vision of primary care. Thus, a tentative finding of this study is that field experience in alternative-based community health programs has a significant effect on promoting a community-based approach to PHC.

Both Conservatives in Quadrant 4, the authoritarian side of the typology, are significantly older than the other respondents. In a sense, they represent the 'old school' of thought that marked a transition to public health, but under the more traditional public health concepts of twenty years ago.

The Fence Sitters include Norton and David. The grouping of these two individuals is of interest in several ways. Norton, who was Minister of Health from 1988-1993, formulated the Ministry's PHC approach during this period. As noted in the history of the development of the health system in Burundi in Chapter V, the delivery system had begun to move towards a public health approach in the early 1980s, several years after Alma Ata. However, it was
Norton’s stronger emphasis on public health that moved the Ministry forward. He realized that the only way to bring this about was by ensuring that a) key decision-makers within the Ministry received public health training so that they all could speak the “same language” and b) key decision-makers chosen for the central-level had to have come up from “the bottom.” In other words, to reorient his delivery system, he no longer wanted urban doctors in central level positions, and preferred to rely on those who had worked in the periphery who knew the realities of the field.

Of interest are the remaining seven decision-makers representing the Progressives and Non-risk Takers in Quadrant 3. They embrace the qualities of a highly preventive approach based on community participation. All of these seven (and the inclusion of David) can be considered Norton’s “protégés.” All were selected to come to the central level from rural leadership positions. All were either sent for MPH training, or received short-term training outside the country in public-health related areas. All are relatively young, having finished their MD degrees within the previous five to six years. Those on the Progressive side of Quadrant 3 passed through community-based health centers which had greatly influenced their perceptions of health care delivery. All saw the necessity for collective decision-making with the community. Several mentioned the necessity to view health holistically and the need for inter-sectoral collaboration. At the time of the interview, all were serving as
program heads, having assumed these positions within the last two years. In a sense, these people represent those who had a vision of what the health delivery system could be, but were frustrated by the factors that impeded their vision. Even though Norton set the stage for their training, their own experience (and perhaps younger ages) gave them even more liberal visions of PHC than Norton, who was obliged to operate under the constraints of a highly authoritarian regime.

David straddles the fence on the community development/authoritarian continuum. He is perhaps the most influential member within the Ministry's staff, and served as the closest advisor to the Minister. He was the point of first contact for the donor community, and carried the Ministry's vision to both the Ministry staff and those on the outside. As noted in the section profiling the respondents, David undertook his MPH training in the U.S. and was exposed to the role of community participation in a pluralist society. However, he still tended to operate in the authoritarian manner of the Burundi civil service. This slightly authoritarian style may be attributable to the high position he held within the Ministry and the Ministry's stated desire to establish a strong role for a planning department.
C. Factors Influencing A Decision-maker's Belief System of Primary Care

A list of factors influencing an individual's vision of Primary Health Care appears in Figure VI-2. Decision-makers were specifically asked: "You have just described your vision, which is very interesting. Your way of viewing a primary care based system and that of another colleague can be, and most certainly would be, different from one another. Is there anything in particular in your life, such as a work experience, training, a person or another important experience which has had an impact on your way of viewing how a health system should be organized?" I grouped the responses by the three most mentioned response categories: Training, Practical Experience, and Individuals. All of the decision-makers noted more than one influence. However, first responses were considered the most significant influence unless otherwise stated in the interview.

1. Role of Training

An individual's training played the greatest role in shaping a PHC vision. For those who had no foreign-based long-term or short-term training, domestic short-term training proved significant because it departed from the medical approach to which they were accustomed. Two decision-makers said that the public health training they received at the University of Burundi had a major negative impact on their initial interest in the public health field because it was presented poorly. Until 1993, the medical school faculty, which is dominated
Figure VI-2. Factors Influencing PHC Vision
by Belgian and French medical doctors who worked as technical assistants, downplayed the importance of the public health curriculum. Several mentioned that their medical degrees had prepared them for an urban clinical context, but not for rural Burundi.

The Expanded Program for Immunization (EPI) which began in the 1980s played an important role in funding and providing short-term public health training programs to Health Ministries throughout the world. Its impact on Burundi is evident in the present survey results. For example, several respondents regarded EPI training programs as playing an important role in giving them, as one respondent commented, “a broader vision of health problems and deeper understanding of programs.”

Management training also played a significant role in shaping how individuals perceive primary care. One decision-maker mentioned that he had planned on specializing in surgery until he participated in several short-term training programs in community health and health management. This experience greatly influenced him to seek a Master of Public Health (MPH) degree.

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2One of the major challenges the government of Burundi faced in preparing a sufficient number of doctors to serve its population was poor collaboration between the School of Medicine at the University of Burundi and the Ministry of Health. Lack of collaboration among different sectors is a perennial problem within the highly hierarchical government system. The clinically dominated School of Medicine fell under the jurisdiction of the Ministry of Education and felt little, if any, affiliation to its poorer counterpart, the Ministry of Health.
2. Role of Practical Experience

An individual's practical experience also shaped what kind of vision he/she held. Practical experience refers to professional appointments held in the health care setting throughout one's career. Of particular interest is that four respondents who put the most influence on the role practical experience played in shaping their visions, were also those who had worked in an alternative-based community health project or program. It is also noteworthy that these individuals also had the greatest community oriented beliefs about PHC.

Many decision-makers stated that it was only through practical experience that they began to have a clearer idea of health service organization and the difficulties that the delivery system faces in meeting the needs of the population. One key advisor in the system noted a very significant event that shaped his understanding of the realities and challenges facing both the delivery system and the population.

I used to do a lot of surgery...there is a lady who broke her humer bone. I referred her immediately to Ngosi [provincial capital] when I saw her. What does it mean to refer somebody? It means you give a piece of paper to the patient and he/she has to manage to get to Ngosi. As a doctor I thought that I had fulfilled
my duty by giving this written paper to a patient asking her to go see Doctor ‘X’ in Ngosi. A year later, I was assigned in Ngosi and at that time I did not have a surgeon. I was the regional medical doctor and I was also in charge of the surgery service. There, a lady came to me with a note on which I recognized my handwriting. It was a note dated a year ago. I asked her: ‘What happened?’ She replied, ‘I have asked my children in Bujumbura to come here and support me but they refused...’ So I operated on her, a year after, in Ngosi. That is why I told you earlier that there are things, many things, that I came to understand through practical experience... This is the period when I started to have a clearer idea about the organization of health services.

In this light, rural postings were often mentioned as affording physicians a better understanding of the realities facing the health delivery system.

3. Role of Significant Others

Half of the respondents claimed that certain individuals played a role in shaping their vision. “Significant others” refer to individuals who either professionally and/or personally played a role in shaping the decision-maker’s vision. Foreign consultants with whom decision-makers collaborated in the present or past were mentioned as influences by two individuals. Two
decision-makers noted that exchange of experience with their peers assisted them in understanding they were not alone in feeling ill prepared for the problems they faced in the field. One respondent, an ex-minister, found his exchanges with other Ministers of Health to be extremely useful. The following experience had a major impact on shaping his vision, which was highly focused on ensuring a functioning national health insurance scheme for the country. He stated:

African ministers of health meet at least twice a year in Geneva at the World Assembly, or in Brazzaville...and on those occasions we shared our experiences. But I was badly surprised when I talked to my colleague Minister from the Ivory Coast about how to organize the management of drugs, because this was my major problem in 1989 as people diverted these drugs. He told me that he was not facing such a problem simply because he did not have drugs to manage. And you know Abidjan is a big city and modern too! The Minister told me that they have not had a budget for ten years because they owed a huge sum of money to the drug companies. Then I visited their University medical hospital and talked to the doctors there. They told me that health care is free, but in fact, patients who needed to be operated upon had to buy all the materials (scalpel, gloves, etc.) for the operation, which is
very expensive. So, in the village, the people would pool their funds in order to help the person. I decided that since we are a smaller country than the Ivory Coast we had better suppress the system of free health care and encourage community participation to avoid such problems...and I urged my colleagues and the government to put in place the system of a 'Health Insurance Card.

Another individual stated that he was highly influenced in his vision by his own grandmother who was a traditional practitioner.

There were many young children around there and some of them were chosen to go get the plants in the bush. I was part of that group of young children. Later on, all the other children were asked to stop doing that work because they did not respect the recommendations. I was the only one left. The plants were to be fetched at a specific time of the day, around 6:00 p.m. The recommendations were that we had to run non-stop to the bush to get the plant and run back non-stop to my grandmother to give her the plants. We were not allowed to talk with the people we met on the way to or back from the bush in order to keep the secret aspect of the procedure of traditional care. And later on, I had to
decide on the school to attend, secondary school. When I discussed with my mother, she said to me 'whatever school you want to choose, think of medical studies because you will be a good doctor. You know how to keep a secret and how to follow a recommendation.' And this idea stayed deeply rooted in my mind until my orientation to medicine.

Only half of the sample mentioned the role of significant others as a factor in shaping their vision of PHC. Nevertheless, the preceding statements give specific examples of the importance of this influence in molding decision-makers' perceptions.

D. Summary & Conclusions

This chapter has explained and classified the belief systems of key Ministry of Health decision-makers. Content analysis was used to classify individuals and common belief systems into four groups. Further analysis indicated that common life history experiences played a role in shaping belief systems, noted by individuals with similar belief systems who have had similar life history experiences. Specifically, decision-makers who passed through a community-based health care delivery experience in their professional careers held more progressive belief systems about how primary care should be
delivered. Training in public health played the greatest role in shaping an individual's belief system, particularly those in the Progressives group.

The finding that an individual's life experience does play a role in shaping his or her PHC vision is of particular interest to decision-makers in both public and private health organizations and institutions. It provides valuable information about where financial and human resources could be most effectively channeled when trying to move a community-based approach forward within an organization or institution. For example, a donor organization with limited funds and interested in a long-term impact on primary care might choose to spend their dollars on public-health training. The information also offers insight into the kinds of attributes one would seek in hiring a person who would be instrumental in promoting a certain health care approach. Health administrators might seek out individuals who lack public health training if the organization's agenda is to encourage more out-of-pocket payments or to bolster hospital services.

