ANALYSIS OF AID COORDINATION IN A POST-CONFLICT COUNTRY: THE CASE OF BURUNDI AND HRH POLICIES

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Abstract

Aid coordination in the health sector is known to be challenging in general, but even more in post-conflict settings, due to the multiplicity of actors of development, to the sense of emergency in providing health services, combined with the so-called ‘weak institutional capacities’ at local level, resulting from the conflict. This study sought to analyze broad determinants of aid coordination using the example of HRH policies in Burundi, during the post-conflict period. Burundi is a country in Central Africa, which experienced cyclic ethnic conflicts since its independence in 1962, the last conflict being the longest (1993-2006).

Determinants of coordination were analyzed using the policy-analysis triangle (Gilson et Walt), using data from documents and semi-structured interviews, conducted in 2009 and in 2011, at national, provincial and facility-levels. A conceptual framework, combining organizational and social sciences theories, was devised in order to assess the organizational power of MoH, the one supposed to act as coordinator in the health sector.

Findings showed a lack of coordination due to post-conflict specific context, to competition over scarce resources between both donor and recipient organizations and to an insufficiently incentivized and complex coordination process in practical.

Most importantly, this research demonstrated the crucial role of post-conflict habitus and mistrust in the behavior of MoH and their influence on organizational power, and, in turn on their capacity to coordinate and exert an appropriate leadership. These findings, together with the growing body of literature on organizational sociology and collective trust, point at the crucial need to rebuild some of the wounded collective trust and organizational leadership in Burundi and in other fragile states.

Key Words: coordination, aid for development, Burundi, post-conflict states, trust, habitus, social capital, power analysis

This PhD thesis is dedicated to JMDB, aka Yoda.

He represented, during the writing of this monograph, a vital figure which was annihilated in the past.

His support allowed me to achieve this work, which, in fine, contributes to rebuild my own ability to trust.

This thesis is also dedicated to the four anonymous persons in Burundi, who trusted me enough to share with me their deepest and most painful memories.

More widely, it is dedicated to any human being and any population, whose sense of life and hopes were destroyed by an individual or collective trauma, should it be emotional, physical or of any other nature.

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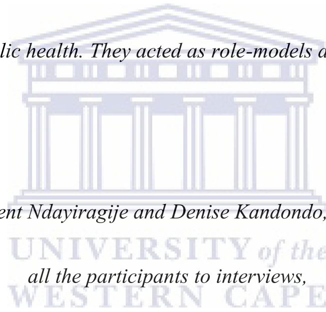

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“Je tiens à signaler que les rapports ‘scientifiques’ - c’est-à-dire basés sur l’observation des autres – sont faux et factices : pour connaitre une population, il faut à la fois la « vivre » et la « regarder ». C’est pourquoi ceux qui vivent doivent apprendre à regarder – ou ceux qui regardent doivent apprendre à vivre, - au choix. »

“I would like to emphasize the fact that ‘scientific’ reports based on individuals’ observation are fake and artificial: to understand a population, one needs to both ‘live it’ and ‘look at it’. That is why those who are living have to learn to look and those who look need to learn to live.”

Germaine Tillion, Fragments de Vie, textes rassemblés et présentés par Tzvetan Todorov, Editions du Seuil, pp.179, personal translation

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ABBREVIATIONS

AAA	Accra Agenda for Action
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal care
ARV	Antiretrovirals
BIF	Burundian Franc
BTC	Belgian Technical Cooperation
CAMEBU	Centrale d'Achats des Médicaments du Burundi (Burundi central drug purchasing agency
CCM	Country Coordination Mechanism
CNDD-FDD	Comité National de Défense de la Démocratie-Forces de Défense de le Démocratie
CNTS	national center for blood transfusion
CPSD	Cadre de Partenariat pour la Santé et le Développement (partnership framework for health and development)
CPIA	Country Policy and Institutional Assessment
CSO	Civil society Organization
DAH	Development Assistance for Health
DfID	(UK) Department for International Development
DHS	District Health System
DP	Development Partner
DRC	Democratic Republic of Congo
ECHO	European Community Humanitarian aid Office
EDF	European Development Fund
EU/EC	European Union / European Commission
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GHIs	Global Health Initiatives
GNI	Gross National Income
GoB	Government of Burundi
HIPCI	Highly Indebt Poor Countries Initiative

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HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HSS	Health System Strengthening
IDA	International Development Association
IDP	Internally Displaced Persons
IHP+	International Health Partnership Initiative
IMF	International Monetary Fund
INSP	Institut National de Santé Publique (National Institute for Public Health)
JICA	Japanese International Cooperation Agency
MAP	Multisectoral AIDS Program
MDGs	Millennium Development Goals
M&E	Monitoring & Evaluation
MoA	Ministry of AIDS
MoF	Ministry of Finance
MoH	Ministry of Health
MSF	Médecins sans Frontières
NAC	National AIDS Council
NCAC	National Committee for Aid Coordination
NEPAD	NEw Partnership for Africa's Development
NGO	Non-Governmental Organization
ODA	Official Development Aid
OECD	Organization for Economic Cooperation and Development
PES-NAC	Permanent Executive Secretariat of the National AIDS Council (SEP-CNLS)
P4P	Pay-For-Performance
PHC	Primary Health Care
PLWA	People Living With HIV/AIDS
PMTCT	Prevention of Mother-To-Child Transmission
PNSR	Projet National Santé Reproduction (national reproductive health program)
PRSP	Poverty Reduction Strategic Paper
PSP and PSP2	Projet Santé Population et Projet Santé Population 2 (Health and population project of the World Bank, 1 and 2)

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RPF	Rwandan Patriotic Front
SWAP	Sector-Wide Approaches
TB	Tuberculosis
UN	The United Nations
UNAIDS	The United Nations Office for AIDS
UNDAF	The United Nations Development Assistance Framework
UNDP	The United Nations Development Program
UNFPA	The United Nations Funds for Population Activities
UNGASS	The UN General Assembly Special Session
UNIFEM	The United Nations Development Fund for Women
UK	United Kingdom
USA	United States of America
USAID	US Agency for International Development
USD	United States Dollars
USLS	Unité Sectorielle de Lutte contre le SIDA (health sector HIV unit)
WB	World Bank
WHO	World Health Organization

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CHAPTER 1: INTRODUCTION

1.1 CONTEXT AND PRELIMINARY WORK FOR THE PHD THESIS

My first visit to Burundi began on the 25th August 2005, the day the new president – the first democratically elected president since the beginning of the civil war in 1993 – came to power. The purpose of this visit was to be introduced to some of the major local partners of a hospital-based HIV project funded by the French bilateral cooperation. One of the aims of the project was to foster local-level collaboration.

I soon became intrigued by the situation as it seemed that the French cooperation had actually approved funding for two projects in Burundi in two distinct hospitals in parallel. This duplication arose as the two hospitals had applied simultaneously for the same project, without being aware of one another's application – despite the fact that Burundi is a tiny country and there were only three people working on HIV at public hospital level at that time. This started me wondering about the possibility that local people were not communicating.

The project eventually started in the two biggest hospitals in the capital, Bujumbura. During the following two years, from 2006 until 2008, I was deeply involved in the project implementation in one of the two hospitals, first by spending six months in the field and then by following-up the project from France including conducting regular monitoring and evaluation visits.

During this period, I was often staggered by the mistrust amongst local citizens in ordinary life. People often placed more confidence in foreigners like me, than in their own neighbors. Having faced interethnic and political violence for many decades, the younger people had not learned to trust, while the older people had learned to mistrust one another in order to protect themselves. They also lacked hope for the future and tended to depreciate themselves, either at an individual or collective/institutional level. They looked down on themselves, compared to white people or to the citizens of neighboring countries (i.e. Rwanda) who were doing better than they were. People also tended to victimize themselves and used it as a means to perpetuate suspicion, hatred and resentment.

At a professional level, what I deduced to be an individual and collective impact of civil war was also tangible. Most of my colleagues were quite passive, self-deprecating or hopeless ("what is the point in…") and were not entrepreneurial. They never spoke out (which I only realized years later) and did not question the appropriateness of a request, especially if it came from the hierarchy or from a donor (the latter being conflated with the hierarchy). In this context, they sometimes manifested their resistance by not doing what was asked.

It took a considerable amount of time to overcome their inability to trust one another (which could be misinterpreted at first sight as shyness). As a principle of the project I worked on was to facilitate local ownership, this also acted as necessary empowerment. People involved in the project slowly started to participate actively in it and eventually became proactive and took on leadership roles.

In 2006 and in parallel with these observations, I undertook some preliminary anthropological/socio-psychological work, with the over-ambitious aim of providing some local people with material for peace and reconciliation. This took the form of in-depth interviews with four people – two Hutus and two Tutsis – chosen from amongst the people who trusted me sufficiently to disclose and share with me some of their deepest memories (the four in-depths interviews were over eight hours each, in French, unpublished, personal). The themes explored in the interviews were their perceptions of the ethnic divide during the period immediately before the war, of the events during the war, and of their future as a victim on one hand and as part of the society on the other. Some told me that it was the first time they had ever talked about such memories. The interviews were anonymized and cross shared amongst the four participants, though they never agreed to meet.

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In summary, this work showed the incredibly high level of mistrust and hypocrisy amongst ordinary citizens; the ethnic and political natures of the conflict had literally fractured the society. For several years, people had been living with the fear of being killed, even by a neighbour or a friend. People could not trust anyone anymore, due to the permanent and pervasive threats of death, even from someone who was previously an intimate friend or a family member: "Even a friend could kill his friend, without any warning"; "A friend could share a drink with you and then immediately after, kill you" (ITW 4, 2006).

People's cognitive social capital (degree of trust in others) was destroyed, as were some components of their structural social capital (professional and neighbour networks) – while some other components of the social capital were negatively emphasised (ethnic). This experience constitutes the basis for my reflection on the capacity and ability of an individual living in a country affected by a civil war, such as Burundi, to collaborate in a collective action such as development.

In addition to my questioning the impact of conflict on individuals' abilities to successfully implement a project, I also started to examine the role of official development aid (ODA) on the reconstruction and development processes. Issues around the impact on general health services of donors in general, and of vertical HIV funding in particular, emerged in my mind. While the effect of HIV ear-marked funding was becoming quickly tangible, the gap between HIV- and non-HIV related areas widened. Impact of HIV-vertical funding on Human Resources for Health (HRH) was prominent to my eyes as I felt that the project in which I was involved participated to skills poaching, amongst other effects. These experiences and ideas were shared with other researchers at international conferences (poster presentation at Geneva Health Forum May 2008 and oral presentation at IAC Mexico August 2008) and eventually synthesized in a paper (J Cailhol et al. 2010).

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This is how, in late 2008, I eventually decided to undertake a PhD, initially addressing a very broad topic: 'The impact of international funding on HRH in Burundi'.

I piloted this topic in the first semester of 2009 during field work for the World Health Organization (WHO), in which I had the chance to act as a lead researcher. The aim of the research was to trace the impact of Global Health Initiatives (GHIs) on country health systems in several countries. The main conclusions (in Burundi but also in other countries) were that while diseases such as HIV benefited in terms of short-term outcomes from a large amount of quickly released funding, negative impacts, or at least insufficient positive impacts on general service delivery were also evidenced. The lack of coordination between health system actors – at all steps of the policy cycle and at all levels of the health system – came out strongly, in terms of HRH policies, such as working conditions, trainings content but also in all other blocks in health system related areas, such as health information systems or drugs supplies (World Health Organization 2009; Samb et al. 2009).

I then investigated the main issues arising from this second deep field experience, through published literature. What came out clearly was that papers addressing the issue of aid coordination were quite scarce, especially since the era of globalization of development assistance, which had evolved from bilateral to multilateral arrangements. In addition to being recurrent, aid coordination issues grew in complexity with the quick changes in aid landscape. Moreover, difficulties in aid coordination were reported to be exacerbated in fragile states where local ownership and leadership were usually considered to be low as a result of the conflict itself or of externally driven peace agreements which led to the end of the conflict.

This is how I eventually decided to plunge myself into the analysis of aid coordination – taking one example that I had at heart, which I had experienced, namely HRH policies and especially their coordination. Hence, underpinning my interest in coordination was a questioning of recipients' and donors' relationships in the development area, or "arena", as Olivier de Sardan calls the development field (Olivier de Sardan 1995).

1.2 DEVELOPMENT ASSISTANCE AND ITS EFFECTIVENESS

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Joseph Stiglitz, Nobel Prize economist and director of the World Bank (WB) at that time, defined development as "a transformation of society" (Stiglitz 1998). He recognized that past development strategies had not been successful, given the increase in the numbers of people living below the poverty line and, paradoxically, that successful countries did not necessarily follow the recommended paths (examples of South-East Asian countries). He then identified key ingredients for successful development strategies, which included the active roles played by government and civil society (ownership and participation) in a vision of transformation – and he emphasized the importance of coordination of different agencies within and among levels of government but also between private and public sectors. While he did not explicitly include donors in the agencies which need to be coordinated, nor did he refer explicitly to the power dynamics between donors and recipients, this latter point seemed implicit in the following sentence: "interactions between donors and recipients may sometimes impede the transformation".

This speech was part of a shift towards a new paradigm of development, after the above-mentioned failure of development strategies based primarily on project aid,

policy conditionality and economic growth, which failed to take into account country-specific contexts (Dijkstra and Komives 2011). This new paradigm, set in late 1990s, was rooted in the adoption of the Millenium Development Goals (MDGs) and, linked to these goals, in the development of poverty reduction strategies (PRS) by recipient countries. The underlying driver of the PRS development was to foster donor coordination and government leadership. Donors were then expected to provide assistance to reach MDGs, by following and funding PRS, under the leadership of recipient's governments (Dijkstra and Komives 2011). Since this change in paradigm occurred, references to aid coordination, leadership, ownership and to their insufficiencies have increased in the development literature.

The global community's focus on aid effectiveness and aid coordination culminated in 2005, with the launch of the Paris declaration (Organisation for Economic Co-operation and Development 2008a). The declaration identifies a number of elements essential to be achieved, both on the part of donors and recipients, such as an increase in partnership, ownership and leadership, in order to improve aid coordination. While it is noteworthy that these elements touch on, amongst others, behaviors and attitudes of donor and recipient organizations, simply knowing that it is necessary to change is far from sufficient to induce a change in behaviors and attitudes. Also, inducing a deep change in the behaviors and attitudes of a given country or organization or its constituencies requires a deep understanding of what constitutes a country – its history, its socio-cultural peculiarities, its interactions with others – and a number of disciplines need to be employed such as sociology, history, psychology, political science. A systematic approach, based on long observation and on different types of interactions at both individual and institutional levels, is therefore a prerequisite in order to understand requirements for a sustainable change in donors' and recipients' attitudes and behaviors in a given context.

1.3 DEVELOPMENT ASSISTANCE FOR HEALTH (DAH) IN FRAGILE STATES

After a conflict, donors usually arrive with high expectations of the ease of rebuilding a post-conflicted country, considering that it needs to start from 'scratch' – and this assumption of fertile terrain for transformation usually attracts considerable amounts of aid.

However, there are numerous challenges specific to fragile and post-conflict states. First, the extent of these states' reliance on external aid, much greater than that of other states, makes them extremely vulnerable to a potential discontinuation of aid. This influences the way aid is absorbed and, in turn, how global initiatives and policies are translated into national policies. Secondly, when aid represents a significant proportion of the health sector budget, it might have disruptive effects on the health system, if not coordinated (Buse and Walt 1997). The high number of actors usually present in fragile and post-conflict situations makes the aid coordination challenging, however (Engberg-Pedersen and Andersen 2008a; Engberg-pedersen and Andersen 2008b). Moreover, during the post-conflict transition stage, donors might avoid engagement with the government and deploy aid instruments difficult to coordinate, such as non-governmental organizations (NGOs) or projects (Lanjouw, Macrae, and Zwi 1999). Thirdly, given the level of destruction, the time needed to rebuild a health system in a country affected by conflict is longer than in any other country, and aid might be too short-term.

Adding to these common challenges encountered in fragile and post-conflict contexts, each country has specific challenges relating to its own roots of conflict, pre-conflict context, pre- and post-independence history, as well as economic and social architecture.

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This whole set of challenges related to aid coordination in post-conflict states needs to be scrutinized carefully in order for aid to be the most effective possible.

1.4 THESIS AIM, OBJECTIVES AND OUTLINE

Since 2005, Burundi's health sector has been progressively engaging with development aid and subsequent reforms. Partners and donors are numerous, from bilateral and multilateral donors to GHIs and international or local NGOs. Unsurprisingly, however, Burundi has been experiencing a tremendous HRH crisis at all levels of health care, deepened by several years of conflict. Moreover, people working in the health sector have been internally wounded by the long-lasting conflict, and a climate of mistrust prevails amongst them. The combination of the HRH crisis with the increasing number of partners engaging with the health sector, within a society made fragile by the conflict both at individual and institutional levels, poses huge challenges for aid coordination. This PhD thesis aims to provide an in-

depth case study of factors influencing aid coordination in the health sector in Burundi, through the example of HRH policies.

1.4.1 Objectives

The objectives of this thesis are as follows:

- To review the socio-historical context of Burundi and the influence of international aid for development on country's transformation,
- To present major organizations active in the health sector in early 2000 in Burundi,
- To describe these organizations' HRH policies and the extent of their coordination between 2002 and 2008,
- To analyze context-and process-related factors inhibiting HRH policies coordination,
- To analyze stakeholders' own positions towards coordination, their understanding of coordination and their perceptions of other's positions toward coordination,
- To provide an in-depth Ministry of Health (MoH) power analysis, using a new conceptual framework,
- To discuss specific challenges of coordination in post-conflict settings and ways forward.

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1.4.2 Outline

This thesis starts with a context section which provides an overview of the history of the Great Lakes Region in which Burundi is situated, and of Burundi's historical, political and socio-economical contexts. This section ends with a snapshot of the health sector in Burundi, the legacy of the war, and the state of aid coordination in the country. It also provides some key context-related factors hampering aid coordination.

The context section is followed by a literature review on aid coordination, especially in fragile and post-conflict states, and related challenges. The review identifies current gaps in research regarding aid coordination: specificities of coordination in fragile states, power relationships underlying coordination, lack of clear definition over institutional capacity (to coordinate) and lack of research on HRH policies coordination. The combination of the background section and the literature review provides insights into the complexity of aid coordination in post-conflict setting such as Burundi.

The methods section first reviews the existing conceptual framework for policy analysis and presents the conceptual frameworks selected for the study, the contribution of organizational theory and the methods used.

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The findings section is divided into four sub-sections. The first sub-section introduces the 19 organizations active in the health sector in Burundi, in terms of governance, type of financing and policy elaboration highlights; the second sub-section presents an analysis of HRH policies of the 19 organizations between 2002 and 2008; it also presents the process-related factors inhibiting coordination; a third sub-section presents views and interests each stakeholder has vis-à-vis coordination; a fourth sub-section presents a thorough institutional power analysis of the body theoretically in charge of coordination, the MoH.

A discussion chapter explains the contribution of Bourdieu's theory to this research, and proposes a new definition of aid coordination in the health sector, as well as some tracks in order to improve coordination. A chapter related to methodological challenges closes the thesis.

CHAPTER 2: CONTEXT: BURUNDI, A HISTORY OF AID AND CONFLICTS

"*Inequality has always been pervasive in Burundi society. That there is no equivalent in Kirundi for equality – or for liberty – speaks volumes for the nature of traditional Burundi underpinnings. Social inequalities tended to generate their own mechanism of social cohesion. Today, social inequality is increasingly correlated to ethnic identity. This is an unprecedented phenomenon in the history of this country.*" [(Lemarchand 1994) chapter 1, 'Burundi paradox']

This chapter is divided into four sections.

First, an overview of historic background of the Great Lakes Region is provided, including the former linkages of the region with the development community. Then, a description of the contemporary situation in Burundi (political, economic and socio-demographical) follows, starting from 2002 when the conflict became less violent and the first aid for development resumed. The third section describes the legacy of the civil war on the health sector and the current state of aid coordination – while a final section provides a synthesis. This chapter contains already some of the findings linked to context, in order to facilitate the understanding of the rest of the findings.

Health sector actors, their organizations and their policies will be further detailed in the findings section, as part of the organizational and stakeholder analysis.

2.1 REGIONAL HISTORY

Burundi's history is inextricably linked to the historical context of the Great Lakes Region. A regional history provides a background for an analysis of the relationship between Burundi and development assistance partners as well as a picture of the social and economic fragility of the country.

The Great Lakes Region comprises four countries – Uganda, Rwanda, Burundi and Democratic Republic of Congo (DRC) – and shares a common history of a colonial and post-colonial cyclic violence, fed from one country to another. The gathering of these countries into one Region was based on politics rather than geography, as will

be shown below [(Scherrer 2001) chapter 2, destructive interaction between Rwanda and Burundi].

From the 14th century, southern Uganda and southern Kivu were part of Rwanda. Rwanda and Burundi were initially two separate kingdoms, sharing almost similar socio-cultural customs [(Scherrer 2001) chapter 2]. Both kingdoms were populated by similar groups – Tutsis, Hutus and Twas – with a well-established power-sharing system.

Burundi was first colonised by Germany in 1890 – but after World War 1, Burundi and Rwanda fell under the Belgian tutorship [(Scherrer 2001), chapter 9, Burundi-Rwanda's false twin].

In both countries, German settlers, followed by Belgian settlers, manipulated the pre-existing social classes in order to divide the society into three distinct ethnic groups [(Scherrer 2001), chapters 2 and 9]. Settlers consecutively applied the 'divide them to rule them' principle over half a century, until the independence of Rwanda in 1959 (starting with a social revolution) and of Burundi in 1962 [(Scherrer 2001), chapter 2]. Upon independence, both countries inherited an ethnocratic government set up during the colonial era – a Tutsi-led one in Burundi and a Hutu-led one in Rwanda – with almost no power-sharing, despite the two countries being composed of around 85% Hutus, 15% Tutsis and 1-2% Twas [(Scherrer 2001; Lemarchand 1994), chapter 2].

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The first prime minister of Burundi, Louis Rwagasore (Uprona party) was assassinated in 1961, soon after his election. During the following four years, Burundi had six different governments, until a *coup* in 1966 successfully led by the military. Between 1966 and 1993 the country was ruled by three different leaders from the Tutsi group, from the same region and from the political party Uprona, backed by a military regime [(Scherrer 2001), chapter 9].

Cyclic inter-ethnic violence took place in 1965, 1969, 1972, 1988 and 1991 [(Scherrer 2001), chapter 9], with 1972 seeing the highest number of killings. The so-called 'event' of 1972 (the expression used by Burundese) was literally a "selective genocide" (Lemarchand 2002); [(Scherrer 2001), chapter 9, p. 219] triggered by a supposedly failed coup led by Hutus in which between 80,000 and 100,000 educated

and wealthy Hutus were selectively killed, along with Tutsis who were political opponents (Lemarchand 2002).

The first democratically elected Hutu president, Melchior Ndadaye (Frodebu), was also killed in 1993, a few months after his election (Lemarchand 2002). This assassination, followed by more assassinations of people who may have replaced the late-president, left a void at political level (Manirakiza 2007) and to revenge killings of Tutsis by Hutus. This was followed in turn by repression by the Tutsi-constituted army.

From 1993 to 2005, ethnic violence continued, along with political chaos, resulting in internal displacements and emigrations (Maps 1 and 2). In 1994 there was ethnic cleansing in major parts of the capital, Bujumbura, leading to an ethnic apartheid and to "balkanisation" [(Scherrer 2001), chapter 9]; (Watt 2008). While transitional governments were put in place after the Arusha Agreements in 2000, the new peace agreement was only signed with the last rebel group (Front National de Libération-Palipehutu) in September 2006 (Watt 2008); [Scherrer 2001) chapter 9].

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Meanwhile, since 1959 in the neighbouring Rwanda and under the flagship of a Hutu revolution, the Hutu-led government overtly practiced ethnic cleansing over decades, provoking massive movements of Tutsis refugees across borders to Burundi, Uganda and the DRC [(Scherrer 2001), chapter 2]. Tutsis from Burundi distrusted Hutus, given the consequences of their governance in Rwanda (Lemarchand 1994), whereas Hutus of Rwanda distrusted Tutsis, after what happened to Hutus in 1993 and 1972 in Burundi (Watt 2008).

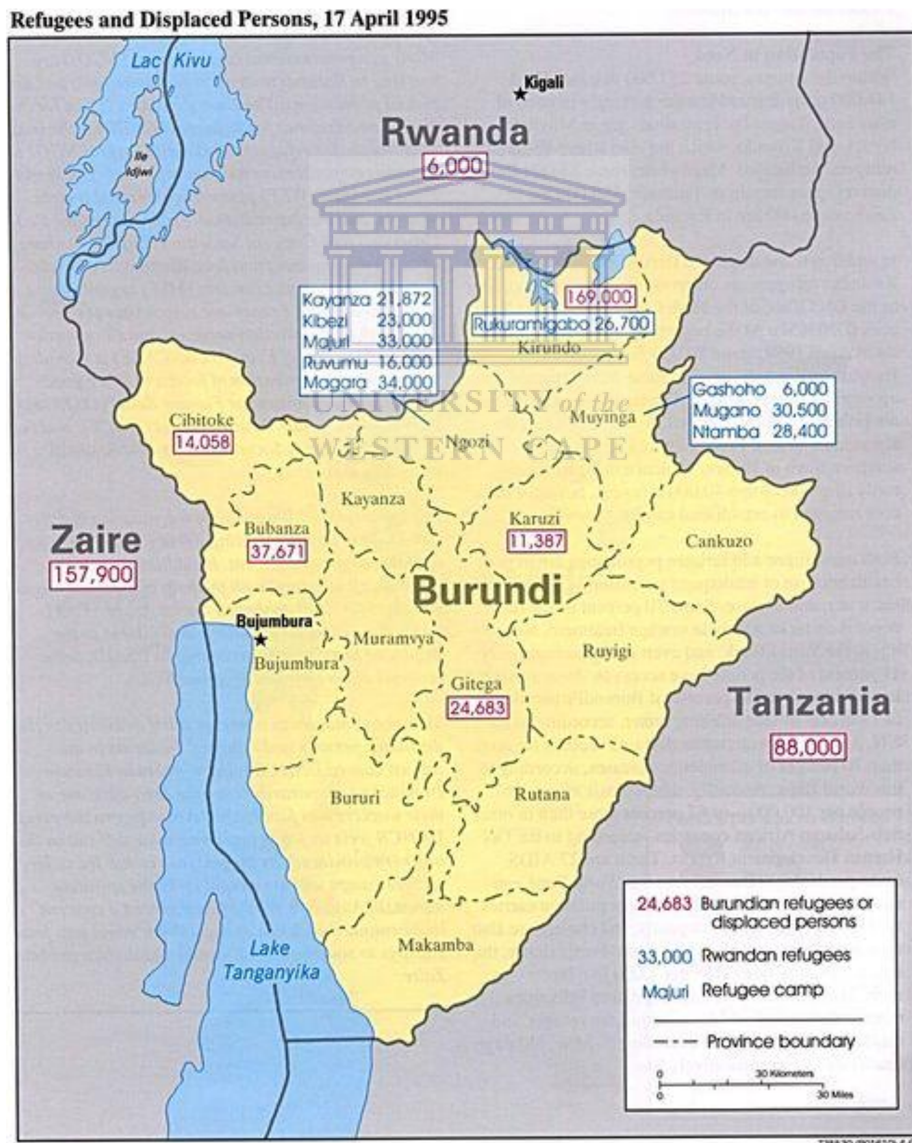
In April 1994, the plane transporting the Rwandan president, Juvenal Habyarimana, was shot down, killing him and the Burundi president (who had just replaced the late Ndadaye). This triggered the Rwandan genocide in which a million Tutsis and moderate Hutus were killed within three months. Hutus from Burundi who had fled to Rwanda in late 1993 to escape the Hutu massacre in Burundi, participated in this Tutsi genocide [(Scherrer 2001), chapter 9].

The Rwandan Patriotic Front led by Paul Kagame successfully invaded Rwanda and took power in June 1994. However, *some* Hutus 'génocidaires' formed a rebel movement called Forces Démocratiques de Libération du Rwanda and, along with

other rebels from Burundi, still continue to destabilize the Great Lakes Region, perpetuating 'ethnic' killings in Kivu, Burundi and Rwanda by crossing very loosely patrolled borders (Vignaux 2004).

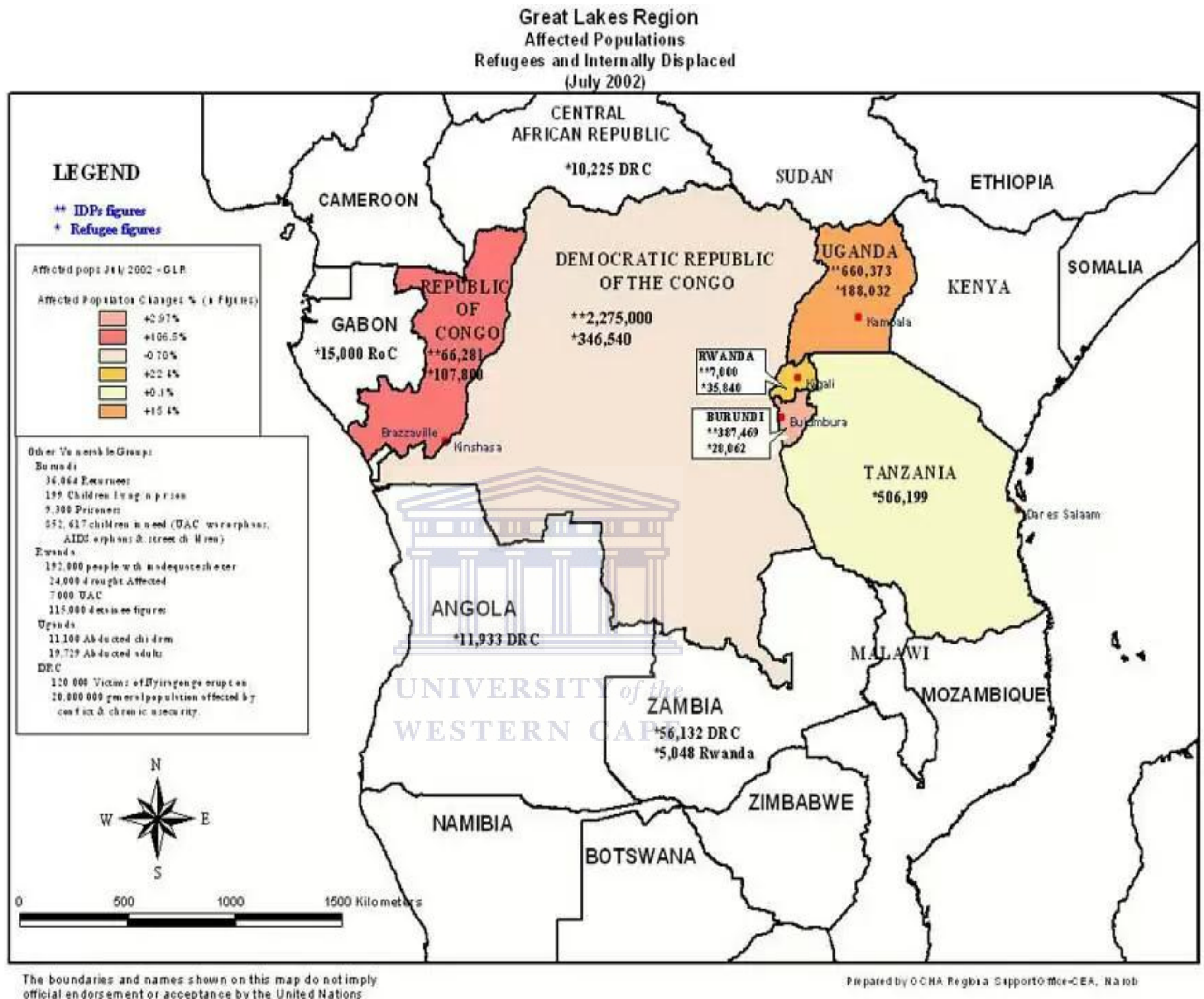
The post-independence period therefore saw a succession of so-called 'ethnic wars' in these three countries – Burundi, Rwanda and Zaire / later DRC. Tutsis from Rwanda and Hutus from Burundi constituted the first refugees of decolonized sub-Saharan Africa, moving to neighbouring countries such as Tanzania and DRC [(Scherrer 2001), chapter 2]. The three countries exerted a destructive interaction between each other, by repeatedly becoming hinterlands for ethnicized rebels.

Map 1: Refugees and internally displaced persons (IDP) in Burundi, 1995



Source: Central Intelligence Agency ("Burundi, Refugees and Displaced Persons" 1995)

Map 2: Refugees and internally displaced persons (IDP) in the Great Lakes Region, 2002



Source: Unites Nations Office for the Coordination of Humanitarian Affairs ("Great Lakes Region" 2002)

2.2 BURUNDI'S CONTEMPORARY ECONOMIC, SOCIAL AND POLITICAL CONTEXT

2.2.1 Demographic, economic and social characteristics

At the beginning of the 1980s, Burundi was regarded as economically successful, with a positive exportation balance, mainly due to high coffee prices [(Scherrer 2001), chapter 9]. While urban areas were the most developed, with westernised infrastructure and high quality education, the country, which was mainly rural, was showing a growing rural/urban inequity in terms of development, however [(Scherrer 2001), chapter 9].

The economic meltdown in the mid-1980s was first caused by a drop in export prices of Burundi's two main products, tea and coffee, on which the country strongly relied. The stagnation of the Gross Domestic Product (GDP), combined with population growth which did not slow down, induced a pauperization of especially the rural areas, emphasized by inadequate development policy at that time. The already pre-existing rural-urban inequities were thus further aggravated. Structural adjustment adopted in 1986 led to a deep devaluation of local currency (in the 1980s, 1 USD = 80 BIF; in 2011 it was 1080 BIF), a decrease in public sector performance, yet poor results in the private sector.

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The continuous crisis from 1993 to 2005, and an economic embargo imposed by neighbouring countries (Rwanda, Kenya, Tanzania, Zambia, Uganda and the DRC) from 1996 to 1999, threw the country into a situation of extreme poverty (Chrétien 2000). This was exacerbated by the slow return to the country of Burundian refugees – around 200,000 people were still living in Tanzania in camps, following the 1972 and 1993 major conflicts – as the Tanzanian government was sending them back little by little, since the end of the conflict (Radio France International 2010). A high population growth rate, combined with a steadily high fertility rate (6.8 / woman in 2009) added to the return of refugees, and raised critical issues of land ownership and land use, since the main income-generating activity was agriculture.

With a population density of 326/km^2 in 2010 (World Bank), Burundi is the second most densely populated (World Bank 2010) and one of the poorest countries in sub-Saharan Africa, with more than 80% of the population living below the poverty line (UNDP 2011) in 2011. The human development index for 2011 placed the country at

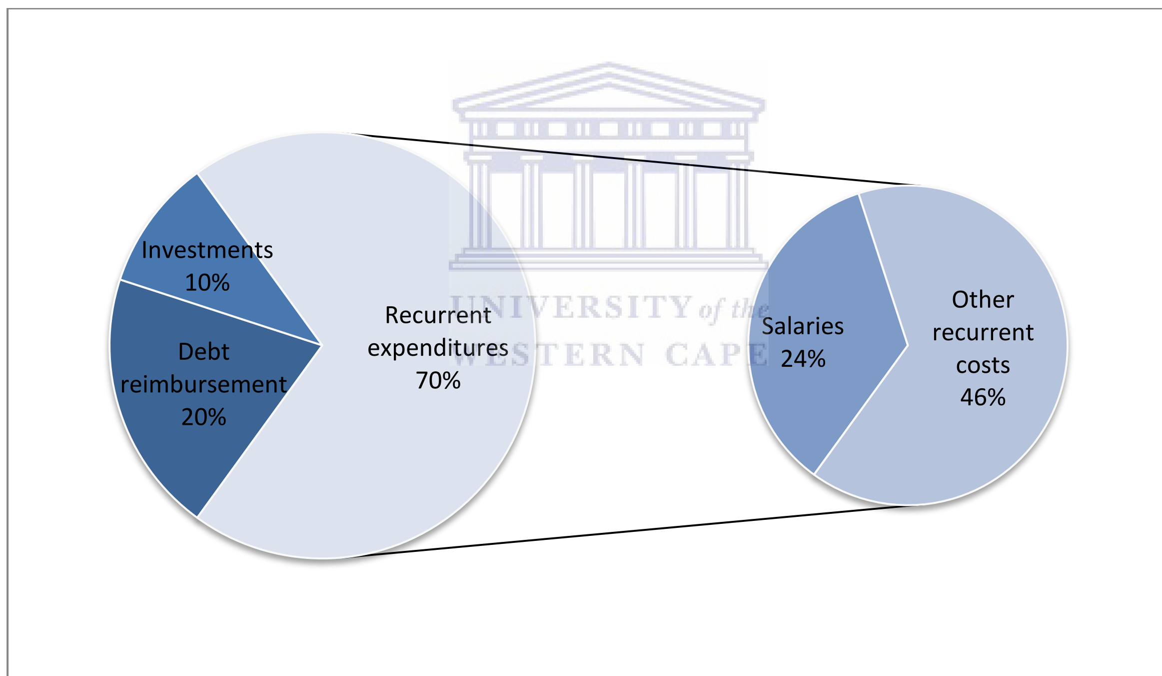
the 185th rank out of 187 countries (UNDP 2011). In 2010, the Gross National Income was 170 USD (current USD) per capita (World Bank 2010).

Between 2002 and 2010, the national budget increased steadily, however – from 162 billion BIF in 2002 to 863 billion BIF in 2010. While some of this increase was from an increase in the state's own income (+146% between 2002 and 2008), it was mainly due to an increase in development assistance (+508% during the same period) (ISTEEBU 2008).

In 2008, the majority of the state budget was spent on recurrent expenditures (70%), as presented in the pie below (ISTEEBU 2008).

Graph 1: Use of the state budget, 2008

(own creation)



2.2.2 Political context after 2002

From late 2001 to 2005, two transitional governments were appointed. The former president Buyoya (Uprona) was appointed for the first 18 months of this transitional period.

In 2005, a series of elections was held, and Pierre Nkurunziza (CNDD-FDD) became the first democratically elected president since the start of the war in 1993. A referendum that year voted in a new Constitution, with three articles emphasising

various quotas: Article 124 states that the two deputy-presidents need to belong to different politico-ethnic families; Article 129 states that members of government have to be representative of the Burundese nation and need to be constituted of 60% Hutus and 40% Tutsis; Article 135 states that key persons in public administrations and political positions, have to be nominated while maintaining the balance in ethnic/political/gender and regional origin distribution (Gouvernement du Burundi 2005).

Pierre Nkurunziza again won the presidential elections in 2010 and his party won the legislative and communal elections organised at the same time. Opponent parties did not accept the outcomes of these elections, however, accusing the ruling party of electoral fraud (Human Rights Watch 2011). In parallel with this, and since 2005, accusations and evidence of corruption had accumulated against the ruling party, as reported by an independent body monitoring corruption and government activities (Observatoire de l'Action Gouvernementale 2010). On the 2011 corruption perception index, there are only two countries in sub-Saharan Africa below Burundi, namely Somalia and Sudan (Transparency International 2011).

2.2.3 Influence of external donors and of international community on the region, before 1993 and during the conflict

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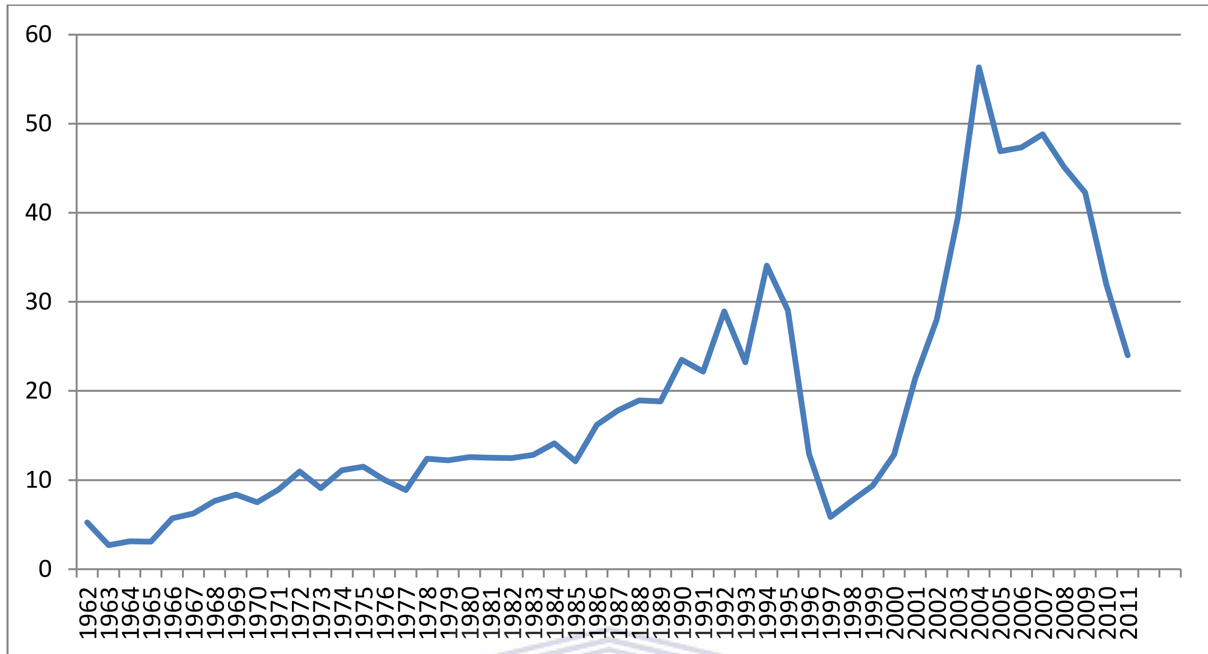
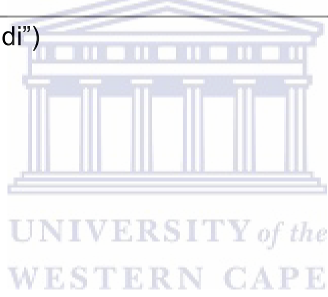
Since independence, external donors have always been present in Burundi and have progressively increased their contributions (see Graph 2). Before the conflict in the country, the World Bank (WB), through its International Development Association (IDA), was the largest multilateral donor – but before and after the last conflict, countries swapped their relative contributions. Before 1993/1994, French-speaking bilateral donors were dominating the scene in Rwanda and Burundi, with France, Belgium and Switzerland being the most important in Rwanda, while Belgium and France were the biggest donors in Burundi, providing support at similar levels. Graph 3 shows the relative instability of aid from one year to another for Burundi, however, with the exception of Switzerland.