An understanding of both decision-maker's PHC belief system and the Ministry's PHC approach serves as a backdrop against which we can identify the differences between the two. The following chapter, therefore, will assess whether gaps exist between individual and Ministry PHC approaches. More
importantly, if gaps do exist, the next chapter will analyze what factors promoted or impeded attainment of their belief systems.
VII. Gaps in Decision-Maker Belief System, Ministry of Health Policy and Program Implementation

A. Decision-Maker Influence on Defining the MOH Approach

Decision-makers were given three different opportunities in the interviews to describe their influence on the MOH approach (See Appendix 1). First, having described their vision of primary care, they were asked if they had been able to influence the development of the delivery system with their personal vision. Second, each individual was asked to describe how policy is formulated in the Ministry. This account showed whether there was a perception of only a limited number of individuals involved, or whether a group-oriented consensus-based process prevailed. Third, once decision-makers defined the policy process, they were asked if they felt they had an influence on this process, and if so, to give an example.

All decision-makers said that they influenced the Ministry’s over-all approach. At first, I was surprised that they all felt this way. Most Barundi are modest and reserved about their accomplishments. However, the locus of control was not so much on the individual but rather on the collective unit. In other words, the use of a consensus-based decision process was striking. These initial responses revealed that policy decision-making within the Ministry was based on group effort and focused on consensus. One ex-minister felt
that his influence was very broad and long-term. He first mentioned that he influenced his direct collaborators, those at the intermediate level, and had helped a great number of people within the government understand the reforms needed to begin to meet the needs of the health sector. He further stated,

I think that in five or ten years from now, everything will be put in place the way I imagined it. People understand now that a project can continue even if its initiator pulls out, a great number of people understand that now. It is easy to continue when many people have the same vision.

Another decision maker focused on the strong commitment and leadership among senior level decision-makers in contributing their views. She emphatically stated:

I look at my role. Well, you know we do not have a right at this point, to not have an idea about things,...especially as a leader within the institution. I feel each leader has his or her way of looking at things. The important thing is to be able to transmit one's way of looking at things, one's convictions about how the health system should be developed. Everyone participates with
his convictions and tendencies in a health policy...And you know, we are not a very big staff for carrying out decision-making in policy definition. Therefore each of us is on our sideline. If in the end we all end up talking about community based health...with the community as the primordial base of the system...then this is our way of contributing to the policy.

Two individuals who were more recently placed at the central level from previous positions as Provincial Medical heads, noted that aside from their influence, the formal work setting and influence existed on an informal level too. One noted, “But even in an informal sense, when you are informed of what is happening, and you know who is in charge of the actions, you can still have an influence informally. It is really easy to do here.” The implication here was not of a devious nature, but based on the fact that as a relatively small central Ministry staff, informal conversations regarding the Ministry’s issues at hand happened all the time.

All respondents described a similar policy process whereby certain broad orientations are set by top government officials and used as a point of departure by the ministerial cabinet. For example, the problem of reducing population growth was defined as the second national priority (after national unity). As such, family planning played a major role in the Ministry’s policy
document. In policy development, once the general orientations were proposed, a commission of around twenty technicians representing project directors, department heads, and others must agree on the proposal. Decision-makers all described a process whereby specific sections of the document are developed by different sub-groups. This document is presented at the intermediate level and sector heads and hospital directors are also associated. The final policy document must be approved by the Ministry cabinet, and then is ready for presentation for approval by the Board of Ministers.

One highly placed individual commented on the projected impact of using such a broad consensus-based process: “All these people constitute about 100 persons. If you have 100 persons scattered throughout the country, who have the same understanding of the orientations, even if one of these 100 persons decides to pull out, the rest of the group will continue the work.”

Another decision-maker stated that as a member of the Minister’s cabinet, most of the Ministry decisions were made at this cabinet level. He described the process as “an exchange of views which leads to a general agreement. Based on this agreement, a decision is made about how to conduct certain issues.”
The third question to assess decision-maker policy influence asked whether or not they had a direct role in policy development. One of the older respondents felt that in his present position he had less influence. However, throughout his career in the Ministry, which included being a past minister, he played a very influential role. Specific examples of policy development roles were cited, ranging from playing the lead role in developing the Ministry's HIV/AIDS policy to being a member of the policy commission, or holding a lead role in it.

Thus, while policy development was an exercise that had only been undertaken for the first time in 1988, the model employed enlisted a broad based consensus process, where exchanges of opinion were welcomed. As such, all decision-makers involved in this research felt they contributed to policy development in one form or another.

B. Factors Promoting or Impeding Vision

Decision-makers were asked if there were similarities or differences between their own vision and what was being practiced by the Ministry. I separated their responses into factors that promoted and impeded vision achievement.
1. Factors Promoting Vision Achievement

Figure VII - 1 lists the common factors stated at least three times that were attributed to bringing an individual's vision closer to that of the MOH. Strong public health support was the major factor noted by almost half the respondents. The second most common response is that personnel are better trained, indicating that the Ministry's focus on training its staff was producing results.

Also, there were differences among the decision-makers in the kinds of promoting factors they mentioned. For example, several mentioned the role of political factors in moving toward a more community-based, less authoritarian primary care system. Several decision-makers mentioned that the political environment is evolving,¹ the population is "claiming" what was promised to them in health, and the existence of more democratic institutions. There was also a recognition by this group of the "semi-decentralization" that took place in the Ministry. One stated that the creation of health provinces was an improvement, as noted by the presence of drugs in the periphery and hospital directors and provincial heads who had been given decision-making authority over personnel.

¹The words 'evolving' or 'evolution' were often used by interview respondents to describe the process of change that was occurring due to the effects of liberalization and democratization within the government and civil society.
Figure VII - 1 Factors Promoting Vision Achievement

- Improved implementation of established policy
- Government support for health sector
- Ministers with Public Health background since 1988
- Existence of "semi-decentralization"
- Good assistance from technical assistants
- More personnel
- Politics becoming more democratic
- Evolution in Population's way of thinking
- Better trained personnel
- Strong MOH public health support
Others noted that due to the better understanding of public health in the Ministry, there was improvement in community health education efforts, a greater understanding of the population's needs, and better communication with the community. Furthermore, two individuals referred to the impact of government reforms outside the health sector as playing a role in creating the right climate for a community-based approach. They specifically noted that the present focus on liberalization, privatization and competition made people more creative and independent. Another noted that policy is playing a greater role in government. This decision-maker specifically stated,

I think the factors are the application of the established policy. Because we know that when one starts to formulate policy, and the strategies which follow...when they are well established, frankly it becomes much easier to move forward. But I think all of this came about due to a step that the government was able to make. There has been a good evolution among government heads...the authorities...who are now conscious that things need to be applied...[and] that there needs to be a relationship that follows the spirit of the established policies. It is in this sense that a great evolution has taken place.
One individual claimed the strengthening of the central level as playing a major role. Specifically, policy decisions and strategies now had more influence because there was presently a central level staff following a precise program.

The Conservatives were far less critical of political structures than those found in Quadrant 3. One Conservative believed that the health system was on the right track towards community participation, apart from the political problems. Emphasizing the financial aspects of community participation, he noted that the only thing left for the MOH to do was ensure the collection of money for the national insurance card. Both statements underscore the perception that health is a separate issue from politics, and that politics neither impedes nor promotes their vision achievement.

2. Factors Impeding Vision Achievement

A general statement can be made that there were more impeding factors than promoting factors. Figure VII - 2 portrays common responses regarding factors that impeded an individual's vision achievement. Half of the respondents mentioned poor management and lack of supervision and follow-up as an obstacle between their vision and the actual approach of the Ministry. Lack of resources was equally mentioned by half of the sample.
Figure VII-2: Factors Impeding Vision Achievement

- C.P. = $, not opinions or part. of pop. in management
- Political barriers create greatest handicap
- Need for more democratic systems
- Central level unwilling to let go of power for decentralization
- Decentralization only theoretical or incomplete
- People afraid to speak/demand things
- "Closed" or "static" system/lack of innovation
- Lack of appropriate training (public health)
- Lack of resources
- Poor management/lack of supervision/follow-up

Number of Responses
Of particular interest are the following set of common responses which are politically-related criticisms. There was a strong perception that the Ministry's system was a closed or static system, or that it lacked the ability to be innovative. One individual talked extensively of this impediment. In describing a common criticism that most staff are used to waiting for orders from the central level, he stated:

The system that we have is immobile, we must work in a very precise context...The fact that you know a person is your point of reference, even for the littlest thing, brings you to the point of no longer thinking of other possibilities for blossoming professionally, by other roads. You say to yourself, 'I will refer to my boss' and you finish by being a prisoner of this system in the long term.

There was equally an emphasis on the authoritarian nature of the system as an impeding factor. Specifically noted was that decentralization was only theoretical or incomplete, that the central level was unwilling to let go of power. Related to the concept of decentralization were comments regarding the need for more democratic systems, or that political barriers created the greatest handicap. Therefore, it is not surprising that some noted that people are afraid to speak or demand things. Finally, a minority felt a major difference
between their vision and that of the MOH was that community participation was referred to more often as a monetary factor, not as participation in the management of health services. There was also a perception that even though the Ministry had made progress in creating a public health awareness, further training was necessary, especially at the provincial level. Lack of public health and planning experience among Provincial Medical Heads blocked decentralization efforts.

One of the Conservatives noted that a factor impeding community participation was that the Ministry didn’t know the best method to bring people together to understand an action. As usual, for this group this was seen as a technical or methodological problem, not as a political obstacle.

C. Key Differences Between Decision-Makers and MOH Approach

Chapter V showed that the Ministry’s policy document outlines an approach that in its broadest definition is “multi-sectoral, community based, integrating curative care, disease prevention and health promotion” (MOH, 1988 p. 3, my translation). At a general level, then, the Ministry is a prevention-based system not too dissimilar from its decision-makers. Nevertheless, the document’s ambiguity about key concepts such as community participation and decentralization left much room for interpretation. When asked about the
role of health policy for the Ministry, one decision-maker’s response clearly illustrates this point.

I think if we take a look at the policy of 1988, we can see that there are a lot of achievements. But I think that the policy needed a redynamization, and I would say, a follow-up. Words like “decentralization”, “reactualization” [up-date] existed in the policy of 1988, but they were not well defined. Their meaning was not clearly explained and everybody could act according to the way he/she understood the meanings of these words. Now our aim is to be precise in the policy with these [terms] so that we can be more concrete in the planning to come.

The concepts of decentralization and community participation laid the foundation for the Ministry’s new approach. Thus, it is not surprising that there is a range of interpretation of the concepts held by Ministry staff. The greatest number of comments in the interviews centered around insufficient progress in community participation and decentralization. Given the political and social variables affecting Burundi society in the period under study, this relative lack of progress is not surprising.
The following section portrays in greater depth the differences in views between the Ministry's approach and those of decision-makers regarding these key concepts. Highlighting decision-maker's views on community participation and decentralization in Burundi health delivery affords insight into some of the human agency and structural variables affecting PHC implementation in Burundi.

1. Community Participation

One of the major findings of this research was that the Ministry's stated policy document and the views of the majority of decision-makers were fairly similar. For the most part, all decision-makers focused on a prevention-oriented system with a community-based delivery approach. They differed on the degree to which the community was expected to be involved and exactly how it was to be involved.

The Ministry's policy document makes one small reference to the "participation of the population" in its objectives for decentralization. The objective states that the Ministry will "elaborate a policy concerning the participation of the population in the definition of the needs and the administration of health establishments" (MOH, 1988. p. 17, my translation).
Between 1988 and 1993, a specific policy about community participation had not been developed, other than the population's financial participation in the 'Carte D'Assurance Maladie' (Health Insurance Card) and the pilot Bamako Initiative undertaken in the Muyinga province. By 1993 neither endeavor was meeting with much success, mainly because the Ministry failed to appreciate and fully confront the political and intensive management ramifications of involving the community.

Decision-makers' views of community participation in the health sector are depicted in Chapter V, and therefore do not need to be repeated in this section. However, since community participation was noted as a key element for a primary care approach by the majority of decision-makers, each was probed further. I asked whether or not the political structures of the country would allow for a community approach. The question was phrased to take into account the current crisis brought on by President Ndadaye's assassination. Had it not been for the crisis, this would have been an extremely sensitive and difficult issue to bring up.

One decision-maker, a Hutu, said the following about hopes and fears that many Hutu held but rarely talked openly about.

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Very few decision-makers had a favorable impression of the Bamako Initiative. The Ministry of Health had intended to extend the Bamako Initiative beyond Muyinga, on a province-by-province basis. By the end of 1993, further progress in this effort was limited.
It will take time. But if things were to come back to normal, considering that the power [of the democratically elected government] were to maintain itself as it is...the results would not be expected right away to be positive. But, I had hopes that the structures of the party [FRODEBU] itself and the politicians, if all of them worked towards this, the participation of the population could have been obtained...There was also a little doubt about community participation, which is that a part of the population is involved in political opposition parties. As such, they can intervene in or play a role in pushing people or blocking them in order to prevent them from succeeding. But we had some confidence because these parties are a minority. But we hoped that this could be overcome since the administrators were all from FRODEBU...That we could have in the hills, well to show that they won and that they want to develop their country. Personally, I had the impression that this could work.

This statement signifies the hopes of the majority to take Burundi’s development into their own hands, an opportunity that they had never held. It further illustrates the fragility of relationships in a society in which pluralism has never been the norm.
Another decision-maker, a Fence Sitter, was asked informally at the end of the interview why, if everyone interviewed believed in community participation, hasn't it been achieved? His statement, like the one above, shows how the pre-conditions for community participation, go well beyond the health sector:

Community participation does not regard health alone. For community participation to be effective, all sectors need to be developed. It is more in the administrative area than in health...it is something global. If democratization is there, then we can organize talks in order to have the same views...[about] community participation. The population did not know that the health center is theirs. You must have heard that in some areas health facilities were destroyed. This question needs a change of mentality and this change can be made by the people themselves. People should not be afraid to give their opinion.

This decision-maker was questioned further about how to bring the population to claim their needs when the political system does not allow it. His response was that freedom of expression lies in democratically elected representatives so the expression and solution finding can be found at all levels.
Community participation as a means for freedom of expression was a major focus of other interviewees as well. Another stated Burundi has no choice but to move forward with community participation and more democratic institutions. Such a process was clearly defined as long term, given the country’s political history. This person noted:

People must be able to go out...to be able to speak! If people can talk freely, if they can express themselves without feeling afraid...I think the evolution of things will improve. Otherwise, if we stay in a closed system, I think we will always have these problems. It is really in the interior of the country...it is the peasants who committed massacres. So, I think that is why we must have the community’s participation.

This implies that the intellectual elite understood democracy, but the local population had not come so far. This is in contrast to another individual who observed that ethnic conflict was the intellectual’s problem. Nevertheless, the relationship (close proximity) of democratization nationally and within MOH were intertwined in the minds of decision-makers.
Very candid statements were made by a decision-maker about the political barriers to promoting community participation among political authorities whose collaboration would be needed to support such an effort.

I think it is possible [community participation] but difficult because the political authorities do not understand what to do and how to do it...They are not sensitized enough...otherwise, I think it is possible but difficult...difficult...because even for political authorities at the intermediate and peripheral levels it is difficult to sensitize them, to convince them in matters of primary health care. This was noticed during the struggle against cholera, for instance, and we were not satisfied with the support of the political and administrative authorities at the intermediate and peripheral levels. Political instability is a bad factor which does not allow the success of our policy, of our strategies. They have something else in mind, most of the time and they accept when you sit with them talking about these issues. They will tell you that they will try their best, on the spot; but when you go to see them a few days later they tell you that, 'We have been busy doing something else.' This is a problem! It is the political barrier which is the greatest handicap. Otherwise, the administrative personnel of public
health is motivated for action but the support of the political leaders is lacking.

He went on to cite how ethnic conflict is a compounding barrier. There are many factors which prevent us from achieving our objective. There is even the context of political/ethnic conflict. If you talk to a person of a different ethnic group than yours that person may understand something else. This is a problem and what it is even worse...some people do not even want to see another person from a different ethnic group than theirs...This is a big problem.

All of these statements indicate that the impediments to a community participation approach within the health delivery system exceeded the scope of the Ministry. The social structures and history of ethnic conflict have created a Burundi character whereby freedom of expression and democratic processes, an important base of a community approach, will take years to learn even under the best circumstances. The statements also show that Ministry staff, either Hutu or Tutsi, were for the most part, fairly progressive in their view and had a good understanding of the relationship between a democratic system and community participation.
The question of equity in the distribution of resources as the base of the conflict, was mentioned by only one decision-maker. This Tutsi stated the following:

I think that the issue of community participation is a must. Whatever the system, especially now that we are in a democratic process, in order to satisfy the people, the cards must be put on the table. People have to see that which is happening...they have to see that there is an equitable distribution. Because where do the conflicts come from? They come from inequality: some people take too much...And if you take a look at the provinces...well, there are places where there were not enough structures, compared to others. This is why it is necessary, if one has the goodwill for doing things, for distributing things equitably. If a person does not undertake distribution with the collaboration of the people, he is bound to fail. People will not be satisfied. They will always think he has put aside some resources in order to favor a given person or group of people. In the present context of our country where there exist ethnic conflicts, political conflicts...transparency is needed. You must have people participate even in this planning.
Norton, the ex-minister who had such an impact on orienting the Ministry's new approach, reflected on the different meanings of community participation as well as how people adopt new ideas. Note that his statement situates community participation in a fairly apolitical context. He stated:

In our case, I think that if we have not been able to reach the objectives set in community participation, I do not know if it is the system which blocked the initiatives. I think that it was an innovation that people did not understand the same way so...it is necessary to take time, in order to inform the partners and explain to them the meaning of community participation. We were not able to do it as we wanted it to be done. But, we did do something. We did do praiseworthy things such as building of health centers. Most health centers are built by the population...they participate as they can. The population knows that it is part of the center because they participated in the building...Concerning the finance we needed time to convince our collaborators first. It was a "bohoro-bohoro" process. It was a difficult program, as I said, because some people needed to be convinced in order to go and convince other people. I can say that I was convinced in what I was doing, that is why I insisted. Just like President Buyoya, he was convinced in the 'Unite Nationale
(National Unity), but all his collaborators were not. But they were always together and they ended up being convinced and started to convince other people. When I entered the government, I did not have the same convictions about National Unity as I had when I left it. It means that the President and his collaborators had an impact on me.

2. Decentralization

Decentralization was a government objective as well as a prime objective for the Ministry of Health between 1988 and 1993. Fully aware of the challenge of providing access to quality health services for an entire nation, decentralization was a necessity that the service oriented Ministry could not ignore. This is illustrated by the major focus on decentralization in the Ministry’s policy document and among all decision-makers interviewed. Moreover, when decision-makers were queried about whether there were any Ministry policies that were not implemented, decentralization was mentioned by over half the respondents (See Figure VII - 3). The following assessment illustrates the perception that decentralization weakens the delivery system.

The health sector [meaning government provided health services] constitutes the lung of health in Burundi. So this entity has to be very operational, otherwise the whole system will be affected.
Even if there are central projects, national programs, a strong, central administration that works, as long as the health sector is not operational, I think that there will not be any progress. So it is urgent that the intermediary level be reinforced in matters of human, logistical resources in order to allow a convenient enough management of the health sector.

During the time I spent collaborating with the Ministry, I always perceived a desire among Ministry staff to ensure decentralization. It was a word used by everyone. But, like the word community participation, just what decentralization actually meant, and how it would be achieved, remained elusive. There were many criticisms of the weakness or lack of responsibility given to the provinces to run their programs.
One respondent said that decentralization is only an abstract construct within the Ministry.

We talk about decentralization, but this decentralization is still theoretical. My trips to the field have shown me that really, decentralization is only theoretical. For example, you go to a province, and you ask questions to a provincial medical doctor...He is there, he is without any resources. He is a Provincial Head without a vehicle to enable him to follow the activities happening in his province. So how can he adapt his program to the cultural context of his province? You must have the power to make a decision! As long as that decision is in consultation with the team with which you work, I think that this is sufficient for taking decisions. The Provincial Head must come to the central Ministry to ask for the authorization to take a certain decision. This is really a block!