Graph 2: Net official development aid (ODA) to Burundi as % of gross national income (GNI), 1960 to 2011



Source: OECD database(“Index Mundi”)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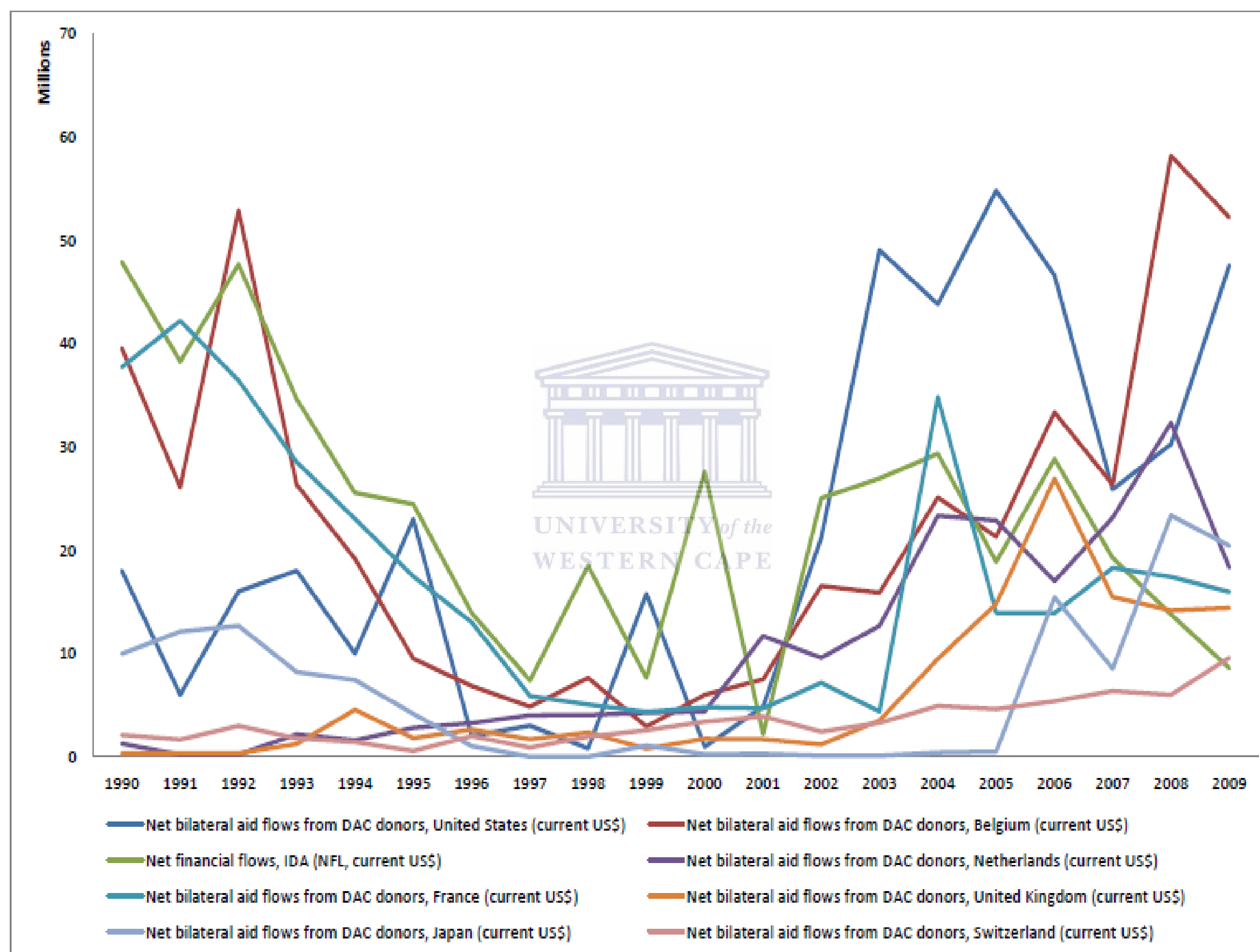
Graph 3: Contributions of bilateral donors and the International Development Agency (IDA) to Burundi, 1990-2009 (in current USD)



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Source: World Bank database(World Bank 2010)

During the 1993 ‘crisis’, the country suffered economically: aid for development stalled almost entirely from 1993 to 1999, with ODA dropping from US$230 million to US$17 million (Manirakiza 2007). Economic exchanges stopped during 1996 to 1999 during the economic embargo, including passenger flights, completely isolating the already land-locked country (graphs 2 and 3).

The Arusha peace agreements, first signed in 2000, were negotiated for months from 1998 in a climate of mistrust, first under the moderation of Julius Nyerere (Manirakiza 2007) and thereafter Nelson Mandela. However, the actual implementation of a transitional government happened only in late 2001.

The following year, in 2002, the government of Burundi presented their Social Emergency Plan 2003-2005 (linked to the strategic orientations of the PRS paper 1). The Plan was estimated to cost more than 982 Million USD, of which 90% was externally funded [(Union Européenne), pp.4].

2.2.4 Development assistance and relationships with the international community since 2002

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In mid-June 2002, the Government of Burundi (GoB) was 129 million USD in arrears, as a direct consequence of the conflict and the drop of coffee prices (International Monetary Fund 2002). Since 2003, ODA has been accounting for around 40% of the gross national income (GNI). ODA has been dominated by multilateral institutions, with the IDA being the most prominent leading one in 2009-2010 (Figure 1).

After the end of the conflict, the landscape of donor contributions to Burundi changed radically. Beside IDA still constituting the major multilateral funder, in terms of cumulative funding from 2001 to 2009, the United States of America (USA) outweighed Belgium, making it only the second bilateral contributor (graph 3). The third bilateral contributor became the Netherlands, while Japan’s contributions are growing quickly. The United Kingdom (UK) and Switzerland, absent from the aid landscape in Burundi before the conflict, started to contribute as well. However, if we analyse all the donors, the European Union (EU) institutions constitute the major donors in Burundi.

The USA also had a growing influence in Rwanda after 1994, explaining its increasing influence in Burundi as well.

Figure 1: Gross Official Development Aid (ODA) to Burundi, 2008-2010

(Accessed online stats.oecd.org 13/03/2012)

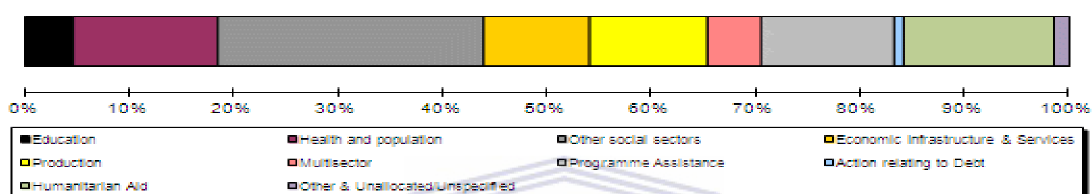
Burundi

Receipts	2008	2009	2010
Net ODA (USD million)	522	561	632
Bilateral share (gross ODA)	48%	25%	44%
Net ODA / GNI	44.8%	42.2%	39.8%
Net Private flows (USD million)	- 38	- 27	64

For reference	2008	2009	2010
Population (million)	7.9	8.2	8.4
GNI per capita (Atlas USD)	140	150	170

	Top Ten Donors of gross ODA (2009-10 average)	(USD m)
1	IDA	404
2	EU Institutions	131
3	AfDF	113
4	France	66
5	Belgium	56
6	Japan	48
7	United States	46
8	IMF (Concessional Trust Funds)	44
9	Germany	29
10	Global Fund	25

Bilateral ODA by Sector (2009-10)



Sources: OECD, World Bank.

Note from the author: IDA here is the first contributor, due to the fact that gross ODA is represented here (includes loans). If loans are deducted (net ODA), EU institutions become the first contributor to Burundi.

2.3 HEALTH SECTOR IN BURUNDI

Burundi is now in a transitional stage between emergency aid and development aid. The country's institutional capacity in general and in the health sector in particular has the reputation to be very weak, even though the concept of institutional capacity is difficult to measure and this will be central to this study. The civil conflict deteriorated the health-care infrastructure and the whole health system, resulting in high rates of HRH exodus and further health system disorganization (Wakabi 2007). Until 2005, basic health needs were supplied by NGOs specializing in humanitarian aid – and these are being progressively replaced by other NGOs with long-term development expertise, who increasingly receive GHI funding and direct assistance.

What follows is an overview of the health system as it was towards the end of the conflict in 2002 – with a special focus on health financing, HRH and aid coordination.

2.3.1 Health system: legacy of the war and current challenges

Overview of the health sector: legacy of pre-war organisation

The public health sector in Burundi is organized in the shape of a pyramid. Still very centralized, it operates on four levels: a national level, divided into programs and cross-programmatic administration; a provincial level; a district level (currently being developed since 2008); and a facility level, with the primary health care (PHC) centres. Activities, including addressing tuberculosis (TB), malaria and immunization, are conducted as part of an integrated minimum services package at facility level and coordinated by district or provincial offices.

Before 1993, vertical programs within the MoH, such as TB, malaria, reproductive health or immunization programs, used to be run independently, and managed their own funding from external donors. This lack of involvement of the MoH's central unit in resources management is demonstrated by the fact that no Directorate General for Resources existed since independence, the first director general being appointed only in March 2006.

> *"Following deliberations during the general health forum held in 2004, it was noted that there was still a need for setting up a management structure which would be tackling human and financial resources, issues relating to infrastructures, equipment and which would be separate from the Directorate General for Health, which is only dealing purely with technical aspects of health, sanitary administration."* (ITW15N09, group 1, local)

Bilateral donors used to work with the MoH and its programs, or with NGOs, in an independent way through project-funding. Therefore, governmental officers at MoH central level were not used to plan, but rather to implement projects.

There is also a private health sector – both for profit and not-for-profit. The not-for-profit sector mainly comprises missionary hospitals and PHC centres which have signed an agreement with the public health sector, as well as service delivery NGOs with specific mandates like HIV-care (funded through the Global Fund for AIDS, Tuberculosis and Malaria - GFATM) or emergency obstetric care (funded by Médecins sans Frontières - MSF).

The for-profit sector is now growing, with a number of private clinics, mostly in the capital, competing for skilled personnel with the university hospital.

Epidemiological change attributable to the conflict

In 1990 the life expectancy in Burundi was 50 years and dropped to 47 years as a consequence of the war (World Health Organization). Given the low life expectancy even before the conflict, it is obvious that the epidemiological transition from infectious diseases to chronic diseases had not yet taken place. The conflict moreover affected the main health indicators such as maternal or child mortality. Epidemics such as cholera outbreaks and malaria, and endemic diseases such as TB increased. Malaria cases per year increased more than four times, from around 375,000 in 1989 to more than 1,600,000 in 2004 (Niyongabo et al. 2005); HIV prevalence in rural areas more than tripled, from 0.7% in 1989 to 2.5% in 2002 (Niyongabo et al. 2005); the TB incidence went up from 209 in 1990 to 570/100,000 cases in 2003 (World Health Organization); the malnutrition amongst general population increased, with a decrease in daily energy intake from 2,170 Kcal in 1,990 to 1,650 Kcal in 2005 (World Health Organization).

2.3.2 Health funding environment

Health financing: dominated by out-of-pocket and ear-marked funding

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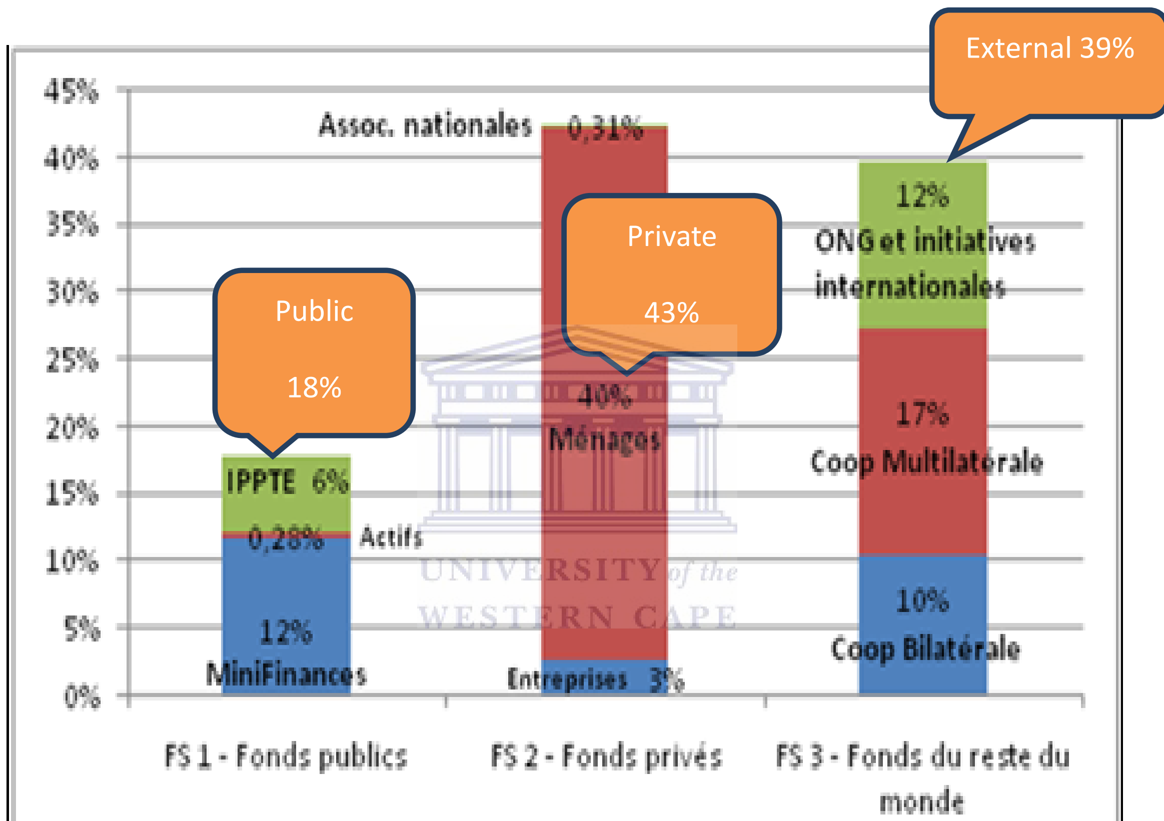
In the immediate post-conflict period, the landscape of health sector funding (including for HIV) was very much dominated by ear-marked funding. Beside the remaining emergency / humanitarian aid (various United Nations' agencies for emergency, international NGOs, European Community Humanitarian aid Office - ECHO), HIV received two large amounts of funding from the WB (Multisectoral AIDS Project 1-MAP1- from 2001) and GFATM-HIV from 2002; malaria ad TB was funded by GFATM; and immunization by Global Alliance for Vaccines and Immunization (GAVI). The reason for this probably lies in the fact that it was easier for disease-specific donors to organize themselves since they had a narrower objective than rehabilitating the entire health system. Also, funding fitting disease-specific objectives was available at global level.

As shown in Graph 4, private expenditures represented 43% of total health expenditures (40% out-of-pocket and 3% from private enterprises), whereas external donors represented 39% (12% GHIs and NGOs, 17% multilateral donors and 10%

bilateral) and public sources only 18% (6% Highly Indebt Poor Country Initiative – HIPCI - and 12% Ministry of Finance).

Graph 4: Proportion of health financing according to the source, 2007

(adapted from original National Health Account 2007 in French (Ministère de la Santé Publique 2007))



The main source of health financing is therefore out-of-pocket funding, as is the case in many sub-Saharan countries. Due to the scarcity of funding in the MoH as well as in the country generally, from 2002 public sector health facilities started charging user fees. Thus while the population still had access to a certain extent of free care during the conflict, as provided by emergency NGOs, once the conflict had ended, access to health care for the majority of the population was dramatically reduced, given the general introduction of user fees (Philips et al. 2004).

The first five years of President Nkurunziza electoral mandate were marked by a willingness to commit to the MDGs, with policies such as free education at all

primary schools and free health care for all children under five and for women delivering babies (May 2006). Despite the alignment of these policies with MDGs and this attempt at health equity, their implementation was chaotic as the policies had not been discussed beforehand with the ministries who must implement them. As a result insufficient numbers of HRH and a lack of preparation for these measures has led to clear cases of overwork in PHC centres (Observatoire de l'Action Gouvernementale 2009).

Emphasis on HIV: HIV distinct from the health sector and linked to the conflict

Just after the peace agreement was signed in 2000 in Arusha, a PRS began to be devised by donors and negotiating parties. It was also generally believed that the civil conflict, with the large numbers of internally displaced people and the chronic failure of the health system, fuelled the HIV epidemic. The alarming figure of 12% prevalence in the general adult population was cited several times, in funding proposals and the HIV plan 2002-2006.

> *"At the early stage, HIV sounded like a doomsday, resulting in a panic generating situation. It was urgent to put a halt to its propagation. " (ITW22N09, group 4, local)*

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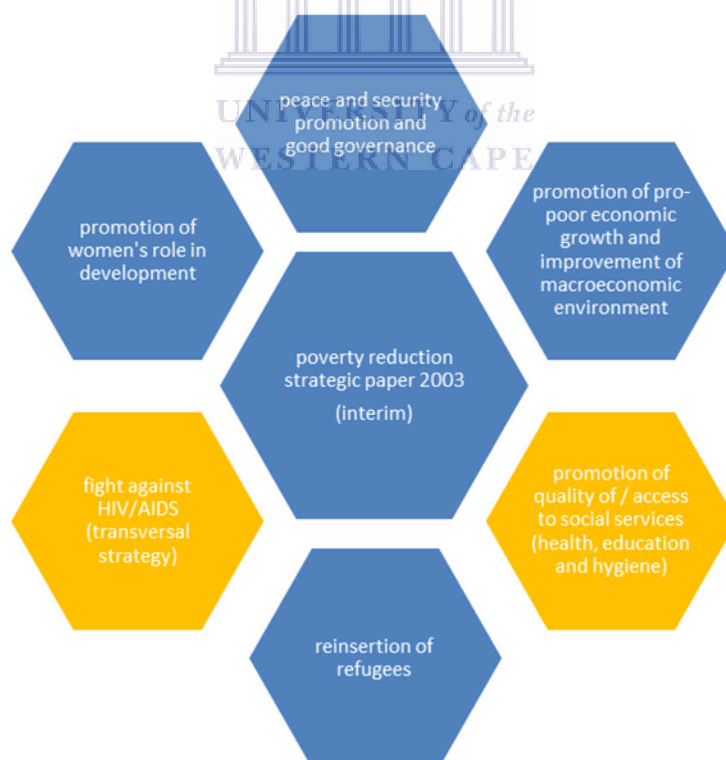
Later, a national survey funded by the WB proved this figure was exaggerated, since the national adult prevalence was 3.2% (Dec 2002). However, the figure of 12%, used many times, combined with the global awareness around HIV and strategies to contain the epidemic globally, was the probable reason for HIV being cited as one of the six strategic axes of the PRS paper (see Figure 2). The PRS paper is the leading document for donors. The United Nations Development Program (UNDP) financed its elaboration in a 'participative way'. The six strategic lines had a strong orientation towards alleviating poverty and the consequences of the conflict, as well as preventing the resurgence of conflict, in a virtuous circle of development. The visibility given to HIV by allocating one strategic line to it (which, in turn, justified the extent of the funding allocated to HIV), gave an exceptional statute to HIV, considered as a 'sector' *per se*.

> *"What was clear is that disease was given priority over health". (ITW28N09, policy analyst, local")*

"This is another point which I have never understood. I think that under the influence of whom I don't know […] but when the poverty reduction strategy paper was developed, HIV was included as a sector. Its budget is bigger than the budget of health and education and agriculture altogether, which seems to be abnormal. This is what I was told not long ago, that there are abnormal things even if I don't know how it has all happened. I know that we have criticized it. It is still appearing in the documents, I have not discussed about with people working in the ministry of planning so that I know exactly the state of things. Otherwise at the level of the sectoral approach, as for the MoH, even before thinking that the two ministries would merge, one always thought that the HIV was part of the health sector." (ITW13N09, group 1, local)

Figure 2: The six strategic lines of the interim poverty reduction strategic paper, 2003

(created from the original document in French on PRS paper)



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The emphasis put on HIV, starting from the fact that it was one of the axes of the PRS paper, had consequences in terms of health planning, as described below.

2.3.3 Health planning in the post-conflict period

Precedence of vertical plans over national health plan

With the UN General Assembly Special Session (UNGASS) Declaration in 2001 and related international pressure to give political visibility to HIV, a separate Ministry of AIDS was created in 2001, which served to assure donors that the country was taking into account the need to tackle HIV in a cross-sectoral way. Soon after this, the National AIDS Council and its Permanent Secretariat (PES-NAC) were launched, independent from the MoH. The creation of PES-NAC and of the Country Coordination Mechanism, were the first steps to enable application for HIV-related funding, such as those proposed by the WB (MAP1) and GFATM.

In parallel, and prior to funding applications, criteria such as having a national HIV plan had to be met – which is the reason an HIV strategic plan existed before the national health plan. Figure 3 shows that the HIV plan 2002-2006 and the WB-funded MAP1 started at the same date, four years before the national health and development plan (2006-2010). The existence of the HIV plan facilitated the application to GFATM-HIV round 2, which was approved and started in 2003.

The other plan, active immediately after the end of the conflict, was the GAVI multiannual plan 2002-2006 – which had to be approved by the Inter-Agency Coordination Committee (IACC), independent from the MoH. The functioning of the GAVI coordination committee and the Country Coordination Mechanism (CCM) were relatively independent of the MoH which was not fully functional at that time – and this was probably crucial to getting the funding applications elaborated in a sound way and submitted in a timely manner. Indeed, between 2002 and 2005, the country was still recovering from the conflict and there were only transitional governments, while institutional capacities were still very scattered (see background section on local political context).

The satisfactory functioning of the CCM also explained the approval of two further rounds of support from GFATM, one for malaria in 2003 and one for TB in 2005,

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despite the absence of proper strategic national plans related to these two diseases. (The national malaria plan was started in 2008 and TB plan in 2007). The 'emergency' epidemiological context justified applications for funding (whose elaboration was usually supported by external consultants). The greatest malaria epidemic in the history of Burundi in 2000 had probably motivated application for GFATM-malaria funding, and justified its approval. It affected more than 3 million people (out of 6 million inhabitants), with a mortality rate of 10% -15% (Niyongabo et al. 2005). The approval of GFATM-TB funding in 2004 was also justified by the high prevalence of HIV (confirmed in urban areas, around 10%) and a subsequent increase in TB incidence.

All three GFATM funding and MAP1 were managed separately from the MoH (see findings section 1 for further details). This very tight financial management was established in order to prevent any grants mismanagement, since disbursements were conditional on the approval of quarterly reports. In addition to the precedence of vertical programs' plan over the national health plan, the management of the vertical programs grants, from their conception to implementation, was independent from the national health plan.

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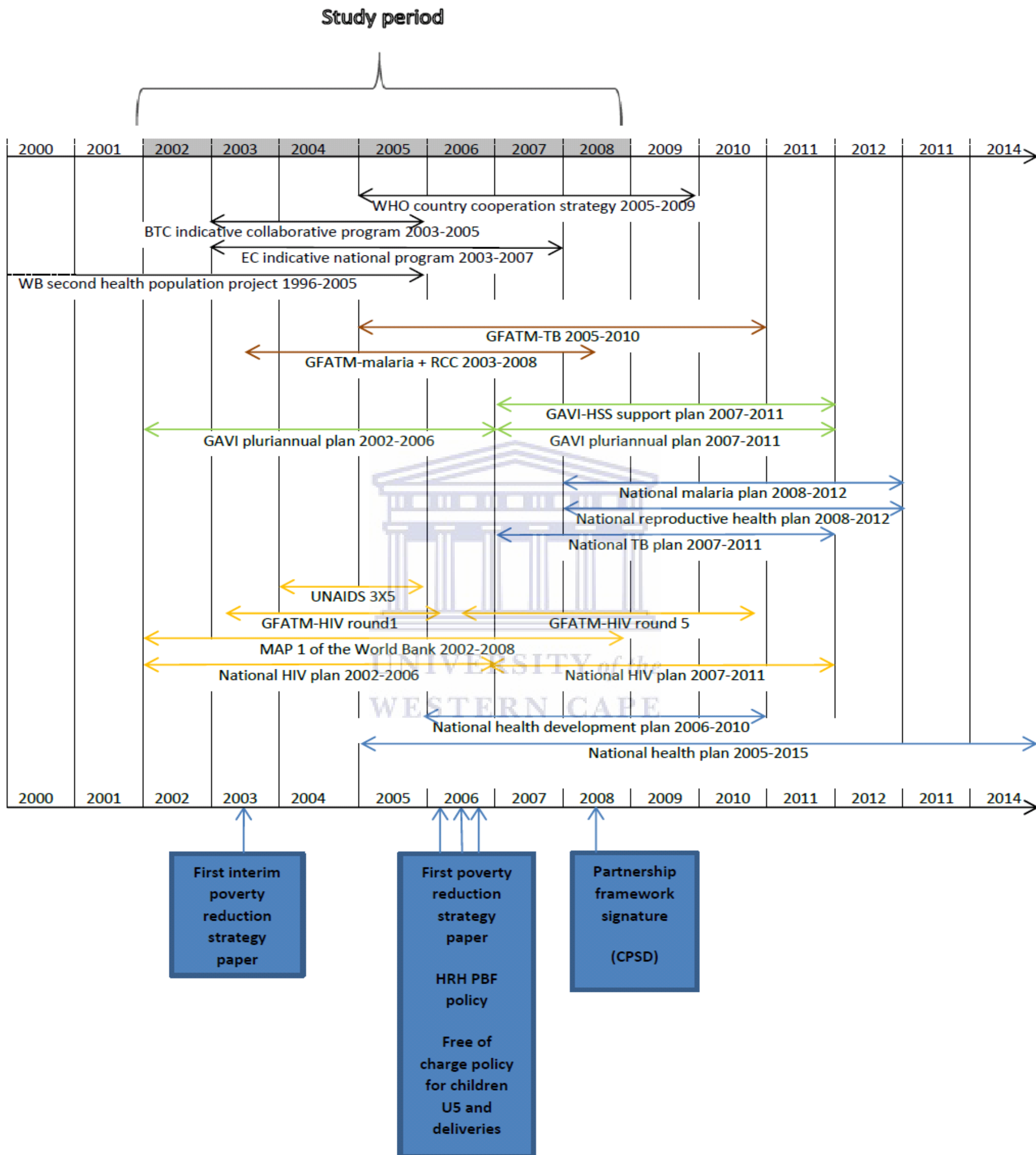
Figure 3: Aid organizations' multiannual plans / programs and approved funding proposals and government's policies relevant to the study period

(own creation)



Blue: national health plans and vertical programs' plans

Orange: HIV-related plans

Green: GAVI and GAVI-HSS

Brown: GFATM non HIV

Black: non earmarked aid organizations (EC, WB for PSP2, WHO and BTC)

2.3.4 Need for alignment with global priorities and statements

The internal elaboration of policy and planning documents had to take into account both national and global priorities.

The MDGs were developed at a UN Assembly and adopted by UN countries at the Millennium Summit in 2000. A total of eight goals were to be reached by 2015, amongst which three concerned the health sector: to reduce under-five mortality by two thirds; to halve maternal mortality; to halt and reverse the impact of HIV/AIDS, malaria and other diseases.

The four objectives of Burundi's national health plan 2006-2010 were directly derived from these three health-related MDGs and one other goal, related to health system strengthening (HSS), was added. The fact that MDGs strongly influenced the way the national plan was formulated was not an issue *per se*, since the goals perfectly matched the burden of diseases in Burundi (with perhaps an exception being the burden of HIV). The issue was rather the lack of a match between goals to be reached and the means to reach these goals. There was no acknowledgement of the fact that successful attainment of these goals had to be anchored within the health system. While the specific objectives formulated in terms of HRH for the HSS general objective were appropriate, there was no linkage with the other three objectives.

One example is the immunization program multiannual plan 2007-2011, which had to be revised prematurely before its end, since the introduction of the new rotavirus vaccine had not been taken into account at the time of its elaboration. A new multiannual plan 2010-2014 was elaborated, purposefully to fit with this global policy change (ITW3N11, group 2, local).

In addition to the MDGs, multiple global or regional level priorities needed to be taken into account for the elaboration of the national health plans and programs. Figure 4 was created using the different recommendations mentioned by interviewees or cited in the policy and planning documents.

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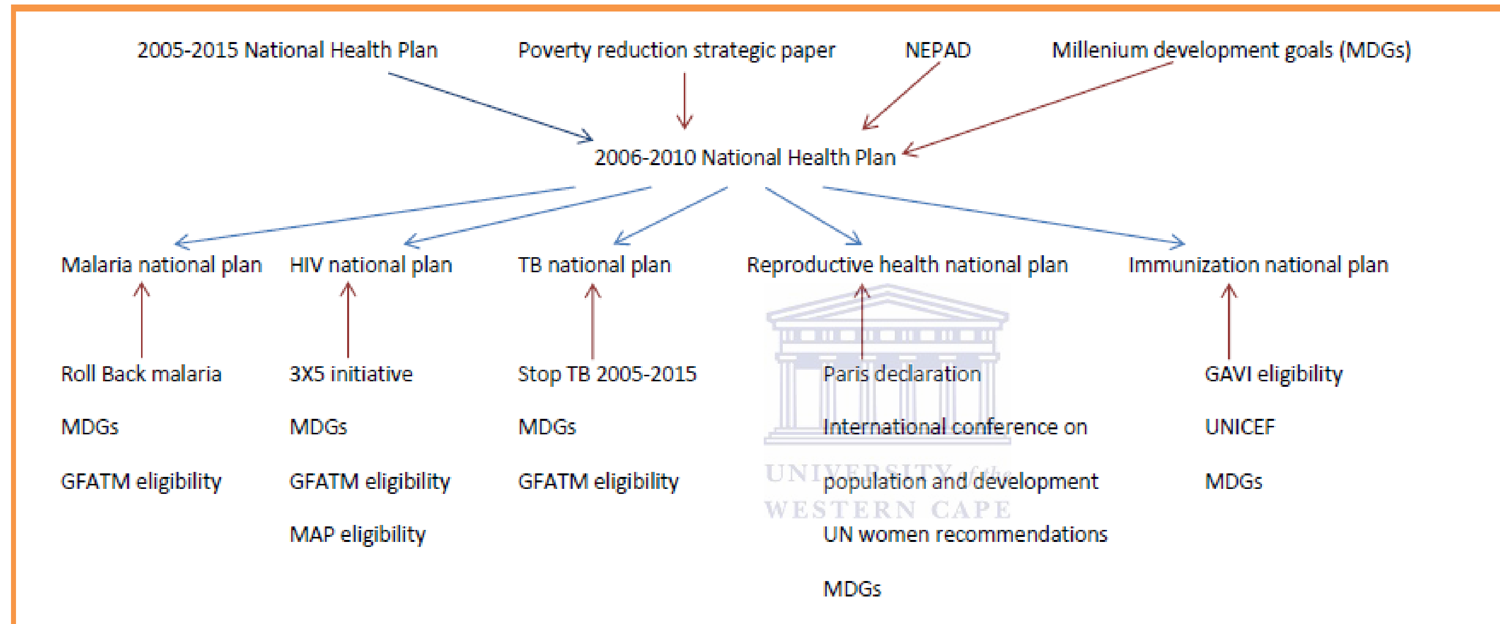
Figure 4: *Theoretical* influences and *de facto* influences of the national policy documents elaboration process
(own creation)



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Theoretical influences = blue arrows
De facto influences = brown arrows

Finally, there was also a need to take into account differing and changing HRH orientations at global level. For instance the World Health Organization (WHO) advocated for a task-shifting policy:

> *"The WHO advocates a task-shifting strategy for improving task performance. Competent nurses can carry out some tasks. It is crucial to recognise their added values. Protocols and guidelines are needed. This could be applied at the community level. The WHO wants this implemented in the short run. A specific training will complete nurses' basic training. I will dedicate myself to have it integrated in the policy." (ITW2N09, group 5, local)*

Meanwhile, the global agenda had shifted towards Pay-For-Performance (P4P) strategies, in which inputs and outputs were clearly controlled and adjusted according to pre-set criteria (Eijkenaar et al. 2013).

2.3.5 The quantity, quality and morale of HRH

Education

As of 2005, Burundi had only one public school of medicine with an annual graduation rate of around 50 physicians (Ministère de la Santé Publique 2006). Training in specializations are offered through collaborations with European schools of medicine, but few trained specialists return to their own country due to poor working conditions.

The government is aware of the insufficient number of nurses and has decided to increase the number of students in nursing schools. Around 800 clinical staff (nurses, laboratory technicians and nurse assistants) graduate each year from six nursing schools, of which two are private, and from one unique laboratory technicians' school. However, 75% of the nurses graduate with the lowest qualification (two years of training after junior high school). Pharmacists are exclusively trained in foreign countries.

The in-service component of the training is seldom developed and relies almost exclusively on in-service training organized by vertical programs and projects.

There was no channel of communication between the MoH and the Ministry of Education, this absence dating back before the conflict (ITW24N11). While the Ministry of Education was in charge of medical doctors' education and set its graduate numbers and education content, the MoH did not produce an estimate of the number of practitioners needed in the upcoming years. It was in charge of placing the newly graduated medical doctors, however.

Until 2010, there was neither an in-service training institute nor an HRH development plan with established needs. This hampered in-service training and HRH production coordination. Nonetheless the annual number of graduates from the school of medicine increased from 20 in 2005 to 80 in 2009. Since there was no communication between the two ministries, it was likely that this was due to an independent willingness of the Ministry of Higher Education, who was certainly sensitized to the HRH crisis, as well as the topping-up of salaries of professors and hiring of foreign professors, funded by the WB's project "Projet Santé Population 2" (PSP2). Unfortunately, the WB reported that many of the graduates produced in this period prior and till 2009 emigrated. The WB was retrospectively very critical of its own strategy (PSP2 implementation report). Had additional strategies, such as retention, been implemented at the same time as the increase in production, in cooperation with the MoH, the positive effects would probably have been more tangible and long-lasting.

Density and distribution

A study conducted by the International Office of Migration revealed that 150 physicians left the country between 1993 and 2002, because of the conflict, low salary levels and poor working conditions (UNDP 2005). HRH in the public sector in Burundi are now insufficient with respect to either the WHO sanitary norms (1 physician for 10,000 inhabitants and 1 nurse for 3,000 inhabitants) or the 2.3 health care provider/1,000 inhabitants needed to achieve MDGs (World Health Organization 2006). For the whole country, there was an average of 0.2 physicians for 10,000 inhabitants and 1.4 nurses/3,000 inhabitants, after removing the 46 physicians and the 202 nurses working at MoH level in 2006 (Ministère de la Santé Publique 2006). The situation of physicians appears catastrophic but the situation with nurses is not much better, as 68% of nurses have the lowest qualification (A3 level nurse, obtained two years after junior high school) and their production was stopped in 2011.

An absolute shortage of HRH, especially in high-skilled HRH such as specialized nurses and medical doctors, affected all sectors of health, and was attributed to the brain drain to foreign countries (Canada, Belgium and France) during the conflict.

The rural-urban gradient in supply had similar roots to those in many other African countries, where urban areas, equipped with better infrastructures, attract skills. In Burundi, the civil conflict context also added to the rural exodus by forcing civilians to seek security in urban areas. The few who stayed in rural areas sought better working conditions in NGOs, rather than staying in the declining public sector. Despite the signing of the peace agreements in 2002, armed rebels were still active in many parts of the countryside until at least 2008 and HRH were not willing to go back to the rural areas. This security factor further impacted negatively on the rural-urban gradient, but was out of the control of government, or at least, of the MoH.

The distribution between urban and rural areas is very unequal as shown in Table 1. The capital is the only province with a slightly higher rate of physicians, with 1.4/10,000 inhabitants. Distribution of nurses varied according to the level of insecurity and the level of external support to the province.

According to the civil service rules, the MoH is allowed to recruit HRH themselves. Those HR are concentrated mainly in urban areas where needs are almost satisfied, whereas no- one wants to be sent to remote areas without a proper allowance.

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Table 1: Human resources for health density by province, 2006 (Ministère de la Santé Publique 2006)

Province	**Population** (2006)	**Physicians** (density/ 10,000 inhab)	**Nurses** (density/ 3,000 inhab)
Bubanza	345,536	0.1	0.6
Buja*-Rural	383,132	0.1	2.0
Buja*-Urban	499,491	1.4	3.8
Bururi	493,889	0.2	2.2
Cankuzo	200,084	0.3	4.1
Cibitoke	471,616	0.1	1.4
Gitega	701,793	0.2	1.3
Karuzi	417,558	0.2	0.8
Kayanza	526,358	0.1	1.6
Kirundo	591,690	0.1	0.5
Makamba	459,703	0.1	1.3
Muramvya	279,336	0.2	4.2
Muyinga	580,770	0.1	0.5
Mwaro	253,017	0.2	1.0
Ngozi	711,402	0.3	0.5
Rutana	288,484	0.2	3.3
Ruyigi	361,794	0.2	1.5

*Buja: Bujumbura

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Working conditions

Salary levels in the public sector are decided by the Ministry of Civil Service and Ministry of Finance (MoF) and based on the highest degree obtained as well as on years of service. However, remuneration differs considerably between sectors: for example, civil servants in the finance, justice and security sectors received significant increases in salaries and allowances in 2006, leading to large discrepancies among salaries within the civil service (Cour des comptes 2008).

From December 2008 to May 2009, there were repeated national strikes of physicians and nurses calling for salary increases, with some reports of repression of freedom of expression. Salaries were eventually, increased from 2010-2011, through the creation of an exceptional statute for health workers (Gouvernement du Burundi 2009).

2.3.6 Nascent coordination mechanisms: uncoordinated coordination

Both government and donors, under the influence of the Paris declaration and the Accra Agenda for Action (AAA), have made four notable efforts towards better coordination, resulting in different frameworks.

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Firstly, a National Committee for Aid Coordination (NCAC) was created in 2005 to coordinate all external aid to Burundi. The NCAC supervised 13 sector groups, of which one was for HIV and another for health, illustrating the persistent willingness to separate HIV and health at ministry level. These sectors were put in place according to the PRS paper:

> *"The National Committee for Aid Coordination was put in place by donors. It is a structure which is highly paid to perform other people's job and therefore results in a conflict between civil servants and employees of this structure."*
> (ITW22N09, group 4, local)

The two most active groups were the health and the education groups, with efforts in the health group towards improving partnerships between government and technical and financial development partners (DPs). Their achievement was the establishment of a framework for consultation of health development partners (CPSD) in March 2007.

Secondly, this framework was a consultative organ, whose aim was to improve aid effectiveness in the spirit of the Paris Declaration, via increased coordination between financial and technical DPs in the health sector and the Ministry of Health (Harmer 2008). Following the creation of this framework, a partnership framework acting as a Memorandum of Understanding was signed in February 2008 between major bilateral and multilateral partners, some NGOs, some UN agencies and the MoH. Expected intermediate outcomes of this framework were: 1) improved efficiency of international aid and 2) quantitative and qualitative improvement of service delivery. In order to reach these objectives, the financial and technical partners and the MoH committed themselves, in particular, to "increased coordination and consultation" (Gouvernement du Burundi 2008a). This framework also introduced the creation of a permanent technical multi-sectoral organ, in charge of piloting and monitoring progress using MDGs indicators. This organ had two tiers: the one was political (political CPSD), meeting quarterly for decisional purposes; and the other, technical, meeting monthly. The technical organ (technical CPSD) proposed solutions to the political organ, on the basis of the preliminary work of four working groups, created according to the four problematic areas within the health sector in Burundi - namely HRH, financing, health information system and drug supply (Gouvernement du Burundi 2008a).

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The first meeting of the technical group of the CPSD was held in February 2009. However, the extent to which CPSD meetings were held seemed to depend on other external factors. For instance, between May and December 2009, no meeting was held, since the P4P platform dominated the scene [("International Health Partnership +" 2009) and ITW09N29]. Also, when held, meetings looked more like an information sharing platform, than a coordination platform (non-participative observations of CPSD meetings 2011).

Thirdly, since 2007, Burundi has also been involved in piloting the International Health Partnership Initiative (IHP+). The aim of IHP+ was to lead to the signature of a 'compact' between government and all DPs in the health sector. This compact was supposed to act as: a national health strategy; a joint monitoring and evaluation (M&E) framework; and as a mid-term expenditure framework to which all DPs contributed (International Health Partnership + 2015). Practical actions in order to better coordinate activities in the health sector, linked to the IHP+, included: an

attempt to harmonise performance-based financing (P4P) initiatives which were officially on-going all around the country; the elaboration of the first national health expenditures estimates for 2007 (finalised in 2009); and the decision to mainstream part of MAP2 funds from the PES-NAC to the MoH and part of HIV prevention activities (PMTCT) from the PES-NAC to the reproductive health department within the MoH.

Disbursement of IHP+ funds was very low (8% of US$800,000 over the first two years) due to the heavy demands of administrative procedures and the lack of ownership by the government ("International Health Partnership +" 2009). According to one IHP+ progress review conducted in 2009, sector dialogue was still very weak, essentially conducted by donors. There was no participation of multilateral donors such as GHIs and WB, although more than a third of external aid to health sector was HIV-related. The US Agency for International Development (USAID) and the Japanese International Cooperation Agency (JICA) were not keen on signing the compact (Garay and Flahaut 2009). The lack of skills and capacity to coordinate was acknowledged both by the donors and government (Garay and Flahaut 2009; "International Health Partnership +" 2009).

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The compact was eventually signed in December 2012, for the period 2012-2015. While JICA and USAID were not signatories, as expected, the three major contributors to health sector – the Belgian Technical Cooperation (BTC), EU and WB - were, as were four UN agencies and three civil society organizations (CSOs), beside the MoH and the MoF.

Among the donors, joint missions of key donors started to be organized annually from 2007, with uneven participation. The (UK) Department for International Development (DfID), the EU and BTC were the lead donors in this initiative, but were not necessarily followed by others, especially the multilaterals. DfID withdrew from Burundi in 2012.

> *"Together with bilateral donors, in particular with those who are EU member states – they are not such numerous in the health sector - we try to promote [coordination] precisely …everybody tries to coordinate in order to be able to move forward a joint planning. We are lucky in Burundi this year, to have a*

> *planning window during which everyone needs to plan." (ITW14N09, group 3, expatriate)*

Multiple initiatives from global levels try to promote coordination, without preparing the terrain. While some donors organized themselves into alliances, the government sometimes perceived this as pressure.

2.4 SYNTHESIS OF THE CONTEXT SECTION

The post-independence history of Burundi has comprised 40 years of a succession of armed conflicts, overt or creeping, and of military dictatorship. The population paid an expensive toll for these conflicts, both in terms of material damage - human lives, pauperization, land and livestock loss, physical and psychological injuries, restricted access to education, water and sanitation - but also in terms of the destruction of the social fabric – mistrust amongst population, increased ethnic, regional and political divide.

In 2005, a constitutional democracy was established under external pressure but it is still young and fragile. Aid for development, including for the health sector, started to become available progressively, with the dearth of resources attracting a number of external actors. HRH in particular were considered as an obstacle to health indicators improvement and received much focus. Recipients and donors are now facing new challenges related to aid coordination, especially since the Paris declaration put an emphasis on aid effectiveness.

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CHAPTER 3:
LITERATURE REVIEW

3.1 INTRODUCTION

The literature review has been developed according to the thread of fragile and post-conflict states. A first section provides the definition(s) of fragility and post-conflict states and reviews the main consequences of conflict on the health sector, especially on HRH. We will see that the notion of fragility is subject to much debate. Its definition seems to vary according to the discipline to which authors are affiliated: political sciences, development field and epidemiology specializing in disasters and conflicts.

A second section comprehensively reviews the research in aid coordination, including non-fragile states, since studies are scarce.

A third section explores the meaning of aid coordination in a fragile and post-conflict setting. It traces the history of the Paris Declaration, considered as a milestone for development assistance effectiveness as it insists, amongst others, on increasing aid coordination in parallel with each recipient country's ownership and leadership. It outlines how these latter factors are usually lacking in post-conflict countries, hampering their coordinating capacity and the effectiveness of post-conflict aid. It covers also the notions of trust and legitimacy and explores their linkages with the above concepts of ownership and leadership. This section reviews papers from different disciplines in order to give the most comprehensive and inclusive review of factors contributing to coordination. The definitions given in this section shall be understood by the reader as introductory to the methods section, where a conceptual framework specific to this research will be devised.

A final section describes the literature gaps.

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3.2 HEALTH - AND FRAGILE AND POST-CONFLICT STATES

3.2.1 Definition of fragility and post-conflict state

Fragility is a relatively new notion in the development area and is used mainly by donors as countries are rarely keen to call themselves 'fragile (Engberg-Pedersen and Andersen 2008). The fragility of a state is difficult to measure, however, as seen in the numerous attempts in the literature to define it (World Bank 2014; "Fund For Peace" 2015; Organisation for Economic Co-operation and Development 2008b; DfID 2005). The four most commonly used definitions are those used by the Organization for Economic Cooperation and Development (OECD); the WB; the UK Department for International Development (DfID); and the Fund for Peace.

The OECD definition is that "states are fragile when state structures lack political will or capacity to provide the basic functions needed for poverty reduction, development and to safeguard the security and human rights of their population" (Organisation for Economic Co-operation and Development 2007).

The WB definition has changed many times since 2006. First, there was an internal list of Low Income Countries Under Stress, defined as countries with a Country Policy and Institutional Assessment (CPIA) score of 3.2 or less. The list became public in 2009 and changed its name to "fragile situations" which were defined as countries with a CPIA score below 3.25. In 2011 the list acquired its current denomination of "harmonized list of fragile situations", defined as countries with CPIA below 3.2 and/or the presence of UN and/or peace-keeping/building missions/ troops during the past three years (World Bank 2014). The WB uses this ranking to allocate resources from its IDA.

DfID refers to a fragile state as "a state where the government cannot or will not deliver core functions to the majority of its people, including the poor" (DfID 2005).

The Fund for Peace's Fragile States Index is produced by a comprehensive tool based on 12 key indicators from three areas - political, economic, and social.

Each institution classifies fragile states depending on the presumed cause of fragility. For instance OECD categorizes fragile states according to (i) post-conflict/crisis or political transition situations; (ii) deteriorating governance environments, (iii) gradual

improvement, and; (iv) prolonged crisis or impasse (Organisation for Economic Co-operation and Development 2009).

For the Center for Global Development, a country is deemed to be affected by conflict if there was any battle-related death during 1998-2003. A major conflict is defined as a conflict responsible for more than 1,000 deaths in any given year during this period (Center for Global Development 2004).

These definitions of fragility have in common that the assessment is either based on the actual functionality of the state or on the consequences of fragility on the quality of the relationship between donors and recipients (Engberg-Pedersen and Andersen 2008).

The concept of fragility is increasingly under scrutiny by political science researchers, given the strong association it has with state capacity, legitimacy and power (Lemay-Hébert and Mathieu 2014; Grimm, Lemay-Hébert, and Nay 2014; Brinkerhoff 2014). It is a concept which relies on a Weberian definition of the state, and is based on a state's capacity to secure its population and on its legitimacy (Grimm, Lemay-Hébert, and Nay 2014; Nay 2014).

Authors pointed out that the notions of state and legitimacy used in the context of fragility are influenced by Western ways of thinking and are not necessarily applicable to non-Western countries (Grimm, Lemay-Hébert, and Nay 2014; Lemay-Hébert and Mathieu 2014). It is noteworthy that so-called fragile states do not often label themselves as fragile. When they do so, it might be intentionally in order to attract certain type of funding - as illustrated in the Ugandan case study, which explains how the country managed to be perceived both as strong and fragile by the donor community (Fisher 2014). Moreover, the same authors argued that the WB and the OECD acted as "knowledge hubs" and imposed their hegemony over their own priorities and vision of fragility (Nay 2014). These institutions are shown to have fragmented fragility into measurable indicators, such that any improvement, attributed to interventions conceived by donors, serves as evidence of their effectiveness and usefulness of their existence (Brinkerhoff 2014; Rocha De Siqueira 2014).

Brinkerhoff referred to this process as an "epistemic bubble", borrowing the term from the initial inventors of this concept, Adler and Bernstein who used it to describe a process in which the same authors share similar views on causal relationships and

solutions to problems they set. In the post-9/11 global context, this “epistemic bubble” serves the peace-building and global security agenda (Brinkerhoff 2014). Indeed, applying a ‘fragility’ concept based on Western values leads to the production of tools meant to measure this concept, which further influences the way Western countries intervene in these fragile countries, thus justifying their interventions. Brinkerhoff warns of the absolute necessity of understanding highly complex contextual factors in order to grasp underlying power issues if an intervention, decided collectively, is to be successfully implemented (Brinkerhoff 2014).

The simplification of contexts may lead to blue-print approaches, not necessarily suitable or sustainable in specific contexts. These limitations in definitions of concepts should be kept in mind throughout this thesis, since they are transposable to other concepts such as ‘ownership’ or ‘leadership’ or even ‘capacity’.

3.2.2 Health in fragile and post-conflict states

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Conflict has two types of consequences on health: directly at the level of the individual and indirectly through the consequences at health system level (Kruk et al. 2010).

For individuals, consequences can be short-term in terms of conflict-related immediate morbidity (infectious diseases epidemics, injuries, malnutrition, poor maternal and child health etc.), but also long-term, in terms of mental health (e.g. post-traumatic stress disorder) or in terms of physical health (e.g. chronic diseases such as HIV).

The health system is a victim of conflict in all its components. Health facilities are destroyed; supplies are interrupted (drugs, material, devices etc.); HRH, if not decimated by the conflict itself or by other conflict-related collateral events, flee abroad or to urban areas leaving behind local institutions without their capacities (Kruk et al. 2010). A weakened health system, in turn, affects health at the individual level, by simply failing to provide health care.

It is important to note that in terms of the proportions of morbidity and mortality, physical violence directly related to arms only relates to a minority. The vast majority of health-related consequences of a conflict are invisible ones, such as mental illness

burden; or indirect ones, such as those related to the health system (Rubenstein 2011).

During conflicts, health care is often provided by NGOs, through highly verticalized assistance.

In the immediate post-conflict period, there is a transition stage between conflict and rehabilitation, but this stage has seldom been studied (Kruk et al. 2010). There is some evidence that reconstruction work concentrates on urban areas, which are most accessible and where there are quick achievable results (Waters, Garrett, and Burnham 2007), leaving behind more complex issues such as those related to the health system. In these situations, there may be a political vacuum – such as in Southern Sudan (Cometto, Fritsche, and Sondorp 2010) – whereby the MoH is unable to exert leadership on health system reconstruction, thus leaving policy formulation and the identification of issues in the hands of donors.

3.2.3 HRH in fragile and post-conflict states

HRH in fragile states needs even more specific attention than in other countries as they are likely to have suffered from the conflict in many ways and may well have lost their motivation for work. Consequences of conflict on HRH, compared to the general population, have seldom been studied, however.

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Health workers might be targeted and killed in a conflict (Garfield 1989; Ityavyar and Ogba 1989; Webster 2011). They might also suffer psychological distress, such as depression, fear of the future, non-directed anger and frustration (Sans and Hewison 2003).

HRH often migrate for reasons of security, but also to seek better working conditions. Some simply leave the country for abroad: in Liberia, during the 14 year-long conflict from 1990 to 2004, the number of medical doctors dropped from 237 to 20 (Varpilah et al. 2011); in Nicaragua, during the first two years of revolution from 1983 to 1985, 25% of skilled health workers went abroad (amongst which 50% of all the medical doctors) and the majority of the remaining ones went into the private sector (Garfield 1989).

In addition, training institutions have often closed down, or their capacity to deliver proper education has declined, thus negatively affecting the quality of HRH whose

training is often delayed or disrupted, affecting their resulting ability to provide care (Newbrander, Waldman, and Shepherd-Banigan 2011). HRH management skills also decline, since the highest skills are usually the first ones to leave the country (Newbrander, Waldman, and Shepherd-Banigan 2011).

In general, donors rush into the country after the end of the conflict to help with the rehabilitation of the health services (Waters, Garrett, and Burnham 2007). Their activities tend to be more focused on emergencies and on diverse specific (mostly vertical) programs, however, thus ignoring or neglecting the strengthening of the overall HRH functioning (Fujita et al. 2011). This could prevent the overall functioning of HRH.

Amongst others, neglected areas are those acting as linkages with other components of the health system or those linked to effective implementation of new policies – for example HRH legal and regulatory frameworks, coordination and monitoring (Fujita et al. 2011). Fujita therefore emphasizes the need for innovative thinking when planning HRH in post-conflict states (Fujita et al. 2011).

3.3 AID EFFECTIVENESS AND AID COORDINATION

3.3.1 Rationale for the Paris Declaration

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The adoption of the MDGs standardized a set of development goals at global level. Ways of achieving the MDGs differed from one donor to another however, which proved to be counterproductive for aid effectiveness. Differences in vision might be found not only between different donors, but also between donors and a government – sometimes even within government, as governments are not homogenous entities (Dodd and Olivé 2010).

Donors have their own agendas when providing aid, as do the recipients for accepting it (Dodd and Olivé 2010). Actors providing DAH are increasingly numerous and heterogeneous and have different ways of operationalizing aid. A study by Ravishankar et al. showed that between 1990 and 2007, DAH quadrupled, with the share going to NGOs almost doubling, increasing from 13.1% in 1990 to 24.9% in 2006, while the share from private foundations also increased from 19.0% in 1998 to 26.7% in 2007 (Ravishankar et al. 2009).

If the MDGs were to be achieved, not only did their need to be an increase in financial resources (despite the global economic meltdown), but the ways in which aid money was being used – by both recipients and donors – needed to be changed drastically (World Health Organization 2001). In this context, the question of aid effectiveness became an urgent concern at global level. Continuous innovations were devised to try to improve aid effectiveness, with variable results. For instance, new financial mechanisms such as the one used by the GFATM was meant to increase country ownership, but the extent to which this happened depended on “country capacity” (London School of Hygiene and Tropical Medicine et al. 2005).

Complex determinants clearly influence aid effectiveness, beyond simply funding mechanisms or sound policies at global level.

An international conference on health financing was held in Monterrey in 2002, after the exacerbation of the financial crisis following September 2001. The conference insisted on the need for a renewed partnership framework between donors and recipients in order to reach the MDGs, including a recognition of recipient countries' ownership and leadership (United Nations 2002).

The Paris Declaration

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Following the Monterrey Consensus, the Paris Declaration on Harmonization and Alignment which addressed aid effectiveness was adopted in 2005. It insisted on fundamental transformations that needed to be accomplished by both the DPs and the recipients. Five tools were proposed to improve aid effectiveness: ownership, harmonization, alignment, monitoring results and mutual accountability (see Box 1 below). These imply deep changes in organizations' mind-set vis-à-vis themselves as well as other organizations (i.e. ownership, leadership, partnership).

Beyond the rhetoric of the Declaration, there are a number of shortfalls, however. First, how these changes might be achieved was not detailed in practice. Some indicators attached to each tool were developed. For instance, the ownership measurement indicator is “partner countries have operational development strategies” [(Organisation for Economic Co-operation and Development 2008a) pp. 11]. It does neither say how these strategies are to be developed, however, nor how to measure the extent to which a country ‘owns’ a given strategy. Another weakness is that there are no clear definitions for ownership, leadership and coordination

capacity - and these notions are presented as being dependent on one another. Indeed, the Declaration clearly stipulated that a country exerts ownership by showing leadership and by coordinating aid. While this seems intuitive and obvious, it does not provide a clue for countries - and sounds more like the chicken and egg story i.e. that it is difficult to know which comes first. Similarly, how donors may help a country to exert their leadership is not detailed at all, while in practice leadership represents a node of power struggle.

Box 1: Ownership principle in the Paris Declaration [(Organisation for Economic Co-operation and Development 2008a) pp. 5]

Ownership

Partner countries exercise **effective leadership** over their development policies and strategies, and **co-ordinate development actions**.

Partner countries commit to:

- **exercising leadership** in developing and implementing their national development strategies through broad consultative processes;
- translating these national development strategies into prioritized results-oriented operational programs, as expressed in medium-term expenditure frameworks and annual budgets (Indicator 1);
- **taking the lead in coordinating aid at all levels** in conjunction with other development resources - in dialogue with donors and encouraging the participation of civil society and the private sector.

Donors commit to:

- **respecting partner country leadership** and helping to strengthen their capacity to exercise it

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In the Declaration only a few paragraphs deal with fragile states, excerpts of which are presented below. No practical advice is given on how to effectively adapt to fragile environments, whereas weak ownership and capacity are acknowledged.

> *"The long-term vision for international engagement in fragile states is to build legitimate, effective and resilient state and other country institutions. While the guiding principles of effective aid apply equally to fragile states, they need to be adapted to environments of weak ownership and capacity and to immediate needs for basic service delivery"* [(Organisation for Economic Co-operation and Development 2008a) pp. 8].

In order to counteract these shortfalls, these concepts have been deepened and concrete steps for action were identified in the Accra Agenda for Action (AAA), adopted in 2008 (Organisation for Economic Co-operation and Development 2008a). Ownership, as one focus area, was described in the AAA as "developing countries determine and implement their development policies to achieve their own economic, social and environmental goals" [(Organisation for Economic Co-operation and Development 2008a) pp. 17]. To this end, the AAA suggested: a broader participative approach to policy making, while respecting international engagements; general capacity-strengthening activities, directed towards institutions, systems and expertise; and a greater use of country-systems (which is similar to alignment).

The two concepts of ownership and leadership will be developed further in the next section, in relation to the health sector.

Alongside ownership, governance improvement is considered to be central in the aid effectiveness agenda (Dodd et al. 2009). In their modified framework for health development governance, Kirigia et al. included, amongst the four functions of governance, one function entitled "effective internal and external partnership", which is close to the concept of aid effectiveness (Kirigia and Kirigia 2011). This function has ten sub-functions, amongst which is the one "strengthening capacity by coordinated support". In their paper, authors explicitly give the coordination function to governments, which is in line with global consensus (OECD, WB, UN). However, as recipients' capacity of leadership and quality of governance will shape the quality of coordination, many donors are frightened to loosen their tight on their funding, given the "low" quality of governance of the recipient's country, according to their standard. While aid effectiveness has been linked to "good" governance, whether this definition of good governance built by donors also fit to recipients' context is uncertain (Booth 2010).

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3.3.2 Aid co-ordination in the health sector

Aid coordination before the Paris Declaration - and definition

During the 1980s, while the amount of aid and number of actors were rapidly increasing, policy researchers were already promoting coordination as an essential instrument to improve aid effectiveness in the health sector (Buse and Walt 1996; Buse 1999). Since the late 1980s - some time before the adoption of the Paris

Declaration – countries had implemented a broad spectrum of coordination mechanisms, which were largely described during the 1990s (Lanjouw, Macrae, and Zwi 1999; Buse 1999; Pavignani and Durão 1999; Lake and Musumali 1999). The effectiveness of these coordination mechanisms was assessed, though mainly limited to process assessments at national level (Lake and Musumali 1999; Pavignani and Durão 1999; Walt et al. 1999a). What emerged was that the mechanism used to coordinate was less important than the commitment of all actors to its principle and the adaptation to the context. Pavignani et al. described key ingredients of successful aid management using the case of Mozambique- being credible and long-term plans, MoH leadership, solid and widely accessible information and institutional memory, amongst others (Pavignani and Durão 1999). In the past, several other factors – such as differing interests and competition between donors and ambivalence or limited capacity of recipients – have hampered coordination (Buse and Walt 1997). In 1996 in Bangladesh, Buse counted no less than 13 multilateral and 18 bilateral organizations in the health sector alone, in addition to more than 400 NGOs (Buse 1999). The author emphasized not only the difficulty this posed for coordination by the number of donors, but also the attractiveness of the power this produced in the position of the coordinator.

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Aid coordination in a country's health sector was first defined by Buse and Walt in 1996 as follows: "any activity or set of activities, formal or non-formal, at any level, undertaken by the recipient in conjunction with donors, individually or collectively, which ensures that foreign inputs to the health sector enable the health system to function more effectively, and in accordance with local priorities, over time" (Buse and Walt 1997).

According to this definition, coordination depends directly on the quantity and quality of donors at country level, and of the recipient. As we have seen in the previous section, with the proliferation and increasing heterogeneity of donors, it is understandable that aid coordination has become a challenge in the health sector in particular.

Aid coordination after Paris Declaration

Since the adoption of the Paris Declaration, coordination has received increased and renewed attention both at policy level and in the research domain (Organisation for

Economic Co-operation and Development 2008a). The impact of the Paris Declaration on coordination in the health sector started to be assessed (Sundewall et al. 2009), recent literature being focusing on stakeholders' perceptions of coordination (Sundewall, Forsberg, and Tomson 2006; Sundewall et al. 2010). In Bangladesh for instance, donors and recipients were reported to have different definitions for coordination and ownership, constituting an obstacle for resolving disagreements (Sundewall, Forsberg, and Tomson 2006). Assessments often found a lack of integration of sub-national levels with the coordination process (Sundewall et al. 2009).

The Paris Declaration application was also examined in Lao by Dodd et al., specifically in the HRH domain. Authors found an intent-practice gap in donors' and government's engagement with the aid effectiveness agenda (Dodd et al. 2009). Identified challenges were: the difficulty of operationalizing the Paris Declaration when it came to details; the lack of a clear grasp of the benefits of the effectiveness agenda; a high transaction cost of coordination; and difficulties with changing the current ways of functioning (Dodd et al. 2009).

Meanwhile, recipient countries still complain about the number of bilateral and multilateral agencies that provide assistance in the health sector (e.g. 16 in Rwanda in 2009), with the subsequent administrative burden this produces as well as difficulties with coordination (Rwangombwa 2009).

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Since GHIs emerged as major actors in the aid arena in early 2000s, the way countries incorporated this new aid mechanism with regard to coordination also started to be assessed. To date, the only research conducted analyzed the effects of GHIs on HIV program coordination in seven countries (Spicer et al. 2010). Authors reported a gap between intent and practice at sub-national level, though GFATM's positive effect on national level coordination was noted in particular (Spicer et al. 2010). Moreover, a proliferation of coordination structures was thought to render the governance of the health sector even more complex and fragmented (Spicer et al. 2010).

Two major gaps were identified in the current research on coordination: the absence of longitudinal studies on coordination and the absence of an assessment of the new modalities of partnerships (such as Memoranda of Understanding, like the one

signed in 2008 in Burundi; codes of conduct; partnership forums), which are being experienced in many countries (Harmer 2008).

Aid coordination in the health sector of fragile and post-conflict states

Fragile and post-conflict states usually experience a sudden influx of donors. Severino and Ray have suggested that “in some cases, the gains from having more actors involved are outstripped by the losses that stem from policy incoherence and coordination costs in fragile states” [(Severino and Ray 2009), pp.6]. Given the difficulty of coordinating actors in a stable context (as described in the above sections), coordination in a fragile or post-conflict context is even more challenging (Fujita et al. 2011).

Fujita worked particularly on the coordination of HRH development in three post-conflict countries: DRC, Cambodia and Afghanistan. One of the findings of his study was that donors usually come with their own agendas and projects and have their own policies and plans for HRH strengthening (Fujita et al. 2011). Yet coordination of these policies and plans are essential in order to build a functional ‘house’. Figure 5 below shows Fujita’s analytical framework for HR for health system development. Here, HR development is presented as a ‘cross-cutting function’, also related to MoH capability – while coordination of HRH policy and plans, amongst others, is in the foundation of the house. It is noticeable that in the Fujita model, the MoH is explicitly given the role to coordinate and monitor the HRH house.

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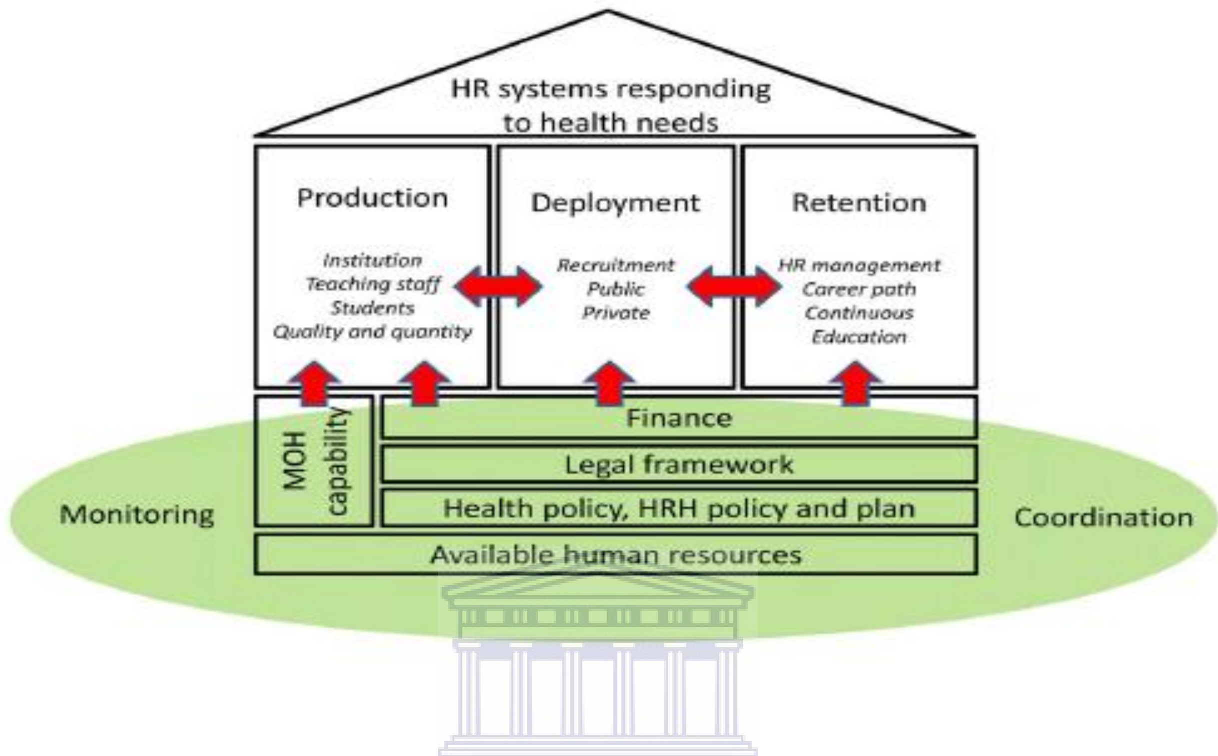
Pavagnani et al. analyzed MoH leadership in aid coordination in Mozambique, also a conflict-affected country. Here, the MoH was seen as not trusting in its own ability to lead donors. It was also seen as having an ambiguous role, however – at times voluntarily devoting itself to fragmentation between donors, at other times being willing to reach a consensus amongst donors at all costs (Pavignani and Durão 1999).

Both findings from Fujita and Pavagnani emphasize the central role of the MoH’s capability in coordinating aid and related policies.

Figure 5: The human resource for health system development: An analytical framework, the house model

(from (Fujita et al. 2011)



3.4 CHALLENGE OF AID COORDINATION IN FRAGILE AND POST-CONFLICT CONTEXTS: THE CENTRAL ROLE OF ACTORS' RELATIONSHIPS AND THEIR 'INNER ATTRIBUTES'

In the development literature, recipient countries in post-conflict contexts are usually found to be lacking in the following 'inner' attributes: institutional capacity, leadership, ownership, legitimacy, trustworthiness (Brinkerhoff 2010; Mills and Fan 2006; Lund, Uvin, and Cohen 2006; Waters, Garrett, and Burnham 2007; Rubenstein 2011; Kruk et al. 2010; Shuey et al. 2003). These attributes are all entangled, and form key ingredients for coordination. The Paris Declaration refers to the necessary ownership by government – which, by extension will provide a basis for better coordination by government, and therefore improved aid effectiveness. Ownership is related to other qualities: leadership from the government and respect of government leadership by donors, which talks to legitimacy and also trustworthiness.

This section provides definitions of these concepts that are mostly commonly used, – i.e. institutional capacity, ownership, leadership, legitimacy, trustworthiness – in order

to understand how they interrelate and play into coordination capacity and how they are damaged by conflict.

3.4.1 Institutional capacity

An evaluation of the applicability of the Paris declaration on aid effectiveness to post-conflicted countries referred to the “weak institutional capacity” as a source of lack of coordination and therefore of insufficient aid effectiveness (OPM/IDL 2008). Indeed, the effect of conflict on HRH – such as the ‘brain drain’, decreased quality of training, high turnover and shortages, all described above – has a direct impact on coordination capacity. While it seems that the literature refers largely to ‘capacity’ as technical skills needed for coordinating tasks, limited numbers of full-time staff (who are sometimes unmotivated) makes these institutions unreliable for coordination tasks in the long-run (Cometto, Fritsche, and Sondorp 2010). Many donors now focus on capacity building of fragile and post-conflict states (DfID 2005; Goodhand and Sedra 2010; Clarke 2013; IPIS).

A first issue is that the literature is scarce about what ‘capacity’ exactly means or implies. It is noteworthy that the word ‘capacity’ is often interchanged with other words such as ‘ability’, ‘capability’ and ‘power’.

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A review by Baser and Morgan on capacity and capacity development in the development literature raised several points, amongst which the following are directly useful for this research (Baser and Morgan 2008). The notion of capacity in the development field has often been considered as an output, within the classical ‘input-output-outcome-impact’ framework, thus impeding an operational vision of capacity; hence, capacity development was considered as a process and improved performance as the outcome of capacity development. Authors used the complex adaptive systems thinking approach and proposed a new way of seeing capacity, that of “mastering change” and “a potential state”.

Brinkerhoff recently proposed a comprehensive definition of capacity as “the evolving combination of attributes, capabilities, and relationships that enables a system to exist, adapt, and perform” [(Brinkerhoff and Morgan 2010), pp. 3]. This definition seems to embrace both social and technical aspects of individuals and to be applicable to individuals and groups of individuals such as organizations and any human system, in a dynamic and transformative way.

Baser and Morgan further listed five core capabilities, the elements of which are strongly related to leadership, trustworthiness, legitimacy and ownership, which will be discussed below (Baser and Morgan 2008).

A second issue is related to capacity development in fragile states and concerns the usual inverted proportional relationship between aid effectiveness and capacity development (Cometto, Fritsche, and Sondorp 2010). While external actors are eager for high aid effectiveness, developing recipient government capacity might decrease the effectiveness of aid, at least in the short-term (Cometto, Fritsche, and Sondorp 2010). In fragile states, donor agencies are disproportionately more effective than local institutions and are reluctant to involve them in, or to rely on them for, implementing projects since they have time requirements for funding disbursements. Rather, donors contract private agencies or NGOs, thus hampering the capacity development of local institutions (Cometto, Fritsche, and Sondorp 2010).

Brinkerhoff argues that capacity development, already difficult in politicized environments, is even more difficult in fragile contexts (Brinkerhoff and Morgan 2010). He notes that "capacity development concerns power: the power to decide what to do, what resources to provide, and where to target them" [pp. 3 in (Brinkerhoff and Morgan 2010)]. Fragile states concentrate even more power and thus politics, given heightened visibility (due to high media coverage) and a political vacuum which attracts power. In addition, donors sometimes have interests beyond the scope of development (Brinkerhoff 2010; Cometto, Fritsche, and Sondorp 2010). To circumvent these challenges, Brinkerhoff argues that capacity development in fragile contexts needs, amongst others, a systemic approach and "in-depth knowledge and understanding of specific country contexts". This knowledge takes time and might be difficult to acquire, given the usually high staff turnover as cited above and quick changes in power dynamics in the field.

Figure 6 below illustrates the long, incremental and difficult capacity development process. The process first starts at individual level, usually by providing resources in order to increase technical skills; these skills then benefit the organizations to which these individuals belong; as local institutions grow in capacity, they enable macro-contextual changes including in the political sphere, and the scope of change will expand.

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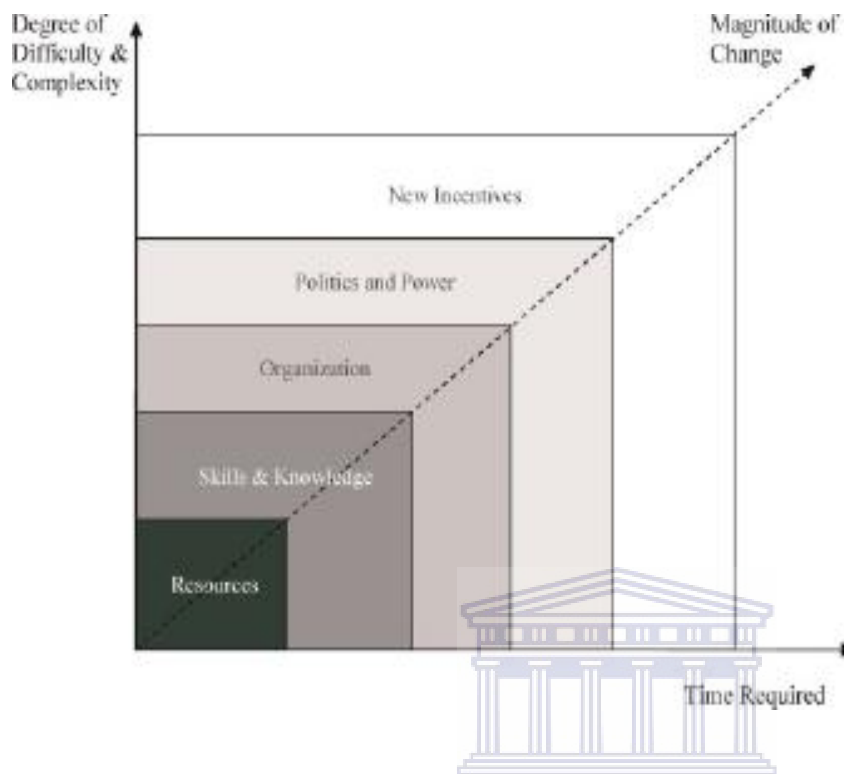
Figure 6: Capacity development model,

adapted from Fowler (Brinkerhoff 2010)



Capacity development intersects with HR development. Given reduced HR capacity and short-term targets, expatriates and external agencies tend to do 'capacity substitution' and 'gap filling'. In addition, however, some external agencies may engage in 'capacity-sucking', by hiring already scarce skilled local HRH, thus diverting them from their initial role which was capacity development (Brinkerhoff and Morgan 2010; Brinkerhoff 2005).

3.4.2 Ownership

Ownership in this context is usually defined as the degree to which the government takes the lead on development policies (Sundewall, Forsberg, and Tomson 2006). According to Goodhand and Sedra's analysis of conflict-to-peace transition in Afghanistan, "[OECD] principles are extremely vague on the matter of ownership and […] what it means in practice is […] less clear" [(Goodhand and Sedra 2010), pp. 81].

On the one hand, ownership is often described as a value or a quality which should arise from the recipient country, without really giving details on how to "make it happen" (Dodd et al. 2009). On the other hand, even in countries where ownership

and leadership are considered strong (like Rwanda), donors do not necessarily respect government preferences and policies in terms of health sector financing. In 2009 in Rwanda, sector budget support and general budget support constituted only a third of all health sector assistance, while they constituted the preferred funding mechanism on the part of the government (Rwangombwa 2009).

Ownership in post-conflict settings is difficult when a sudden influx of donors arrives with charitable and new development ideas. Indeed, post-conflict settings are considered by donors such as the WB as an excellent field for radical policy change (Mills and Fan 2006). However, while the conditions usually needed for ownership is a country-led agenda, policy and strategy documents are often written mainly by external consultants (Shuey et al. 2003; Goodhand and Sedra 2010). Shuey et al. worked in Kosovo in the immediate post-conflict period and examined the policy making process in the health sector. They showed that there was an issue of ownership – as the interim document on policy guidance was mostly developed by international consultants as a matter of emergency and within the timelines for grant application, with limited participatory approach (Shuey et al. 2003).

Severino and Ray rejected the lip service donors paid to ownership on one hand, while acknowledging that at times local capacity issues do not leave the donors much choice to respect ownership principle (Severino and Ray 2010). They proposed to call for donor harmonization in countries where there is a "disequilibrium between supply and demand" of aid and subsequent difficulties from local government to coordinate [(Severino and Ray 2010), pp. 25].

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3.4.3 Leadership

Fragile and post-conflict states often lack local champions and leadership, which undermines good policy formulation (Alliance for Health Policy and Systems Research and World Health Organization 2008).

According to the definition in the Paris Declaration, leadership and ownership seem to be closely linked, with the definition of ownership usually used being the one presented above.

Management science provides the largest literature and the most usable definitions of leadership, as leadership and organizational performance are known to be correlated (Lowder 2007).

For example, Lowder’s use of the system and actors’ perspectives to analyze leadership is of great interest here. He first summarized descriptions of a positive leader, though from different perspectives, as someone who “uses virtues as a foundation for decision-making” [(Lowder 2007) pp. 4]. He then identified five dimensions of effective leadership: personal effectiveness (e.g. trustworthiness, optimism, priority-setting ability, etc.), interpersonal relationship effectiveness (trusting others, decision making objectivity, etc.), managerial effectiveness (e.g. communicating ability, empowerment of others, etc.), operational effectiveness (relationship building, organizational vision, etc.) and societal effectiveness.

Leadership is therefore a set of individual qualities, embedded in a wider system, i.e. organizational and societal settings, which continuously influence and are influenced by the leader. It is understandable, then, that effective leadership is difficult to identify in post-conflict states, in which all the components of the system - i.e. society, organizations and individuals - are unstable. Any attempt to empower a new leader might be counteracted by the pervasive mistrust in the society (Brinkerhoff 2010). As building leadership takes a long time (see Figure 6), donors might be attracted to assuming leadership themselves, as this takes less time and is less energy-consuming (Brinkerhoff 2010).

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3.4.4 Legitimacy

Definitions of legitimacy are multiple and depend on who developed the definition. Generally, there is agreement that legitimacy is a perception, shared by many individuals, of actions of an entity – actions which are desirable / appropriate / justified, within a given set of norms and values (Kapiriri 2012). In a post-conflict country, government needs to gain legitimacy both in the eyes of the population and in the eyes of the donors. These might be contradictory, since donors and the population do not necessarily share the same set of values and norms which will serve as the basis for their judgments.

Moreover, the government put in place after the end of a conflict might not have sufficient legitimacy in the eyes of its population, either because it was ‘placed’ by external brokers after peace negotiations or because of its involvement in the conflict itself. And even in cases where the population is initially hopeful, governments are

often unable to gain legitimacy, since results are difficult to achieve and legitimacy is based on tangible and prompt results (François and Sud 2006) .

Legitimacy is directly derived from trustworthiness and trust is considered central to gain legitimacy (Alonso and Brugha 2006). As legitimacy is by definition subjective in nature, the prevailing suspicion towards government in post-conflict periods will hamper legitimacy construction.

3.5.5 Trust

There is a huge literature on trust and on its linkage to social capital which this study cannot cover entirely. The concept of social capital will be partly developed here (in its components of bonding and bridging) but also later in the conceptual framework section. What is important to keep in mind for this thesis is the linkage between trust and social capital, as well as the fundamental need for trust in order to achieve a given collective action – given that coordination is essentially collective action. The linkage between trust and collective action is illustrated by Ostrom in Figure 7 below (Ostrom and Ahn 2008). The rather linear figure does not capture the very complex nature of the linkage between these variables, but emphasizes the fact that trust is a fundamental point of leverage towards collective action, and therefore towards coordination. Also, other institutions' characteristics, such as ownership, leadership and legitimacy should be included.

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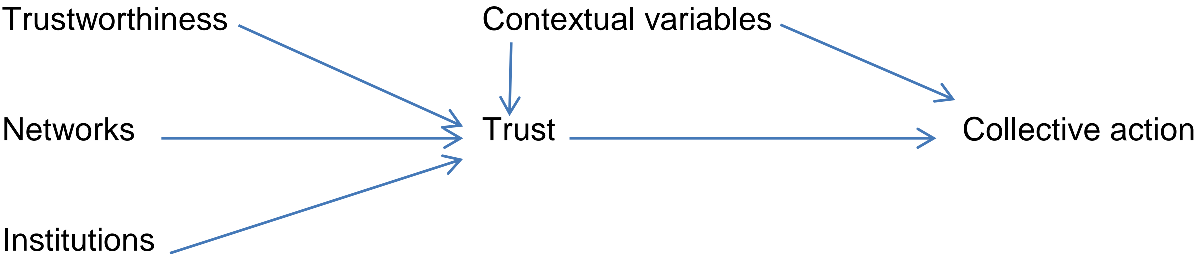
Figure 7:
Trust, forms of social capital,
and their linkages to achieving collective action
(Ostrom and Ahn 2008)



According to Ostrom et al. (Ostrom and Ahn 2008), trust is “a particular level of the subjective probability with which an agent assesses that another agent or group of agents will perform a particular action”. This definition, which is an economist point of view, implies a calculative perception of the society, but might be well appropriate in a post-conflict context, when people are suspicious of each other’s real intentions. This definition also implies that an agent is able to predict quite accurately the behavior of another agent. In the particular context of fragility and post-conflict period, behavior of recipients’ countries might not be predictable – for instance a fear of corruption leading to mistrust of both donors and population towards aid recipients, usually government institutions (Alonso and Brugha 2006; Kapiriri 2012; François and Sud 2006). This definition of trust (amongst others in the literature), manages to explain the roots of lack of trust in the population in Burundi.

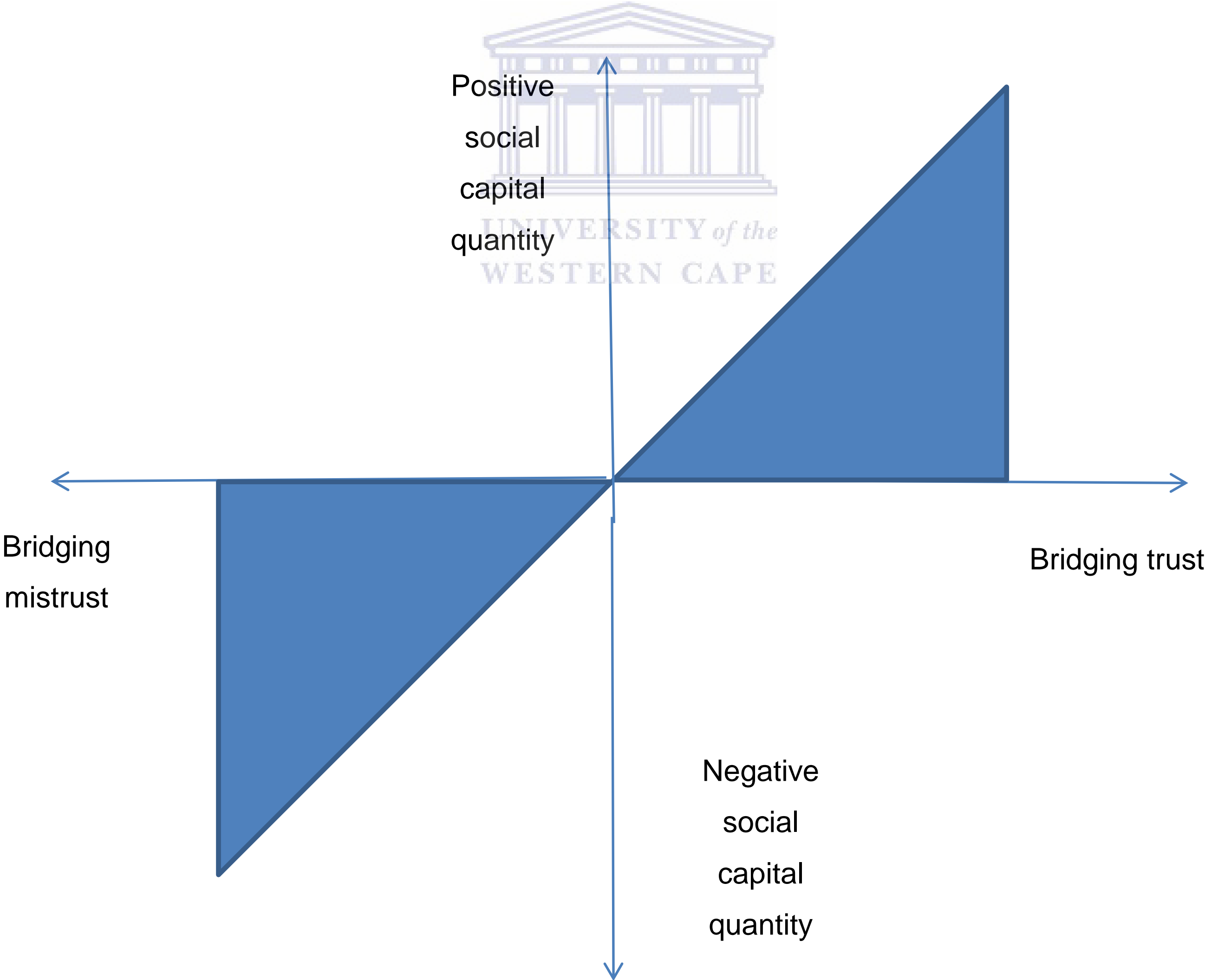
Trust and social networks form social capital. Putnam, one of the social capital’s theorist, divided social capital into two different types, which might be of special interest for this study (Siisiäinen 2000): a “bridging” social capital between heterogeneous groups of people, which involves social relational identities and is motivated by relationships and perpetuated by interdependence; and a “bonding” social capital, between homogenous groups, implying categorical social identities and motivated by a perception of commonality with people even those who are complete strangers.

Davis analyzed the motivation behind the accumulation of these 2 types of capitals (Davis 2014). He argued that bridging social capital accumulates via rules and desire of efficiency, whereas bonding social capital is created via values and desire of collective action. He further explained that categorical social identities (bonding social capital) are created through affective relationships, on an emotional basis, whereas relational social identities (bridging social capital), are created through cognitive relationships, on a rational basis.

When transposed in a context of endogenous conflict like Burundi, we easily understand that bonding social capital will increase, since society was fragmented by heightened identities and values, based on ethnicity or politics, and bridging social capital will decrease, since civic rules disappear, replaced by anarchy. Conflictsin general decreases the space for rationality and reflectivity, and increases the emotional basis for developing identities. This accumulation of one type of social

capital alongside the loss of the other, however, could be qualified as asocial capital or negative capital, as illustrated in Figure 8 below. Indeed, a society is functional when it has these two varieties of social capital, at sufficient quantity and balanced with one another. If one type of social capital – for instance bridging social capital – is eroded due to mistrust across ethnic groups or political parties (e.g. in Burundi), it will favour social connection between reduced groups of people who are the same, increasing bonding social capital. Resources or capital will flow between these groups, while others are left out, thus perpetuating bridging mistrust. This could be viewed, from a general social/societal point of view, as negative social capital, since it acts against the cohesion of the whole society.