I inquired further about whether or not a Provincial Head could be innovative in responding to a particular problem in his province: would he or she have the freedom to make such decisions?
I do not think so...In reality this is a step that needs to be taken. Theoretically, what we do is good. But, it has to be done...It has to be practiced. At the ministerial level, at the central level, we have to let go completely. We have to have confidence in the authorities we have put at the intermediate level. So we need to give him confidence and give him all the means, all the abilities to manage, so that he can be able to apply and be innovative in function with what he sees in his province. So, I think this is really a step we have to take. The central level has to let go of the means and give the power to this intermediate level. The intermediate level equally has to let go to the peripheral level.

The frustrations of working in a highly centralized decision-making hierarchy were echoed by another respondent. This description illustrates the feelings of futility among staff further down the ministerial hierarchy.

There is a certain blockage that is found...shall we say at all levels. This is because there is no authority given to the person that should have it. A title is given to a person, but this person does not have the power to exploit this title...to make decisions. It is really at the decision-making level that there are always problems. Because someone who is placed here, and according
to his title should be making all the decisions...but has no authority. However, I myself, who is inferior to this person...I see that it is he who should be making decisions. But, this person must go to an even superior level for decision-making. However, if the decisions could have been made at this level, things would have been much easier. We could even be innovative...we could give ideas and innovations into the system in which we are working...Otherwise, if there are these hierarchical relationships which are fixed, which are not flexible, there will always be problems. This is what I think is lacking in this country.

Another decision-maker explained centralization this way:

I told you that it has always been a question of decentralization, but...apparently it did not happen as it should because I think that people are afraid of giving responsibility. At the central level, it is not evident, for instance, that the program directors accept to decentralize because when you are chief of a program, you have the resources, you are happy, you are an important person and, it is difficult for you to give responsibility to other people. I think that these are some of the factors that acted to the disadvantage of
decentralization. But a meeting was organized and now the MOH makes people delegate power. This is a challenge.

This response illustrates the challenges any post-authoritarian system faces in moving towards more democratic procedures. Rent seeking by government officials who continue to profit from their status is a common blockage in decentralization efforts (Clark, 1994).

Another spoke of how he would remedy the above situation if he were in control of the health sector. He was aware of how the centralized system stifled innovation in the health sector.

I think that when undertaking decentralization, it is already a certain openness towards innovation. So, in naming someone responsible and telling him, 'Develop your system'...he works with local realities...Somewhere a nurse in a health center can really undertake an approach that I might not have thought of, or even the Ministry might not have thought of. And, it might contribute to the improvement of the system...Right now the system puts you in a place. And it seems that it limits you. However, there are other things you can share. So for me, the best minister is one who
allows his collaborators at all levels to think...to be innovative, to put things forward for improving the system.

Some respondents linked decentralization to the context of democracy. One individual very insightfully stated:

I think that we were in the beginning of the construction of this democratic entity. For example, the administrators are not elected nowadays...I think that there should be elections from the bottom to the top. If this problem exists, it is because the people do not trust the leaders because when you elect a person, you accept what he/she tells you. For instance, a few days before the crises, the population had started to chase down some people regardless of the authorities because the population did not elect those authorities. I think that if there are elections from the bottom, not only concerning the administrators, but at the level of the hillside...If a person whom the population trusts is elected at the head of each colline and then, I think that those people can be listened to. This is the type of decentralization that is wished...and our technician at the health center or at the province would play the role of advisor to the politician who is elected. The Provincial Head must be the technical advisor of the governor in matters of
health for the development of the province. If we had enough staff, I would prefer that a native of the province be appointed as the provincial doctor because he knows his province and he can, with the governor and with the other people, better develop that province than an outsider. He can gain their confidence more easily than an outsider. This is to be done step-by-step.

He went on further to cite a specific focus for decentralization based on democratic reforms:

There has been an administration from a unique party and this cannot be changed in one day. But I do believe that the solution is there. If we could have democratically elected structures with a certain democratization and...what I mean is finances. Human resources can be obtained but they may lack the money and depend on the central level. There must be a decentralization of all the sectors of the country, including health. Any future development should be take into account and set up decentralization. People's representatives are needed as well as representatives of other sectors related to health for a harmonious development of the province. This country is small and it is possible to develop all this very quickly if there is good
confidence in it. This can prevent catastrophe in the future because if people are responsible for themselves, if they know they share the good and the bad, I think that they will not have time to think about killing each other.

The above comments were made by a decision-maker who had trained in the United States, and therefore had first-hand experience of a pluralist society. His comments indicated that perhaps he had gained an insider’s view of democracy based on that experience.

One individual spoke about the progress in decentralization prior to 1988 in the breaking down into 15 health provinces to correspond to the 15 administrative provinces of the country. Although he felt it was a good step forward, the financial and material decentralization did not follow. He spoke of his own role in trying to promote further devolution of power for decision-making as early as 1988.

In 1988, I really tried to shake people up in order to achieve this because there were problems in supply. It was necessary to go to Bujumbura, or go to the region...I had hoped we would go further at the time [with decentralization], but it was difficult. The
Ministry was too much centralized from 1987 when I arrived, to June 1988.

When asked what brought about the change, he stated that for the first time doctors came from the periphery. He named every individual who was appointed from either the periphery or the provinces and placed in a directorship position at the center. At the time, he felt there would be real movement in pushing decentralization forward because everyone understood the realities faced in the provinces. He said:

The Director of Budget and Supplies was a pharmacist at the central level. As a matter of fact, we [the respondent and his newly appointed colleagues from the periphery] were in big conflict with him in trying to decentralize the management of material and financial resources. Let us say that this was the real cause of change in favor of decentralization. These are the elements which came in the central system. And coming from the periphery, many people understood what I was trying to do, but it was difficult to convince the Minister...but finally we did succeed. This was Mr. Niogoka who was Minister for one year. But with Norton, it was much easier.
Referring to the policy to give Provincial Medical Heads decision-making authority over human resources, it is interesting that this decision-maker felt the Provincial Heads would begin to grab other powers under an authoritarian system. Clearly, he underestimated the degree to which the authoritarian system was engrained in the bureaucratic behavior of individuals, even those beyond the central level of the Ministry.

On the logistics side, there was resistance regarding decentralization. It was not well understood because the control of resources is not an easy thing to do. We knew that it was not going to be easy. But facing the resistance, I said to myself, we are going to start with decentralization of administration. The people who are going to be appointed will start claiming other things as soon as they get into the management of personnel.

When he was asked to identify differences between his vision and that which was practiced, he responded:

On the top people are trying to decentralize, to bring decisions closer to the community. Programs are being prepared, but, what is lacking is the association of the peripheral population. I cannot say I have field experience because it has been five years now
since I left the rural area. Human beings forget rapidly...if
tomorrow you became President of the United States, you will
forget that you were in Burundi. You may remember but there are
details that you are going to forget rapidly. This is to tell you that
there are doctors and specialists who have worked in the field
and who have elaborated the system, therefore I am sure that they
know the realities of the field. Field realities change very quickly
and after leaving the field we forget rapidly that we were in it. This
is why I think that if planning is to be done for health development,
it is absolutely necessary to start from the bottom.

This view and others documented here support the Ministry's
stated policy of the need for a community-based approach. The
problem, of course, is that beginning at the grassroots can be very
threatening.

D. Summary

This chapter has argued that decision-makers influenced both policy
and program implementation in the Ministry. The chapter further shows that the
greatest disparity between decision-makers' visions and the Ministry's PHC
program implementation results were in progress made in community
participation and decentralization.
By 1993 some effective decentralization had been accomplished. This is illustrated by the three examples. First, Provincial Heads were given authority over human resource allocation. Second, a decentralized drug supply and distribution system brought some improvements in the availability of drugs to the periphery. This lack of drug availability was one major factor that had been inhibiting the population's confidence in the health system (USAID, 1992). However, further improvements were still needed. Finally, autonomous management of hospitals in Bujumbura showed the challenges and the benefits of decentralized management on a small scale.

On a day-to-day level, decentralization was always addressed as a purely managerial issue, devoid of any insinuation of power roles. Interview responses regarding decentralization indicate that only four individuals perceived links between decentralization and promoting a more democratic process in the country. Most often, those who were most critical were those who had previously held positions at the provincial level. They had personally experienced the frustration and powerlessness of having responsibility to run a health delivery system for a large population, but given little or no control over financial and material resource allocation, and no ability to follow-up. Similar administrative weakness exists among regional levels of other African health ministries (Walt, 1994). Thus, while the Ministry had moved forward in decentralization through the creation of an intermediate level, for the most part
its operating mode remained highly centralized. This corroborates Conyers (1986) argument that in decentralization, several often conflicting objectives can be operating at the same time. If the Ministry had the will, as evidenced by its policy statement and comments by decision-makers, why then was it immobilized? Why is there a gap between the stated policy approach and day-to-day actions, even with the support of key decision-makers? Both the issues of decentralization and community participation lend an understanding to these questions because they show how the context of Burundi imposes structural barriers on human agency.

The lack of progress in decentralization and community participation can be attributed to many structural variables beyond the realm of the Ministry’s capacity, let alone a few health planners and policy makers. Given what we have learned thus far, the concluding chapter will use a realist perspective to explain how the interaction between decision-makers (human agency), the Ministry of Health (institutional culture) and contextual factors (structures), produced Burundi’s primary care approach (social action).
VIII. Conclusions

A. Introduction

Eighteen years into Health for All, few policy-makers have begun to take stock of how the political, economic and social changes of the last two decades have interacted with government approaches to primary health care. By 1978, most African health Ministries held direct responsibility for delivering care to their populations with a mere ten to twelve years of administrative experience since the onset of independence. The past two decades have witnessed significant changes in direction for dealing with developing countries' health problems. At the same time, reforms sweeping across Africa are now beginning to signal to decision-makers that they are no longer operating under the same premises of Alma Ata in 1978. It is time to assess the changes that have taken place, and how they influence our thinking about primary care and its implementation. This dissertation has tried to conduct one 'reality check' in the case of Burundi.