Figure 8
Relationship between social capital and bridging trust
(own creation)



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This concept has received some focus and named differently according to authors: un-social capital (Levi); dark side of social capital (Ostrom); perverse social capital (Rubio) (Nussio and Oppenheim 2012). Some empirical studies were performed, mainly in conflict-affected areas, to demonstrate the existence of this particular type of social capital, either bonding or bridging, and its relationship with trust: Nussio et al in Columbia, and Deng in Southern Sudan. In Colombia Nussio et al found that paramilitaries were likely to have “lasting anti-social capital” via increased bonding capital (in-groups), whereas bridging capital (towards out-groups) was difficult to accumulate, probably due to indoctrination before and during the conflict [(Nussio and Oppenheim 2012), pp.30]. Deng demonstrated the difference in the nature of trust between endogenous and exogenous wars: in the first case, mistrust between communities prevented the formation of social capital (by stopping formation of bridging capital), whereas in the latter case, cooperation within and across communities was enhanced, due to external threats (increased bridging capital) (Deng 2010).

Trust of ordinary citizens and external actors towards governmental institutions

According to Macrae [in (Alonso and Brugha 2006)], one of the key challenges for DAH is the lack of trust of external actors in local institutions. Indeed, institutional capacity has been lost and damaged by the conflict, and external actors or donors are usually reluctant to trust local institutions – in terms of budget management or policy development, for instance. They are fearful of funding mismanagement, corruption or inappropriate policy-making due to a lack of capacity/experience, or the overwhelming post-conflict environment, yet external actors are not necessarily more skilled to face such a challenging environment. Donors usually have a negative perception of government capacity and integrity, and believe that government is unwilling or unable to coordinate (Buse 1999).

In addition to the lack of trust from external actors towards local actors, there is a much more insidious mistrust from the population towards governmental actors. The population might have more confidence in external actors rather than their own government or institution; in the case of civil conflicts, such as in Afghanistan, leading

to the use of private health care providers using public funding (Palmer et al. 2006). This issue of social trust is of huge concern in post-conflict countries (especially in a context of civil war), where a population has lost trust in a government which is at times unable to protect them from the conflict.

Social fracture and government mistrust, generated by the conflict, may interfere negatively with policy implementation.

Trust between citizens

An ethnic conflict has a greater probability of impacting on the degree of trust between each other, compared to non-ethnic based conflict, such as external war (Rohner, Thoenig, and Zilibotti 2011). The study conducted in Uganda showed that an ethnic conflict increased the "mistrust towards people outside the ordinary social network". While the cohesion within an ethnic group is hence enhanced, the cohesion within the nation is decreased (Rohner, Thoenig, and Zilibotti 2011).

However, it is almost impossible to disentangle the effects of conflict on ethnic divisions from the effects of ethnic divisions (underlying and prior to conflict) at the onset of the conflict unless social cohesion was measured before and after the conflict.

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Brune and Bossert showed in their research in Nicaragua at community-level that interventions aiming at improving social capital did not succeed to increase trust between citizens (Brune and Bossert 2009). Authors conclude that trust might require much more time to be restored, yet it is essential to a sustainable and non-fragmented state-building (Brune and Bossert 2009).

3.5 CONCLUSION AND GAPS IN THE LITERATURE

Post-conflict states face a triple burden: the need to start planning and policy-making anew; a generalized lack of capacity for planning as well as to implement plans and policies; a flood of donors and implementers to contain and channel. As stated by Rubenstein, post-conflict countries have to start many processes anew (Rubenstein 2011), whereas other countries can continue with pre-established processes with, in most cases, only incremental changes. While this newness might have some benefits

in terms of health sector reforms which could be easily implemented, it mainly has inconveniences – in terms of the number of tasks to be accomplished in a short time in a context of limited capacity as stated above. This triple burden is detrimental to aid effectiveness, as illustrated in the above section.

The literature review has shown that some areas need further investigation, however.

3.5.1 Gap 1: Aid coordination in post-conflicted countries

This literature review has shown that coordination plays a central role in aid effectiveness, especially with the growing number and diversity of partners in international aid, including the new GHIs. Fragile and post-conflict states experience challenges in coordination, due to both a lack of local champions and therefore leadership, and to a great dependency on aid. However, the mechanisms through which damaged values and relationships between actors impact on aid coordination has seldom been researched.

Moreover, there is a lack of specific coordination evaluation in fragile states. A first analysis of the applicability of the Paris Declaration in fragile states has shown a need for more flexibility (OPM/IDL 2008).

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3.5.2 Gap 2: Lack of clear capacity definition

While there seems to be consensus around the fact that recipient countries need to strengthen their capacity to coordinate, there is no consensus around what capacity means exactly. The Paris Declaration refers to the need for increased leadership, and ownership by the recipient country in order to coordinate, whereas donors such as the WB refer to legitimacy of an institution as the basis for assessing its capacity to lead and thus to coordinate. Indeed, to be coordinated, donors want proof that the institution will act in a proper way and will not disappoint them.

These judgments over recipient capacity are stated by donors, without any clear measurement of what capacity is exactly. Brinkerhoff definition of “the evolving combination of attributes, capabilities, and relationships that enables a system to exist, adapt, and perform” seems to be inclusive of all aspects – human, social, organizational, behavioral [(Brinkerhoff and Morgan 2010), pp. 3]. This definition will need to be linked to measurable items in order to be applied to the question being addressed in this thesis, namely the capacity of the MoH to coordinate.

3.5.3 Gap 3: Coordination as a power relationship

Overall, coordination assessments have taken the angle of process and/or mechanisms analysis. Donors' and recipients' perceptions of coordination have also been assessed. As coordination intrinsically implies interactions between the coordinator and the ones who are coordinated, power relationships need to be considered. According to Foucault, power relationships exist wherever there is "an action over action of others" (Patton 2012), such as coordination implies.

For instance, when an MoH perceives itself to be in a weaker position than the donors, asymmetrical power is a significant barrier to taking the lead in coordination (Walt et al. 1999b) and this asymmetrical power might be heightened in a post-conflict context (Goodhand and Sedra 2010).

Power relationships also exist also between external actors. The relative power of external actors might change quickly (Cometto, Fritsche, and Sondorp 2010), for instance according to variations in funding volumes or donors' priorities in terms of the target country (e.g. DfID and the end of funding in Burundi).

To date, little attention has been paid to the power relationships involved in the coordination process and to the extent to which these might influence coordination.

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3.5.4 Gap 4: HRH coordination

Global efforts towards better coordination and improvement of aid effectiveness, as well as recognition of HRH as an area of focus, are great steps forward. How these new interests are combined in practice and how the coordination efforts translate in the field needs to be assessed, however.

The area of HRH, which is a critical node of the health system, is of particular concern in terms of coordination, while no published study could be found on the coordination of its policies.

CHAPTER 4: METHODS: CONCEPTUAL AND METHODOLOGICAL FRAMEWORKS

The aim of this study is to analyze aid coordination of HRH policies in the post-conflict period in Burundi. This chapter is divided into 2 main sections. The first deals with conceptual frameworks. The first section will start by presenting the conceptual frameworks usually used to analyze coordination policy. Given that there are a number of definitions and frameworks in the literature, I have selected either the standard ones or those I found most useful, providing justification for the choices made. Then the section progressively demonstrates the necessity to create a new conceptual framework to analyze stakeholders, namely organizations. Broadly this entailed a combination of both deductive and inductive processes: I have analyzed data using existing frameworks and deduced arguments from them, while I have also worked inductively, describing situations and actions, and then drawing new framework and conclusions from them.

After having set the scene for the conceptual analysis, the second section of this chapter presents methods used for data collection, analysis and ethical issues.

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4.1 CONCEPTUAL FRAMEWORKS

4.1.1 Starting definitions and framework

Definition of aid coordination

The standard definition of ‘coordination’ in the Oxford dictionary is “the act of making …groups of people …work together in an efficient and organized way” with a second definition, applied to human body, being “the ability to control …movements well” (Oxford advanced learner’s dictionary). This is similar to the definition of ‘power relationship’, defined by Foucault as “an action over actions of others” (Foucault 1994).

Therefore, we understand that coordination, which is the process to control what a group of people do, or at least the direction in which they go, has to deal with power and power relationships. David Booth showed through examples from Niger and

Malawi that fragmentation of responsibilities hinders coordination, whereas a strong central authority (which therefore concentrated power), is beneficial to coordination (Booth 2012).

The unique definition of aid coordination in the health sector has been worked out by Buse and Walt [(Buse and Walt 1996), pp.1]: "any activity or set of activities, formal or non-formal, at any level, undertaken by the recipient in conjunction with donors, individually or collectively, which ensures that foreign inputs to the health sector enable the health system to function more effectively, and in accordance with local priorities, over time". It is noteworthy that the notion of power does not appear explicitly in this definition, despite it being inherent in each situation where actors come into play and despite the definition of coordination including "control" or to "act over actions of others".

Policy definition

The standard definition of a policy is "a course or principle of action adopted or proposed by an organization or individual" (Oxford dictionary).

According to WHO, health policy is "a set of decisions or commitments to pursue courses of action aimed at achieving defined goals for improving health, stating or inferring the values that underpin these decisions" (World Health Organization 1998).

According to these definitions of policy and the definition of aid coordination above, aid coordination is a policy by itself and may be analyzed using a policy analysis framework.

Rationale behind the choice of the policy analysis triangle as policy analysis framework

Power relationships are present in each component of coordination: organizations' behaviors will be strongly influenced by power relationship between organizations, since each one brings to the table its own ideas/objectives and since each organization is driven by its own vision; power relationships will also influence how the coordinator is chosen and how the joint objective is set; the broader context, either global, national or local, will also play a role, through influencing the level of

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each actor's power, which, in turn, will be translated into behavior and objectives. Power relationships are therefore multidirectional.

Aid co-ordination in particular concentrates this concept of power even more, as both concepts deal with power individually. Indeed, aid, which is transferred from one donor organization to one recipient organization, will influence the nature of the relationship that the two organizations have. The recipient organization can position itself on a level equal to the donor's, or it can be subordinate. The level the recipient organization choses will depend on a range of reasons (economic, political, historical, socio-cultural, psychological etc.) and will directly influence how it negotiates aid, manages and coordinates it.

Aid coordination analysis should therefore pay attention to power relationships between actors related to aid for development, in addition to the context in which coordination takes place, and the processes used in coordination.

While classic frameworks on policy analysis focus mostly on policy content, Walt and Gilson contributed to deepening the process by taking into account other factors which influence the policy cycle, namely the context, actors and process (Walt and Gilson 1994). They emphasized the role of actors and the interplay of their power relationships in the policy process. The framework is summarized in the Figure 9 below.

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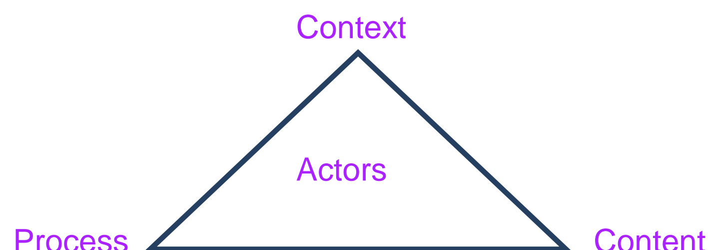
Figure 9:
The policy analysis triangle (Walt and Gilson 1994)



If we apply the policy triangle to Buse and Walt's aid coordination definition, it may be broken into the four key concepts of the policy triangle. Each component needs to be analyzed separately, but also as a whole, since the frontier between each component

is blurred. We will detail the framework used for the analysis of each of these four components.

4.1.2 Content analysis: HRH policies

The ‘content’ analyzed in this thesis will be HRH policies, both formal and non-formal ones according to Buse and Walt definition, developed by any of the organizations involved in the health sector in the post-conflict period in Burundi.

HRH policies were clustered according to Martineau and Martinez framework (Martinez and Martineau 1998): staff supply; education and training; performance management; and working conditions (personnel administration and employee relations) (see Table 2 below). Martineau and Martinez’ classification was selected from amongst numerous others as it fitted best with the HRH issues raised in the national health plan 2002-2006. Compared to others, this framework also has the advantage of having categories broad enough to easily classify different organizations’ HRH policies such that there are a significant number of policies in each category.

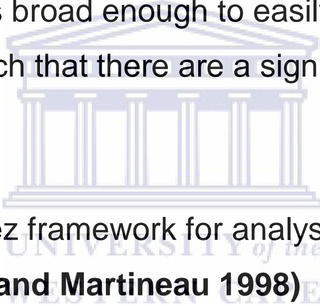


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Table 2: Martineau and Martinez framework for analysis of human resources, the 4 core HRD functions **(Martinez and Martineau 1998)**

A. Staff Supply	Ensuring that the health system obtains an adequate supply of staff to achieve its objectives within agreed budget constraints. This includes using staff from the existing labour pool in the most cost-effective way, or influencing the production of different types of staff to those currently available.
B. Performance Management	Optimizing productivity and quality of work of the workforce. This includes designing or adapting performance management and performance appraisal systems.
C. Personnel Administration and Employee Relations	Setting pay levels and conditions of service; career structures; incentive systems; structuring, managing and harmonizing relations between employers and staff. This includes managing labour relations and finding ways for effective involvement and communication between employers and staff, including their representing bodies.
D. Education and Training	Producing appropriately skilled personnel for the labour market. This includes interventions on curriculum design and enforcement of training standards on the basis of a process of continuous appraisal of needs generated within the labour market.

The **content** of what needed to be coordinated was explored through HRH policy and planning content analysis, analyzing HRH policies of each significant actor in the health sector in Burundi. The assumption was that donors and government were aware of the HRH crisis in Burundi as HRH was identified as a major constraint in the National Health Plan 2006-2010 which was adopted following a national forum held in June 2004 (Ministère de la Santé Publique 2005). These constraints, specific to Burundi, were classified into the four HR development functions identified by Martinez and Martineau above (see Table 2).

4.1.3 Process analysis

Since DPs are increasingly involved in the policy development cycle and influence each level of the policy cycle, aid co-ordination should be analyzed at each level of aid, particularly when discussing issue identification, policy formulation, policy implementation and policy evaluation in weak countries. Not only are donors intimately involved in the whole policy making process, but they might also exert influence at different levels. For instance, issue identification and funding priorities may happen at global level and then be transferred to national level; policy formulation may happen at national level, often supported by donors' expertise and policies formulated at global level may be transferred to country level. Policy implementation may also be guided by donors, depending on a country's capacity to implement. International NGOs, or local NGOs funded by international agencies, may be contracted to implement these policies.

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Policy evaluation, when it does happen, might be difficult to conduct independently, since donors engaged in the policies are often the ones involved in financing the evaluation (example of P4P).

While inputs from lower levels will be considered, we will focus on coordination analysis during the three first steps of the policy cycle – problem identification, policy formulation, policy implementation – at national level.

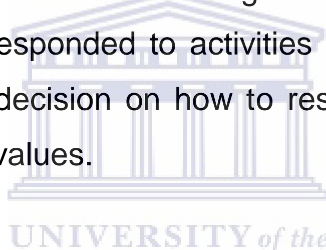
The difficulty of analyzing coordination is that coordination is itself a policy, and also a process. When it comes to analyzing HRH policies coordination, there is first a need to analyze HRH policies process, then analyze whether the whole HRH policy process was coordinated across organizations which participated in HRH policies, to a lesser or greater extent.

If we refer back to Buse and Walt's definition of aid coordination, the process of coordination is defined by "any activity or set of activities, […], undertaken by the recipient in conjunction with donors" (Buse and Walt 1996).

The analysis of coordination will be facilitated by the creation of linkages between an organizations' strategic planning process (vision, decision, action – from the business and management field) and the policy elaboration process (politics field) (Figure 10).

Each step of the policy cycle corresponds to each of the three core elements constituting an organization, i.e. vision and values/decision/activity:

1. problem or issue identification resulted from the vision an organization had (or missed) of the reality/the ground, according to its values;
2. policy formulation corresponded to the decision the organization took (or not) in order to resolve the issue identified according to its vision and values;
3. policy implementation corresponded to activities undertaken (or left out) by the organisation, following its decision on how to resolve a certain issue, identified according to its vision and values.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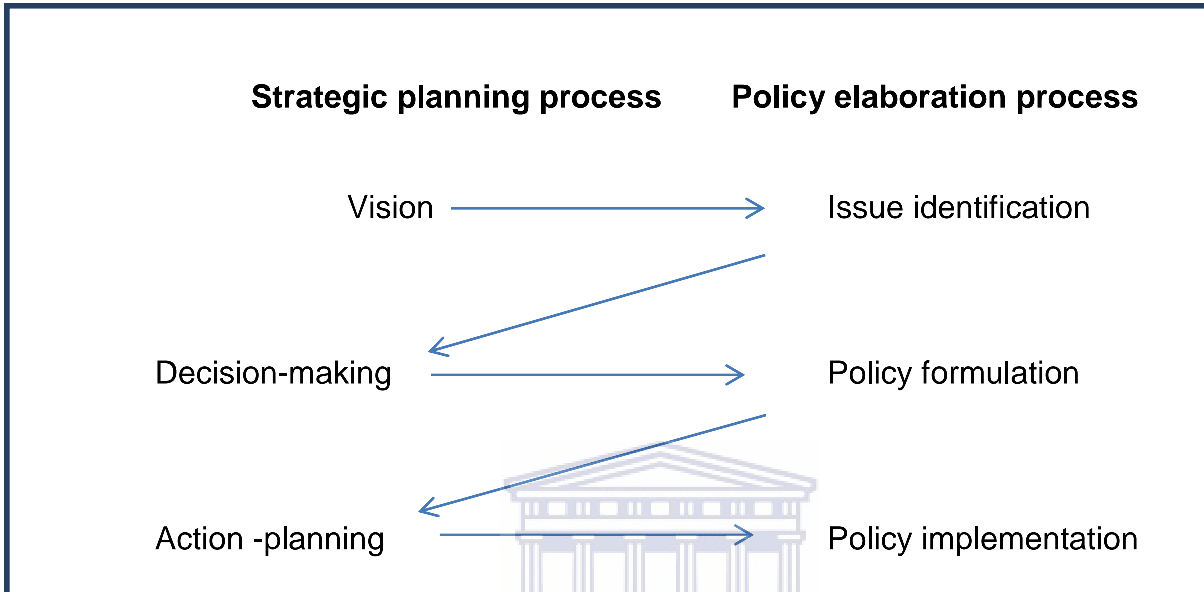
The words 'in conjunction' have been used in the definition of coordination process by Buse and Walt, but we extended it to include 'shared' elements across organizations, to take into account the fact that all actors could not be physically together at each step of the policy cycle and for each policy. HRH policies were compared across organizations. Coordination across HRH policies was assessed by tracking the existence of any **shared** or **joint** vision/decision/activity **across** all 19 organizations. Coordination comprised only when joint decisions were taken, while similar decisions or shared decisions could be the beginning of coordination. Definitions of similar/shared and joint process, for this research, were devised as follow:

- Similar vision/decision across actors: vision or decision were identical or close, but without communicating (similar by chance or because of context); the same decision may be taken by many actors, but independently from each other
- Shared vision/decision across actors: actors did communicate and agreed on a certain vision or decision, but without a collective dimension;

- Joint decision: a decision is taken collectively by actors

Figure 10:
Linkages between the strategic planning process and the policy elaboration process (own creation)



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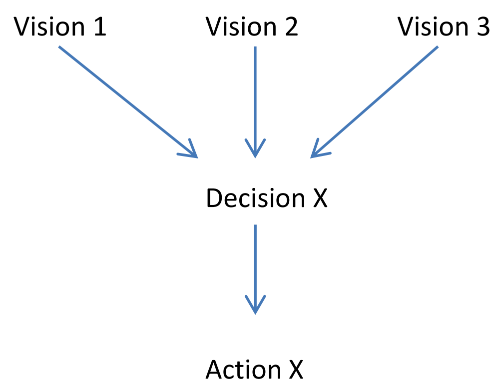
For a matter of enabling the representation of existing different types of coordination, the ideal policy coordination was represented in a simple and linear figure, as follows:

Figure 11:
Coordinated policy formulation and implementation



This figure will serve as a framework for our analysis of HRH policies coordination, while keeping in mind that it is only the process which is simplistically represented here.

4.1.4 Context analysis framework

Context is usually described using, to name a few, Leichter or Collins frameworks (Leichter 1979; Collins, Green, and Hunter 1999). However, in the context of Burundi, these frameworks were difficult to use. For instance Leichter divided context into situational, structural, exogenous and cultural factors (Leichter 1979). If one tries to fit Burundi's context into this framework, the conflict could be considered as a sudden factor and therefore classified as situational. But when a conflict lasts over ten years, individuals become used to it and develop adaptive behaviors in order to survive. In a sense, the conflict becomes part of everyday life, with durable effects on society. Moreover, conflicts were recurrent in Burundi since decolonization and most of the times it was creeping, with sudden peaks (see context section).

Conflict could also be considered a structural factor, similar to some long-term economic policies. But conflict also shaped culture, resulting, for example, in pervasive mistrust in current society in Burundi.

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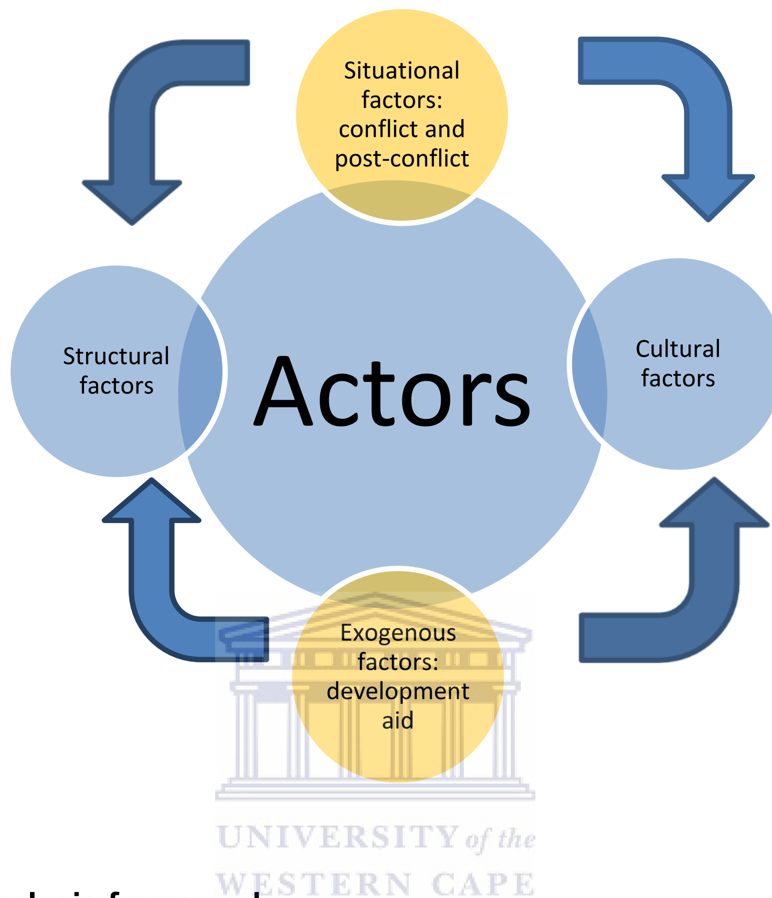
In the same way, development aid has been present in Burundi for such a long time (for more than half a century, since decolonization). It is impossible hence to relegate development to being an exogenous factor since it has almost became a structural factor. This is tangible when we listen to some interviews and to the easiness with which stakeholders talk about donors, as if their presence was natural and obvious. The need to deal continuously with foreign people in the country - which started way before aid for development, with colonization two centuries ago (see history section) – has led to an acculturation to their presence. Hence, one needs to keep in mind, while looking at findings, that the categories of context (structural, cultural, situational and exogenous are deeply entangled, as illustrated in the Figure 12.

Figure 12: Context-related factors
adapted from Leichter for this thesis



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4.1.5 Actors' analysis framework

The component the most difficult to analyze is the one of 'actors', constituted by organizations in the context of this study. There is an entire discipline built around organizations, which we need to get acquainted with, before proceeding towards the question of "how" to analyze them.

From this section, I outline the process I went through to build my own conceptual framework for the analysis of the actor's component of aid coordination policy analysis. I mainly combined three disciplines to arrive at the final framework: management sciences, organizational theory and sociology. The reader might feel frustrated at first sight, but it is only the illustration of how definitions in each field were patchy and needed to be combined with definitions and frameworks from other disciplines, in order to get to a sufficiently comprehensive framework, which will be used in this study.

Definition of an organization

The functioning of organizations started to be theorized in the late 1900s. During the industrial era, companies began to be transformed from small and familial organizations to national or international ones, thus rendering their management aspect crucial.

Organizational theory is a branch of management sciences. Management is a science of action, which borrows its methods and results from other fields, such as organizational sociology, micro-economics, psycho-sociology and philosophy, in order to lead organizations. Organizational theory gains inspiration from these disciplines to increase the efficiency and efficacy of organizations (Rojot 2005).

There are different streams in organizational theory, with the common factor being the improvement of companies' productivity. But since the birth of organizational science, there has been huge difficulty in defining what exactly an organization is, despite multiple attempts (Bourricaud, Parsons, Khandwalla, Presthus, Litterer). Again common to them all is that they all include the concepts of 'actors', or 'relationship', or 'objectives', or all of them.

Crozier and Friedberg were the first to introduce the concept of power relationships into the organizational theory (Crozier and Friedberg 1977). They defined the creation of an organization as "a response to the problem of collective action" [(Crozier and Friedberg 1977), pp. 19]. Rather than defining 'organization' by its content or its operating system, they defined it through its necessity of existence (Crozier and Friedberg 1977). According to Crozier, organizations were created to respond to the necessity of a collective action, but simultaneously, their creation created new problems, inherent to organizations, to their efficiency and survival (Rojot 2005).

> *"Basic to the theory of organizations is the premise that all organizations need coordination; coordination means integrating or linking together different parts of an organization to accomplish a collective set of tasks".*
> [(Van De Ven, Delbecq, and Koenig Jr. 1976), pp. 322]

When applied to context of aid for development, actors for development organized themselves, or were organized, into 'organizations', to be able to act in an efficient way (according to the first definition of coordination above).

Therefore aid coordination can be seen as coordination of organizations which provide, receive and implement aid, or similarly, as coordination of recipients' and donors' organizations. Aid coordination might be defined, therefore, as a collective action towards a common goal which was set to be development – keeping in mind that 'development' itself is a contested concept and practice; a point I will come back to later in the study.

In the health sector, the recipient organization supposed to take the lead in aid coordination would be the MoH, according to OECD principles on aid effectiveness, extrapolated for the health sector (in (Buse and Walt 1996), pp. 180).

How to analyze organizations

Actors – organizations in our case – are usually analyzed using a stakeholder analysis which is "a tool for generating knowledge about actors - individuals and organizations - so as to understand their behavior, intentions, interrelations and interests; and for assessing their influence and resources they bring to bear on decision-making or implementation processes" [(Brugha and Varvasovszky 2000) pp.1].

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In addition to seeking to analyze the position, values and interests a stakeholder has towards a given policy, stakeholder analysis includes a thorough power analysis (Brugha and Varvasovszky 2000). Power analysis either increases chances of success when conducted prior to a policy implementation for instance or enables a retrospective understanding of why a certain policy has been undermined or another has succeeded.

Things get complex when it comes to assessing power, however, and there are different definitions of power in the policy making arena. Some of the main authors and their definitions follow.

Power definition

Overall, there seem to be ideological and philosophical battles over definitions of power, understood either as a coercive and controlling force leading to conflict and inequality or as an enabling force leading to collaborative actions. Hereafter I

presented few authors' definitions, which were inclusive of the notions of "control" or of "ability", to fit the topic of this study, aid co-ordination. The aim was not to cover all the existing definitions of power, which is out of the scope of this study.

Dahl defined power as a capacity (power over) which is similar to Foucault who defined a power relationship as "an action over actions of others", thus adopting a dominant-dominated relationship approach (Foucault 1994). By contrast, Arendt defined it as an ability (power to), which enables a given person or institution to act in a certain way (Buse, Mays, and Walt 2005; Pettit 2013).

Hydén's definition of power, for policy analysis purpose, derives directly from Dahl's: "the capacity to exercise control and influence over others by the use of means –soft or hard – […]" [(Hydén 2006), pp 15]. However, he stressed the fact that there is no need to distinguish "power over" and "power to", since the "power over" leads to "power to".

Power analysis frameworks

Besides, and derived from, these theoretical considerations over the definition of power, there are also methodological issues around power, making power analysis challenging (Walt et al. 2008). Indeed, due to the numerous definitions of power, ways to measure it are also numerous. Some are very theoretical while others are based on the perceptions of the assessor and are therefore not easy to apply in a reproducible way because of the inherent subjectivity. These challenges might lead to results that lack robustness.

Despite these challenges, some authors managed to develop practical tools, amongst which the most detailed for the health sector is the 'policy toolkit for strengthening health sector reform' which drew on earlier work by Brinkerhoff (Crosby and Brinkerhoff 1994). It is noteworthy that the definition of power in this toolkit is very close to the one entailing capacity, proposed by the Brinkerhoff (Brinkerhoff 2010).

According to the toolkit, the working definition of power is a **combination of resources (or capital or means in Hydén's sense), the ability to mobilize these resources, and leadership**. This is the definition which will be used in this thesis, especially to measure the power of the recipient organization which is supposed to

take the lead in coordination. Each component of this definition is analyzed thereafter:

- The various forms of resources/capitals identified are economic/financial resources, human resources, political resources and 'other' types of resources. There are no specific methods of measurement attached to each type of resource. While 'hard resources' - such as economic/financial ones, or even human ones –
- are easy to define and therefore to measure and to compare across stakeholders, the definition of other 'soft resources', such as political ones which fall into the category of social capital, remains more elusive.
- In the toolkit, the ability to mobilize resources is defined and scored, based on the decision making capacity a stakeholder has on the use of its resources [(Crosby and Brinkerhoff 1994), pp. 39]. It is understood more as a capacity related to a particular position/function held by the stakeholder, in the organization or in the hierarchy. But resource mobilization capacity does not rely solely on the position of a stakeholder; while they might well hold a legitimate decision-making position, they might not be able to use this capacity given a lack of self-esteem, vision or leadership.

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The definition of leadership is "the willingness to initiate, convoke, or lead an action for or against the policy" [(Crosby and Brinkerhoff 1994), pp. 41]. Intended for policy analysis, this definition classifies stakeholders as having leadership or not. While an understanding of leadership might be relatively intuitive, it has a number of limitations when one want to apply it, however. For instance leadership might not be limited to just a "willingness"; some stakeholders might be "willing" in thoughts and words, but not put this into action. Leadership is also very difficult to measure in practice. The definition provided by Lowder and presented in the literature review might be very useful since he proposed practically measurable criteria.

Hence one of the biggest challenges when dealing with health policy analysis applied to aid coordination resides in the absence of clear methodological tools to measure power and its constituents.

4.1.6 Contribution of Bourdieu to power analysis framework

The contribution of Bourdieu, namely the triad field-capitals-habitus, seemed to be of paramount importance in order to overcome these challenges related to power measurement at organizational level, for a number of reasons.

- He combined two levels of analysis, usually divided between two distinct disciplines: the macro-level organizational analysis undertaken by sociologists and the micro-level analysis performed by social psychologists (Emirbayer and Johnson 2008). This combination of disciplines will help in analyzing both individual and inter-organizational factors influencing stakeholders.
- He clearly defined four forms of capital, including social capital, applicable either to individuals or to organizations (Bourdieu 1986).
- He introduced a new concept, the 'habitus' (Bourdieu 1986), to which the leadership and the ability to mobilize capitals might be partly related, as will be demonstrated below.

This triad of Bourdieu – of field, capital and habitus – has been increasingly considered for its contribution to organizational theory in particular, and management sciences in general (Khanchel and Ben Kahla 2013; Emirbayer and Johnson 2008; Ozbilgin and Tatli 2005; Navarro 2006). While the first two concepts of field and capital seem to have been incorporated to some extent in the literature of organizational analysis, the one of habitus seems to have been neglected (Emirbayer and Johnson 2008). Navarro suggested that the triad should be considered as a very useful model to analyze power relationships in sociology (Navarro 2006).

i. The field

The definition of a field is a "network of social relations, structured systems of social positions within which struggles take place over resources, stakes and access" (Bourdieu 1994). In his use of the word "struggle", Bourdieu emphasized the importance of power relationships existing within the field.

Everett, one of the authors who adapted Bourdieu's work for the purpose of organizational analysis, linked the concept of 'field' to organizations and its capitals (Everett 2002). According to Everett, organizations struggle to dominate the field, using the capitals each of them possesses.

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The field framework in particular has the advantage of assembling three levels of analysis within it: the "analysis of a cluster of organizations"; the "analysis of the social configurations in which organizations are embedded"; and the "analysis of individual organizations" (Emirbayer and Johnson 2008).

ii. The capital

A myriad of definitions of capital – as many as definitions of power – exists in the literature in fields such as sociology, economics, philosophy and management sciences. Amongst them, Bourdieu's definition seems comprehensive, since it can be applied to organizations and individuals; it includes both relationships and individual or organizational wealth; and it has both objectively measurable items and subjective notions such as representations of others or by others.

Bourdieu defined capital as "accumulated labor in its materialized form or its embodied form". According to Bourdieu, four forms of capital exist, applicable to both individuals and organizations [(Bourdieu 1986) pp. 47-58]:

- Economic capital: "immediately convertible into money".
- Cultural capital: "long-lasting dispositions of the mind and body (e.g. ability or talent), cultural goods and institutionalized state" (e.g. diplomas).
- Social capital: "durable network of more or less institutionalized relationships of mutual acquaintance and recognition (made possible by solidarity)".
- Symbolic capital: "the representation of capital each individual and organization has" (i.e. legitimacy). This form of capital is special in the sense that it is constituted differently from one individual to another – i.e. it is subjective since it is influenced by the perceptions each individual or organization has of others. Trustworthiness, as presented in the literature review section, falls under this type of capital, as a representation of capital other individuals or organizations have towards a given individual / organization.

The notion of trust, subject of many debates in the social capital literature, does not come explicitly out of Bourdieu's social capital concept, but is implicit in it, as a capital of recognition. Sissiainen tried to formulate a definition of trust from a Bourdieuian perspective: "a universalized value posited at the basis of voluntary and disinterested action and exchange" [(Siisiäinen 2000) pp. 13]. And what emerged

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from the literature review is that trust is an essential component which will enable the building of networks and relationships, constituting social capital.

iii. The habitus

The definition of habitus is: "[…] a system of lasting and transposable dispositions which, integrating past experiences, functions at every moment as a matrix of perceptions, appreciations and actions […]" [(Bourdieu, 1977: 72, pp. 95].

Bourdieu has had, and still has, many supporters and detractors, especially regarding the concept of habitus. The main critiques vis-à-vis habitus were that it operated as a 'black box' and that it was identified through its effects. Indeed, the notion of habitus is multidimensional by nature, as it tries to align the collective or social and the individual dimensions in humans, by linking socio-historical determinants to the uniqueness and plurality of an individual. The fact that it is multidimensional makes its usage and interpretation difficult. Bourdieu's notion of habitus might be further interpreted as a combination of a primary habitus, (which are the initial conditions of life, exerting an effect of "inculcation"), and of secondary habitus (later social experience, exerting an effect of "social trajectory") [(Lahire 2001), pp. 141-174]. This makes the habitus of a given individual such unique and such unpredictable, even though the initial conditions may be similar.

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This type of sociology at individual scale is called psychological sociology, and constitutes one aspect of sociology. Habitus theory is regarded by some authors as constituting one theory of the construction of the psyche, in the succession of Hegel (Lahire 2001). Emirbayer emphasized how the concept of habitus make possible the explaining of individual behaviors, dictated by their own experiences, within organizations and proposed its use in organizational sciences (Emirbayer and Johnson 2008).

While habitus is indeed a 'black box', human psychology complexity cannot be conceptualized and individualized with inputs and outputs so easily. An examination of the links between habitus and leadership, for example, (a notion recurrently used in coordination and in development field) might include the following. The discipline in which leadership has been most deeply explored is management science. According to the definition proposed by Lowder, leadership is a set of social capital and psychological traits which positively affect interpersonal relationships in order to

achieve collective actions (see literature review section 3.4.3). Since an individual's psychological trait (the way they perceive and appreciate themselves and others, and their respective positioning) and their interactions with others (the way they act with others) are precisely influenced by habitus (according to Bourdieu's definition), it seems that leadership could be interpreted as an outcome of the combination of capital and habitus.

Bourdieu illustrated the linkage between these three concepts of capital, habitus and field in the following equation:

[(capital) (habitus)] + field = practices

The equation was illustrated in Figure 11 below.

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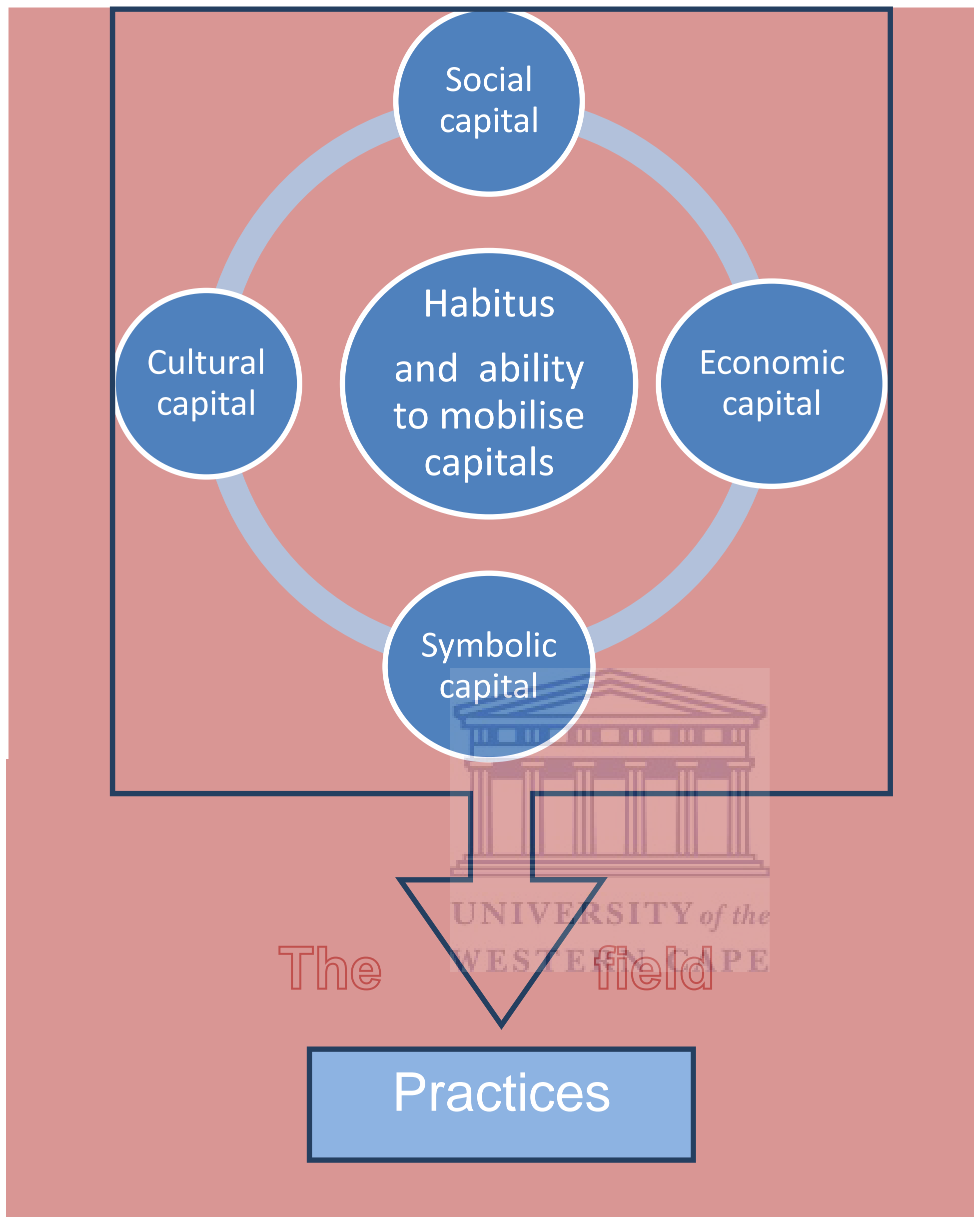
Figure 13: Illustration of the equation of Bourdieu (own creation)



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This conceptual framework section provided the ground for this research by presenting definitions of ‘coordination’, ‘policy’, ‘organization’ and ‘power’ and showed the complex task ahead. Aid organizations need coordination to be able to function efficiently, and this study seeks to analyze how policies set by organizations are coordinated. Aid coordination is a policy set at global level by, *inter alia,* the Paris Declaration and applied at country level by aid organizations, and should be analyzed as such, taking into account the power relationships between organizations. A new theoretical framework, combining Crosby and Brinkerhoff’s definition of power, Bourdieu’s concept of capitals, habitus, and Lowder’s definition

of leadership was devised and will be used mainly to assess MoH organizational power.

4.2 METHODOLOGICAL FRAMEWORK

4.2.1 Research design

The research question sought to analyze factors which helped and hindered aid coordination in the post-conflict period.

The research was conducted in six steps.

1. The 19 organizations were first described according to their main characteristics: global and in-country histories; mission and objectives; organogram of the institution and legal statute if they were a government body; accountability lines; levels of autonomy in terms of financial management; governance and functional linkages between them; as well as their policy/planning documents or funding applications elaboration processes. Additional information was provided whenever it was felt it would facilitate the understanding of selected organizations' relationships and functioning.
2. HRH policy-content analysis was conducted by scrutinizing the HRH policies proposed by each of the 19 organizations in their policy and planning documents, from which we selected and analysed policies strictly referring to HRH. Policies were classified according to Martinez and Martineau's four dimensions and according to the three steps of the policy cycle (Martinez and Martineau 1998): problem identification, policy formulation, policy implementation. This exercise was applied to each policy or planning document of each of the 19 organizations.

   For each organization we developed a table with 12 cells: three policy steps X four HRH dimensions. Each step of the policy cycle was interpreted as corresponding to each of the three core elements constituting an organization, i.e. vision, decision, activity:

- problem or issue identification corresponded to the vision an organization had (or missed) of the reality/the ground;
- policy formulation corresponded to the decision the organization took (or not), in order to resolve the issue identified according to its vision;
- policy implementation corresponded to activities undertaken (or left out) by the organization, following its decision on how to resolve a certain issue, identified according to its vision.

The national health development plan was read using the grid of HRH, as a baseline for the policy content analysis.

3. HRH policy coordination was assessed by cross-analysing the HRH policy-content across the 19 organizations and compared to the ideal coordination definition. Process-related factors inhibiting coordination were also described here, and linked up to each step of the policy cycle.

4. A stakeholder perception and position analysis was conducted in order to assess actor-related factors inhibiting coordination: knowledge of, interest in /position towards coordination. In the context of this section, a stakeholder was considered an aid organization. Stakeholder-related factors influencing coordination were, of course, related to other factors already presented in the two previous sections, process and context-related factors.

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Themes were clearly intertwined and were arbitrarily and artificially disentangled into themes, to help with the presentation (Olivier de Sardan 1995). Frontiers between process and context, context and actors, actors and process were at times blurred with, for instance, actors adopting such behaviour because of context X leading to a process Y.

Both references to broad coordination or specific HRH policy coordination in the documents and interviews were analysed, in each pre-defined group of aid organizations involved in the health sector. Framework analysis was used, guided by the questions below. Answers were charted, to provide a clear picture of the complex and sometimes ambivalent positions aid organizations took around coordination.

- What definition of coordination was implicit or explicit?
- Who should take or be given the lead in coordination?

- Who / what should be coordinated?
- Towards what common objective should the coordination be directed?
- What are the means for coordination?
- What interest / position/ has the group vis-à-vis coordination?
- What interest / position/ had others towards coordination?

5. The contextual factors inhibiting coordination were extracted from interviews at national level and deduced using framework analysis. They were combined with, and compared to, factors included in the documents analysed. They were included in the context/background chapter and in the other sections related to actors and process.

6. The MoH's organizational power was measured according to the definitions selected and presented in the previous section on conceptual framework.

4.2.2 Data collection period

The period considered was from 2002 to 2008. This long period was justified by the fact that the slow transition between emergency and development aid.

The civil war officially ended in 2006, when the last rebel group officially signed a cease-fire agreement and disarmament started, though the agreement was not fully respected, leaving areas of insecurity until 2008. It is therefore difficult to set a formal date of the end of the war, and it would be more accurate to qualify it as a progressive entry into a post-conflict situation.

Major development aid started to arrive in Burundi from 2002 with the first significant funding for the health sector starting in 2002 (MAP1 of the WB) and in 2003 (round 2 of GFATM-HIV and GFATM-malaria). These two factors – the beginning of GHIs' funding and the entrance in a transient governance mode – led us to commence the analysis in 2002.

4.2.3 Data collection process and sampling

Data comprised semi-structured interviews at national, provincial and facility levels, and official documents from the main organizations selected for the study.

The main organizations in the health sector were identified from government documents and the flows of financial aid. Nineteen organizations in the health sector were selected for this analysis, all of whom having had a significant role from 2002 to

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2008 in the development of the health sector in Burundi. Two criteria were used for

	Profile	Number of interviewees 2009	Number of interviewees 2011

selection: exerting a direct or indirect influence on HRH policies at any level of the policy cycle; and providing a financial contribution to the health system, at any of the three levels, national, provincial and local.

The national level interviewees were selected based on the relevance of the position they held in their institution to the topic of the study (HRH and/or aid coordination) and/or identified through sequential reference sampling.

Three provinces were selected: Bujumbura-mairie (capital-city), and two provinces (Ruyigi and Kirundo) which had the highest rates of HIV prevalence and which received aid for DHS from BTC and the EC respectively. Within these three provinces, four facilities were selected (public hospital, public PHC center, private PHC center, NGO-run HIV-clinic).

Semi-structured interviews were conducted at the 3 levels using interview guides, purposely developed according to the type of interviewee: government official (health sector or not); funding institution; implementing agency (NGO or not); HRH at facility level. Questions covered the four domains of HRH as cited above and their coordination across programs or facilities (Appendix 1).

Data collection was first conducted between February and June 2009, as part of a WHO study "Maximizing positive synergies between Global Health Initiatives and health systems". Data were collected by the main researcher (the PhD candidate) and two research assistants recruited locally and trained for the purpose of the study. Another round of data was collected between March and June 2011, as part of the INCO-DEV project of the EC, entitled 'Impact of GHIs in five African countries'. Interviews were conducted by the same researcher and research assistants.

Overall, 128 people were interviewed over the two rounds, as shown in Table 3, together with their profile. The response rate was over 98%. Only one person refused at national level in 2009 (one donor organization) and one in 2011 (one senior officer of MoH) citing time constraints.

National-level	Elites (Ministers, DGs or chief of cabinet of MoH, MoA, MoF, Ministry of Civil service) Members of the 19 organizations selected for the study Key informants from other relevant organizations (DfID, Cordaid-NGO, policy analyst)	31	27
Provincial-level	Provincial health office director Provincial AIDS council representative Focal points of vertical programs when present	9 in 3 provinces	11 in the same provinces
Facility-level	Facility director 2 key informants per facility when available (doctor, nurse)	30 in 4 facilities in each of the 3 provinces	25 in the same facilities

Table 3: Number of interviewees and their profile at the 3 levels of data collection, for 2009 and 2011

When citing the interviews in this thesis, the following coding has been used: ‘ITW X’ (for interview with the numbering); ‘N’, ‘P’ or ‘F’ (for national, provincial or facility-level); and ‘2009’ or ‘2011’ (being the year in which the interview was held).

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Policy and planning documents collected consisted of: national strategic plan for health sector and for each program within the MoH (HIV, reproductive health, malaria, TB, immunization); funding proposals for GFATM, GAVI and GAVI-HSS; project appraisal document of the WB; country cooperation project documents from corresponding bilateral, multilateral or UN agencies; and annual activities or implementation reports corresponding to each program. Documents were either collected in 2009 and 2011 during the national level interview processes (hard copies or electronic copies), or downloaded from partners institutions’ websites. Some reports were not available at the time of the interview.

A list of documents consulted is provided in the findings section (Table 5).

4.2.4 Data analysis method

Interviews were coded, using the framework analysis methodology, by the main researcher, in French, so as to not lose the meaning of the content. The framework analysis was selected for its appropriateness in situations where *a priori* issues were already identified, and for research questions with policy implications. Framework analysis also allows keeping the meaning of data in a whole (i.e. in the interview), as compared to grounded theory, which was important in our study (J. Green and Thorogood 2004).

Framework analysis consisted of 5 steps. The first step was familiarization with the data, by listening to records and reading the transcripts several times; the second step was thematic analysis, where thematic frameworks (HRH dimensions and health policy analysis triangle components, i.e. context, actors, content and process) and coding frames were identified; the third step was indexing; the fourth, charting the indexed data by theme; and the fifth and final step was mapping and interpretation.

The thematic framework consisted of a reading grid inspired from the HPA triangle, and all information pertaining to the following items was extracted:

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- process: coordination, joint activities, collaboration, harmonisation, alignment, integration, accountability, objectives, targets, aims, outputs
- actors: capacity, power, leadership, ownership…
- content: themes related to HRH issues or HSS issues related to HRH (absolute shortage, lack of production, lack of retention, lack of training
- context: post-conflict, insecurity, poverty, broader extra-sectoral constraints, aid for development.

Analysis and interpretation were supported by the use of various tools in Atlas.ti®: (version 6, Scientific Software Development GmbH, Berlin, Germany) Boolean operators to query quotations related to more than one code (e.g. GFATM AND in-service-trainings); use of the code network, to map the interrelationships between codes, and the type of relation (i.e. association, contradiction, causality, being part of, being a property of); creation of super-codes, constituted of two or more codes combined (e.g. coordination AND working conditions); creation of code families.

Documents were analysed according to the three components of HRH policies and the four domains of HRH. The codes and themes were the same as the ones used in the interview analysis.

4.2.5 Data quality

Transparency

The sampling process (relevance of the institutions and interviewees included) as well as the coding process were clearly explained while presenting the results to stakeholders and during the writing process. The two ministers of health (and the minister of HIV/AIDS when that ministry was still in place) during the period of the data collection (2009-2011), had been personally briefed and/or interviewed for the purpose of the study and were in full agreement with its aim.

Validity

The study was conducted in close relationship with the government of Burundi, in order to disseminate and validate its results. Preliminary findings were already presented in May 2009 to technical members of the MoH and main partners in a workshop in Bujumbura. Further results will be disseminated locally when synthesized in papers.

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Qualitative results were discussed against contextual factors to increase the degree of credibility.

Qualitative results were triangulated with local researchers and other researchers, part of the team at UWC's SOPH to ensure maximal validity. Qualitative data were also compared with quantitative data and the content of reports.

Reliability

Interviews were conducted by researchers fully aware of the local context and purposefully trained (myself and two local people, both with a background in clinical psychology and social sciences research experience). They were translated into English by two local translators who were able to take into account particular meanings existing in French used by Burundese, in order to not lead to any misunderstanding or loss in information.

Codes were discussed between researchers in order to increase reliability and transcripts were made available in English. Unedited quotations have been included in the thesis (in English).

Memory bias may have interfered with some responses, as the data collection was mainly retrospective and over a long period of time (2002-2008).

Also, the reliability of the answers, given the context of the country and the content of the questions (politically or financially sensitive), has to be questioned. The outsider position that the main researcher held (and at the same time, an insider to some extent because of the previous relations with the country), provided fertile terrain for trust and respect of interviewees. However, positions in Burundi are very insecure and the nature of questions, leading at times to criticize the government's capacity or partners' interests, could have led respondents to hide their true perceptions of the situation. However, this bias is inherent to the qualitative nature of research.

We tried our best to rule out these biases, by triangulating responses from different participants and interpreting them in the light of their respective positions and institutions.

Comparability

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The same institutions and facilities were included across the two periods. Whenever possible the same participants were also interviewed or, if not, persons holding the same positions were included. All interviews were conducted by the same researchers across the two periods.

Reflexivity

Interviews were conducted while keeping in mind the position of the interviewers and the main researcher, the latter acting both as an insider and an outsider. Efforts were made to remain the most neutral possible and to adapt the questions to the position of the interviewees. Qualitative data conducted by the local researchers, acting as mainly insiders, might also have influenced the answers to the interviews. Data analysis took into account the position of all the interviewers as well as the broader socio-political context.

Generalisability and transferability

We compared Burundi's context with other post-conflict countries context, in order to discuss findings transferability. Even if each context is unique, some features, such as partners' practices, could be similar across countries. Moreover, GHIs, acting as a blueprint, might have related effects in other countries.

We also discussed the findings' transferability to areas of coordination other than HRH.

4.2.6 Ethics considerations

Ethics permissions

Ethics permissions were obtained from the national ethics committee in Burundi for both rounds (see Appendices 2, 3, 9).

In addition, data collection for the first round was undertaken as a sub-study of a project which was already approved by UWC Ethics Committee, entitled 'Experience of three African countries with Global Health Initiatives' – though further approval was obtained for round 2 (Appendices 8 and 10).

All study participants were informed about the purpose of the study in the language of their choice and their rights and were asked to sign a consent form (Appendices 4, 5, 6, 7, 11 and 12).

The interviews, audio recordings and the notes were kept anonymous and stored in a secure place. A confidentiality clause was included in the employment contract of the research assistants.

Informed consent

The study was clearly explained to each participant until they understood it fully. Written informed consents were obtained before each semi-structured interview. Participants were informed that they could withdraw from the interview process at any time during and after the completion of the study – and that if they withdrew, they would not be negatively affected in any way.

Initially, participants were given the choice of language – Kirundi and French. Where participants were fluent, interviews were conducted in French, which was often the case.

Confidentiality

Confidentiality was guaranteed to every participant interviewed. Interview notes and transcripts, and audio taped materials were all stored in a secure place and access was limited to the co-researchers and to research assistants.

When quoting anyone, interviewees are referred to through the use of broad categories such as 'donor institution' or 'government institution', to make sure that the identity of the interviewee is not revealed.

Responsibilities to research participants

Researchers ensured that participants did not feel uncomfortable by having them choose the venue of their interview at their convenience. Researchers did not make use of their position to force participants to participate or to disclose information, especially on sensitive issues.

Practical limitations in methods

There are several limitations in this thesis, however.

With regard to coordination analysis, time-based trends could not be respected: some policies were formulated before others, so influences of one policy over another, including those that were formulated later were not distinguishable.

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The document analysis was not exhaustive as some were not available or were difficult to access.

'Coordination' was a relatively new concept globally. In our findings, it seemed it was used rhetorically, rather than coming from a real understanding of what coordination implied. Nonetheless, rhetoric may become reality after a while, since time is key to the ownership and incorporation of ideas. Our sets of findings could not capture any trend in this sense, given the short time span.

With regard to language, all interviewees were fluent in French, even for Burundese. All the transcripts were translated into English for triangulation. Some meaning could have been lost during the translation process or some cultural specificity misinterpreted, but the use of local researchers contributed to minimise the extent of these bias. The fact that the main researcher was French added to the quality of the interviews. Indeed, even though Kirundi is the official language in Burundi, French is

the second commonest language and is extensively used in official documents and meetings. Higher education is provided in French.

With regard to sampling, all organizations involved in the health sector could not be exhaustively included in the study, given limited time and funding. Some donors were not major actors in the immediate post-conflict period and were not taken into account in this organizational analysis, even though their influence might have grown over the years. A brief overview of excluded organizations is provided in Appendix 18. However, the relatively large size of the sample is likely to counteract the possible sampling bias.

With regard to the researcher's position, interviews were easy to get, including 'elite' interviews, either as being a foreigner, and being working for first the WHO and then for a foreign academic institution gave me symbolic power and put me in a higher position, or as a return on investment was expected.

Some interviewees might not have expressed their true opinions, for fear of repression or of a breaking of confidentiality. In general, however, local people had more confidence in foreigners, as Burundese believed foreigners to be trustworthy, compared with Burundese in general. In addition when interviewee was concerned about repressible content, they asked not to be audio recorded, or asked to stop the recording. Caution was exercised when interpreting sensitive content, by triangulating findings with local research assistants, and by taking into account the potential interests/fears of interviewees. Any case of reference to embezzlement from the part of the interviewee was treated with special caution, so as to not perpetuate what could be a simple rumour. But somehow surprisingly, interviewees were quite open about this topic, and pointed out at one person in particular, holding this person responsible for his act, and generally not at one institution (in case of embezzlement only). These cases were reported only when a triangulation was possible.

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CHAPTER 5: FINDINGS PART 1, AID ORGANIZATIONS' GOVERNANCE AND OPERATING SYSTEM

5.1 OVERVIEW OF SELECTED ORGANISATIONS

This chapter introduces the 19 organizations selected for the study as at 2011, the selection method having been presented in the methods section above (methodological framework data collection process).

All organizations were described according to the following features, extracted from documents analysis and from interviews: history/ missions; governance/hierarchical linkages between each other; and financial instruments/budgeting process/funding sources. Additional information was provided whenever it was felt it would facilitate the understanding of selected organisations' relationships and functioning.

These descriptions provided the basis for further analysis of inter-organizational relationships and relative power, and key material for coordination analysis. Their descriptions are strongly marked by the conflict, however, which both complicated coordination analysis but also contributed to explaining why coordination is so challenging. They will be deepened in following chapters.

The full descriptions are provided in Appendix 19, while a shorter summary is provided in Table 4 below.

The 19 organizations are as follows:

1. The Ministry of Health (MoH)
2. The National Reproductive Health Program
3. The National Malaria Program
4. The National TB and Leprosy Program
5. The National Extended Immunization Program
6. The National HIV Sectoral Unit for health sector
7. The Ministry of AIDS (MoA)
8. The Permanent Executive Secretariat of the National AIDS Council (PES-NAC)
9. The World Bank (multisectoral AIDS programs 1 and 2)

10. The GFATM -TB component
11. The GFATM - HIV component
12. The GFATM - malaria component
13. The Global Alliance for Vaccines and Immunization (GAVI)
14. The GAVI-Health System Strengthening (GAVI-HSS)
15. The European Commission (EC)
16. The UK Department for International Development (DfID)
17. The Belgian Technical Cooperation (BTC)
18. The World Health Organization (WHO)
19. The United Nations for AIDS (UNAIDS)

5.1.1. Clustering

After an initial analysis, the 19 organizations were clustered into five groups according to the similarity of their objectives and/or to their belonging to a larger 'family-organization', as follows:

- Group 1: stand-alone Ministry of Health (MoH), with a broad objective of public health improvement.
- Group 2: MoH-related disease-specific organizations, with a common objective of improving specific indicators (the five vertical programs / unit).
- Group 3: bilateral and multilateral donors, with broad objectives of public health improvement (DfID, BTC, EC).
- Group 4: donors or non-MoH related disease-specific organizations (GFATM-HIV, GFATM-malaria, GFATM-TB, GAVI, GAVI-HSS, WB, PES-NAC, MoA).
- Group 5: UN family (UNAIDS, WHO).

In addition to these five groups, some relevant organizations or individuals were included: Ministry of Finance, Ministry of Civil Service, NGOs related to HIV (RBP+) or to performance-based funding (Cordaid), and one independent policy analyst.

Eventually, main features arising from this preliminary description of main actors were presented.

Table 4:
Presentation of the 19 organizations selected for the analysis, according to their missions, governance and financing system (as of 2011)

	HISTORY/MISSIONS	GOVERNANCE	FUNDING SOURCE OR BUDGET
Group 1: MoH central			
MoH central	Existed since pre-colonial era Latest decree for organizational change in 2006	Centralized governance Minister nominated by president Cabinet and two director-generals (DGs): 1) DG resources who manages, amongst others, the Directorate for HRH 2) DG health, who manages, amongst others, the Directorate for Programs and Health Services	Annual budget negotiated with Ministry of Finance Mainly used for recurrent cost
Group 2: MoH vertical programs			
National TB Program	Created in 1984 as a department Transformed into a program in 1992	Managed by a program director, under the Directorate for Programs and Health Services	Mainly funded by external donors Funding bypasses MoH central
Sectoral HIV unit of the MoH	Created in 2002, replacing the national HIV program created in 1986 Mandate = implementation of HIV strategic plan elaborated by the NAC, in the health sector	Managed by a unit director, under the Directorate for Programs and Health Services	No funding on its own Funding disbursed upon authorization from PES-NAC, or some small and one-off funding from UNAIDS or WHO
National Malaria Program	Created in 2008 Before 2008, part of the program against transmissible and malnutrition-related diseases	Managed by a unit director, under the Directorate for Programs and Health Services	Funding disbursed from GFATM-malaria grant upon authorization from PES-NAC
National Reproductive Health Program	Created in 1998 Transformation of national-level coordination body for family planning	Managed by the program director, but directly attached to the Cabinet Self-governed	Mainly funded by external donors (see Appendix 14 for distribution)

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	HISTORY/MISSIONS	GOVERNANCE	FUNDING SOURCE OR BUDGET
National Immunization Program	Started in 1980, mainly against outbreaks Operates with GAVI since 2002	Managed by a program director, under the Directorate for Programs and Health Services	Mainly funded by GAVI and GAVI-HSS Funding bypasses MoH central
Group 3: Bilateral and multilateral donors with broad public health objective			
Belgian Technical Cooperation	Largest bilateral donor since independence Health is one sector of concentration and Burundi is one target country	Lead donor for health sector since 2011 Operates through technical assistance and projects	5 million euros for Kirundo province 2008-2011 (directly funded at provincial level) 5 million euros for hospital rehabilitation and institutional support 2008-2011
DfID	In the health sector in Burundi since 2004 Exit strategy planned for 2012 Main supporter of IHP+ with WHO	Lead donor for health sector from 2007 to 2010 Operates mainly through technical support	5 million pounds, 2007-2011
European Commission	Started in 1962, never stopped funding Burundi Development aid (EDF) and/or emergency aid (ECHO) Peace supporter	One representative at country level Operates through technical assistance and projects	250 million euros for the entire ECHO funding 1993-2008 PATSBU (health program of EDF) = 25 million euros 2008-2013
Group 4:Donors or non-MoH related disease-specific organizations			
World Bank	Operated since 1963 Mission = poverty reduction	One representative and task team leader at country level Special 'envoys' for projects formulation Operates through projects	1560 billion USD in total (all sectors), since 1963 Health and Population Project 2: 30 million USD MAP 1 and 2: cumulative disbursement 04/2011 = 48 million USD
Ministry of AIDS	Created in 2001 Mandate = coordination of HIV activities and resources mobilization	Directly linked to the President's office, above other ministries Became a vice-ministry of MoH in 2007 Shifted back to a ministry in 2008 Merged with MoH in 2010	Annual budget from MoF for recurrent cost (e.g. 2009 budget was about 3 million USD)

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	HISTORY/MISSIONS	**GOVERNANCE**	**FUNDING SOURCE OR BUDGET**
PES-NAC	Established in 2002, according to the three principles of UNAIDS Mandates = technical coordination of HIV activities implementation	Under the charge of MoA and under authority of NAC and NAC executive committee	WB funding for operational cost Manages MAP1/2 and GFATM-HIV and GFATM-malaria grants
GFATM/CCM	CCM created in 2002, before first GFATM grant application Mandate = formulation and implementation/ evaluation of grants	Composition of CCM: mixture of government, civil society and patients representatives (see Appendix 17 for details)	CCM functioning funded by GoB and GFATM Financial and programmatic management different according to sub-type of grant: 1) GFATM-HIV: principal recipient (PR)= PES-NAC and since 2012, double PR, PES-NAC and a local CSO 2) GFATM-TB: PR = national TB program 3) GFATM-malaria: PR = project health population 2 of the WB until 2006, PES-NAC since then
GAVI	Started in 2002 Mission = to promote equity in access to immunization between/within countries and to contribute to MDGs achievement	Inter-Agency coordination committee, composed of main donors and government officials reviews grant submission A technical committee is in charge of proposal elaboration, upon proposition of the immunization program	As of 04/2011, disbursed 27 million USD, directly from GAVI upon approval of the IACC Funding bypasses MoH central
GAVI-HSS	Started in 2006 Mission = to alleviate health system bottlenecks which impede immunization and impact child/maternal health care	One coordination unit, apart from national immunization program	As of 04/2011, disbursed 7 million USD Financial management by MoF, but funding 'lost' in 2011 Since then, WHO manages the funding

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	HISTORY/MISSIONS	GOVERNANCE	FUNDING SOURCE OR BUDGET
Group 5: United Nations family			
WHO	Missions: consultative and catalyst roles (such as for DHS implementation or IHP+) and technical assistance (policy and plans elaboration)	One country representative and four departments: child/adolescent and reproductive health; transmissible and non-transmissible diseases (including implementation of the 3x5 strategy); emergencies; health systems	Provides one-off funding and technical assistance to MoH Budget from member states and private donors
UNAIDS	Launched globally in 1996 in replacement of WHO global program for AIDS	Two working groups at country-level in Burundi: UNAIDS and extended UNAIDS WG	Provides once-off funding Budget from member states and private donors

5.2 MULTIPLE, HETEROGENEOUS AND CHANGING ACTORS

The selected organizations differed in terms of the roles they were playing vis-à-vis aid: they could be donors or recipients and/or coordinators and/or implementers. Sometimes one single organization took on more than one role simultaneously. For instance, the PES-NAC used to be the principal recipient for GFATM-HIV; they were responsible for hosting and paying the GFATM-HIV funding coordinator and for implementing activities out of these funds.

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A number of selected organizations were not ‘organizations’ *stricto sensu*, but entities or part of a larger organization. They were nevertheless considered as organizations for the purpose of this study, since they functioned independently from their ‘mother-organization’. For instance, all five of the MOH’s vertical programs were considered as separate ‘organizations’ because of their relative autonomy, both in terms of financial and programmatic management.

Some organizations such as GHIs were global-level organisations, operating as financial instruments, sometimes without any country representative. These organizations’ core principles were to increase recipient countries’ ownership, by precisely letting countries take the lead on funds management. For this study, however, they were considered country-level ‘organizations’, since most of them had a coordinator at country level (GFATM, GAVI-HSS) or had a country representative (WB), with clearly individualized physical offices. Moreover, on the ground, interview

participants clearly distinguished GFATM-HIV, the TB and Malaria programs, as well as GAVI-HSS as individual organizations.

Following global priorities regarding HIV and at the instigation of UNAIDS and the WB, two main institutions and several units were created in 2001/2002: the MoA, PES-NAC/NAC and HIV sectoral units in each Ministry, including the MoH. The institutional place of MoA was unstable, however, with much reshuffling since its creation. The NAC was structured on the same pattern as the MoH, with provincial and local councils (corresponding to the smallest administrative units, the hill) (see Appendix 19 for further details). The following excerpt from an interview clearly illustrates the history of institutional changes and influences at HIV/health sectors levels:

> *"When the WB decided to inject funds in AIDS in sub-Saharan Africa, it launched projects known under the name of MAP. As far as Burundi is concerned, the MAP was already put in place and since substantial support was expected, the WB and the government agreed to create the MoA.*
>
> *"Then it was decided to put the MoA on an upper level by having it depend on the president's office. In this context, it was taken as a president's office service which could refer [down] to further ministries to implement its action plan. Then an implementation government organ was created in order to tackle AIDS issue under the name of NAC. Its manager was the President of the Republic, its deputy manager the Vice-President of the Republic. Afterwards, a day-to-day management organ was put in place to deal with AIDS activities and funds under the name of Permanent Executive Secretary of the NAC.*
>
> *"In addition to that, sector units were created in each ministerial department, province and commune where an AIDS committee was put in place. This committee was planned on the village level to meet decentralisation requirements. Everything was put in place by late November 2002 […].*
>
> *"As said above, the WB had already given its green light go to finance operational costs of this organ. Owing to a government reshuffle, the MoA*

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was connected to the MoH [in 2007], turning the MoA [into] a Vice-Ministry in charge of AIDS. At present, the MoH is separated from the MoA without having it depend on the president office.

". (ITW11-12N09, group 4, local)

Two new vertical programs were also created, following the awareness of the issues at global level: the Malaria National Program was created in 2008, possibly related to the emergence of global funding for this issues (GFATM); the Reproductive National Program was created following a regional conference on reproductive health in 1998.

5.3 MULTIPLICITY OF NGOS, OUTPERFORMING MOH – DURING THE CONFLICT FOR PHC AND AFTER THE CONFLICT FOR HIV ACTIVITIES

Two main factors, which coincided chronologically, acted against an active coordination of NGOs on the part of the government (MoH).

The first factor was that during the war, NGOs clearly dominated health service delivery. They were mostly international (MSF, International Red Cross, Health Net-TPO, Cordaid, Mimiza) – and managed to provide civilians with some continuity in terms of emergency health care, free of charge. They supported public facilities which had experienced an acute brain-drain through maintaining declining infrastructures and equipment, or through providing care in stand-alone facilities (e.g. MSF for deliveries). Local populations appreciated the quality of their services and trusted them, in contrast to public services which became unreliable as the conflict deepened ("Rapport d'achèvement du MAP1" 2009). NGOs also provided a relatively even geographical coverage, even in unsecure areas which were heavily affected by the war, given their experience in conflicted settings ("Rapport d'achèvement du MAP1" 2009).

The discrepancy in the utilization of NGOs facilities between compared with public ones became even more acute when user fees were established by the government in 2002, in reaction to the state's continuously worsening financial situation (Philips et al. 2004).

At the end of the war, some NGOs closed down while others stayed in order to help with health system rehabilitation in the public sector. Some NGOs shifted from providing humanitarian to HIV care, implementing the first HIV activities which were

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mainly preventative and rehabilitative. At the same time, new NGOs, both local and regional, were created around HIV activities. This latter specialization of NGOs in HIV constituted the second factor inhibiting coordination:

> *"The fight against AIDS was intensified in Burundi at the most critical moments of this country's socio-political life. Because of the war, many structures were not in good shape, there was a kind of absence of structuring namely in public sectors. The civil society has gained some momentum at the moment when the public sector was a little bit absent…" (ITW19N09, group 4, local)*

There were two reasons why some NGOs shifted their activities from emergency to HIV. At the beginning of the HIV funding (2001-2002), the nature of HIV activities was mainly preventative since ARVs were still not available at low cost in Southern countries; and the MoH was not considered competent to undertake prevention activities. Indeed, donors and aid implementers did not consider that the public health sector had the necessary capacities to implement HIV activities, given the disastrous impact of the war. Hence, NGOs soon specialized in HIV and expanded their scope of activities from HIV prevention to ARV provision, when generic ARV became available.

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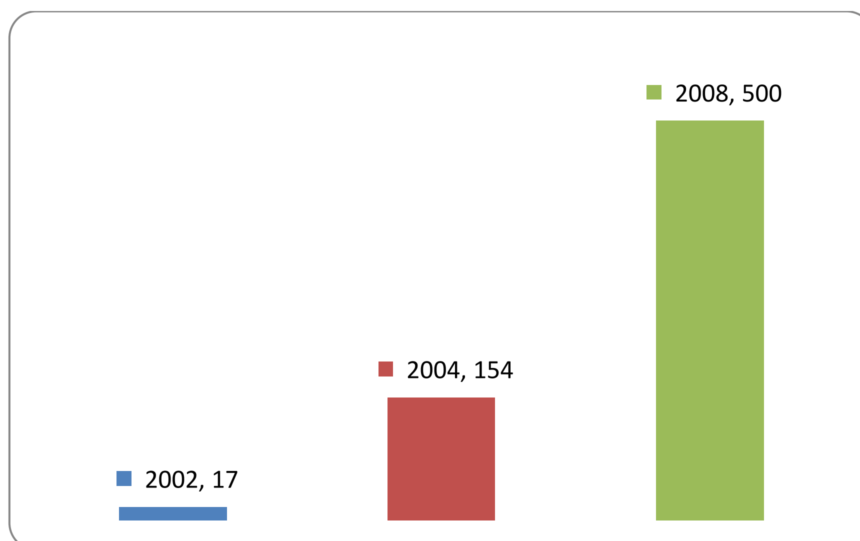
> *"I rather think the issue was that MAP1 and GHIs, they came in with a lot of money – and I think it was about … double or triple of the overall budget of the MoH which deals with all the health conditions and the health system; and these so important amounts have been utilised for some diseases only. […]*
>
> *"I don't know whether it was due to the [institutional] restructuring, which took place at the beginning with respect to HIV, was inappropriate: another ministry was set up and the MoH had to intervene by begging the contribution of associations to wage prevention actions, to provide treatment against HIV, while even authorized public structures existed but were not utilised. I don't know who has forgotten who, but obviously, after a thorough analysis, I have concluded that they have been…I don't know whether they excluded themselves or if they have been excluded." (ITW13N09, group 1, local)*

The resulting NGOs landscape in Burundi was very heterogeneous: a number of NGOs were operating throughout the country with the MoH unaware of their existence; NGOs had differing scope of activities, given the extensive gaps in the public sector, from HIV to PHC. NGOs were mainly accountable to their donors and were not easily accessible to a governmental coordination organ, even if it had existed. In order to reach their objectives and to secure funding for the following year, each NGO set up their own HRH policies (e.g. by recruiting their own HRH or by topping up salaries of HRH in the public sector). Some of those NGOs and CSOs which specialized in HIV were funded by MAP1 or GFATM-HIV, through PES-NAC.

The number of local NGOs and CSOs grew rapidly, from 17 in 2002 to 154 in 2004 and over 500 in 2008 (see graph below) (SEP-CNLS 2009; SEP-CNLS 2005). These structures performed very well, in terms of timely budget disbursement and activity implementation, justifying a budget reallocation of +76% ("Rapport d'achèvement du MAP1" 2009).

Figure 14: Evolution of the number of local NGOs and CSOs between 2002 and 2008



Both the multiplicity of NGOs and their differing natures hampered their coordination. The mid-term review of the national AIDS Plan 2002-2006, ordered by the PES-NAC

and conducted by a team of five consultants led by an international expert, pointed out that despite CSOs being “leaders in HIV medical care and prevention”, some CSOs “operate alone”, and that there is a “lack of coordination between them” (SEP-CNLS 2005). A bill was drafted in 2008 in order to make mandatory the registration of international NGOs (Gouvernement du Burundi 2008b), but it was made law only in 2011 and under the pressure of donors (IHP+). Interestingly, the registration had to be done with the Ministry of Foreign Affairs, and not with the MoH.

> *“Those who benefit the most [from international HIV funding] are international NGOs. They get registered with the Ministry of Foreign Affairs and the MoH is not aware. The MoH complains a lot about this. Back to [the] time of Minister XX, I tried to help her planning a meeting of all NGOs in order to gather their strategic plans, but we failed. Now they are thinking about an MoU, that each NGO will sign with the province governor, and they will check if the MoH is aware of their existence, as well as whether they fit in the NHP” (ITW23N09, group 5, local).*

When NGOs were about to close down, donors were called to fill the gap so that population would not be left without coverage. These handovers needed to happen very quickly, leaving no time for proper coordination between donors on HRH hiring conditions, for instance (Cordaid and EC in Ruyigi province).

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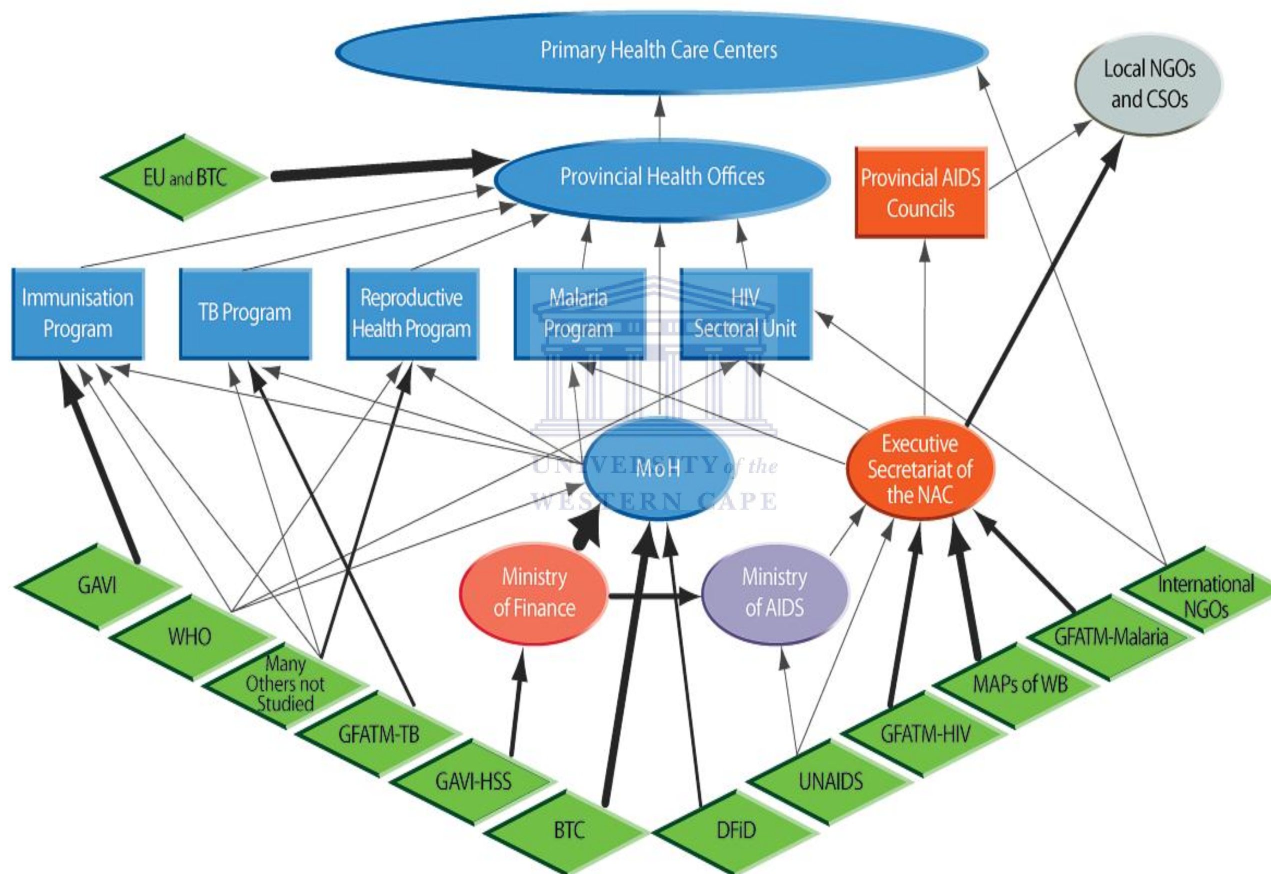
5.4 COMPLEX FINANCIAL AND ACCOUNTABILITY CHANNELS

The complexity of institutional changes sketched above is matched, if not surpassed, by the complexity of financial channels and relationships. This is presented in Figure 15 below which I created using data from document analysis and which captures qualitative channelling as well as the relative weights of funding. Accountability channels are exactly the inverse flow of financial channels.

Figure 15:
Synthesis of financial channels between the selected 19 organizations and some other key organizations (local NGOs, Ministry of Finance), as of 2008 *(own creation)*



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Blue: governmental organizations **Green:** donors' organizations **Orange:** AIDS council organizations
Bold arrows: financial flows over 1 million USD for 2007, with size of arrow being proportional to the amount

The MoF distributed funding to the MoA and the MoH central according to their negotiated annual budget (mainly recurrent costs). BTC and DfID, and to a much lesser extent WHO, were the only donors directly supporting the MoH central. UN agencies such as WHO or UNAIDS did fund vertical programs on a once-off basis, to cover financial gaps or in the case of emergencies (such as epidemics).

In contrast to the literature, GFATM in Burundi cannot be considered a single organization but rather as three different organizations, corresponding to each of the three diseases to which it contributed. While the three components had similar principles, especially with regard to funding application procedures and eligibility, the management differed greatly from one component to another. The difference was significant with respect to the selection of the principal recipient (PR) by the GFATM: while the National TB Program became logically the PR for the GFATM-TB grant, the PES-NAC was given the role of PR for GFATM-HIV grant (together with the MAP grant) and, more surprisingly, also for GFATM-Malaria.

Heavy funding eligibility criteria, combined with a high degree of mistrust towards the MoH and 'the government' in general with regards to funding management, led to the funding dedicated for HIV to completely by-pass the MoH, with only a small amount going to the health sector HIV unit. This mistrust from donors towards government is one key factor which contributes to low financial capital and low ability to mobilise financial capital at MoH level, as we will see later.

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Some programs, such as reproductive health or TB, had greater latitude for financial management compared to others, despite being located at the same level in the MoH organogram. The Reproductive Health Program was directly attached to the Cabinet, which facilitated funding's request and procurement, whereas the National TB Program managed its own GFATM-TB funding. Both programs also received direct funding from other donors.

Malaria and immunization programs had to go through more rigid financial management systems. The Immunization Program receives funding from GAVI as a form of reimbursement upon implementation of vaccinations and is subject to tight monitoring by the IACC. The Malaria Program is under the management of GF-malaria coordination, and is only one of the numerous sub-recipients of GF-malaria funding, along with NGOs and CSOs.

5.5 DONORS' OWN ORGANIZATIONAL STRUCTURE AND PROGRAMMATIC APPROACH

The programmatic approach, as adopted by the National Health Plan, focused on programs indicators. The main donor and funding agencies based the program performance measurements on specific indicators and on disbursements ratios, usually included in a logical framework. Disbursements rules were the same from one country to another, set as a blue-print approach, as for GHIs. Program plans and funding proposals were developed around targets to reach, usually in a quantitative way and budget items were related to these targets.

While these issues were similar in many countries, consequences were more severe in terms of the disorganization of the health system in Burundi for instance, where the lack of HRH was an alarming issue and priorities were numerous (Cailhol et al. 2013). Government staff were overwhelmed in meetings, with each partner being willing to start working in the country at different moments.

The different programs' plans, the cooperation plans of different donors, the funding proposals and the national health policy document timelines did not coincide, either in terms of length or in terms of period covered (see Figure 3 on planning documents coverage). Donors were therefore unable to wait for each other to start their activity planning as they had to follow their country directives, as well as their own donors' exigencies, in an era where the levels of accountability has much increased.

Even within the HIV sector, components and objectives of MAP1 projects and the HIV plan did not necessarily correspond, producing difficulties of coordination with projects other than the ones funded by the WB (SEP-CNLS 2005).

Even the different organizations within the UN system could not coordinate to have the same planning timelines, putting a strain on country-level coordination:

> *"Ban Ki Moon may say two years for everyone. But for the UNDAF [United Nations Development Assistance Framework] it is five years, for the UNIFEM [United Nations Development Funds for Women] it is three years, for UNAIDS it is two years - 2008-2009. It is treacherous because government does not have enough HRH. They would need one person for each UN organization, but it is impossible. The UN system will then*

focus on one person and this person will be scattered and cannot work properly." (ITW23N09, group 5, local)

Moreover, the planning procedures were different from one donor to another, adding work to the already constrained HRH at MoH level, and leaving no intellectual space for coordination 'thinking'. Some donors based their functioning on the performance of the country team and, for instance, assessed the timeliness of a grant submission, without waiting for other donors - thus undermining coordination (e.g. the WBG).

5.6 CREATION OF A CROSS-SECTORAL MINISTRY OF AIDS

HIV was considered not only a health-related issue, but an issue pertaining to all sectors. The existence of a specific strategic line corresponding to HIV in the PRSP (see Figure 2), justified the creation of the Ministry of AIDS - located in the President's office so as to be hierarchically higher than other ministries so that it might play a cross-sectoral role.

[The creation of MoA] …was to make HIV predominant and visible. It was a political concern. This was even imposed by the WHO and UNAIDS so as to ensure the ownership of HIV issue by the government. Nevertheless, the government was reluctant to accept this - as in many other countries. We were told that HIV is a multisectoral problem and it was advocated to the MoA should be linked directly to the Presidency. (ITW2N09, group 5, local)

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When HIV was defined at global level as a priority and emergency, a large amount of funding became available, especially through GHIs (Samb et al. 2009). At the end of the war, Burundi applied for this funding, while the entire health system was in dire need of funding. Burundi was certainly willing to fit into the global discourse of HIV as an emergency; and indeed HRH and HSS were not yet set as a priority on the global agenda (Piva and Dodd 2009). The country therefore had to adapt to this discourse to obtain this funding, after many years of crisis and embargo. Presenting the HIV epidemic in Burundi as an emergency and as a fight against poverty (though justified to a certain point), could be seen as fitting in to the global political discourse in order to obtain funding.

This could be considered retrospectively as the starting point to the AIDS exceptionalism which prevailed in the country for some years, following the end of the conflict. Subsequently, specific HRH policies were created which supported the implementation of HIV activities. This exceptionalism was further facilitated by the relative ‘void’ of HRH policies and planning at MoH level (a legacy of the pre-conflict structure). Coordination of HIV activities by the health sector was thus difficult and perpetuated a parallel system for years.

Introduction of HIV activities, first focussing on prevention, marginalised the MoH and gave a strong role to the Ministry of AIDS. The curative activities came afterwards, first initiated by NGOs. Naturally, the first funds allocated to HIV treatment were allocated to NGOs, which had accumulated experience, giving little space to the MoH to coordinate. There was to some extent a contradiction between the sector-wide approach and the intersectoral approach. MoH was considered as not having the capacity to deal with inter-sectoral coordination and was replaced by MoA and PES-NAC. MAP2 of the WB was negotiated to be channelled through MoH.

> *“We collaborate with various sectors and we are aware that the most crucial sector in the fight against AIDS is certainly the MoH. But the sanitary dimension is not the only one catered for. In the mobilisation of resources, we must also consider needs of other sectors, namely vulnerable populations such as orphans of whom we are taking care for. […]This is a dimension not handled by the MoH, but related to other ministries, which need also to be supported by us [PES-NAC] or by other civil society actors. So, whatever the position of these ministries is, we, in our PES capacity must cooperate with all actors and each of them seems to have a well-defined place in the strategic plan. Otherwise whatever we said about being in line [with] the Paris Declaration etc. - all are good orientations for us. This will enable [us] to put together resources for a given sector at the level of the MoH, which deals [with] health business. And we are aware that is it the proper way, even for MAP 2….”*
> *(ITW16N09, group 4, local)*

This first findings chapter introduced the 19 main organizations involved in aid relating to health broadly, in the immediate post-conflict period in Burundi. It

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highlighted the main features of the functioning of donors and recipients in terms of financial management and governance. This chapter set the complex scene of organizations, all with differing missions, governance, accountability, functioning. It is clear already that the MoH was left aside by NGOs and HIV-related organizations, purposefully or not, and this preliminary finding will be further developed in the following chapters (especially in chapters 7 and 8).

CHAPTER 6: FINDINGS PART 2, HRH POLICY CONTENT AND PROCESS ANALYSIS

While an initial snapshot of the miserable landscape of HRH in the aftermath of the civil war was given in Chapter 2 on 'context, the 19 organizations presented in the previous chapter all had, to a variable extent, explicit or implicit policies related to HRH – one on supply, another on salaries etc. We understand the detrimental effect that this multiplicity of HRH policies might have on HRH, in the absence of any coordination. This chapter will strive to analyse the existence and extent of coordination of HRH policies across organizations and will provide some key process-related factors contributing to explain its insufficiency.