Understanding how PHC has evolved in a variety of contexts sets the stage for lessons learned over the past 18 years. This chapter begins by summarizing the findings concerning the research questions that guided this research. It then explains PHC as a social action in Burundi. I use a realist approach to explain the interaction among human agency, institutions and
structure. Finally, I conclude by setting Burundi’s PHC experience in the broader context of PHC and democratization in Africa.

1. From PHC Belief Systems to Vision Achievement and the MOH Approach

This research was guided by five research questions whose results are summarized below.

a) Classifying the MOH approach reveals an institution that has evolved over time. The early 1960s were characterized as a highly curative hospital based delivery system inherited from the colonial period. By 1993, the MOH had a progressive statement for a health delivery system that emphasized prevention and community based care for all of Burundi’s population. Key concepts of the policy document and decision-makers’ responses centered on reforms to decentralize hospital and clinic operations and to finance the health sector through a national insurance scheme.

b) The analysis and classification of decision-makers’ beliefs showed a variety of beliefs about PHC. The majority, however, were fairly progressive and insisted on the importance of community involvement in the management of health. Four groups representing distinct variations of PHC beliefs emerged
from the analysis: Progressives, Non-Risk Takers, Fence-Sitters, and Conservatives.

c) Training experience in public health most influenced the belief systems of decision-makers. Practical experience in the field also played an important role in shaping an individual’s vision of PHC. Only four of the twelve respondents mentioned significant persons who influenced their vision of PHC.

d) All of the decision-makers played a role in the ministry’s PHC approach through actual day-to-day program implementation decisions or through the policy development process. Descriptions of the policy developed showed a strong consensus building process beginning with ‘policy commissions’ with further inputs from different levels of the ministry.

e) Several factors promoted and impeded the achievement of an individual’s vision. Factors promoting vision achievement included the fact that the MOH now had a strong public health orientation and better trained personnel to define and implement PHC strategies. Linked to these responses were those who stated that the Ministers since 1988 had public health backgrounds and that the MOH had more personnel than previously. Other responses targeted the role of democratization in society; that is, the
population had 'evolved in its thinking' and that politics were becoming more 'democratic'. The existence of 'semi-decentralization' was also deemed important, in addition to good government support for the health sector. Finally, the improved implementation of established policy was cited by two of the twelve respondents.

Factors impeding vision achievement centered first on technical matters such as poor management and supervision and a lack of resources. However, the majority of the remaining responses pointed to the political influences of the health care system. Almost half the respondents stated that the MOH was a 'closed' or 'static' system that lacked innovation, or that people were afraid to speak or demand things. The issue of decentralization also proved important to many respondents who noted that decentralization was theoretical or incomplete, and that the central level was unwilling to relinquish power. Finally, other impeding factors included political barriers, the need for more democratic systems, and the criticism that community participation was most often viewed as a monetary variable (e.g., out-of-pocket expenses or co-payments), not a managerial one.

B. What has mediated PHC?

This study set out to explain the evolution of Burundi’s primary health care approach by viewing PHC as the result of social action. Using a realist
perspective, social action of PHC is mediated by the interaction among
decision-makers, their institution (the Ministry of Health) and structures (e.g.,
political systems, types of conflict, donor influence).

Table VIII - 1 depicts the evolution of the key structural influences on the
MOH and its decision-makers. The time line is broken into ten-year periods,
with seminal events or actions delineated. This table outlines the basis for
these conclusions.

1. Decision-makers' beliefs

MOH decision-makers held a variety of beliefs about primary care. The
majority favored a community based approach with strong involvement of the
population in the management of the health system. How decision-makers
came to hold these beliefs was of interest in this research for several reasons:
First, it assists in understanding PHC beliefs as a culturally produced
phenomenon. Second, an awareness of what influences a decision-maker's
belief system is useful to any organization or institution trying to promote a
participatory and preventive primary care approach. The finding that public
health training proved the most significant factor may not appear to be an
important or surprising finding for some individuals. However, for donors or
other organizations who are making choices about how best to invest
increasingly scarce dollars, this finding is highly relevant. The example of

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Table VIII - 1: Time Line of Key Structural Influences on Health Ministry and Decision-Makers

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Structural Influences</th>
<th>Evolution of Ministry of Health</th>
<th>Decision-Makers</th>
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<tr>
<td>1970s</td>
<td>1972: Major ethnic conflict: Hutu uprising stimulate massive retaliation by military, killing all Hutu leaders and students at institutions of higher learning. Over 500,000 persons, almost all Hutu, are killed in massacres. 1976: Second coup d'état with Colonel Bagaza taking power. 11 year rule characterized by co-optation of token Hutu in government; strong efforts to undermine Hutu opposition; increase in persecution of segments of civil society including Catholic clergy targeted for pro-Hutu sentiments.</td>
<td>1978: Burundi's delegation to Alma Alta signs declaration of 'Health For All' backing the principles of primary care based on equity and community involvement. 1982: EPI begins and creates first awareness for prevention efforts and greater access to care among rural population. Funding of materials resources and personnel training make EPI the &quot;backbone&quot; of MOH efforts. 1983: Faculty of Medical Sciences opened at the University of Burundi to train medical doctors to the country. Strong clinical focus prevails.</td>
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<td>1980s</td>
<td>Period is marked by increased social and political isolation of Burundi from the donor community and the world and rapid rise in foreign debt.</td>
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<td>Time Frame</td>
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<td>Evolution of Ministry of Health</td>
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<td>1993</td>
<td>Increase in freedom of speech noted by proliferation of alternative newspapers, books, criticizing past governments and political rallies by opposition (FRODEBU, Party for the return of the Monarchy)</td>
<td>June: Norton, who provided strong public health leadership to the ministry since 1968, resigns from post to make way for new Minister of Health.</td>
<td>frustrated by a gridlocked system where innovation is impossible.</td>
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<td></td>
<td>First democratic elections with Melchior Ndadaye, leader of the opposition party elected as President and first Hutu head of state ever. Military leader voices support of new government.</td>
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<td>Key criticisms of center's on lack of progress in decentralization and community participation.</td>
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<td>Legislative elections bring Hutu majority to National Assembly. Ndadaye, painted as a radical during the elections, continues &quot;ethnic arithmetic&quot; with a balanced Hutu/Tutsi cabinet. However, many Tutsi government appointees replaced by Hutu creating animosities.</td>
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<td>July: High levels of tensions abound. Coup d'état attempt thwarted.</td>
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<td>October: Military coup d'état and assassination of Burundi's president and government leaders in the line of power ensures destabilization. Widespread retaliation among rural Hutu against Tutsi begins in rural areas. Military returns power to a government with no leadership and paralyzed by fear.</td>
<td>October coup d'état and massacres pose major challenges to an MOH-dominated by Tutsi providers. Many health centers are burned and several providers are killed in retaliation. All relief efforts are undertaken by white foreigners, since even indigenous Red Cross chauffeurs are attacked and killed on the roads by armed bands</td>
<td>Top decision-makers mobilize to coordinate relief efforts for injured and displaced populations. Efforts towards reforms halted.</td>
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<td>1980s</td>
<td>1987: Buyoya takes power through military coup d'état.</td>
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<td>1988: Months of rumors regarding Hutu uprisings in northern provinces spur conflict between Hutu and Tutsi with military retaliation many casualties.</td>
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<td>1989: Pressure from external forces (IMF, World Bank, and other donors) push Buyoya to liberalize and undertake democratic reforms. Government cabinet reflects almost 50/50 breakdown between Hutu and Tutsi. A Hutu Prime Minister is appointed. Efforts made in privatization of state enterprises and the development of the private sector to join Burundi in the global economy.</td>
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<td>1991: Small rebellion occurs when Hutu rebels attack military camps throughout the country as a destabilization effort. Military reacts for the first time, as a disciplined force without excessive abuses.</td>
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<td>1992: Referendum passed to change constitution, to allow multi-party system and elections for parliamentary positions.</td>
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<td>'National Unity' declared the government's number one priority.</td>
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<td>Organized discussions/conferences among political, civic, and military elites on democracy.</td>
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<td>1985: Family Planning is added to prevention efforts. However, it is highly controversial due to perception that it will decrease the ethnic majority population.</td>
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<td>1988: Nexon appointed as Minister of Health. First Minister with a public health background and a civilian.</td>
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<td>Ministry develops first health policy document with stated focus to reorient Burundi's delivery system to community-based system centered on the equitable provision of curative, preventive services and health promotion for all of Burundi's population through decentralized service delivery.</td>
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<td>Significant efforts made to train staff in public health abroad and through short-term training programs in-country.</td>
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<td>Decentralization begins with the creation of 15 Health Provinces directed by a Provincial Medical Heads.</td>
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<td>Policy and program decision-making in central level ministry based on consensus among key decision-makers. Major policy reforms target:</td>
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<td>Decentralization “participation” of the population through health insurance system</td>
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<td>1998: Strong move to place doctors brought in from regions at the central level, to ensure appropriate understanding of realities facing delivery system.</td>
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<td>By 1993: Majority of senior decision-makers trained in public health and have experience in the periphery.</td>
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<td>Decision-makers recognize that the MOH had made vast improvements in its primary care approach. Reinforced Health Information System now provides epidemiological data on disease status, an important element for policy and program decision-making.</td>
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<td>However, progressive decision-makers</td>
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Norton's vision for a MOH staff that "speaks the same language: public health," his subsequent use of resources for public health training, and documentation of resulting beliefs show the formidable influence of such actions. This research demonstrates, however, that such actions alone are not enough. The social production of PHC is mediated by many other influences that cannot be engendered by donor agencies alone.

In the realist approach, human agency encompasses not only the intentions of people but their capacity to make a difference (Thompson, 1984). The evolution of Burundi's primary care approach, especially from 1988 onward, indicates that the decision-makers in this study did influence the primary care approach of the ministry. As a highly placed official, Norton probably had the greatest influence not only within the MOH, but also in convincing his Minister (cabinet member) colleagues of the need for health sector reforms. His capacity to act brought a change in the beliefs among his senior staff and ultimately created a group of decision-makers whose beliefs about primary care were even more progressive than his own. These resulted in ministry reforms (e.g., decentralization and community participation) related to primary care, that were fairly progressive, especially in the Burundi context. These decision-makers, however, enjoyed neither the discretion nor the institutional capacity to make radical changes in how the Ministry of Health went about the business of implementing reforms. Simply put, many changes were
beyond their realm of influence. Human agency, or the capacity of decision-makers to make a difference, was mediated by the authoritarian and centralized organizational character of the ministry. This is not to imply a linear mechanistic process. Rather, the PHC process is an interactive one whereby the institutional setting also conditions the decision-makers. Although many decision-makers held progressive beliefs, the routine actions I witnessed during a two and a half year period, reflected the learned behaviors of bureaucrats operating under an authoritarian system.