6.1 NATIONAL PRIORITIES IN TERMS OF HRH IN 2005

The National Health Development Plan was read using the grid of HRH, as a baseline for the policy content analysis. The Plan 2006-2010 was built around four general objectives: three were pertaining to specific diseases or areas and one to health system strengthening. The setting of these four objectives has been influenced*, inter alia*, by the MDGs.

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In order to achieve each general objective, specific objectives were set, and amongst these, ones related to HRH. These were extracted and displayed in the Figure 16 below – which shows that the four specific objectives are exactly those mentioned in the NHP, whereas the HRH objectives were found amongst other policies, under each specific objective, as a means to reach this general objective.

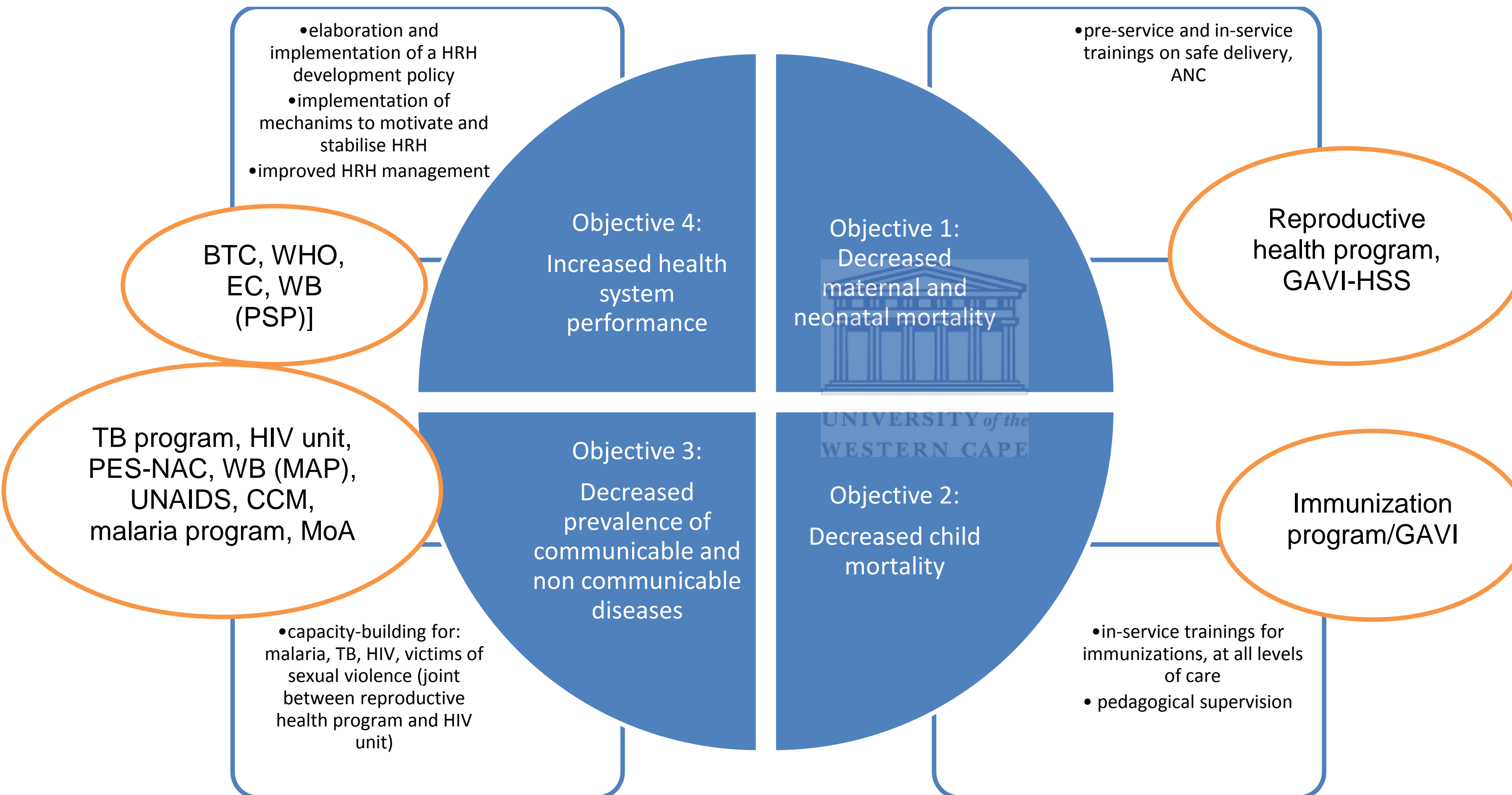
Donors were split across these four objectives, with different types of funding and clear frontiers existing between disease-orientated organizations (vertical programs of MoH, GHIs) and non-disease orientated organizations (EC, BTC, WHO). As a result, there was no 'physical' space for all aid organizations to meet and no willingness to coordinate them ever appeared.

In addition to these clearly denominated policies, other policies were found scattered in the planning documents. All were categorized according to the four HRH domains and included in the policy content analysis.

In parallel, two general health sector policies and one HRH policy, which were not part of the initial 2006-2010 National Health and Development Plan, were implemented in order to fit with national priorities. These were:

- the removal of user fees for children under 5 and for women giving birth (May 2006);
- district health system implementation plan (2007); and
- pay for performance policy (P4P) (December 2006).

Figure 16:
The four general objectives of the National Health Plan 2006-2010, the related HRH strategies of the selected organizations



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Blue boxes: HRH policies related to objectives

Orange circles: organizations in charge of implementing HRH policies described in blue boxes

6.2 OVERVIEW OF HRH POLICIES

From a total of 59 policy and planning documents gathered from the 19 organizations, we tracked down and analysed explicit or implicit policies strictly referring to HRH between 2002 and 2008. Policies were classified according to Martinez and Martineau's four dimensions and according to the three steps of the policy cycle: problem identification, policy formulation, policy implementation. For each organization, we developed a table with 12 cells: 4 policy dimensions X 3 policy steps.

HRH policies of these organizations were then compared to the National Health Plan's HRH policies and cross-compared in order to assess coordination. The process is drawn in the Figure 17 below.

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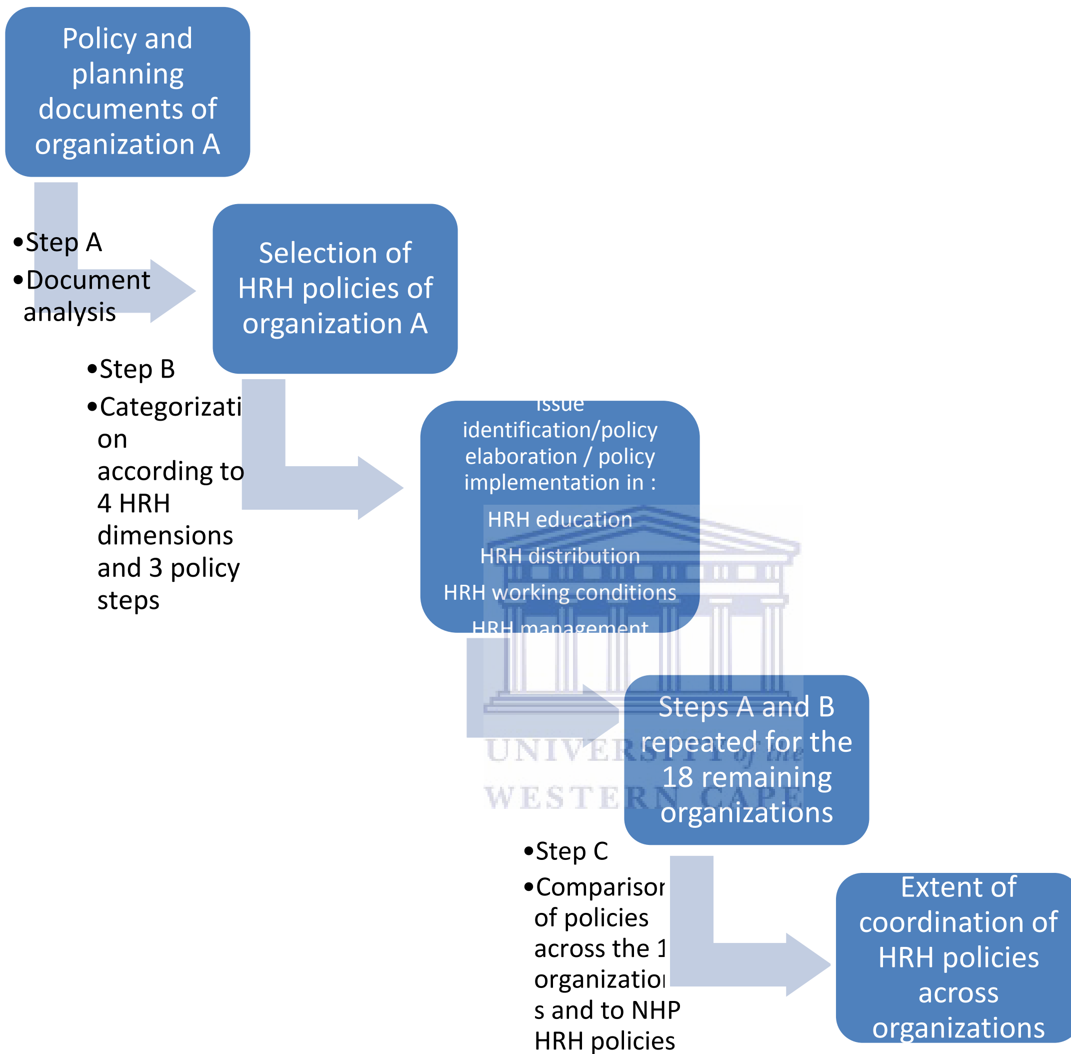
Figure 17:
Comparison between HRH policies of the 19 selected organisations and the National Health Plan



Documents' details, as well as their policy/planning documents or funding applications elaboration processes were regrouped in Table 5, displayed according to the organization in charge of their elaboration.

Table 5:
List of documents consulted,
with their elaboration process highlights, according to the organization

Organization in charge of document elaboration	Policy and planning documents consulted	Policy elaboration highlights	Corresponding evaluation documents consulted (independent or not)
MoH central	National Health Plan 2005-2015 National Health and Development Plan 2006-2010 and its attached financial plan HRH pay-for-performance policy (2006)	National Health Plans: bottom-up approach, according to health forum priorities set in 2004 Elaborated by a multisectoral team and national/ international consultants Financial plan and P4P elaborated by an international consultant	Report on technical assistance for HRH management (2005) HRH analysis from MoH-WHO (2008) Evaluation of national health plan 2006-2010 (2011)
National TB and Leprosy Program	National TB strategic plan 2007-2011	2001-2005 plan elaboration halted by the civil conflict 2007-2011 plan elaborated after the National Health Plan 2006-2010 Aligned with stop TB partnership and MDGs International and national consultants hired for elaboration	Annual activities reports on TB program 2007-2008
Health sector HIV unit	National HIV unit plan 2008	Annual activity plan elaborated according to funding obtained or to seek Participated to HIV strategic plan	National HIV unit activities report 2007
National Malaria Program §	National Plan against Malaria 2008-2012	No plan before 2008 (no specific program) Technical support from WHO for its elaboration	NA
National Reproductive Health Program	National Reproductive Health Strategic Plan 2008-2012	No plan before 2008, but only annual activities reports Technical assistance from UN bodies plan elaboration	Annual reports on national reproductive health program 2005 to 2007 (no plan)

§ This program was created only in 2008

Organization in charge of document elaboration	Policy and planning documents consulted	Policy elaboration highlights	Corresponding evaluation documents consulted (independent or not)
National Immunization Program / IACC (GAVI)	GAVI /Immunization Program Multi-annual Plan 2002-2006 GAVI /Immunization Program Multi-annual Plan 2007-2010 GAVI / Immunization Program Annual Plan 2007	Multi-annual plans were turned into annual plans, with activities planned according to the level of certainty of funding retention IACC coordinates grant application elaboration	Immunization plan /GAVI annual report 2006
BTC	Indicative collaborative program 2003-2005 Technical and financial document for Kirundo project Institutional support project document	Embassy identifies priorities while cooperation elaborates policy and implements	Analysis of BTC contribution to Burundi 1996-2002 (OAG)
DfID	NA	NA	NA
European Commission	EU Cooperation Strategy and National Indicative Program 2003-2007 LRRD 'santé plus' project document (EDF10)	National indicative program joint elaboration between global/national levels and according to national and EC priorities Projects elaborated by international consultants	EU-Burundi Joint annual report (2002) Note on the situation in Burundi-UE (2007)
World Bank	Second Health and population project (PSP2)* MAP1 proposal	PSP and MAP elaborated by international consultants, fitting the country assistance strategy (CAS) CAS negotiated between GoB and WB representatives	PSP2 report* Final report on MAP1 implementation MAP1 implementation completion and results report* (2009)
MoA	No specific document available	NA Participated in HIV strategic plan	NA

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Organization in charge of document elaboration	Policy and planning documents consulted	Policy elaboration highlights	Corresponding evaluation documents consulted (independent or not)
PES-NAC	National Strategic Plan against HIV 2002-2006* National Strategic Plan against HIV 2007-2011 National Strategic Plan for HIV M&E 2007-2011	Strategic plans elaborated through a participative and inclusive process led by GoB	Annual activities reports of national strategic plan against HIV: 2003 to 2008 Mid-term review of the implementation of the national strategic plan against HIV 2002-2006 (2005)
GFATM/CCM	Funding proposals for: GFATM-HIV (RIBUP, 2003-2006* and APRODIS, 2006-2010) GFATM-malaria 2003-2006 and its RCC 2006-2008 GFATM-TB 2005-2010	CCM gathers before grant application and nominates *ad hoc* working groups in charge of sub-sections	Grant performances reports GFATM-HIV* GFATM-malaria* GFATM-TB* CCM retreat report 2008 Annual report on the RCC 2007-2008 (GFATM-malaria)
WHO	WHO Country Cooperation Strategy 2005-2009 WHO Health Sector Reform Strategy (2006)	Elaborated through multi-level and participative process Aligned with 10 different frameworks	NA
GAVI-HSS	Proposal for GAVI-HSS support (2006)	Elaboration coordinated by IACC	GAVI-HSS evaluation (2009)
UNAIDS	3 by 5 Initiative 2004-2005	Adapted from the global 3 by 5 strategy	NA
Others			Evaluation of the impact of the removal of user fees on the quality of care among pregnant women and children under 5 (OAG)

*All documents were written in French except for those marked, which were written in English

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Tables 6 to 9 summarize the different HRH policies according to the four HRH dimensions and to the three steps of policy cycle and to each organization.

All these HRH policies emanating from the NHP were taken as reference (represented in the first line of each table from Tables 6 to 9).

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Table 6: Human resources for health (HRH) supply policy cycle by organization

(from documents analysis as per table 5)

Organization	Issue identification	Policy formulation	Policy implementation
MoH central	Shortage at all levels Geographical misdistribution	Increase in production Decentralization using incentives Increase HRH mobilization Use of HRH from bilateral cooperation Increase financial support to HRH through mobilization of partners	Production of MD increased Importation of MD from China and Egypt Decentralization policy according to the constitution of 2005 (pending) PSP2 and then HIPC served to delocalize MD to rural areas
TB and leprosy program	Insufficiency of HRH skilled in TB	Recruitment of management staff (TB) Integration of HIV/TB/malaria activities	Management staff recruited at provincial level
Malaria program	Insufficiency of HRH skilled in malaria (technical and institutional)	Recruitment of additional staff	0
Reproductive health program	Insufficiency of HRH skilled in family planning Overconcentration of HRH in urban areas	0	0
Immunization program /GAVI	Shortage of HRH in rural areas	0	0
HIV unit of MoH	0	0	0
National HIV plans (PES-NAC)	Lack of HRH skilled in HIV in public sector	Recruitment of management staff (HIV) Dedicated staff for HIV Decentralization using incentives New cadre of HRH HRH strengthening	HIV management staff recruited at central level Dedicated staff for HIV with incentives or contracted by PES-NAC Health mediators as new cadre of HRH (for HIV)
UNAIDS	HRH crisis to undermine ARV scale-up	Clinical sessions for HIV Deployment from other services to HIV services Task-shifting Financial incentives PPP with NGOs Improve planning	Clinical sessions in HIV-related NGOs
GAVI-HSS	0	0	0
EC	0	0	0
BTC	Shortage of skilled HRH	Waiting for HRH decentralization by MoH	Waiting for policy to be active
WHO	Geographical misdistribution of HRH Deficit of skilled HRH	0	0
World Bank	HRH skilled in HIV out of public sector	Greater GOB fiscal support to health system, HSS through PSP2	Foreign professors for medical school with PSP2

MD: medical doctors

HIPC: heavily-in-debt countries initiatives

PSP2: projet santé et population 2 of the World Bank (health and population project 2)

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Table 7: Human resources for health (HRH) education policy-cycle by organization

(from documents analysis as per Table 5)

	Issue identification	Policy formulation	Policy implementation
MoH central	Low quality of HRH Lack of coordination of in-service trainings Inadequate pre-service and in-service trainings	Revise pre-service training curricula Increase in-service trainings (HIV, malaria, reproductive health, TB, PHC, immunization) Elaboration of a HRH development policy	No curriculum revision for medical school Curriculum revision to start in 2009 for nurses (BTC) HRH development policy elaborated in 2010 (Swiss)
TB and leprosy program	Low quality of HRH	In-service trainings in TB HIV-TB joint trainings MoH to strengthen its HRH Add HIV-TB to medical school curriculum	In-service trainings provided on TB
Malaria program	Low quality of HRH	0	0
Reproductive health program	In-service trainings: - not efficient - benefits low	In-service trainings on reproductive health	In-service trainings on reproductive health with GAVI-HSS funding
Immunization program /GAVI	In-service trainings: - too centralized -benefits low	Regular in-service trainings on vaccines Elaboration of an annual training plan Decentralize trainings	In-service trainings on vaccines
HIV unit of MoH	Poor implementation of in-service trainings	Partners to coordinate for in-service trainings (on HIV)	In-service trainings on PMTCT, ARV
National HIV plans (PES-NAC)	In-service trainings: -lack on HIV topic -not standardized	In-service trainings for HIV MoH to strengthen quality of trainings Strengthen pre-service trainings	In-service trainings on HIV Creation of a national reference center for HIV (trainings' coordination, decentralization and harmonization)
UNAIDS	In-service trainings not standardized	To add HIV in pre-service curriculum In-service trainings on HIV Standardization of in-service trainings	In-service trainings for HIV

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GAVI-HSS	Low skills amongst technical staff	Emergency obstetric care trainings in 4 provinces	See reproductive health
EC	Too many in-service trainings without benefit	No in-service trainings in the 4 provinces supported	0
BTC	Low skills in general	In-service trainings on PHC in 1 province	In-service trainings on PHC in 1 province
WHO	Inadequate pre-service trainings Lack of coordination of in-service trainings	0	0
WB	In-service trainings: -insufficient on HIV topic -not standardized	Capacity-building in HIV (MAP1)	In-service trainings on VCT, STI, PMTCT, OI, ART (MAP1)

Table 8: Human resources for health (HRH) working conditions policy-cycle by organization (from documents analysis as per Table 5)

Organization	Issue identification	Policy formulation	Policy implementation
MoH central	Low wages in public sector Inappropriate incentives Rigid salary grid	P4P policy Advocacy towards donors District implementation (2007) Mechanisms to motivate and stabilize HRH	P4P in 4 provinces with Cordaid
TB and leprosy program	Low wages in public sector Heavy workload Low morale	P4P in TB program at central level (with donor funding)	P4P at central level Financial incentives to attend trainings
Malaria program	NA	NA	NA
Reproductive health program	Low morale in public sector High turn over		P4P at central level Financial incentives to attend trainings
Immunization program /GAVI	Low wages in public sector High turn over Heavy workload	P4P for all	P4P at central level Financial incentives to attend immunization trainings
HIV unit of MoH	NA	NA	Financial incentives to attend HIV trainings
National HIV plans (PES-NAC)	Low morale Heavy workload in rural areas Low wages in public sector High turn over	Financial incentives for specific tasks (HIV) Donors to support HRH financially Professionalization of NGOs GFATM-HSS grant application Clinical sessions for HIV with P4P	Top-up salaries for HIV management staff at central level Financial incentives to attend HIV trainings GFATM-HSS proposal rejected Clinical sessions for HIV with P4P
UNAIDS	Low wages in public sector	Financial incentives for HIV tasks	Financial incentives to attend HIV trainings
GAVI-HSS	Low wages and low staff morale	P4P in 4 provinces	Financial incentives to attend trainings Top-up drivers salaries Approached Cordaid and TPO for P4P in 4 provinces
EC	High turn-over due	P4P in 4 provinces	P4P in 4 provinces

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	to low wages		
BTC	High turn-over due to low wages	P4P in 1 province	P4P in 1 province
WHO	Low wages in public sector	0	0
WB	Low wages in public sector	Increase salaries with PSP2	Financial incentives to attend HIV trainings (MAP1) Top-up salaries for faculty prof (PSP2) and HIV management staff (MAP1)

Table 9: HRH management policy cycle by organization
(from documents analysis as per Table 5)

Organization	Issue identification	Policy formulation	Policy implementation
MoH central	Poor HRH management Management too centralized Difficulty to manage some units and hospitals with an exceptional statute	Improve HRH management Create a HRH Directorate	HRH Directorate created
TB and leprosy program	Lack of supervision Lack of task delineation	Recruitment of supervision staff at provincial level (TB)	Provincial staff for TB recruited in 8/17 provinces
Malaria program	0	0	0
Reproductive health program	0	0	0
Immunization program /GAVI	Lack of supervision by provincial level	Increase pedagogical supervision	Not all supervision missions achieved by lack of resources
HIV unit of MoH	0	0	0
National HIV plans (PES-NAC)	Loose and inadequate supervision	Donors to increase their support to management	0
UNAIDS	0	0	0
GAVI-HSS	0	0	0
EC	Poor management	P4P	P4P in 4 provinces
BTC	Poor management	P4P	P4P in 1 province
WHO		District implementation	Districts started to be implemented
WB	Lack of supervision at provincial and facility-level (MAP1)	To invite partners to complementarity of supervision and partnerships	0

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6.3 HRH POLICY COMPARISON ACROSS ORGANIZATIONS AND PROCESS-RELATED FACTORS INFLUENCING COORDINATION

HRH policy coordination was synthesized according to the four policy domains and by type of coordination in Table 10. Process-related factors inhibiting coordination were also described here, and linked to each step of the policy cycle.

At times findings were generalized to coordination in the health sector, even if we drew on examples from HRH policies. Six types of coordination appeared from data analysis and some are illustrated in by specific examples at the end of this section.

1. Coordination type 1 is the one presented in the methods section (figure 13), and constitutes the ideal coordination, against which policy process across organizations was compared. This type of coordination was found only once in our findings– about a joint decision over, and implementation of, training between two vertical programs.
2. Coordination type 2 corresponds to a beginning of coordination, where one decision is taken derived from multiple visions (incorporating them to a certain extent or not) and to which all actors adhere. However, for a number of reasons, the decision might not be translated into action.
3. Coordination type 3 is similar to type 2, with a coordinated decision, but actors diverge again when it comes to actions, as if they look for ways to get around the decision (illustrated in case study 1).
4. Coordination type 4 is a case of coordination at action and implementation levels, when decision makers are different from implementers.
5. Coordination type 5 is a case of partial coordination (illustrated in case study 2).
6. Eventually coordination type 6 is when there is no coordination from decision to action.

Factors which strongly influence the selection of one type of coordination over another relate to process, actors and context, as detailed above and in the next chapters. The word ‘selection’ is used here purposefully, since sometimes one type of coordination is naturally ‘selected’ by the context, or is naturally used by actors without consciously forcing it. It is therefore more a case of ‘passive’ coordination. When’ for instance’ local stakeholders say “we wait [for] donors to coordinate themselves” (ITW 11-12N09), it is a case of passive coordination.

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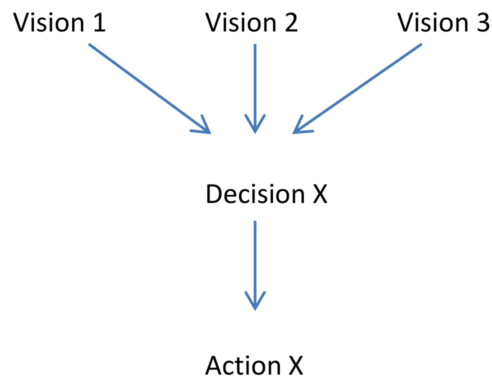
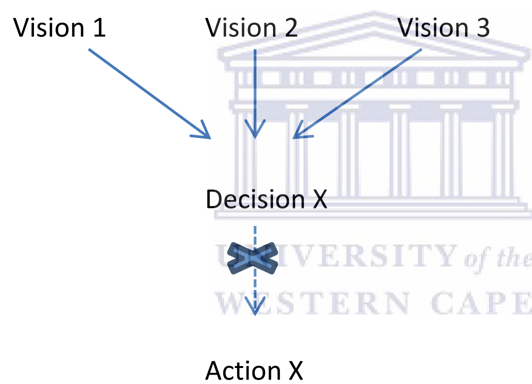
Figure 18:
The six types of coordination arising from data analysis



Type 1: coordinated policy formulation and implementation



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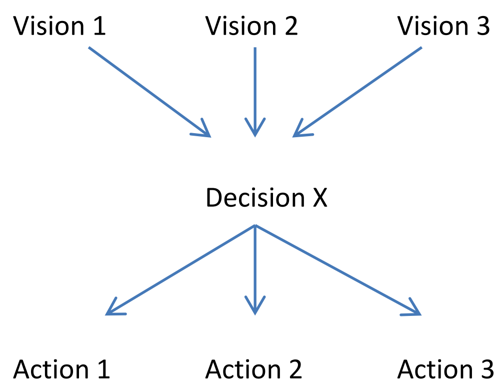
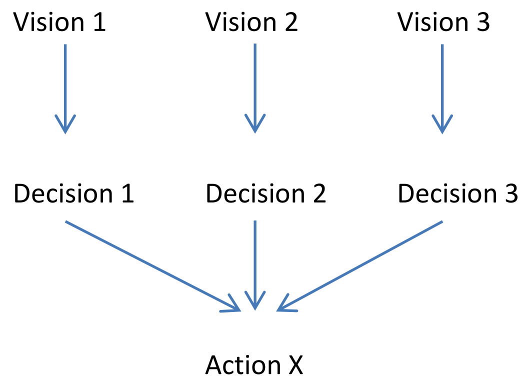
Type 2: coordinated policy formulation without implementation

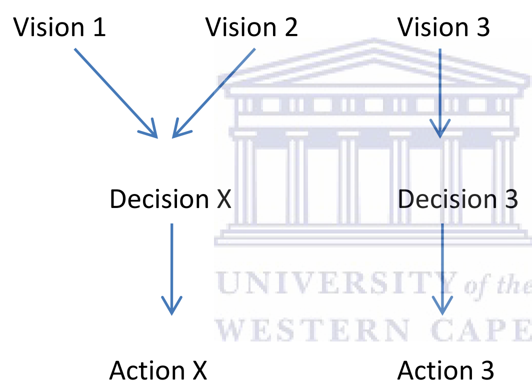


Type 3: coordinated policy formulation but uncoordinated implementation

Figure 18 (continued):
The six types of coordination arising from data analysis



Type 4: uncoordinated policy formulation but coordinated implementation



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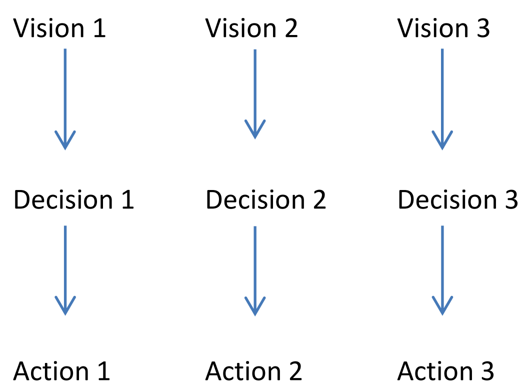
Type 5: partially coordinated policy formulation and implementation



Type 6: uncoordinated policy formulation and implementation

Table 10: Extent and type of coordination of human resources for health (HRH) policy formulation and implementation stages, by HRH domain

	Extent of coordination of policy formulation	Extent of coordination of policy implementation	Coordination type
HRH supply	Similar formulation of HRH supply policies, according to each program's needs	Non coordinated recruitment for targeted positions, across public/NGOs and programs, task-shifting limited to HIV tasks	6
	Shared policy of increasing production of HRH	No coordination for medical supply increase	3
HRH education	Similar formulation in-service trainings by each disease-specific program	Each program organized activities around in-service trainings	6
	Joint in-service trainings on HIV/TB	No joint training on HIV/TB	2
	Joint in-service trainings between GAVI-HSS and reproductive program	Joint in-service trainings happened	1
	Shared policy on strengthening pre-service trainings	No activity implemented for medical pre-service trainings	2
		BTC coordinated with HRH Directorate for improvement of nurses training curricula	5
HRH working conditions	Similar formulation of financial incentives	Non-coordinated financial incentives	3
		per diems (unformulated policy)	?
	Shared formulation of P4P	Geographic zoning for P4P **BUT**	4
		No joint process or even information sharing on P4P➔ unequal financial support	3
HRH management	Shared formulation of P4P and district support	implementation of districts with unequal financial support	3
	Similar formulation of increasing support for supervision		?

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6.4 EXTENT AND TYPE OF HRH POLICY COORDINATION

6.4.1 Issue identification

The first columns of Tables 6 to 9 and the Table 10 showed that there was some coherence in terms of problem identification across all the documents, with all donors and government bodies being aware of similar HRH issues. This similarity across visions might have resulted from the General Forum on Health held in 2004, in which all actors in the health sector participated. Nevertheless, this finding, apparently positive in terms of identical vision across organizations, was only superficial, as described below.

Narrow and organization-specific issue identification

A comparative analysis of each organization's documents led us beyond the superficial impression of an existing similar vision across organizations and allowed us to notice slight differences in interpretations. Issues were seen through each organization's lenses, formatted according to their targets and then interpreted to be important or not for the interest of the organizations.

In each official document or proposal consulted, issues related to HRH supply – such as "lack of HRH in terms of quantity" and, to a lesser extent, the "geographical inequity in terms of distribution" – were acknowledged (national health plans X 2, HIV national strategic plans X 2, GFATM-HIV and TB proposals, 3X5 initiative, national TB plan, national reproductive health plan, national immunization plan). Yet beyond this superficial homogeneity in terms of vision, aid organizations tended to look at the general issue of HRH shortage and misdistribution through their own lenses and according to their organizations' targets (National Reproductive Health/HIV Plan, 3X5 Initiative, GFATM-HIV proposal).

Divergences across organizations appeared while looking into details of funding proposals and planning documents: organizations tended to promote their own interests and spoke from their own point of view, rather than in the interests of the wider health system. Very few organizations looked at HRH issues using a health system or long-term approaches, by widening and lengthening their points of view. Policy and planning documents of national vertical programs related to the shortage of HRH in terms of absolute shortage and inequity in distribution but more frequently as an issue of "lack of specialized personnel" with regard to their own needs, as illustrated by sentences from documents: "lack of HRH a major

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barrier for HIV program implementation" (GFATM-HIV proposal round 5), "lack of HRH in public sector leads to weak response in PMTCT, OI and M&E in HIV programs" (national HIV strategic plans), "scale-up of ARV constrained by lack of HRH" (3X5 initiative).

Similarly, most documents had the same vision on the extremely low wages in public sector. But again, beyond this similar vision of issues undermining HRH working conditions, some organizations looked at issues through their own lenses, narrowing down issues to program's outputs (e.g. inability to detect malaria cases, TB cases).

Hence, despite the relative and apparent homogeneity of HRH issues, policies proposed to mitigate these issues diverged across actors.

Unclear and uneven issue identification process

Most organizations did not clearly link the issue with the potential negative outcome that this issue could induce. This shortfall sometimes resulted in documents with lengthy lists of issues, from which no sense of priority emerged, thus questioning the usefulness of the issue identification exercise itself. It looked as if issues were not identified using a thorough process of critical analysis and prioritization but were rather just thrown into documents, for an advocacy purpose. We will see how this lack of prioritization undermined the policy formulation step.

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There was also an imbalance in terms of the importance given to each HRH dimension in all the documents consulted: the performance management dimension was the most poorly represented, followed by the working conditions dimension. The education dimension was the best represented, with all documents referring to it, followed by the HRH supply dimension. We can hypothesize that some organizations were not sensitized to some issues such as management, or were not willing to acknowledge them, since there were difficult issues to address. Perhaps the other issues, such as the low quality of HRH training, were more easily and quickly 'addressable' in a short-term, and took over the policy scene.

6.4.2 Policy formulation

The second columns of Tables 6 to 9 and the Table 10 showed that policies formulated were poorly coordinated, except for P4P policy, supposed to fix both working conditions and poor HRH management. This case is detailed in a specific case study.

The devil's in the detail

Similar to the stage of issue identification, policy formulation was at times vague. What exactly was meant by 'capacity-building' where it was listed as a strategy was unclear. It was also difficult to understand from the policy documents how 'HRH strengthening' would happen in practice (i.e. which means would be used and which component would be strengthened).

'Capacity-building' and 'HRH strengthening' sounded like fashionable concepts, used in order for proposals or plans to be approved. Two ways of interpreting this vagueness could be proposed: the first way is that keeping the concept vague enough allowed donors and programs to, on one hand, justify the fact that some effort was made in relation to HRH and, on the other hand, adapt the funding usage to their own purpose. The second way is that donors perhaps left the concept vague enough, in order to give sufficient flexibility for countries to take ownership of the funding usage. Either way, the vagueness of the formulation did not help coordination.

The vagueness of formulation could be illustrative of aid organizations and MoH feeling overwhelmed by the significant amount and importance of HRH issues that need to be addressed. In the post-conflict context everything needed to be rebuilt – and since little prioritization was done at an initial stage, a number of vague policies were formulated, alongside more targeted and quick-fix ones. The vaguer a policy was, and the more organizations were able to adhere to it, providing *in fine* a false impression of coordinated formulation. However, while aid organizations might all share a common objective to reach, the precise means to attain the same objective might differ, according to the organizations' ideology, governance, specific objectives – thus inhibiting coordination.

Policy formulation or statement?

Furthermore, the vagueness of the formulation of some policies, such as "to improve the quality of HRH", "to improve the HRH management", questioned even the very nature of the policy itself. Similarly, some policies formulated sounded more like advocacy (e.g. "mobilize donors […]", "increase financial support […]"), rather than a policy.

Could all policies really be considered as such, according to the strict definition of a policy (i.e. a decision taken by a person or a group or people in charge of a specific area), or, rather, a mere statement of what needed to be done, without even pointing at a precise goal with adapted means to reach these goal?

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Program-centered formulation

Many policies formulated were centered on the program itself (e.g. HIV), and did not necessarily consider the system-wide effects of such policies. For instance, four strategies were similar (recruitment for HIV program management, re-allocation of HRH to HIV activities, sessions for HIV, and dedicated staff for HIV); but they seemed in stark opposition to the general recognition of severe HRH shortage at all levels identified during problem identification; they dealt with drawing HRH off an already constrained pool with subsequent competition between vertical programs and general services.

The policy of recruiting management staff was even more worrying since in Burundi, as in most African countries, program managers are supposed to be medical doctors. This disease-specific criterion was justified by the fact that a manager should hold the highest qualification, in order to be respected enough to manage people (ITW11N27). Subsequently, the question of how recruitment would happen in practice in a context of absolute HRH shortage, without depleting the stock of HRH available in the market at that time, seems to not have been addressed; neither was addressed the issue of distracting skilled HRH from clinical work. There is no doubt that the elaboration of such policies was not shared with other organizations and was only formulated in a very vertical and individual fashion.

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The main short-term solution to counteract low quality of HRH, proposed uniformly across all the documents consulted, was the organization and decentralization of in-service training (except for EC, which refused to organize in-service training, after 2008). The fact that the decisions were uniform did not mean they were made jointly or in a shared manner, however. Training involved only stand-alone disease-related topics, since organizations sought program-related benefits from them:

> *"HIV clinic workers got access to more training sessions. In internal medicine, such opportunities are non-existent. Few from internal medicine came to have a self-training in taking care of HIV patients but very few training sessions were organised apart from HIV field, though pathologies are varied. These are some of the reasons for hospital admission: 1=malaria, 2=HIV and 3=diabetes and arterial hypertension." (ITW1N09, group 4, local)*

The idea of a joint training plan across programs did not appear in any document. The National TB Program was the only exception, as it proposed joint training for HIV and TB

(TB staff to be trained in VCT and ART). It might be the case that an item on HIV-TB integration was present in the Round 7 proposal.

The MoH was appointed explicitly in several documents as having to “take the lead in the task of organizing in-service training”, in other words, in their coordination.

6.4.3 Policy implementation

The third columns of Tables 6 to 9 and the Table 10 showed that there was neither temporal nor spatial coordination in policies implementation. Even when a policy such as P4P seemed to have been formulated in quite a shared way, its implementation was somewhat chaotic, as illustrated by a case-study in case study 1. There was some evidence of partial coordination, however, as described in case study 2.

Quick implementation versus coordination

The data showed that implementation coordination partly depended on the pace of policies implementation, i.e. whether it was quick or slow. Quickly implemented policies were rarely coordinated, since they dealt mainly with emergency issues (or those considered as an emergency, such as HIV). Policies aiming at, for instance, stopping the hemorrhaging of HRH (e.g. improved working conditions), were not coordinated (e.g. unequal salaries across programs), because of the lack of time for it and because of the usual high transaction cost attached to coordination.

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> *“As things stand, there are different contracts leading to various benefits. Many people expressed the need to reach harmony across contracts. This should be done disregarding the kind of funding: this is the kind of contract you should have signed for a given category of personnel within the overall health sector, private, international etc. This should help to face prevailing discrepancy.*
>
> *“Contracts made by Cordaid or EU are illustrative examples: there is an extreme instability due to inequality of salaries between provinces. Once recruited for Ruyigi [province] job position, a worker can ask for relocation to Karuzi [province] where the contract is better”. (ITW1N09, group 4, local)*
>
> *“Vertical programs are urged to provide results. It is difficult to impose a working pace on the central level [MoH]. In our program, if we don’t respect deadlines, we will get in troubles with donors. If there is a common basket, it won’t be easy.*

Vertical programmes, if well managed, usually lead to quicker results." (ITW20N09, group 2, local)

Implementation seemed to have followed two parallel roads: one way for HRH long-term and sustainable development and another one with quick-fix strategies to enable HRH to work in an emergency manner, while waiting for longer-term policies to be active. This split between short and long-term policies had a significant influence on implementation coordination.

Implementation of unformulated / unplanned policies or unclearly formulated policies

Some policies were eventually implemented without being formulated. This, obviously, did not provide an opportunity for policies to be coordinated upstream. Indeed, alongside properly planned activities or policies which could not be implemented given a lack of funding or other reasons, unplanned policies and reforms were implemented (e.g. removal of user fees, P4P and district implementation policies which were not clearly explicit in the National Health Plan). For instance, the removal of user fees for certain categories of patients was announced on 1 May 2006, without any warning or planning, by the President himself, in an effort to reach the MDGs. However, this unplanned policy overwhelmed facilities and HRH, as reported by the Observatoire de l'Action Gouvernementale (Observatoire de l'Action Gouvernementale 2009). It goes without saying that there was no coordination of this unplanned policy (e.g. in terms of HRH supply), since there was hardly anything to coordinate on!

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No mention of *per diems* could be found in any policy document and it seems it was a tacit policy in each organization and not a clearly formulated one. This makes it impossible to co-ordination any implementation. As it was, organizations offering training set *per diem* amounts at various levels according to their internal scales. The discrepancy that arose across organizations produced anarchy as organizations competed with each other to attract trainees, HRH accessed training on a non-equal basis, not necessarily based on needs (ITW1P09, ITW3P09, ITW6P09, ITW6F09, ITW16F09, ITW20F09).

Implementation of a salaries grid was neither coordinated with public sector facilities managers (with staff being divided between those receiving incentives and those who were not, creating internal tensions); nor coordinated between NGOs, such that HRH migrated from one NGO to another in search of better working conditions (ITW18F09, ITW3F09,

ITW19F09, ITW21F09, ITW3P09). No mention of salary levels was made in any policy or planning document of any organization.

Similarly, there was no coordination with central level MoH or across vertical programs: salary top-ups varied from one program to another, causing managers' instability and resentment between workers, undermining collaboration.

> *"A physician [recruited by MoH] is paid $60 per month and an agent recruited there [by PES-NAC] gets $1,200. How can they collaborate? It's a national issue indeed, because there are donors who finance such a project here or there. These projects are operated on a separate basis. They become separate entities, salaries are quite separate, and vehicles are separate as well." (ITW12N09, group 4, local)*

Even when donors imposed some requirements upon contracts, these could be dismissed.

> *"Unfortunately, the government recruited people on salaries that we did not want. The message was clear. They should have short-term contracts with the government and they should be paid at the civil service rate, which is so hard for them. The NAC had recruited people for M&E but it was required to have them sign a contract with the government, so that financial resources had to go through the government. But it was difficult due to issues specific to Burundi [the participant meant 'ethnicity' issue]."* (ITW9N09, group 4, expatriate)

Competitive and parallel implementation

No joint implementation of in-service training was observed across funding channels or aid organizations. The policy of standardization of training modules was not yet implemented: PES-NAC and the mid-term review of the HIV plan 2002-2006 reported that VCT training was provided by four different providers. No joint training was organized between the TB Program and the HIV unit or PES-NAC, despite the policy proposed by the TB Program.

> *"You'll find out that training sessions, the National TB program, […], malaria, all these things are being done, each, supervision activities, whatsoever and everything is coming from anywhere. One day, when we and the minister were making a visit on the site, we met a person sitting there in a health centre whom we asked "What are you doing here?" "I am a malaria microscope technician". Then there was another tuberculosis microscope technician. Thus, if the malaria*

microscope technician is not there, the tuberculosis microscope technician cannot handle malaria activities. You easily realise that this is just a little illustration of the state of things." (ITW15N09, group 1, local)

"There are no planned training sessions in the short or medium term or in-service training sessions in Burundi, apart from actions taken by WHO in this direction. There isn't any coordination, everything is organized from the top down and in disorder, without any planning for basic or in-service training sessions." (ITW2N09, group 5, local)

Programs ended up competing with each other for meagre HRH resources. For instance, the policy to integrate TB and HIV activities for CHW, proposed by the TB Program, has not been implemented to date, showing the difficulty of integrating HRH across two (related) programs. Some coordination happened between GAVI-HSS and the Reproductive Health Program, in the form of in-service training on emergency obstetric care organised by the Reproductive Health Program using GAVI-HSS funding. This coordination was largely helped by inter-individual affinity between managers [(Carlson and Karibwami 2009) and ITW8N11].

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The lack of supervision at facility level was generally acknowledged, with different programs competing with each other for performance, outputs and data, not leaving any space for collaboration or coordination.

"There is one supervision team for each vertical program; there isn't any global supervision team. For the drug stock monitoring, ten teams arrive to look at ten different drugs, and we are asked to keep them apart from each other." (ITW14N09, group 3, expatriate)

The following case studies present the P4P implementation (case study 1), and three examples of partial coordination (case study 2).

Case study 1: P4P
(coordination type 3)

The P4P policy formulation seems to have resulted from a contextually similar policy formulation, rather than a coordinated formulation.

Despite the absence of the P4P strategy in the National Health Plan and the National Health Policy (elaborated around 2004-2005), the P4P strategy quickly gained consensus amongst donors and various actors within government, as the universal solution for poor HRH working conditions. It seems to have started with the P4P policy document (elaborated by the Burundian government, but by an international consultant who was an expert in the P4P strategy). The P4P policy was launched at the end of 2006, just before the NGO CORDAID, coming from neighbouring Rwanda, started its implemention in pilot provinces.

Since then, P4P as a strategy, combining improved working conditions to increase performance, was believed to be powerful enough to continuously improve both working conditions and performance in a virtuous circle (data from documents analysis where P4P was proposed progressively as a policy to improve HRH working conditions and management, as well as from interviews).

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The fact that all aid organizations strongly and quickly subscribed, in theory, to the P4P strategy can be explained by many factors, some being in the interests of both donors and government. Firstly the P4P strategy was attractive since it was new and seemed to be effective in some settings, according to first reports; while secondly donors and government were going to be able to closely monitor their inputs and outputs in the health system. Thirdly the strategy was hypothesized to be financially self-sustainable in the long-run; while fourthly it was also a way to restrain public sector expenditure, since the initial investments were to be provided by donors. And finally as P4P was supposed to be an effective way to improve the quality of care – in stark opposition to a direct investment in HRH remuneration (recurrent cost) – it was generally accompanied by fear regarding the risk of not automatically improving the quality of care.

In summary, while organizations shared the same global vision of the P4P strategy as well as its potential benefits, there was no joint decision *per se*, in the sense of a joint process. It looked more like a decision shared across individual organizations, following a policy that remained a

pilot strategy for some years, as we will see below. Hence, no coordinator appeared clearly, at least at the beginning.

> *"Let's take another example: the P4P. We had a meeting Tuesday on the P4P policy in Burundi and had a quite important discussion. I happened to learn that the PES-NAC/MoA organized the same kind of meeting on HIV and P4P. It is silly that there is such willingness for fragmentation on the part of the MoH, they do not look for harmonization at all." (ITW14N09, group 3, expatriate)*

> *"The P4P workshop held two days ago was not attended by a single NGO while the presentation was relating to the experience of other countries [...]. Only CORDAID was there, because it had a presentation to do. Even the MoA was not invited, they had heard something about the workshop and a DG had come there without any invitation." (ITW12N09, group 4, local)*

P4P policy started to be implemented in a relatively uncoordinated way, even though some geographical zoning was observed. Indeed, Table 11 which shows the geographical distribution of aid organizations for P4P gives rise to several observations. Six aid organizations implemented P4P projects, even if it did not constitute an issue per se – and the starting dates differed largely from one province to another. Of the 17provinces, five plus the capital province, did not get any support and the amount of funding varied largely from one organization to another. An exact calculation could not be provided since each project supported the district health system in parallel. However, a cautious comparison of rough amounts per year and per district provided evidenced of inequalities across districts (equally populated with around 200,000 inhabitants): GAVI-HSS provided < 40,000 USD, whereas BTC disbursed 400,000 euros, the Swiss cooperation 650,000 euros and the EC 150,000 euros. These inter-provincial inequities resulted in migrations of HRH from one province to another, plus some confusion on the ground (data from ITW province and facilities 2009).

In 2010, a special unit for P4P was established within central MoH, to pilot and evaluate different P4P strategies which were being implemented in the country. While P4P strategy became also part of the IHP+ process, there was no communication between this unit and the health partnership framework committee (CPSD).

> *"The MoH is now obsessed by this P4P unit and strategy, and CPSD meetings were halted due to people being overwhelmed by deadlines for P4P. The problem is that the*

P4P unit at MoH is another parallel unit, with people with higher salaries."
(ITW29N09, group 3, expatriate)

The unit also became an arena for ideological battles around the way P4P should be implemented:

> *"While this unit became operational, divergences started to appear between EC and WB, the two largest multilateral donors in Burundi, on the technical points surrounding P4P strategy, reflecting also ideological battles" (ITW20N11).*

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Table 11:P4P projects in the 17 provinces in Burundi, as of 2007
(adapted from the DTF-Kirundo document from BTC)

Grey shading means 'no project'

PROVINCE	Districts quantity/ province	Aid org supporting P4P	Budget by aid org	Duration of P4P project	Starting date of P4P project
Bubanza	2	Cordaid (NGO)	1 200 000 €	2 years	August 2005
Buja-mairie	3				
Buja-rural	3				
Bururi	4	HSS GAVI	2 000 000 USD	5 years	March 2007
Cankuzo	2	Cordaid	1 261 311 €	2 years	August 2005
		EU (taking over from Cordaid)	2 500 000 €	2 years	October 2007
Cibitoke	2				
Gitega	4	Health Net/TPO (NGO)	1 897 504 €	42 months	
		GAVI-HSS	2 000 000 USD	5 years	March 2007
Karuzi	2	EU	2 500 000 €	2 years	October 2007
Kayanza	3	GAVI-HSS	2 000 000 USD	5 years	March 2007
Kirundo	4	BTC	5 000 000 €	3 years	October 2007
Makamba	2				
Muramvya	2				
Muyinga	3				
Mwaro	2	GAVI-HSS	2 000 000 USD	5 years	March 2007
Ngozi	3	Swiss Cooperation	6 000 000 USD	3 years	September 2006
Rutana	2	EU	2 500 000 €	2 years	October 2007
Ruyigi	3	EU	2 500 000 €	2 years	October 2007

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Case study 2: 3 examples of partial coordination (coordination type 5)

Case 1: the supply of non-medical HRH

In terms of the supply of non-medical HRH, a number of new policies were formulated co-operatively by BTC and the MoH, and were launched in 2008. In parallel to the elaborations of the policies, two institutional audits were performed in 2009. The BTC and the MoH signed three projects agreements, amongst which one directly responded to the HRH supply issue: nurses' curricula revision, in parallel to stopping the production of basic-level nurses (BTC project). The only policy coordinated with this latter policy (still not active in 2010) was the BTC project, which started in 2008 in one province. The project raised the issue of HRH shortages in the three districts which constituted the province (Kirundo), but decided to delay recruitment and wait for new staff following the implementation of an imminent decentralization policy. This decision was further justified by the fact that BTC was directly involved in the MoH institutional support project.

Case 2: PES-NAC as coordinator

The implementation of HRH supply policies was coordinated between MAP1 and GFATM-HIV, since the two grants were managed by the same institution, PES-NAC. Actually, coordination of HIV activities was one of the functions of PES-NAC (for detail, see findings part 1). While PES-NAC succeeded in achieving some level of coordination in HIV-related activities (such as writing GFATM grant application round the CCM), it dealt with internal coordination within HIV and not with the wider health sector environment. For instance, it did not seek coordination with the MoH or other agencies, for instance to prevent poaching HRH from other organizations. As a result there was movement of skilled HRH towards HIV-related NGOs or managerial positions.

Case 3: National Centre for HIV Reference as coordinator

The creation of a National Centre for HIV Reference, which was partly supported by GFATM-HIV, was precisely to fulfil the need to harmonise the content of training. The centre had three other missions: research on HIV; provision of decentralized in-service training; and standardization of clinical HIV management. This demonstrated efforts made in the HIV domain to coordinate their HRH education policies. On one hand, it obviously helped to fill the

gap left by the absence of formal in-services training institute at MoH level; while on the other it inevitably favoured HIV-related training.

6.4.4 Cross-cutting themes across policy steps

The chicken and the egg: How to plan without funding? What to coordinate without a plan?

Another striking feature preventing coordination as a whole emerged from the various strategic plans and their attached financial plans – as each plan showed financial gaps. Each plan had a set of specific goals with a provisional budget attached to them, this latter being divided into 'pledged amount' and 'missing amount' (or 'to be looked for'). Therefore, depending on whether the 'missing' funding was found or not, activities related to each goal were implemented – or not. Activities could be either cancelled, postponed, transformed or implemented as planned, depending on funding availability. This meant that a lot of decisions were made in an *ad hoc* manner, depending on the funding available, with some funding arriving sometimes very late or unexpectedly.

Moreover, some financing was more predictable than others (e.g. GFATM and GAVI vs. UN agencies), as illustrated in the quote below:

> *"The funding from GAVI and MAP are easy to manage. If we have a multiannual plan, funding is planned against it and is made available. By contrast, funding from WHO is never planned ahead and comes out of the blue" (ITW6N09, group 2, local)*

Given the short notice and the usual need to spend funds within a specific timeframe (before the end of financial year Y), there was no way to coordinate implementation. For instance, due to unpredictability of funding only 40% of activities planned for year 2007 were implemented (Unité de Lutte Sectorielle contre le SIDA 2008). This led the USLS to implement activities in an uncoordinated way, as illustrated in the following excerpts:

> *"The diversity of partners with whom USLS-health collaborates for HIV activities implementation leads necessarily to duplication. Due to donors' schedules, our unit is forced to work in a climate of rush and some activities need to be rescheduled at the last minute." (ITW6N09, group 2, local)*

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"USLS-health does not have its own funding for its annual action plan. The consequence is an unplanned implementation of activities, according to various donors' funding availability". (ITW6N09, group 2, local)

The lack of predictability of disbursement and the uncertainty over the allocation of external funding are not new in the field of development aid, and have been well analyzed elsewhere (Sundewall et al. 2009). However, the impact of these issues was aggravated in Burundi, where the conflict left the country exposed and extremely reliant on external aid such that government bodies did not have any leverage in decision-making or the implementation of activities. This huge dependency on external aid explained the fact that a very good plan could remain in the drawer, if no funding was found. This lack of autonomy in terms of decision-making and implementation probably participated to the discouragement of government to co-formulate or even formulate sound plans, since it was an energy- and time-consuming activity.

The functioning of programs and implementation of strategic plans slowed down considerably or was suspended during the conflict and some resumed later than others. For the period considered here, 2002 to 2008, there was no annual planning within MoH, but only a five-year health plan (2006-2010) and a ten-year policy (2005-2015). The very first mid-term expenditure framework (2009-2011) and a national annual plan for the health sector were developed in 2009 as part of the IHP+ process. Before 2009, existing annual plans were the national strategic plans for HIV, developed by the PES-NAC and annual activities plan from the HIV unit of the MoH (2008). There were entire 'holes' in the periods covered by these overarching policy and planning documents -– malaria, reproductive health and TB programs had no strategic plans.

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National health plans were written for 2006-2010 and 2005-2015 but no annual health plan was developed before 2009. The first HRH policy document was only produced in 2009 (except for the specific P4P policy document of 2006). Therefore, in terms of HRH policies, before 2010, there was no reference document to form the basis on which to coordinate, for instance, a training plan.

In summary, except for the HIV 'sector', there was no plan to use for coordination. This probably explains the pockets of coordination we found in HIV area (see case study 2 on partial coordination).

Funding makes policy

This finding was applicable to both the formulation and implementation steps. While some formulated policies were purely wishful without any practical details on implementation, other policies seemed to have been formulated exactly because funding was available that issue (e.g. P4P, see case study 1 above). Indeed, if one looks at the annual activity plan for the HIV sectoral unit for instance, only activities with funding available are actually planned as only those activities with available funding were translated into the plan, given the uncertainty of funding. Planning, therefore, did not necessarily reflect needs, so much as the availability and accessibility of funding - and drifted away from its initial objectives.

This was also well illustrated in the comparison of the National Health Plan and vertical programs' plans. On one hand, the national health policy document exposed health challenges, in epidemiological terms but also in terms of the whole health system. On the other hand, the different program strategic plans and funding proposals seemed to have defined their lines of activities in a way that matched the funding available (e.g. provision of in-services training, supervision, M&E – source doc), not necessarily taking into account the national priorities with regard to public health. Sometimes this made planning documents look like shopping lists!

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> *"Donors come with their ideas and usually there is no space for flexibility and integration to the health system….within GFATM-HIV for instance, there are two issues, 'gender' and 'HIV', to deal with. However, we need flexibility, even if we understand gender issue is a central question. There are pre-defined priorities at donors' level……" (ITW22N09, group 4, local)*

> *"Because if you don't include HIV, gender, some donors don't fund anything…..(laughter)…." (ITW13N09, group 1, local)*

Thus the planning process seemed to be a direct translation of funding into planning. This disjointed planning process did not allow for comprehensive planning, including and especially HRH, since funding for HRH was seldom available at both local and global levels.

This findings' chapter might have been relatively complex to follow, as it strives to both present the content of and analyze HRH policies, an essential step before moving to the analysis of the extent of HRH policies coordination. The main conclusion is that coordination of HRH policies across the 19 organizations was poor, with the exception of

few cases of partial coordination between “like-minded” organizations. The process-related factors inhibiting coordination were then examined according to the policy steps. From issue identification to policy implementation, a common observation was that each organization acted for its own survival and had its own disbursement system and functioning, putting a time-constraint on the recipient and implementers. Due to this finding, and to another finding that coordination is an extremely complex and time-consuming process, especially in the post-conflict context with its sense of emergency, many policies were precipitated in an uncoordinated way. The relative poor funding of health sector compared to the ‘HIV’-sector at the beginning contributed to the non-emergence of MoH as possible coordinator and to a preeminence of HIV-related organizations.

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CHAPTER 7: FINDINGS PART 3, ACTORS AND COORDINATION

This chapter provides an analysis of actor-related factors inhibiting coordination, in addition to factors related to process presented in the previous sections. It presents actors' understandings of coordination, what interests they have in coordination (either to be coordinated or not and/or to coordinate or not) and what their position is regarding coordination.

In the context of this section, a stakeholder is an organization involved in development aid – as a donor, recipient, implementer or coordinator. For the sake of brevity here they will be referred to as aid organizations.

References in the interviews and documents (already presented in previous sections) to broad coordination, or to specific HRH policy coordination, were analyzed in each pre-defined group of aid organizations involved in the health sector. A framework analysis was used, guided by the following questions:

- What definition of coordination was implicit or explicit?
- Who should take or be given the lead in coordination?
- Who / what should be coordinated?
- Towards what common objective should the coordination be directed?
- What are the means for coordination?
- What interest / position/ has the group vis-à-vis coordination?
- What interest / position/ had others towards coordination?

Answers were charted, to provide a clear picture of the complex / ambivalent positions aid organizations have around coordination. Several themes corresponding to actor-related factors inhibiting coordination were identified from answers from groups of organizations.

Details of interviewees, other than their location in groups below, are not provided given the need for confidentiality. They are as follow (all were locals, except when specified):

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Group 1: MoH central

- Economist, technical assistant (expatriate)
- Director General for Resources
- Director General for Health
- Minister of Health
- Director of Human Resources

Group 2: MoH vertical units

- Director USLS (HIV unit of MoH)
- Director of National Immunization Program
- Director of National Transmissible Diseases Program (including malaria)
- Director of National Reproductive Health Program
- Director of National Tuberculosis Program

Group 3: non vertical diseases organizations

- Support to non-governmental actors, EU (expatriate)
- DfID health sector representative (expatriate)
- Technical assistant from BTC to MoH (expatriate)
- Health project manager, EU

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Group 4: vertical diseases organizations

- Director of the National HIV Reference Center
- Coordinator of GAVI-RSS
- International technical assistant for WB (expatriate)
- Coordinator of GFATM-HIV, NAC-PES
- General director of NAC-PES
- Financial and administrative director (GFATM and HIV), NAC-PES
- Coordinator of RBP+ (local NGO for HIV)
- Coordinator of GFATM-malaria
- Minister, Chief of cabinet and director general of Ministry of AIDS

Group 5: UN family

- Health system specialist, WHO
- Technical assistant WHO in MoH (expatriate)
- HIV specialist, WHO (expatriate)
- Coordinator (acting), UNAIDS

Not classified

- Chief of Cabinet, Ministry of Finance
- Director General, Ministry of Civil Service

7.1 OVERVIEW OF GROUPS' UNDERSTANDINGS AND POSITIONS

This section comments on the data emerging from the groups of people/organizations interviewed – summarised in Table 12 below. Groups had quite homogenous views and positions on coordination, and when this was not the case, I probed their opinions and perceptions.

Table 12:
Synthesis of position/interest in aid coordination across the five groups of aid organizations *(data from interviews)*

Group	Definition of coordination or synonyms/ meanings	Who should coordinate whom?	Own position / interest towards coordination	Perception of others' position/interest towards coordination	What are the means for coordination?	What are current issues around coordination?
1	Harmonization Integration Information sharing Collaboration Consensus	Who: 'One' Partnership framework Whom: different MoH entities NGOs	Agreement on the need for improved coordination	Opponent: GHIs, MoA, PES-NAC and UN agencies Supportive: WB, some bilateral	Financial centralization Control over others	Pre-electoral climate (prevents from info sharing) Lack of leadership of MoH No dedicated time and money
2	Financial management/ accountability Centralization of funding	Who-whom: Self-coordination	Reproductive Health Program the most strongly not interested, otherwise neutral	Everyone opponent, especially donors and MoH/MoA	'Common basket' Participation to CPSD	Fear of funding mismanagement No trust in MoH No time Differing ideology amongst donors Differing disbursement calendars No communication MoH-MoA
3	Sector dialogue	Who: MoH in theory Whom: vertical programs GFATM GAVI MoA PES-NAC	Supportive of coordination, especially member states and EC	Everyone else opponents, especially WB and MoH	Sub-sector specialization Basket funding Joint planning Donor harmonization Donor consortia	No willingness or capacity of MoH to coordinate No time Internal structure of WB Financial greed

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Group	Definition of coordination or synonyms/ meanings	Who should coordinate whom?	Own position / interest towards coordination	Perception of others' position/interest towards coordination	What are the means for coordination?	What are current issues around coordination?
4	Paris Declaration, Three Ones principles	<u>Who</u>: CPSD CCM donor consortia Ministry of Planning Ministry of Finance <u>Whom</u>: ?	Supportive in theory	Others all opponents	Joint planning Geographical zoning Info sharing SWAP 'Common basket'	Too many coordination bodies No time Lack of incentives to participate in the CPSD
5	Paris Declaration Accra principles	<u>Who</u>: government, UNAIDS for HIV sector CPSD for health sector <u>Whom</u>: ?	Very supportive, especially the WHO-HSS	<u>Opponents:</u> International NGOs and bilateral donors	Joint planning Harmonization of financial procedures SWAP	Institutional divergences Donor conditionality Too many mechanisms of coordination Willingness of visibility Absence of ownership of Paris principles by government No leadership from government

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7.2 FINDINGS FROM EACH GROUP

7.2.1 Interviewees of group 1: MoH central level

Interviewees from this group all acknowledged the lack of coordination as an issue. In terms of definitions however, interviewees used many concepts interchangeably, such as 'harmonisation', 'interactions', 'integration', 'information sharing' and 'collaboration'. 'Coordination' was at times replaced by the notion of 'consensus' that should be reached 'between donors and government'. This 'consensus' was a very neutral word, and did not imply any 'power over' by deliberately removing any 'power' meaning.

All interviewees seemed supportive of a coordination policy, and mentioned the Paris Declaration as a goal, even if it had not yet been achieved. Yet, no one in this group identified clearly 'who' should coordinate aid. Also, 'who' should be coordinated was rather vague or non-existent and interviewees used often an indeterminate subject ('one' should coordinate), as if they were scared to take responsibility. Some of the interviewees made clear statements regarding the lack of leadership on the part of the MoH.

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All participants were aware of theoretical ways to achieve coordination – although it was difficult to distinguish between rhetoric and a real grasp of these concepts as coordination tools. One participant mentioned the application of regulatory statutes to rule different MoH bodies and showed willingness to modify them / apply them (i.e. coordination as coercion or control over). Other means included technical concepts such as SWAP, 'common baskets', the compact of the IHP+, or processes such as joint planning and the mid-term financial reviews. All interviewees from this group identified the partnership framework (CPSD) as the main tool for coordination.

However, interviewees felt that, despite their willingness, the Minister (or alternatively the DG of Health who represented the Minister), did not have any power to insist that parties participate, even though they presided over the CPSD meeting which was the first step towards coordination.

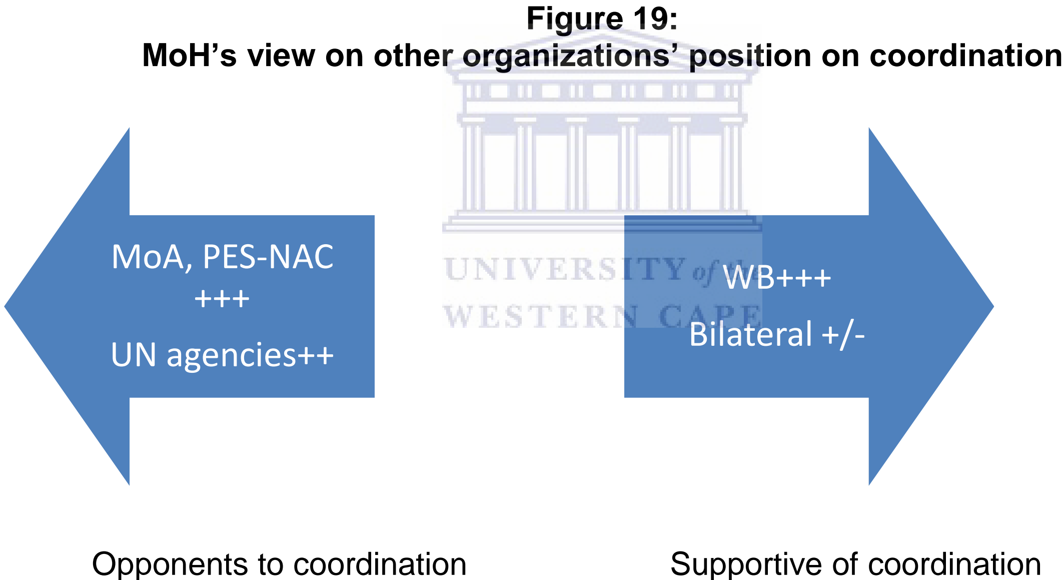
Regarding perceptions of others' willingness to coordinate, MoH actors considered GHIs, represented by MoA and PES-NAC (figure 19) as least interested in co-ordination. MoH explained that GHIs were not interested in coordination since it

would hamper the pace of implementation of their activities (GAVI and GFATM), as coordination needed time and money. In contract, the MoH actors cherished the WB, defending them against other donors who accused the WB of performing bilateral negotiations with the MoH and acting against coordination, as illustrated below:

> *"I think that it has been a misunderstanding. […] It is true that the WB is proceeding more quickly than others today. And I think to some extent that it is also an opportunity to set up the tools and structures which make it possible for all the donors to sit together." (ITW15N09, group 1, local)*

Interviewees had various perceptions of bilateral donors: they perceived USAID as the main opponent to coordination since it initially operated through NGOs (which the MoH did not quite understand); and they perceived Swiss Cooperation Agency as supportive of coordination, despite their scarce HRH.

Figure 19:
MoH's view on other organizations' position on coordination



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Coordination was also substantially linked to financial management. Interviewees argued that it was impossible to coordinate with the MoA and NAC as the HIV budget was separate from the general health budget. They blamed this split for having sidelined the MoH and removed its chance to act as a coordinator.

Similarly, the Directorate for Programs and Health Services was, in theory and on paper, in charge of coordinating vertical programs. For instance, one of the missions of this Directorate was to officially authorize programs to provide in-service training. In practice, the only role the Directorate played was to ensure that two programs did

not clash physically during their in-service training provision. Since vertical programs were managing their own funding, or asking for disbursement to PES-NAC, they by-passed the MoH and its Programs Directorate. Interviewees from MoH central felt they did not have any financial weight and that this was the justification for being bypassed and being unable to coordinate vertical programs.

7.2.2 Interviewees of group 2: MoH vertical programs/unit

All interviewees stated that programs coordinated their own activities when they undertook their own financial management (the case for TB and RH program). The case was much less clear-cut where a program did not do their own financial management (malaria program, HIV unit), or had a co-financial management in place (immunization program).

Interviewees seemed aware of different mechanisms of coordination, but confused the definition of coordination with its mechanisms. ‘Coordination’ and ‘centralization of financial management’ were often used interchangeably, and financial management was considered as one *sine qua non* condition of being able to coordinate.

Programs which self-managed their funding were accountable to donors regarding the use of funding. While they were willingness to coordinate, this was only within their program’s scope, so as to keep a tight grip on funding. Coordination was then synonymous with *funding usage control* and *accountability*: this was true for the TB and reproductive health programs, which acted independently from MoH central and collaborated with a lot of partners. The immunization program had an intermediate position, since they co-managed their funding with the MoH, but due to stringent management conditions imposed by GAVI, they did not have much space for initiative and needed to behave in a particular expected way.

Each program had differing interests in a coordination policy, depending on the tools (or mechanisms) used to coordinate and the power the program had already. The Reproductive Health Program, which functioned completely independently from other programs and from the MoH central level, did not agree that funding should be put in a ‘common basket’. It did not trust the quality of financial management (or the quantity of funding the program would get), if funding was to be centralized at the Directorate General for Resources.

Only one interviewee from the five programs interviewed, designated the MoH as the 'must be' coordinator. For most interviewees of this group, coordination by the government (MoH) meant that the MoH should be managing funding, and none of the programs seemed to agree on that. Indeed, the concept of basket funding (or 'common basket') came up recurrently, but rather as a risk of funding 'disappearance' as happened for some GAVI-HSS funding (see findings sub-section 1).

No interviewees from vertical programs saw any benefit in being coordinated by one organ, rather expressing the feeling that they should 'self-coordinate'. Programs did not seem to be convinced about the usefulness of the new CPSD initiative. Interviewees perceived their participation or non-participation in the CPSD as unimportant, since it was not attached to any incentive or disincentive. Also, they felt that non-participation in CPSD did not have any consequence on program functioning, since programs were self-governed (by legal statute or by custom).

A striking feature was that even though vertical programs did not want to be coordinated, they viewed other organizations as opponents of coordination. Interviewees of this group described 'donors' as one block community not keen on coordinating themselves, and gave two main reasons: a matter of visibility, which will decrease if coordinated; and clashes between their respective objectives and missions (divergence in indicators collected for instance). Some organizations were identified as being particularly bad - such as the WHO, since they did not consult with other partners before implementing HIV activities, for a matter of disbursement timeline. Also the MoA and MoH were perceived as incapable of coordinating between themselves, as they were completely non-communicative.

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7.2.3 Interviewees of Group 3: Bilateral and multilateral donors, non-disease specific

This group was probably the most knowledgeable about coordination and its mechanisms, and was also the least keen to recognize the MoH as having the capacity to coordinate, whereas the previous group (vertical programs) did not perceive the necessity to be coordinated by MoH at all. One expatriate delegate recognized that in theory the MoH should be the one coordinating, but he acknowledged that they lacked "capacity or willingness" to do so. Theory and

practice in coordination were clearly differentiated. This group hypothesized that the lack of capacity in the MoH arose from low salaries and a subsequent low commitment to work and poor leadership.

> *"In the Paris Declaration, it is written that government needs to grow in leadership. The local MoH should take the lead. We need capacities and willingness, but in this country, culture is different. It is difficult to take decisions…..It is intrinsically a matter of salary level [within MoH], low salaries have to be mitigated, so their mind is not taken over by how to attend trainings, so that they will get per diems." (ITW14N09, group 3, expatriate)*

Instead of coordination, the EC used the concept of "sector dialogue" (especially the person in charge of the DEV section), thus downplaying the power relationship within coordination. The EU was very aware of the necessity to implement the Paris Declaration and the IHP+ process with which they engaged. Many tools were cited for coordination: basket funds or common funds, joint planning, harmonization (of procedures presumably -supervision, M&E -), donor consortia, sub-sector specialization (with Belgium having expertise in HRH, institutional support, and France supporting the medical school reforms).

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The EU was also very supportive of aid coordination policy from its own point of view and from the point of view of its member states – and pushed other donors and government towards coordinated actions. The result was that some donors harmonized with others, especially amongst member states, but this depended also on individual state representative's willingness and characteristics. DfID and BTC also seemed keen to harmonize with the EU – although the issue of time constraints applied to each of the three organizations.

EU expressed high interest in coordination policy, to which motivations could be of two-tier: external pressure such as being in line with OECD principles (Burundi was a pilot country) and internal pressure such as coordination principles with member states and aid efficiency ("Operational Coordination between the Community and the Member States of the European Union in the Field of Development Cooperation" 2000). Indeed, the EU is been evaluated every five years by a review of all OECD members. The last review pointed out the necessity to further apply the internal

coherence and coordination policy adopted recently by the EU and the Paris Declaration principles (Organisation for Economic Co-operation and Development 2008c). It seemed also that the EU could be using the coordination principle as a 'motto' in order to take the lead of member states and to hence counteract US and the WB influences in Burundi.

The EU perceived all other organizations (apart from the member states) as being opponents of coordination:

> *"Donors signed the MoU of the CPSD because of its non-coercive nature; otherwise they would not have signed it". (ITW14N09, group 3, expatriate)*

The EU believed that the WB agreed verbally during meetings (when it participated), but acted in the opposite way in the field. EU considered 'the Bank' as being the largest obstacle to coordination in Burundi. Two reasons were hypothesized by this group (not only the EU) to explain why the WB was such opponent to coordination: the first one was that the WB would lose time (as would any organization, and this was a recurrent issue); the second was that the WB has an internal evaluation system, based on the timeliness of country agreement submission, which would provide technical team leaders with promotions, for instance (in contrast to member states and the EU evaluation system).

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This group of interviewees perceived, quite homogeneously, the MoH as a passive opponent to coordination. First it was considered to have no (human) capacity to coordinate (analytical, leadership, time), and no understanding of the linkages between the different tools that the IHP+ process helped to achieve. But most importantly, the MoH was thought to oppose the coordination policy in order to keep asymmetric information on funding, in order to gain funding and support from all sides. This group of donors argued that co-ordination would mean transparency of information between all partners in the heath sector, in order to increase aid effectiveness and avoid duplication. As such the MoH would lose possibilities of getting extra-funding out of duplicated funding and at the moment these hidden advantages constituted one of the ways to attract people at MoH.

This group perceived the MoA as unwilling to be coordinated for political reasons (including incompatibility between the two ministers) and because the MoA was functionally disconnected from MoH.

This group perceived vertical programs, PES-NAC and GFATM/GAVI (even those which did not have representatives in the country), also willing to be independent from the MoH central level - and neutral or even opposed to coordination. According to this group, neither vertical programs nor GHIs representatives participated to the CPSD meetings and none of them saw advantage or incentive to coordinate, and coordination was considered an inconvenience, costing time and energy.

> *It is up to the Minister [of Health] to lead everyone and to call for the participation of the HIV program [PES-NAC] to the partnership framework, since he is the head of all health programs. It is not the case today [i.e. the Minister of Health does not act as a leader] and all the [EU] partners and the EU do not understand why: we are under the impression that they [GHIs, i.e. PES-NAC] have enough funding and that they are detached from the rest of the system. There isn't any extra money in case of coordinated efforts, and programs and PES-NAC have already got enough funding to operate in a silo". (ITW14N09, group 3, expatriate)*

Generally, this group raised the issue of a lack of vision. Coordinated actions were not formulated in strategic plans; and while coordination efforts would serve HSS, only vague or no importance was given to HSS in CCM, or in national plans.

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7.2.4 Interviewees of Group 4: Disease-specific organizations

Interviewees in this group were, homogenously, the strongest opponents of coordination by the MoH. This group expressed, however, divergent opinions regarding who should coordinate. Some rejected the responsibility of coordinating on donors by stating that donors should first coordinate themselves (donor harmonization), thereby providing an example to country-level actors:

> *"I think at national level here we will have no choice once partners would have harmonized themselves, since each development partner has its own framework, tools that he wants to be used in the financial monitoring. We report using these tools and it allows our partner to report also to its own funders. So if our partners are harmonized, we will be harmonized for sure! (ITW11-12N09, group 4, local)*

This group mastered quite well coordination principles, the two most cited being the Paris Declaration and the Three Ones principles of UNAIDS; when listening at them, these principles sounded more like a lesson learned in theory, however. Everyone agreed on the need for coordination and on the fact that there were too many coordinating bodies of which they were critical – although they were not at all self-critical. There was disagreement again on 'who should coordinate', and the following ones were proposed as potential 'coordinator': CPSD; CCM; donors amongst themselves; Ministry of Planning; MoF; and government (without specifying who in the government). The MoH was not mentioned once as a potential coordinator.

> *"There is a redundancy of established organisations: today we have the CCM for GF-funded projects, created by the NAC, especially in cooperation with the WB, in order to respect the Three Ones principles; we have the MoH's partnership framework; we have the Directorate General for the coordination of programmes and relations with partners in the MoA; there is the NCAC; there is the extended thematic UNAIDS thematic group. All of them have never met … to know the duties of each. I think that there is a need to sit together and see what each must do. It is the duty of the Ministry of Finance or the Ministry for Planning or one of the two Vice-President's offices to clarify the situation.*
>
> *One tries to participate in everything but well… I have the feeling the NCAC is just there to list down foreign funding which is entering the country. I have never heard it do any arbitration or demand whatsoever. The CCM relates to the GFATM.*
>
> *In short there is a need for certain coordination, of setting things in order. What is needed is a government leadership. Because in general when donors come, each would like to show one's own flag, to know that everybody has seen one's flag which is each donor's reflex. It is up the Government leadership to decide. […]*
>
> *There is a need for a MoA common basket for its activities in general and then a managing body for that common basket. Otherwise each will say "Well as I have some money, I go to Ruyigi [province], I go to Cankuzo [province]…" "(ITW12N09, group 4, local)*

Different tools for coordination were cited, such as joint planning, geographical zoning, information sharing. There was again some rhetoric around SWAPs and a 'common basket'.

The MoA did not recognize the capacity of the MoH to coordinate – nor did it recognize its own mandate to coordinate HIV activities, despite having a 'DG of programs coordination and relationship with partners'.

Each organization had quite negative views of others with regard to their willingness to be coordinated.

Sometimes there were different levels of understanding of some core principles - such as the political coordination mandate by MoA or the UNGASS declaration - among UN members themselves. Overall, there was a disagreement about who should coordinate who.

> *"There is a national plan, and we all use it - though it is difficult as some requirements internal to institutions (real or interpreted as such) do not support the coordination process.*
>
> *"Example: We need to sit together around the table, to start from the national plan and to decide what must be done. We are told by UN, because we are part of UN, that there is a requirement of UNGASS to have a coordination group apart. In my view, it doesn't sound fair to carry out an internal plan with UN, EU, AU, and have a round table discussion next. I am opposed to that. If there is no national plan, there is no alternative. But Burundi has a relatively strong national plan and therefore elaboration process should be participative.*
>
> *The UN asks us to coordinate with UN members in terms of mainstreaming, in asking FAO etc. to perform a given task. This is a good concept but negotiation rounds should be carried out with the government around a national plan, and not apart. Guidelines of the UN were interpreted in a different way. We were supposed to have UN agencies coordinated not as an obligation to do so apart from government but as efforts to produce complementary input in a round table discussion and make sure we keep open-minded. It is a misinterpretation. I don't think a guideline advocated in terms of UN integrated plan implies an action*

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isolated from government. There should be an initial action platform then we should distribute. (ITW9N09, group 4, expatriate)

Participants from this group argued that lack of time and absence of incentives prevented them from participating in the CPSD. Some feared that CPSD was not inclusive enough (especially from a NAC-PES point of view and RBP+, since CCM was an organ very inclusive of NGOs and CSOs (ITW18N09, ITW16N09).

It is worth mentioning here that the WB played on two grounds simultaneously – on an ear-marked HIV ground with its MAP, and on the health system ground with its second Health and Population Project (PSP2) which is about the end.

7.2.5 Interviewees of Group 5: The UN family

Coordination principles were well known and interviewees of this group defended the point that UN agencies were aligned with the UNDAF.

From UNAIDS' point of view, 'the government' should be the coordinator, without specifying again who in the government this should be.

"I do NOT coordinate, I facilitate coordination, I support the national party to coordinate, the civil society to be more integrated and to listen to the national party, which is in charge of coordination." (ITW23N09, group 5, local)

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Views within WHO were diverging, one saying UNAIDS should be the coordinator in the HIV field, another that the CSPD should be the legal framework and that a similar framework should be created for HIV.

Everyone in this group somehow agreed that there were too many coordination mechanisms, but that inter-institutional divergences and some conditionality prevented them from merging or choosing one unique coordination body.

The problem again was to identify who precisely was being referred to by generic words such as 'the government' or 'the national party': MoH? MoF? PES-NAC? MoA? The President himself? The Ministry of Planning? In all groups and repeatedly across the interviews, it seemed that there was some fear associated with precisely designating someone as coordinator, since it would be synonymous with the concentration of power and responsibility.

Major issues raised against coordination were the opposition of international NGOs, as well as bilateral donors and the MoA. Also it seemed that the capacity of the government to coordinate was estimated to be insufficient.

> *"International NGOs are the worst. They arrive in the country, they register with the Ministry of external relationships and do not come to MoH…….[….]…..The government should be the one coordinating. The problem is that they (the government) are passive and wait for donors to come and submit their plans" (ITW23N09, group 5, local)*

7.3 MAIN ACTORS' RELATED FACTORS INHIBITING COORDINATION

Six main themes arising from the data above were analyzed and are presented here.

7.3.1 Alliances and misalliances between organizations

Institutions interacted very differently with each other, while mistrust existed at different levels. In general, a lack of communication and sharing information between institutions was reported (SEP-CNLS 2001).

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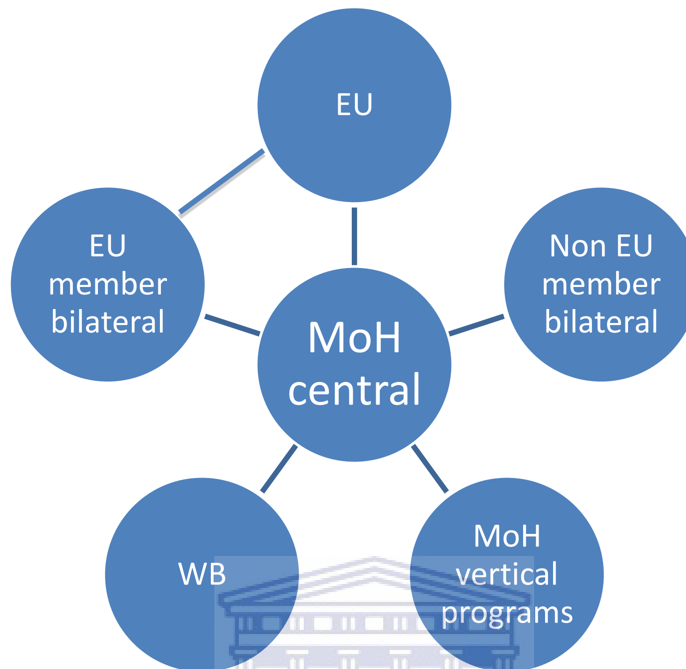
If two by two relationships are examined between the MoH and organizations which had representatives in Burundi, a very heterogeneous landscape emerges, as illustrated in Figure 20 below.

Figure 20:
Relationships between selected donors and recipients



The EU had good communication with its member states, as well as with the MoH. It tried to harmonize with member states in order to talk with one voice with the MoH. There was no communication with other donors such as the WB or bilateral donors who were non-EU member states (such as USAID or JICA) however.

> *"First, it is historical, there are bilateral donors. We try to organize regular meetings with those who are EU members, in order to harmonize, to divide the tasks. One would take and lead such sector, another one another sector and so on, and the rest of the member states would just provide funding. But there is a flagship issue. […]*

> *"We try to have a dialogue with member states and it starts to work well. Each 15 days, heads of delegation and of cooperation meet and discuss … a topic and try to have a common position. In the health sector, we meet with the main three countries. We try to coordinate each other and to push others to harmonize towards a common planning. But it does not work always very well. It is much related to individuals. If individual affinity is good, things progress fast, otherwise nothing happens.*

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“Normally, the EU is in charge of the dialogue with the country, but the EU always associates member states, since it has an obligation of coordination with its member states, in order to not duplicate activities.” (ITW14N09, group 3, expatriate)

Views on who should coordinate, or who was actively opposed to coordination, were extremely divergent and complex. Overall, institutions rejected the responsibility for the lack of coordination, especially to other ‘non-friendly’ institutions - for instance the EU on the WB and non-EU member states (see Table 11, column 5 on ‘others’ positions towards coordination’). Even the definition of coordination was diverse (Table 11, column 2). What was clear was that a common interest – such as aid effectiveness in order to improve the health system of Burundi – was not the first objective of most people in aid organizations.

7.3.2 Competition between HIV-related institutions and blurred responsibilities

In response to global requirements in terms of HIV – amongst which was one stating that “HIV needs a multisectoral approach” – a number of institutional changes occurred. At first, the MoH was ‘left aside’, as seen in the financial channelling. There were issues around the fact that it was out of the scope of the MoH to deal with non-health related HIV issues, and also, to some extent, doubts about the capability of the MoH to deal with such large amount of money, as will be developed in the next chapter.

” …..The WB started to fund HIV since other sectors such as education were being affected, and as an economic impact started to be seen. It was clear that HIV affected development, since it was affecting adults in the most productive stages of their lives. This was in the 1990s. The WBG started to discuss with the Ministry of Finance and with other relevant ministries, to draw projections on GDP etc. The WBG also realized that the HIV issue was wider than simply a medical problem but was rather a multisectoral and behavioural issue, and that such an issue could not be dealt by the MoH alone. The MoH was at that time seen as very technical and not necessarily able to disseminate prevention messages in particular.” (ITW9N09, group 4, expatriate)

In practice, four main national-level institutions were dealing with the coordination of HIV activities, at different points: CCM, MoA, HIV unit of the MoH and PES-NAC. These institutions were tied by complex relationships and changing functions, sometimes competing against each other thus inhibiting coordination. And there was a disconnection between the NAC and the MoH. Whereas the MoH was theoretically in charge of implementing curative HIV activities, from a funding management agency, the NAC progressively became an implementing agency. The MoH resented the financial importance given to PES-NAC and the political importance given to the MoA; the MoH had no legitimate role to manage NGOs, while PES-NAC relied on NGOs to implement HIV activities.

The MoH's resentment even became individual: one Minister of Health refused to communicate facility activities reports to PES-NAC, since the MoH was not receiving any funding for HIV activities.

> *"This financial input was politically oriented with a multisectoral dimension but showing a very limited role played by the MoH. As an actor it is important for me to stress this idea. Throughout almost all of MAP1, the MoH was particularly absent. The MoA held the key to financial availability what led the MoH to some kind of frustration as it felt external to a public health field of paramount importance. This situation was worsened … when Burundi was subject to a cut of financial assistance as a result of civil war and, somehow, to economic sanctions.*
>
> *"This huge financial input gathered much attention from political leaders and the local community, everybody being hooked by the appeal of money without necessary knowing how to use it. As many as USD36 million were made available […]*
>
> *"In my opinion, I believe there was a problem with the WB vision, which did not prioritise provision of care but was much more concerned with promotion of prevention. Therefore if there was no focus on medical care provision, there was a risk of forgetting the MoH in the setting up of the project. In provinces the AIDS committee was chaired by the governor whereas the deputy chairperson was put under responsibility of the health office. However, there were no funds devoted to AIDS in the operational*

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system of health provincial office. We have always found it unacceptable to deny responsibility to the MoH. Civil society organisations took some initiatives by filling the gap but at the same time, creating distrust towards the public sector since financial inputs were oriented to organisations. As a result, medical personnel from the public sector started searching for a job in organisations …..[….]….