2. Ministry of Health Primary Care Approach

The Ministry’s PHC approach was mediated by the decision-makers’ belief systems and their capacity to act on those beliefs. As a reflexive process, the capacity of decision-makers to act was conditioned by the Ministry’s traditional authoritarian organizational character. This section examines four structural influences outside of the Ministry that mediated its approach to PHC. These include military rule and its resulting government operating mode, the democratic transition and spirit of liberalization, economic debt and structural adjustment, and the pervasive history of ethnic conflict. Again, Table VIII - 1 outlines these features.

Military rule ensured the continuation of the Ministry’s centralized authoritarian system inherited during the colonial period. As noted previously,
with no experience of alternative models of governance, authoritarian behavior and the institutional culture were difficult to change, even over time. This is obviously one of the great reform challenges in a country under going democratic transitions (Le Marchand, 1992). Authoritarian government exists as a means to dominate. In Burundi, domination was strengthened due to an historically based need of the minority ethnic group to control resources over the majority of the population, perhaps out of fear for their own marginalization.

If we accept the argument that authoritarian governments exist due to a weak civil society (Nwokedi, 1995), then since independence, the Tutsi elite took drastic measures to ensure that civil society (which would be comprised primarily of the Hutu majority) would never have a chance to develop. Consistent actions to "take down" Hutu leadership had a profound effect on the development of Burundi's civil society over the last few decades. In spite of such oppression, Hutu maintained their quest over time for a share in decision-making power, noted by uprisings among both radical and more moderate groups inside and outside Burundi.

The rising debt of the 1980s, increased persecution of religious organizations, and further isolation of Burundi from the outside world during the Bagaza regime, made the 1987 coup d'etat almost inevitable if Burundi was to come through the decade and have a chance to develop in the future. The
nation found itself in the same position as many other African nations (Adekanye, 1995; Ake, 1996). Buyoya, Bagaza’s successor, did not initially have a vision of power sharing. Donor pressures and the economic calamity confronting the country gave him little choice (Adekanye, 1995). In time, Buyoya realized that his steps toward democratic reform were the only means to secure Burundi’s survival. Many donors and moderate Barundi consider Buyoya a visionary for his intentions and capacity to act in favor of democratic reform. As a Tutsi military officer, he realized the ramifications of pushing too hard too fast, something a donor community that was motivated by a pluralist dream could appreciate less (Rasheed, 1995; Ake, 1996). His moderate actions clearly alienated radical factions of both ethnic groups. These are the harsh realities that face democratic reform, particularly when it is argued by some individuals that Africa has no previous tradition of democratic process (Rasheed, 1995).

Decreased economic debt, SAPs, and the short period of increasing political liberalization between 1990 and 1993, produced positive results in the health sector. The financial burden of the health sector and frozen budget under SAP pushed the question of participation of the population in financing the sector to the forefront. Under a political system that seemed to be promoting equity, the climate of increased trust allowed for a discussion about national insurance. Even the idea of the UNICEF promoted Bamako Initiative
(the pilot community participation project implemented in one province), could not have been considered in a previous era. Increased openness in the health sector is further noted by the candid discussion of certain health-related subjects. In the early 1990s, the government took a new stance in confronting its significant problems such as population growth and AIDS. Taboo subjects of family planning, and human sexuality were being frankly discussed on television, radio, and in community theater. Around the same time, the role of policy began to emerge for guiding Ministry actions, an indication of an effort to develop and to institutionalize a new and persuasive rationale for organizational agency.

Ethnic conflict has remained the predominate mediating force in Burundi. Until there is a resolution over power sharing between the two main rival ethnic groups, neither democratization, decentralization, nor community participation can progress in the health sector. There will always be conflicting managerial or political objectives in decentralization and community participation, even in a country like the USA, with a long democratic history (Starr, 1982). What Burundi and other African nations plagued by ethnic conflict face is a question of survival. Debates over issues like selective vs. comprehensive primary health care approaches have little meaning when there is long-standing distrust and animosity between providers and consumers. Decentralization will remain hopeless when local administrators and citizens
are deeply skeptical about the political leadership, or when that leadership cannot obtain sufficient discretion or funding to assume organizational change. Empowerment is impossible because it implies risk-taking that usually means being targeted for taking a controversial and public stand.

Under such circumstances, Burundi’s PHC approach has suffered a setback. Even selective approaches such as EPI could not be maintained under these conditions. One can only question whether or not decision-makers interviewed would respond in the same way after three years of ethnic genocide. I believe that their ideal for a participatory approach would remain, but they would question its appropriateness for Burundi at this time. Clearly, the next step in the evolution of primary care in Burundi will show that structural forces continue to mediate PHC beliefs and approaches. Burundi, perhaps more than any other African nation, supplies an excellent example of how primary care is the result of social action.

Given the structural factors mediating Burundi’s health system and MOH organizational culture, it is remarkable that the MOH made such significant progress in PHC reforms in a relatively short time. It may seem that Burundi’s MOH made only tiny steps towards its policy goals when compared to policy evaluation expectations in a rapidly changing world. However, given the five-year time frame (1988-1993), and democratic transition that only got underway
in 1990, and was interrupted once more in 1993, the MOH made major steps in reorienting not only its delivery system to a prevention based system, but also to a more consensus-based team approach within its institutional culture. In a sense, this research serves not only as a ‘reality check’, but also as a ‘wake up call’ to donors and ministry policy makers regarding the level of expectations for progress that are placed on a government.

This research shows that there is no quick policy fix to Burundi’s problems. SAPs or other donor conditionalities such as democratic elections can not rapidly heal a century of ethnic antagonisms. Community participation and decentralization -- potentially threatening concepts regarding how power and decisions about much needed resources are distributed -- are not easily remedied by policy statements that treat the concepts as purely apolitical managerial concerns. There is no public administration fix that will bridge the deep seated resentment and hate that permeates Burundi’s society. Such deeply entrenched barriers require more than policy rhetoric and time horizons that are extended well beyond a three- to five-year donor “democratization” project time frame.

My data show powerfully that key words and approaches to PHC in the literature such as community participation, decentralization and related strategies for democratization are typically entirely too absolutist in their tone
and expectations. The literature is useful for understanding factors affecting these processes. However, the literature on community participation, decentralization, and democratization all fall short on providing solutions to Burundi’s context.

This research has argued that both micro and macro influences mediate the chances of the MOH to institutionalize and democratic primary care and resource allocation. As shown schematically in Figure 11-2, these influences support neo-institutional views that link organizations, institutions, and the behavior of health policy decision-makers.

C. Lessons for the Future

This research affords many lessons for the future. Health Ministries in Africa have come a long way since 1978. Both donors and government decision-makers alike are only just realizing the transformations taking place. These changes can be likened to a card game: over time, the dealer randomly throws cards from a new colored deck to each player. When the majority of the cards have changed colors, Barundi suddenly realize they are playing with new rules, even though many of the old remain.

Health for All was promoted with little consideration for the kinds of government regimes that would be its primary implementors. Eighteen years
of experience indicates more strongly than ever that politics and health are solidly linked. The future of HFA depends on our level of understanding of change and how realistically we address the political and personal forces that shape primary health care strategies.

This study provides a snapshot of the democratic process and its role in primary health care delivery in one African nation. In a sense, it is a benchmark in a long and difficult process whose outcome is unknown at this point in time. The July 25, 1996 government take-over and suspension of the constitution by retired Major Pierre Buyoya -- who brought the first attempts at democratic reform to the country -- may give a ray of hope, but leaves many unanswered questions about the future. As such, this research provides a useful point of departure for a longitudinal analysis of primary health care and democracy in Burundi.

Burundi is a complex and deeply troubled nation that fast required me to use multiple approaches to draw together information that would provide a fair picture of the forces influencing the research setting. Even as these words are being written in July 1996, ethnic genocide continues to rear its ugly head in the nation. By using a variety of methodologies, ranging from participant observation, elite interviews, and public documents analysis, I was able to synthesize critical information regarding individual beliefs, institutions, and
structures operating in efforts to implement primary health care in Burundi. What we don’t know from this research are the cross-sectional perspectives of individuals at other levels of the Ministry of Health. The views represented here are those of the central administration. The inclusion of Provincial Medical Heads in this research would have enhanced understanding of decentralization and democratization at the level of field operations. Then too, some of the views examined here were offered by newly appointed persons to the central level of the Ministry. However, a more representative understanding of impediments, taken from a less policy-elite perspective, would have been useful.

The purpose of this research was not to generalize the results of the study to a broader African context, but rather to examine bureaucratic decision making and institutional culture during a process of democratic transition. Burundi’s political history, moreover, is quite particular (with the possible exception of Rwanda). Nonetheless, the research provides a conceptual model to explore the structural, institutional, and human agency factors affecting progress in primary health care. This approach, or variations of it, would serve well for comparing the interaction between democratic reform, Ministries of Health, and their decision-makers in other African nations. This is particularly relevant if we are serious about defining realistic strategies for the Health for All goal.
Finally, this research shows that the literature on primary health care, community participation, decentralization and democratization provides few answers or solutions to the deeply entrenched barriers that pervade in Burundi's ethnically divided society. If anything, the research shows that donor government officials' expectations for progress in these areas need to be more modest and reflect how small steps are in fact major ones in a society where ethnic conflict forms the backdrop of social relations.

I believe that anyone I have ever encountered who has been involved with Burundi, even 'old Africa hands,' find their assumptions for explaining society and human nature challenged by the Burundi experience. None of our life experiences give us the 'cues' for comprehending the level of hate and destructive forces that continue to prevail among Barundi. In a recent communication with a Hutu refugee friend, I asked him for his insight. He summed it up in just two phrases:

*On dit que l'homme naît bon, c'est la société qui le transforme. Si les Hutus et les Tutsis s'entre-tuent, ce n'est qu'à cause des intérêts que les deux groupes refusent de partager.*
It is said that man is born good. However, it is society that transforms him. If Hutu and Tutsi are killing one another, it is only because of the interests that the two groups refuse to share.

Finding solutions to Burundi’s ethnic problems will not be easy. This research is a call for greater humility in expectations for solutions. Both donors and decision-makers must realize that the quick policy fix is not the answer. Change cannot occur until Barundi themselves realize that there are no winners in a society that is paralyzed by ethnic strife.
Health Planner Structured Interview

Preamble: Reason for being here. Thank you for participating.

I. Background:

1. Name: _______________
2. Age: _______

II. Work Experience:

   1.A. Describe a bit about your role within the MOH:

2. Previous Position ______________ Dates: From _____ To _______
   2.A. Describe briefly about your role during this time:

3. Position ______________ From _____ To _______
   3.A. Role:

4. Position ______________ From _____ To _______
   4.A. Role:

(Use additional sheet if necessary)

III. Education/Training Background:

1. What is your training?
   MD ______
   Nurse ______
   MD/MPH ______
   Other University
2. Where did you do your studies?

University of Burundi ______ (degree/area)
Outside ____________________ (where/degree)

3. What other short-term training have you had? / Where?
   a. ________________________________
   b. ________________________________
   c. ________________________________
   d. ________________________________

4. What outside conferences have you participated in? / Where?
   a. ________________________________
   b. ________________________________
   c. ________________________________
   d. ________________________________
   e. ________________________________

III. Government PHC approach evolution:

Preamble:

1. Could you describe your earliest recollection or understanding of how health care used to be organized in Burundi? What were some of the attributes of the delivery system? (If answer is a problem- How is that delivery system different from what we have now. About what year or period are you referring to?)
2. Since that period, how has the delivery system evolved? What would you consider the attributes of each system? In other words, what significant changes occurred within how health care was organized to make it different from the previous form?

3. During the last five years do you feel there has been significant progress or lack of progress in responding to the population's health needs? If so, what kind of progress and why factors have attributed to achieving such progress?

IV. Planner's PHC belief system

1. We have talked a lot about how the health delivery system has changed within the government. As you know, in 1978 at the WHO Conference in Alma Ata, the goal of Health for ALL by the year 2000 was declared. Promoting Primary Health Care is the basic approach used for achieving the Health for All goal. However, there are a variety of Primary Health Care approaches being promoted to reach this goal, ranging from selective approaches promoting strategies such as expanded immunization to other more comprehensive approaches involving community participation in health management and delivery decisions and the association of traditional healers, for example. How do you feel health care delivery should be organized to best meet this Health for ALL goal? In other words, what do you feel are the key attributes of a primary based health care system and how should they organized to meet the goal of health for all of Burundi's population?

(If the community participation is not mentioned in the above question, ask the following)

2. A. Is there a role for the community in health care delivery?

   What should this role be?

   B. Is there are role for traditional healers? Why or why not?

3. Do you think there has been any significant person, training, work or other experience that has had an impact on shaping your vision of how the delivery system should be organized? If yes, could you describe what that was?

4. Is there any other significant event or experience that has shaped your vision.

5. Given the past and evolving political structure of Burundi, do you feel that a community oriented approach is possible? Why or why not?
6. A. The Bamako Initiative was promoted in Burundi recently. What do you feel is the status of this approach at the current time.

B. How is this approach different from previous or current government approaches?

C. What were the factors contributing to its success or lack of success.

V. How planner’s PHC approach compares to that of the government.

1. Considering your vision of how the delivery system should be organized, how do you feel this compares with the actual delivery system as organized by the Ministry of Health. In other words, are there similarities and/or differences?

2. Do you feel any conflict or tension with the current approach?

If so, is there any particular way you can influence the process? If yes, how? If not, why not? e.g., hierarchical system closed system

VI. Role of health policy

1. Over the years the MOH has established its sectorial policy statement. Currently this statement is being revised.

2. What do you see as the current role of health policies for the MOH? Do you perceive a different role for health policy other than that of the current role?

2. Could you tell me what you perceive to be some of the key MOH policies that relate to PHC currently under development or revision? Why are these specific policies important for the delivery system?

(Could we talk about a specific policy that relates to your own program. Does that policy play a role in your program implementation? Why or why not?)

VII. Development of health policy

I have several questions concerning how health policy is developed within the MOH. I would like to get an understanding of your perception if there is a policy process and how this process works.
2. If you don’t have an influence, do you feel you have something to offer in the decision making process?

3. Do you feel your vision of how PHC should be organized has influenced the GRB policy approach.
1. Where do MOH policies come from? In other words, how are policy priorities decided upon? What are factors that influence these decisions? (Use a specific example if necessary)

2. Once policy priorities are defined, what is the next step? What are factors that influence this step?

3. Now what happens? What are the factors that influence at this point?

4. Along this process, if there is disagreement, how is it resolved?

(Keep up to final policy adoption point)

5. How are policies adopted within the MOH? (Use a specific policy example if necessary)

6. How is an adopted policy used? (Again, use a specific example relevant to the interviewee’s program if necessary)

7. Can you think of any examples where policies were adopted but never implemented?

If so, what policies were these? Why do you think they have not been implemented?

VIII. Planner’s role in the policy process.

1. Now that we have talked about how policies are developed, adopted, and implemented, could tell me if you feel you have any influence on this process? Why, or why not? How?

(Name influences)
2. If you don’t have an influence, do you feel you have something to offer in the decision making process?

3. Do you feel your vision of how PHC should be organized has influenced the GRB policy approach.
Intervue Structuré

Introduction: Raisonnement pour l’enquête
Remerciement pour la participation

I. Background:

II. EXPERIENCE DU TRAVAIL:

1. Position Présent_____________ Depuis: De ____ A _______

2. Position Avant _______________ Dates: De ____ A _______
   2. A. Si vous plait, pouvez-vous décrire votre role au Ministere dans cette position?

3. Position Avant _______________ Dates: De ____ A _______
   3. A. Role:

4. Position Avant _______________ Dates: De ____ A _______
   4. A. Role:

III. EDUCATION/FORMATION:

1. Quelle est votre education?
   medicine:__________  Infirmier__________
2. Ou est-ce que vous avez fait vos études?

   University de Brunundi ____________ (niveau/domaine)

   Externe ________________ ____________ (ou/niveau/domaine)

3. Est-ce que vous avez participé aux formations de courte durée? (Il ne faut pas nommer des conférences) Où/Domaines?

   a. ______________________________________

   b. ______________________________________

   c. ______________________________________

   d. ______________________________________

4. What outside conferences have you participated in? Où/Domaines?

   a. ______________________________________

   b. ______________________________________

   c. ______________________________________

   d. ______________________________________

   e. ______________________________________
IV. L'ÉVOLUTION DU L'APPROACH DES SOINS DU SANTE PRIMAIRE DU GOVÉRNEMENT:

Introduction: Dans chaque pays, le gouvernement choisit une approach pour répondre aux besoins de la santé de sa population. Normalement, cette approach changera où evoluerà avec le temps qui passe.

1. Pouvez-vous decrrie votre premier memoire or comprehension de comment les soins de sante etait organize' de cette system pour livré les soins aux Burundi? Il s'agit de quelle annee ou period à peu prés?
   - Quelles etaient les attribues de cette systeme?

2. Comment est-ce que cette system de santé est different de ce qui exist maintenant?

3. Depuis cette period, comment est-ce que le systeme de santé a évoluer au Burundi?
   Qu'est-ce que vous considerez les attribues de chaque system? Dis d'un autre facon, quelles etait les changement significatives qui ont fait qu'un systeme a différé d'un autre forme.

4. Pendant les derniers cinq ans, est-ce que vous pensez qu'il a eu du progrès significatif ou une manque du progrès dans la capacite du ministerie de répondre aux besoins de santé de la population?

Si oui, quelles sort du progrès a été achevé et quelles sont les facteurs qu'on peut attribué au progrés?

V. SYSTÈME DE CROISSANCES EN SANTE PRIMAIRES

1. Comment pensez vous les soins de sante doivent etre organize pour mieux repondre aux but de Sante Pour Tous?
   - Dit d'un autre facon, d'après vous, quelles sont les attribues clef d'un systeme base sur les soins de sante primaires? Comment doivent-ils etre organize pour attendre le but de santé pour toute la population du Burundi?
3. Est-ce que vous pensez qu’il y a eu dans votre vie une personne, une formation, un travail, où une autre circonstance où expérience qui a eu une impact sur votre façon de voir comment un système de santé doit être organisé? Si oui, pouvez-vous me le décrire?

4. Est-ce qu’il y a une autre événement, personne ou expérience qui a formé ou influencé votre vision?

5. En tant donné le passé, le présent, et l’évolution future des structures politique du Burundi, est-ce que vous pensez qu’un démarche orienter envers la participation de la communauté est possible? Et à quelle niveau? Pourquoi ou pourquoi pas?

6. L’Initiative de Bamako a été promue au Burundi récemment. Que’est ce vous pensez est la statue de cette approach dans le présent?

   A. Comment est-ce que cette approach est différent d’autres approaches du passé ou du présent

   B. Quelles sont les facteurs qui ont contribué aux success où au manque du success?

VI. L’approach par rapport au l’approach du government

1. En considérant comment vous voyez que les systemes de santé doivent être organisé, comment vous le comparez avec l’organisation du system du Ministere? Est-ce qu’il y a des similarités ou des differences?

2. Est-ce que vous avez du conftit avec l’approach current du Ministere?

3. Si oui, est-ce qu’il y a une moyen d’avoir une influence dans le processus? Si oui, comment? Si non, pourquoi pas? (system heirarchique, fermé ou autres)

VII. Pendant les derniers années, le Ministere a etablir un politque sectorial qui est en train d’être revisé.
1. D’après vous, qu’elle est le rôle de la politique sanitaire dans le ministère ?

2. Est-ce que vous trouvez que la politique sanitaire doit jouer un rôle différent qu’elle joue aujourd’hui ?

3. D’après vous, quelles politiques sanitaires du ministère existantes ou en révision sont les politiques clé pour le développement des soins de santé primaires ?
   
   Est-ce que cette politique joue une rôle dans la mise en œuvre de votre programme (ou tel programme) ?

VII. Développement de la politique sanitaire

1. D’abord, d’où viennent les politiques du ministère ? Dis d’un autre façon, comment est-ce que les domaines prioritaires pour la politique sanitaire sont décidés ?

2. Dès que une prioritaire est défini, quelle est la prochaine étape ? Quelles sont les facteurs qui influence cette étape ?

3. Maintenant, qu’est-ce qui se passe ? Quelles sont les facteurs ou éléments qui ont une impacté à ce point.

5. Comment est-ce que une politique sanitaire (ou sectorielle) est adopté au niveau du ministère ?

6. Comment est-ce que une politique adopté est utilisé ?

7. Est-ce que vous pensez a une exemple d’une politique qui est adopté mais pas utilisé ?

8. Si oui, quelle était la politique ou ces politiques ? Pourquoi ces n’ont pas été était mis en œuvre ?

IX. Role de l’individuelle dans la processus de la politique sanitaire.
1. Maintenant que nous avons parlé de comment les politiques sont développés, adoptés, et mis en œuvre, est-ce que vous pouvez me dire si vous pensez que vous avez un influence ou impact sur cet processus? Pour quoi ou pourquoi pas? Pouvez vous donner un exemple.

2. Si vous n'avez pas une influence, pensez-vous que vous avez quelques idées à offrir dans la processus?

3. Est-ce que vous pensez que votre vision de comment les soins de santé primaire doit être organisé a eu un influence ou impact sur l'approach utilisé par le government dans le passé ou présent?
<table>
<thead>
<tr>
<th>NAME</th>
<th>VISION OF PHC</th>
<th>WHO/WHAI/T/HOW INFLUENCED</th>
<th>WHAT IMPEDES/PROMOTES VISION ACHIEVEMENT</th>
<th>CAN S/HE INFLUENCE</th>
<th>HEALTH POLICY PROCESS</th>
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<tr>
<td>Jane</td>
<td>- #1 Community Participation- yet because pop is very poor- need to give some kind of &quot;encouragement&quot;. - Traditional med. import Have major value and understanding of community. Must look at community holistically. Med. community needs help from sociologists, anthropologists, etc. - Priority PHC Policies: - prevention of diseases - treatment of infectious diseases, - family planning - health education</td>
<td>- Feels is everything put together... But most likely education had an impact. Notes faculty of medicine exams were graded anonymously...less discrimination. Saw injustices of educational system.</td>
<td>- Progress: much effort put into training of program heads and personnel. - Implementation of established policy due to good evolution among government heads...authorities realize things need to be applied ...is big evolution. (p.5)</td>
<td>Yes- is associated in the formulation of policy. - In feels informal influence is also important - when you know who is in charge of dealing with what area . - Also- does not hesitate to express herself</td>
<td>Feels currently there is improvement in the implementation of policy (p.11) Yet could be improved upon. - Need greater critical analysis to see if could doing better. Need to improve on follow-up. - Is a long road ahead ! able to say the &quot;minimal primary care is being delivered&quot; p.12</td>
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Policy Process:
- Guidelines exist. Much influence of international organization particularly WHO. (not AID like this)
- Look to other countrie
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<th>NAME</th>
<th>VISION OF PHC</th>
<th>WHO/WHAT/HOW INFLUENCED</th>
<th>WHAT IMPEDES/PROMOTES VISION ACHIEVEMENT</th>
<th>CAN S/HE INFLUENCE</th>
<th>HEALTH POLICY PROCESS</th>
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<tr>
<td>Jane</td>
<td></td>
<td></td>
<td>orientation. Impede: Population must be convinced and be ready to move into action. Population because is poor, doesn't appreciate role of civil servant. - No kind of remuneration given to pop to encourage part. -Change will take place much faster if basic training for those who work at the community level is rethought and revised to promote more &quot;social medicine&quot; and promote people with ethics. Training is key. - Root problem in having community part is lack of trust. Is question of trust between social classes. All</td>
<td>see what is happening - Feels first polices care of pre-conception of authorities. Difference that now is more bottom -Data collection is more exploited now than better -Commission establish develop policies. - Given to national commission for final approval, but quite sure about the final adoption of policy undertaken.</td>
<td>Established policies given to various departments, asked to formulate strategy and are given feed back at central level.</td>
</tr>
<tr>
<td>NAME</td>
<td>VISION OF PHC</td>
<td>WHO/WHAT/HOW INFLUENCED</td>
<td>WHAT IMPEDES/PROMOTES VISION ACHIEVEMENT</td>
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<tr>
<td>Sani</td>
<td></td>
<td></td>
<td>must get over their fears (good explanation, p.8)</td>
<td>Policies sent to intermediate level for regional health planning strategies.</td>
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<td></td>
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<td></td>
<td>- Bamako Initiative impeded because those in authority afraid to take decisions on constraints (mentions those concerning health committees)</td>
<td>Policy not implemented.</td>
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<td>p. 9 - explanation of power relationships between health center staff and population. PHC demands behavior change on part of providers. They have never experienced this kind of relationship before.</td>
<td>AIDS prevention and control. Actual policy for case management does not take into account difficulty provider has in dealing with the possibility of his/her sero-prevalence.</td>
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<td>p. 10 - Problem of asking staff to teach what they cannot practice in their own homes.</td>
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Appendix 3
Organigramme du Ministère de la Santé
## Appendix 4. Summary Biographical Characteristics

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<td>David</td>
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**Abbreviations:**
* = Position at the time of interview
- CDD = Control of Diarrheal Diseases
- EPI = Expanded Immunization Program
- F.P. = Family Planning
- h. econ. = health economics
- h. insur. = health insurance
- manage = management
- P.H. = Public Health
- Pre/Hygien = Prevention/Hygiene
- Std = Sexually Transmitted Diseases
- TOT = Training of Trainers
- Malaria = Malaria
Appendix 5: Vignette on a Typical Day of Senior MOH Decision-Makers

A typical day for an MOH bureaucrat begins around 5:30 or 6:00 AM. A breakfast of Burundi-produced tea or coffee is most likely prepared by a spouse, or a live-in servant. This by no means connotes extreme wealth, as even the poorest families hire young girls or bring in relatives from rural areas to assist in household work. Public service salaries are notoriously low. Medical doctors, some of the highest paid public servants, earn an average of the equivalent of 200 to 250 dollars per month. Thus, doctors, while poorly paid, are an elite profession within the country. In many developing countries, supplementing public service salaries with private practice income is the norm. However, in Burundi, private sector medical practice is almost totally undeveloped, due to government controls to ensure that the dearth of physicians remained in the public sector. Some may have relied on outside income related to agricultural production from land holdings in the interior (coffee or cattle, for example). Per diem from donor funded training programs also provide a useful supplement. Most senior decision-makers lived comfortable (compared to the average Barundi), yet far from ostentatious living standards. The majority are at a point in their lives where they own a car, although, not a new one. Lack of money proves a consistent headache, particularly when one income supported four and five kids in addition to the
extended African family of nieces or nephews who often board with an urban based relative for school purposes.

Decision-makers possess a strong sense of self discipline and work ethic. The work day begins at 7:30 A.M. (including Saturday morning) with cabinet members standing at attention for flag raising with the minister. After flag raising, the Minister uses the encounter to connect with his staff and briefly discuss issues at hand with cabinet members for 10 or 15 minutes by the flag pole. Unlike many public service ministries in Africa where bureaucrats might arrive by 9:00 or 10:00 AM, Burundi’s cadre are at work at their desks by 7:45 at the latest.

Daily work centers on administration of programs, and entails internal meetings or meetings with whatever donor might be involved. “Siesta” occurred from 12:00 to 3:00 P.M. Everyone goes home during this period to eat a mid day meal of rice and beans. Eating in restaurants is not particularly common. Work resumes at 3:00 P.M. and continues until 6:00 P.M. Many senior level staff work on until 7:00 or later if a deadline was to be met. If an afternoon meeting’s business is not concluded by 6:00 P.M., it is not uncommon for the meeting to continue to 9:00 or 10:00 in the evening until matters were cleared from the agenda. In other words, MOH business is taken very seriously.
The post-work day, if you are a male, often consists of going to the favorite drinking spot to share in beer and conversation with friends. This is the norm and number-one past time for Barundi men. Most drinking locales are grass or tin roofed covered kiosks nestling on the corner of a local neighborhood street. Men sit on roughly made benches. There is always a charcoal fire off to the side with a separate business of selling beef brochettes on a skewer to accompany the beer. Women are absent from this environment.

In contrast to their male counterparts, female decision-makers -- who are few in number at the MOH and public service ministries -- return home at lunch, often quickly preparing the noon-time meal for the family. The same scenario holds for the evening meal. Once arriving at home from work, dinner has to be made, homework to be looked after, in addition to ensuring washing, ironing, any cleaning, and marketing plans are completed for the next day. In the Barundi household, it is extremely rare for a man to assist in any of these duties, even in the "modern" urban family. As each day starts early, Barundi usually are in bed by 10:30 on a work night.
Bibliography


Vita

Janis K. Timberlake was born in 1955 in Schenectady, New York. She received a Bachelor of Arts in French from Alfred University in 1977 and a Masters in Sociology from Virginia Polytechnic Institute and State University in 1988. Timberlake has worked extensively in Africa over the past 15 years. She served as a Peace Corps volunteer in Senegal where she worked with women's groups and rural villages in community development projects from 1978 to 1981. She spent three additional years (1982-1985) in Senegal as a technical assistant working for a USAID integrated rural development project. From 1991 through 1993 Timberlake was a health planner managing USAID/Burundi's health and population portfolio. She moved to Guyana, South America in 1993 and directed the development and implementation of Guyana's National Health Plan as a consultant for the World Bank and the Inter-American Development Bank. In September 1996 she assumed a position as TAACS Officer (Technical Assistance in AIDS and Child Survival) managing USAIDS Tanzania AIDS prevention activities in Dar es Salaam, Tanzania.

Janis K. Timberlake

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