"However on the level of the MoH (central) and the MoA, discrepancies prevailed….[…]…At a given time there was a need to transfer competence to associations, but decision makers had different opinions. The MoH was rigid and a Minister went so far as to ask provincial health offices to stop providing data to decentralised structures of the NAC." (ITW18N09, NGO, local)

Even if people were part of different committees, such as the HIV- nit director being part of CCM, some institutions did not have functional links, such as the MoH and the MoA, or the MoH and PES-NAC (see Figure 21). The MoH and the HIV unit of the MoH were linked hierarchically (the HIV unit was part of the MoH and accountable to it, though it gets funding from PES-NAC in particular, or UNAIDS). PES-NAC is under the charge of the MoA. The MoH, the MoA, the MoH HIV unit and PES-NAC members participate in CCM.

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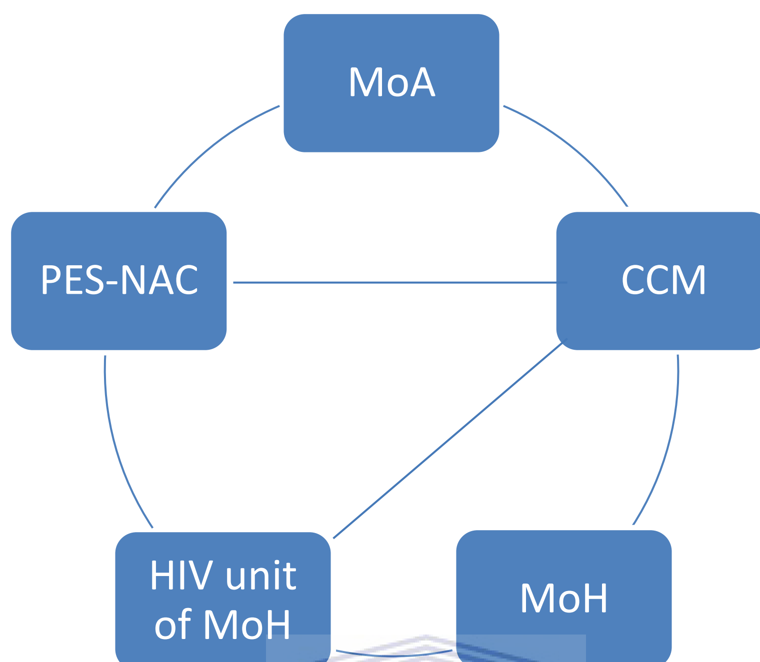
Besides the country institutions, the UN agencies had an obligation to coordinate between themselves, following the UNGASS Declaration (UNGASS 2001). There was an imbalance, however, since some agencies like the WB had a strong presence in the country and large funding, allowing them to work faster and independently. The UN agencies had a thematic group for HIV activities, to try to harmonise their actions, as well as an expanded thematic group. However, the quarterly holding of these meetings was not respected, for a number of reasons such as a lack of leadership across UN agencies and institutional instability at country-level.

Before 2008 the only formal place where all health sector actors eventually sat together regularly to discuss HIV was the CCM meetings. Its primary objective (to which everyone adhered) was proposal development, however, around the three diseases targeted by the GFATM (not even evaluations).

Figure 21:
Functional linkages between the five HIV-related institutions



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7.3.3 Coordination synonymous with loss or centralization of power

This theme came out from a synthesis of data in Table 12, column 7. What came out strongly from interviews was that being forced to coordinate meant loss of power for all organizations as in most cases, coordination was understood as the centralization of financial resources into the coordinator's hands. No-one was prepared to give up on its own resources, let alone into the hands of a general coordinator, in a country which was so poorly resourced.

There was also a fear that coordination would leave out some actors – like civil society organizations – as it is difficult to include everyone, especially if coordination is institutionalized within the MoH via the newly formed partnership framework:

> *"As a matter of fact, for example, I look at the way the partnership framework is operating. I have often attended its meetings and I have never seen there anybody from the civil society. I, in my capacity of […] and being aware of the role of civil society in the fight against HIV, I say that that one must be careful and that one must ensure that, before merging, what the CCM was covering as a partner need to be considered.*

Otherwise I agree that the trend is of reducing coordination bodies as long as when they are growing in number they don't carry out coordination well.

"But there is a need for ensuring the dimension the MAP has been given as a partner involved in fighting AIDS, that it has been taken into account at the MoH level – because I'm telling you what I have witnessed as long as I have been there for a long period. […]

"So if there is a need to be in line and keep a single coordinating structure, I agree but there is a need for such a structure to take into account all the partners who have done an excellent job and, in my view, doing without them and putting them aside would be a disaster which they will not accept after all." (ITW16N09, group 4, local)

7.3.4 Lack of time, resources and skills for coordination

This theme arose also from a synthesis of data in Table 12, column 7.

Working at policy level needs time, but the few expatriates from funding institutions did not have time to understand the power dynamics that can block coordination.

Time and coordination are inseparable, but institutions have not wanted to invest in time and in long-term expatriates, since time represents money. Moreover, the profile of people who used to work in post-conflict settings might be particular: they may not necessarily stay long because of security issues and difficult working conditions; they might also be the younger and less experienced people. Burundi being an aid-orphan, donors, as well as the government struggle to attract and retain both experienced local staff and expatriates.

The mindset slowly shifted, however - for instance the BTC moved to multiple rounds of projects (three or four of three years each - which meant nine to 12 years in a row), enabling investment in long-term projects (ITW32N09). This was probably allowed at the end of a so-called 'transition period' between the end of conflict and the beginnings of peace, during which projects might have suffered from an instable political environment. Donors are generally cautious about investing in such an environment (as explained in previous sections), but this undermines long-term planning which is easier to coordinate.

There was an ‘externalisation’ of the policy and funding proposal development processes, as illustrated by a generalized use of international consultants for the elaboration of national plans and grants applications. This probably contributed to further disruption of the planning process and challenged coordination. Indeed, because many skilled persons had fled the country (and due to time constraints, or that donors had funding available for consultants), the country often relied on external or international consultants. Ironically, the funding budgeted for hiring these international consultants at high cost is labeled ‘capacity building’. This is justified on the assumption that these consultants will transfer their experience to local people – but also as successful grant applications will provide the country with capital. The time constraints attached to grants applications does not usually allow for such ‘capacity transfer’, however, provided that this type of capacity is really what is needed.

While international consultants have good skills in language, in writing and in techniques for developing grant applications, they do not necessarily have a comprehensive understanding and vision of the country’s health system, however, and do not allow for the development of solutions suitable to the context. Funding application processes need to follow specific rules in order to increase the probability of success, such as the usage of particular key words. (This was already discussed in the process section, in which we found that ‘funding makes policy’.) For instance, the reproductive health strategic planning document included the frequent use of words such as “unique cadre”, “coordination”, “consensus”, “initiative and leadership of government”, “organized technical assistance”, “alignment”, which were fashionable at that time [(Ministère de la Santé Publique 2011) pages 4 and 5].

> *“Are we really aligned with national priorities? We need first to look at how these national priorities were elaborated, because in most weak capacity countries, an international expert arrives with a document that he copy-pastes and adapts a little. […] I discussed with some experts from the WHO, who wrote certain planning documents. They did everything from A to Z. When there is no capacity, someone needs to do the job.” (ITW14N09, group 3, expatriate)*

7.3.5 Lack of consensus over who should coordinate whom

This theme came out from a synthesis of data in Table 12, column 3. At the levels of decision making and policy making, there was a mixture/ heterogeneity of actors: global level (which did not have any representatives at national level such as GFATM and GAVI) vs. national level; actors really making decisions in terms of national level policies vs. those implementing them, such as CSOs or NGOs. This heterogeneity was due to the large role played by CSOs/NGOs when institutional capacity was weak and due to the weight given to the participative and all inclusive approach by the global level.

While the heterogeneity of actors could be an added value, the absence of hierarchy and rules in terms of decision-making and in terms of participation in meetings created further disorganization. For instance, the CPSD meetings are open to more than 50 individuals, making the meeting look more like an information sharing platform.

7.3.6 Generalized lack of trust towards the capacity of the MoH to coordinate

This theme came out from a synthesis of data in Table 12, column 7. The stakeholder analysis showed that stakeholders in general, whether local or international, did not trust the MoH capacity to lead or coordinate aid. There were lots of references to the “lack of leadership” of the MoH. Moreover, there was clearly some mistrust with regard to funding management, with the risk of mismanagement if funding was to be pooled and centralized named overtly.

Some funding agencies did not have representatives at country-level (GFATM, GAVI), making the coordination tasks challenging and leaving it up to the willingness of the country. In turn, countries justified the creation of parallel institutions, all different in nature and not necessarily with linkages, on the basis of the accountability required by funding agencies. In their mind, accountability and coordination were incompatible.

Also, given the performance-based system of major donors such as GFATM, transaction costs for coordination of short-term policies were seen to be too high to counterbalance the potential benefit for them. In addition, coordination was reported

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to be reliant on individual characteristics and inter-individual connections (ITW4N09, ITW14N09)).

Long-term HRH environment modification rooted in a health system strengthening context requires that a leader coordinate substantial negotiations and engaged, deep thinking regarding the strategies to be used (e.g. P4P). Even then, coordination was difficult, as overriding factors intervened such as the fact that no coordinator was clearly entitled to coordinate. The MoH was identified as needing to act as the coordinator, despite not having been able to take the lead at the beginning. This last point was a limitation to coordination throughout the whole policy cycle and will be discussed in the next section.

This last finding shall be investigated further, to understand more deeply why coordination has been so challenging, both on the part of the MoH (lack of capacity to coordinate) and of other organizations (unwillingness to be coordinated). In short it has meant that the MoH was not trustworthy in the eyes of donors and other governments' bodies. The fact that the MoH lacked leadership was repeatedly mentioned, yet trust and trustworthiness are not mentioned in most development policy papers as an essential quality in order to develop government 'capacity' and in particular, the capacity to coordinate.

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In the context of this study, especially in a post-civil war context, it appears that trust and trustworthiness issues across society are emphasized, affecting in particular leadership and legitimacy. These notions cannot be overlooked at (see Figure 22 below). Trust and trustworthiness seem to constitute the core elements, on which the legitimacy of the MoH will be developed, and in turn, leadership, ownership, leading to capacity to coordinate, as the final outcome.

This chapter contributes to showing the omnipresence of power struggles between organizations, as expected, exacerbated by the post-conflict context. It also shows the extent to which actors in general, be it they donors or recipients, do not trust the MoH's capacity to coordinate, which constituted our initial hypothesis leading to this study.

Figure 22:
Interrelationships between coordination, principles of the Paris Declaration, legitimacy and trust across / trustworthiness of the MoH *(own creation)*

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CHAPTER 8: FINDINGS PART 4, MOH ORGANIZATIONAL POWER ANALYSIS

Previous chapters have shown that in the immediate post-conflict period in Burundi, HRH policy coordination was far from satisfactory, despite the MoH theoretically being the coordinator.

The analysis of the recipient organizational power (in our case, the MoH) will identify underlying factors regarding its inability to fulfill the role of coordinator and will provide insights into the high level of mistrust that all actors had towards the MoH.

In analysing the MoH's power, we will use the definition of power presented in the methods section as well as the definition of leadership presented in the literature review:

- the working definition of power is a combination of resources (or 'capitals', or 'means', in Hydén's sense), the ability to mobilize these resources and of leadership;
- capitals were categorized according to Bourdieu's proposition: social, economic, cultural and symbolic (see methods section for details); and
- leadership was analysed according to Lowder's definition, whenever data permitted it: the main qualities from Lowder's definition, found to in the interviews were self-esteem, vision, self-esteem (see literature review and methods section for details).

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8.1 ECONOMIC CAPITAL

8.1.1 Financial capital

The Minister of Health negotiated its annual budget with the MoF through its Directorate General for Resources, while program directors negotiated directly with donors (in the case of the TB and Reproductive Health programs).

In 2002, the proportion of the state budget allocated to the health sector was the lowest amongst all sub-Saharan African countries. A very low proportion of the general budget was funded by the government, as seen in Table 13. The sudden increase in 2006 is artificial, coinciding with debt cancellation (approval of the HIPCI).

In 2006, funds from debt cancellation represented 53% of the total MoH budget and 48% in 2007 (La Banque Mondiale and Ministère de la santé publique du Burundi 2007).

Before 2006, the majority of the MoH budget was used for recurrent cost (salaries), while the investment budget was directly managed by external donors – such that in 2006, 82% of the external health sector's budget was by-passing the MoH [(La Banque Mondiale and Ministère de la santé publique du Burundi 2007) p.45]. In practice, the meagre budget was managed centrally and was neither decentralized to provinces nor to the nascent districts. When the MoH received the HIPCI funds in 2006, then, it struggled to manage them, which explained the delay in funds disbursement.

The PSP2 project funded by the WB brought some institutional support, by providing salary top-ups for university professors for instance. However, the project closed down earlier than expected (2000-2004) due to delays in funds disbursement and conflict between the project manager and the Minister regarding project implementation (ITW7N09).

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Table 13:
Evolution of MoH budget 2001-2007 (WB estimation, 2006)

**Power Purchasing Ratio, originally in BIF, calculated on the basis of 1 USD = 1000 BIF*

	2001	2002	2003	2004	2005	2006	2007
Total budget for the health sector - in million USD PPR*	4.3	4.6	4.1	4.9	4.4	16.6	12.8
Total budget for the health sector - as % of government total budget	3%	3%	3%	3%	2%	7%	6%
Total budget for the health sector - as % of GDP	1%	1%	1%	1%	1%	3%	2%

8.1.2 Technological capital and equipment

MoH buildings were old, dating back to the pre-colonial period. All the directorates and units were not on the same premises – and some units were moved to make space for expatriates. Internet access was a huge issue, as was access to computers, printers, and fax machines.

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The Directorate of Programs and Services was physically difficult to find, located in an obscure corridor on the second floor of the central MoH building (as of 2011). The director had a very small and dark office, whereas the TB and Reproductive Health program directors both had very large, light and spacious offices. These discrepancies in material resources – of the one in charge of coordinating programs and the ones he is supposed to coordinate – directly reflects the amount of funding dedicated to each of them. This further influenced the inability of this Program Directorate to mobilize cultural capital within the programs they were mandated to coordinate, as described below.

8.1.3 Ability to mobilize economic capital

Several factors prevented the MoH from exercising leverage on its potential financial resources, though this ability varied within the MoH.

The annual budget of the MoH was prepared by the Directorate General for Resources. The task of budgeting had the reputation of being very complicated, since the majority of external budgets were not quantified in the Finance Law of the MoF. Hence, before preparing the provisional budget the Directorate did not know how much the MoH had to spend the year after, or how much it had spent the year before (La Banque Mondiale and Ministère de la santé publique du Burundi 2007). This lack of predictability of funding did not facilitate the ability of MoH to mobilise its economic capital.

Moreover, most of the funding of vertical programs – such as funding to organize in-service training or for supervision – was kept within programs or with donors and the MoH did not have any leverage over it.

> *"USLS perceived PES-NAC as being their funding agency"* [(SEP-CNLS 2005), pp 8].

> *"The National TB Program has its own [financial] management system. These programmes enjoy to some extent a certain management autonomy which is not official. So they have structures of their own." (ITW15N09, group 1, local)*

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The MoH also did not have any liberty around HRH working conditions, since it depended on the Ministry of Civil Service which itself did not have any freedom to increase salaries as these fell under the International Monetary Fund (IMF) conditions, which did not allow any public sector salary increases (International Monetary Fund 2004; International Monetary Fund 2002). The heavily-in-debt countries initiative was signed in 2006, with conditionality on expenditure which needed to be ear-marked for the health, justice and education sectors. Despite this exceptionality, the health sector could not be an exception to the rule regarding increasing salaries, which also had obvious implications for overarching sustainability.

> *"We are faced with constraints from the WB and the IMF which are against wage bill increase."(ITW25N09, Ministry of civil service, local)*

The documented liens of accountability were not respected: line directorates, especially the Programs Directorate, were by-passed, and the Cabinet signed disbursement authorizations. As noted above, the Programs Directorate's lack of

power was directly related to a lack of financial resources, since funding was managed by programs.

In summary, the MoH had a limited ability to mobilise financial resources, since these were not under its control or were not predictable. The only exception was the Cabinet Minister who somehow had a little more capability than the rest of the MoH.

8.2 CULTURAL CAPITAL

8.2.1 Quantity of HRH

The organogram of the MoH is given below (Figure 23), with key persons and units highlighted in orange.

In 2006 the central level of the MoH (including vertical programs and provincial administrations) was employing almost a quarter of the physicians in the public sector (46 out of 201, 22%). The total number of employees at the MoH exceeded 6,000 (all types, and at central and peripheral levels), but few people occupied strategic positions – which comprised the Minister, cabinet members and directors of directorates, sub-directorates and programs, provincial office directors (at a level below). These positions were mainly occupied by medical doctors. Differences in power were moreover tangible across these 'strategic positions', as described below

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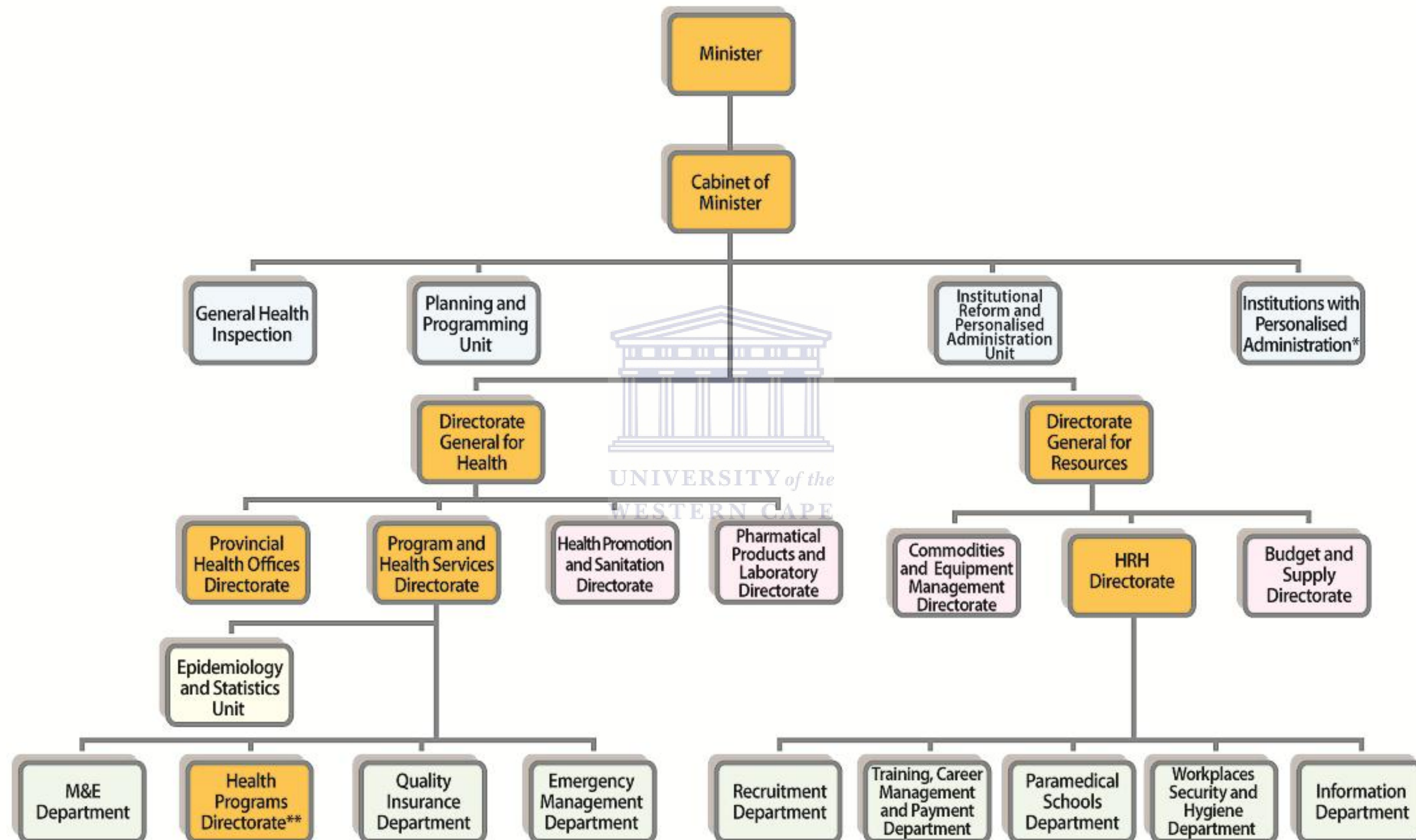
Before 2006, there was no functional unit dedicated to HRH. A virtual unit was composed of one coordinator, two technical advisors and 12 employees, as clerks and secretaries (Côte 2005). The HRH Directorate was created in 2006, under the authority of the Directorate General for Resources, following recommendations of a Canadian consultant (Appendix 13), hired with the PSP2 project of the WB (Côte 2005). Since 2006, the Directorate's mission has been HRH management.

Figure 23:
Ministry of Health (MoH) organogram (adapted, as of 2008)



*: CAMEBU (central drug purchasing agency), INSP (National Institute for Public Health), PNSR (national reproductive health program), CNTS (national center for blood transfusion), independent hospitals. **: HIV (sectoral **unit** and not program), TB and leprosy, onchocercosis, immunization, malaria

8.2.2 Quality of HRH (expertise, performance)

Allocation of positions depended on social connections, within criteria set by the country's constitution (described in the background section 'Political context after 2002'). Given the scarce pool of available HRH in Burundi, it seemed difficult to fill a specific position with a person with relevant technical expertise, given that the constitution's criteria were first to be met as well as other social connections criteria mentioned above.

Positions which were attractive were the ones with financial incentives or salary top-ups, such as senior positions in some vertical programs or special units:

> *"Everyone is waiting to be allocated a better position" (ITW3N09, group 1, local)*

HRH morale in general seemed to be undermined by the low level of salaries at both central and facility levels, influencing the quality of outputs (ITW7N09, ITW3P09, ITW6P09, ITW17F09, ITW21F09). At the MoH central and programs levels, there was a rejection of delegating responsibility to provincial authorities and below.

Moreover, there were several examples of 'capacity stealing' by donors or international organizations, as illustrated below. Two other related issues entailed by-passing the MoH's authority by creating a Ministère BIS (MoA) and the split of individuals between system's interests and own interests, these latter being exacerbated by the conflict.

> *I: Does the Ministry have the capacity of coordinating everything?*
>
> *A: If there is no capacity, it should be given to the MoH. If one bypasses it and establishes a duplicated ministry ('Ministère BIS'), its capacities will never be reinforced. The projects which are now being designed will absorb the few capacities available and the Ministry will be weakened by those who were expected to reinforce it – which will turn into a vicious circle.*
>
> *I: Should then donors change their financing methodology?*
>
> *A: Both the methodology and their mentality. These projects have been designed the way I have said, and then they are to be implemented. And*

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one is very serious when the evaluation is taking place. Results must be visible. For the purpose of proceeding quickly and reach those results on a successful basis, one will look for the best competences that one will pay quite well, which will preferably be taken from the MoH, for people from there have the skills. Later on these projects will notice that they have to work with the Ministry which they have emptied and which has no corresponding counterparts now. And the projects will say: "oooh, the Ministry is a disaster".

I: It is your case in fact, isn't it?

A: What do you mean? (…laughter)

I: But it is the case for many others, isn't it so?

A: Well, one is coping with the system, one is evolving inside it. I'd rather say it has been imposed on me." (ITW17N09, group 3, local)

"There is also another issue, the capacity stealing by UN agencies. The WHO cannot pretend to support the MoH by recruiting its physicians! If the WHO pretends to support the drugs purchasing agency, it is not by recruiting its director!" (ITW22N09, group 4, local)

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8.2.3 Institutional memory and experience

There was a high turnover of people in political and non-political positions – including frequent changes in the Ministry position itself – both at peripheral and central levels (see Table 14). This was largely due to the availability of sufficient salaries, which were usually provided by projects. Skills were linked to projects, which were limited in time, and not linked to the institution. This meant that institutional memory was necessarily weak and as a result, some (local) interviewees noted that "donors' representatives constituted the institutional memory in the country", since their level of turnover was lower than amongst high-level government managers.

Table 14:
Successive governments and Ministers of Health/HIV
with their ethnicities (Hutu-H, or Tutsi-T), region of origin and political parties

Period	President	Political party	1st VP	Political Party	2d VP	Political party	Health minister (all MD)	Political Party	HIV minister	Political party
Transitional governments after Arusha agreement 2001-2005										
Nov 2001 – Oct 2003 (23 months)	**Pierre Buyoya** (T, Bururi)	Uprona	**Ndayizeye Domitien** (H, Kayanza)	Frodebu	NA		**Jean Kamana** (H, Kayanza)	Frodebu	**Geneviève Sindabireza** (T)	Uprona
Nov 2003 – Oct 2004 (12 months)	**Ndayizeye Domitien** (H, Kayanza)	Frodebu	**Alphonse-Marie Kadege** (T, Bururi)	Uprona	NA		**Jean Kamana** (H, Kayanza)	Frodebu	**Luc Rukingama** (H, Bururi)	Uprona
Nov 2004– July 2005 (9 months)			**Frédéric Ngenzebuhoro** (T, Rutana)	Uprona	NA		**Jean Kamana** (H, Kayanza)	Frodebu	**Charles Nditije** (T, Rutovu)	Uprona
Elections August 2005										
Aug 2005– Aug 2006 (11 months)	**Pierre Nkurunziza** (H, Ngozi)	CNDD-FDD	**Dr Ndwimana Martin** (T, Bururi)	Uprona	**Alice Nzomukunda** (H, Buja)	CNDD-FDD	**Barnabé Mbonimpa** (H, Cankuzo)	Frodebu	**Triphonie Nkurunziza** (T, Bururi)	Parena (ex parti Bagaza)
Sept 2006 – Jan 2007 (5 months)					**Marina Barampama** (?)	CNDD-FDD	**Triphonie Nkurunziza** (T, Bururi)	Parena (ex parti Bagaza)	**Barnabé Mbonimpa** (H, Cankuzo)	Frodebu
Feb 2007 – Oct 2007 (9 months)					**Gabriel Ntisezerana** (H, Bubanza)	CNDD-FDD	**Rose Gahiro** (T, Ijenda? Buja rural idem Spéciose)	Uprona	**Barnabé Mbonimpa** (H, Cankuzo)	Frodebu
Nov 2007 – July 2010 (33 months)			**Dr Yves Sahinguvu** (T, Muramvya)	Uprona	**Gabriel Ntisezerana** (H, Bubanza)	CNDD-FDD	**Emmanuel Gikoro** (T, Bururi)	Uprona	**Spéciose Baransata** (T, Ijenda) *(VP Nov 2007 - Jan 2009; then minister)*	Uprona
Elections August 2010										
Aug 2010 – as of 2011 March	**Pierre Nkurunziza** (H, Ngozi)	CNDD-FDD	**Thérence Sinunguruza** (T, Mwaro)	Uprona	**Gervais Rufyikiri** (H, Gitega)	CNDD-FDD	**Sabine Ntakarutimana** (H, Muyinga)	CNDD-FDD	NA	

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“I wonder who said that the MoH has no capacity for project management. The MoH performed management of substantial projects for a long time in the past. When there are projects, there is always a possibility to hire projects managers. When the PSP2 of the WB started, we recruited people for this project, as easily as we recruited people for PES-NAC.” (ITW11-12N09, group 4, local)

8.2.4 Ability to mobilize cultural capital

While reading ‘between the lines’ of documents, two deeper issues, underpinning HRH management, emerged, which prevented the MoH from mobilising its staff.

In general, it was clear that ***the MoH did not have any leverage over its own staff, given the low wages it was paying*** (ITW1F09, ITW13F09, ITW15F09, ITW26F09) but also because of HRH requirements it needed to follow:

“People within MoH are busy looking at trainings in order to complete their meagre salaries. There cannot be any leadership in these conditions.” (ITW14N09, group 3, expatriate)

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“However salaries remain a matter that raises concern. Look, I have one of my workers who was the head of a statistic service, but he has just left for EU project, leaving a second vacant position behind him in the project. When you earn less than US$200 a month in Burundi and meet an employer who makes it US$1,500 elsewhere, it will be impossible to resist against departure. It is legitimate. The Minister [of Health] used to ask us where we will be working in the next six months. He is right as this relocation is likely to affect me. The WHO takes so many personnel from the Ministry such as […]… The problem of salary is a real problem” (ITW20N09, group 2, local)

The management capacity in the MoH was considered low. Management issues appeared to be an internal consideration in the MoH, both within central level but also between different levels of the Ministry. Once staff are hired, they might acquire some experience in management, but the MoH does not have any authority to retain them.

"The national elite, including administrative and financial senior civil servants, was relocated. The second health and population project sponsored by the World Bank is an illustrative example. The administrative and financial manager moved to the PES-NAC. The highly experienced agent in procurement also joined the PES-NAC. The first executive permanent secretary of the NAC was the former manager of the previous HIV Program [before the creation of HIV Unit]. The PES-NAC was based on a strong foundation and was therefore identified as PR for HIV. As for malaria, the PR happened to be the Health and Population Programme 2 up to 2006." (ITW21N09, group 4, local)

Similarly, the staff might ask for reallocation, and this might be accepted without taking into account the needs (ITW1P09, ITW3P09, ITW18F09, ITW20F09). In addition to the MoH being looked down upon by its staff at facility level, the rules of HRH management were very opaque.

In April 2009 a significant reshuffling took place which made it difficult to develop the second National Health Plan, since the previous team already had good ideas regarding it (ITW30N09). This reshuffling happened since the MoH fell a under the constitution's rule of a fixed ethnic distribution:

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"This reshuffle over civil servants happened to be a case for concern to me for a long time as I was submitted to pressure including from the head of state himself. Ethnic balance being part of the constitution, I tried in vain to tell the President that I didn't bother working with hutus or tutsis. The MoH was accused of technical imbalance in its staff components. [It was] meant to be 60% of hutus vs 40% of tutsis." (ITW27N09, group 1, local)

The second big issue was that ***the Directorate of Programs and Health Services did not have any power,*** despite having the coordination mandate. Interestingly, it was only during my second round of data collection in 2011 that I discovered the existence of this Directorate.

The programs were all semi-independent, in the sense that, except for their HR which was paid by the MoH, the only role of the Director of Services and Programs was to sign permissions for staff from central levels to go to supervision teams, as they needed to use cars and authorization had to come from the Directorate. This

was also essentially also to check if there was no duplication of supervision (i.e. two supervision teams going together on the same day in the same provinces and facilities).

“A simple program director does not have real leverage on vertical programs, even though its role is to coordinate them; all the meetings the program director organizes are not followed by any effect.

“Vertical programs are more accountable to donors and, within the MoH, to the Cabinet; the Cabinet signs the disbursement authorization and the Program Director is by-passed” (ITW20N11, group 1, local)

“Program directors do not want to be integrated nor coordinated; they want to keep their management independence” (ITW30N09, group 5, expatriate)

In summary, the MoH had limited ability to mobilise cultural capital, except for the Cabinet, which somehow had a greater power than other services such as to reallocate a given staff member internally and to disburse some funding.

8.3 SOCIAL CAPITAL WITHIN MOH

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8.3.1 Political networks

An article that distinguishes technical and political positions existed (article 144 of the constitution refers to it) which was intended to prevents the appointment of technical staff based on political background. However, in 2008 a study by a local CSO which oversees governmental actions reported that this law is very loosely applied and that technical staff in various ministries was appointed upon their political background, thereby preventing staff with adequate expertise to be appointed, and contributing to the increase of turnover in these institutions.

8.3.2 Professional networks

Physicians have been occupying management positions in international agencies and at the MoH. Until recently there was only one medical school in this very small country from which all physicians graduated. As a result they know each other quite well, including each other’s ethnicity/region of origin/political party which was a source of both negative and positive social capital.

Positive capital was exacerbated when two individuals belonged to the same ethnic group, were from the same region and were both physicians – while negative capital could also be exacerbated since competition was more acute amongst people within the same profession and because individuals without bridging capital were forced to work together.

8.3.3 Ethnic networks

'Ethnic origin' is also public knowledge. Years of ethnic-based civil war has extensively eroded the capacity of individuals to build bridging capital, and forced people to take refuge within bonding capital. These side effects of civil war undermined collaboration, information sharing and communication between individuals belonging to different networks, while reinforcing impermeable networks. Competition between ethnicities, over already scarce resources, was not rare, sometimes involving donors' responsibilities, as illustrated in the example below.

Example 1

Donors were accused of having favoured one ethnicity over another when they created PES-NAC and agreed to fund some CSOs, according to one interview. Whether it was true or not, this issue is related to social connection and the negative social capital induced by the conflict, although the conflict had existed beforehand too.

> *"An ex-minister of AIDS said that all HIV project managers were from one unique ethnicity, as well as beneficiaries of CSOs dealing with HIV. The WB then stopped funding certain projects and the PES-NAC reduced funding sent to provincial AIDS committee" (confidential source).*

8.3.4 Regional networks

'Regionalism' is a reality in Burundi. As in Rwanda, it is an underground issue masked by the ethnicity issue. Regional connections pre-existed ethnicity and seemed to play a huge role within the same ethnic groups. Bururi and Ijenda are two regions (smaller than a province), where the majority of Tutsis originated, with 'Intellectuals' from these two regions competing historically (personal communications).

Example 2, illustrates the entanglement of the different types of social capital (regional, ethnic and political affiliations).

From 2001 to 2005, the same Minister of Health covered the two transient governments. Between 2005 and 2012, five Ministers of Health and Minister for HIV were nominated as shown in Table 12 (four Ministers between 2005 and 2010). Ministers of Health and HIV were always from different ethnicities and political parties, according to the constitution, except for 2007 to 2010 when the Minister of Health and vice-minister of HIV were both Tutsis and from the same political party. However, they originated from two different regions (Bururi and Ijenda) and they barely communicated during the entire period the vice-ministry existed (ITW14N09, ITW18N09).

In early 2007, the Senate notified the President of the unconstitutionality of the composition of government which was not respecting the political party quota, inducing two changes in government the same year (Vandeginste 2006).

Along with the Minister, all political positions – such as Cabinet staff but also technical positions such as director general and program directors – have usually been affected by these changes – although changes also occurred without any change in the Minister position, as in April 2009 when a total of 29 positions within the MoH were changed [personal observations]. This seemed to have been ordered by the President given the lack of respect being paid to the criteria in the constitution, and since a census on the fulfilment of the four criteria in each government institution takes place each year in April and was published in May.

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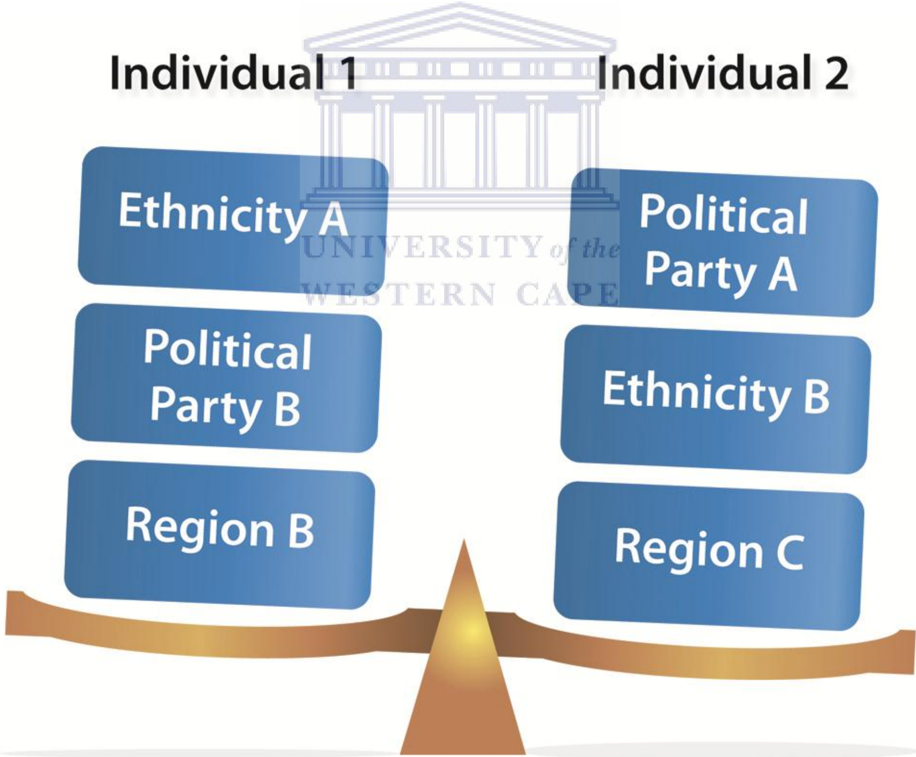
8.3.5 Ability to trust others and resulting complex social capital

Consequences of the five decades of creeping cyclic wars in Burundi were a devastated social fabric with very strong social divisions, a climate of suspicion and hidden mistrust among the population in general and between so-called ‘ethnicities’. The mechanism of massacres and genocides seemed to have been partly retributive to a perceived threat on the part of one and the other ethnicities (Lemarchand 2002). The state is not to be trusted where it has planned genocides and when the law of impunity still prevails (Lemarchand 2002; Lemarchand 1994; “Rapport de La Mission D’évaluation Concernant La Création D'une Commission D'enquête Judiciaire Internationale Pour Le Burundi” 2005).

The same climate of distrust towards others prevailed within the MoH. There was a fear of talking to others with regard to financing, projects opportunities, training etc. – apparently usual behaviour in relation to civil conflict and poor resources/ opportunities. For instance, when a project was approved, no-one shared the information with others (ITW14N09). In doing so, people kept opportunities for themselves or accumulated many projects opportunities. Also, people left it until the last minute to tell others when they planned to move from one position to another.

The four types of social networks combined with the low ability to trust on another influenced an individual's amount of social capital (Figure 24). This interfered with day-to-day interactions between key stakeholders within the MoH and also with local stakeholders external to the MoH.

Figure 24:
Different weight of social networks between two individuals



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The four types of social networks weighed differently according to the wider context and were not long-lasting capital. Belonging to political party A could constitute a significant amount of social capital if this party was the ruling one, or affiliated to the ruling one. However, this could change very suddenly, if political majorities changed, thus creating very unstable capital. At the same time, allocations of position within

the MoH were highly dependent on the amount of social capital an individual had at any given time.

The composition of social networks also influenced the ability to trust. Individuals who shared similar networks trusted each other more than the ones with dissimilar networks, increasing bonding social capital. These fragilities further fanned already high levels of volatility and distrust.

8.3.6 Ability to mobilize social capital

The ability to mobilise other types of capital through social capital was very variable and volatile, depending on the political environment but also on other context-related factors. Networks underlying inter-individual relationships were difficult to grasp and were unpredictable. The level of distrust between individuals was extremely high and at times interactions were considered dangerous and greatly affected day-to-day relationships.

> *"The problem in this country is cronyism. People will consult you according to your social network rather than according to your competence" (ITW7N09, group 1, local).*

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The only exception seemed to be a good and growing ability to mobilize capital with the WB, due to historically good relationship.

8.4 SYMBOLIC CAPITAL

In donors' documents, the weak institutional capacity of the MoH was mentioned several times. The first institutional trust and leadership crisis was the one which hijacked the implementation and renewal of the PSP2 (ITW7N09). After the underperformance of the PSP2 project, the WB decided that the MAP would no longer be managed by the MoH but by a new institution, namely the executive secretariat of the National AIDS Council (NAC), created in 2002The other underlying reason was the foreseen inability of the MoH to deal with broader intersectoral issues that HIV raised (although this may have been just an excuse by donors and some insiders to keep the MoH aside). Similarly, the lack of trust in public sector capacities to not only implement activities but also to manage these funds led the PES-NAC to become the principal recipient of GFATM funding for HIV and malaria components.

Generally, the MoH management was believed to be appointed on the basis of social connections, such as political or regional/ethnicity, and in relation to financial incentives attached to a position, rather than on real technical relevance to the position. This further undermined trust in the expertise of the MoH.

Vertical programs did not trust the MoH either, especially its capacity for financial management. The central MoH justified this lack of management capacity as a result of the newness of the management task and a brain-drain to more highly paid institutions and a General Directorate for Resources created in 2006 only. As explained in the context section, the MoH previously used to manage projects with bilateral cooperation only (a legacy of the past). Others criticized the lack of honesty and risk of embezzlement of funding which was centralized in the MoH, giving the recent example embezzlement of GAVI-HSS funding:

> *"We tripled our financial resources in a few years by moving from US$300,000 to US$900,000. The National Programme for Health and Reproduction was submitted to an audit and clear results were reached. The same should apply to the Ministry of Health. Embezzlers of public funds should be sacked no matter [what] family links they have with people in position of ruling capacity. The Minister underestimated our capacity to manage US$1 million, assuming the Cabinet of the MoH is only able to do so. This led to a heavy discussion session on this issue.*
>
> *I am not of the opinion to adopt a 'common basket' approach. Just imagine a loss of US$4 million from GAVI. Just put the money with people you can control! You cannot easily punish such important personalities as ministers, but you can put the directors of programs into jails. The idea of using a 'common basket' at the level of the general directorate for resources is unreliable." (ITW20N09, group 2, local)*
>
> *"There is no capacity at the MoH level as there is no competitive spirit. People often say "the government pretends to pay us and we pretend to work in our turn". There is no way you can perform capacity building for such a great deal of people – and capacity building can't be implemented if you have a low salary. It is a vicious circle which sounds as follows: no*

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capacity building because of low salary and no motivation hence no capacity building." (ITW24N09, senior officer MoF, local)

"We would have liked to have it [our M&E data] collected from EPISTAT [the national health information system]. However if we had adopted this approach, we would never have got such good results since we do not have any capacity to control them and [to] prevent delay". (ITW11-12N09, group 4, local)

Donors and other institutions were critical about the lack MoH's of vision. One says:

"We have funds. It is not up to us to implement them, they must be implemented at the sectoral level - provided that the MoH has a large enough vision when it comes to redistribute resources mobilised in the fight against AIDS. It [the MoH] must take into consideration the public structures but also those of the CSOs which were really involved in the AIDS-related sanitation dimension rather than the other dimensions which are not relevant to the health sector." (ITW16N09, group 4, local)

In theory, the MoH was formally in a position to mobilise its symbolic capital, since the MoH had a political and legal mandate to coordinate other local and international actors. As such it had the legitimacy to play this role and other actors were waiting for them to increase their leadership and take this on. As noted above, however, in practice the MOH's symbolic capital was low and they failed to mobilise it.

8.5 Habitus as reflected in leadership

8.5.1 Lack of self-esteem

Except for one participant, the five interviewees from the MoH were constantly repeating that the MoH was weak and had far fewer resources and skills than other actors, compared to donors for instance, who had money and skills. They looked down on themselves, and complained about MoH managers leaving for better paid positions and therefore not fully investing in their work. It was nevertheless difficult to distinguish between a real low self-esteem and a benefit of being perceived as poorly skilled or poorly resourced.

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"The government holds donors responsible for what happens in the field, but the fact is that the government waits for donors without doing anything. It is like a syndrome: donor arrives, it settles down, we don't know why it comes for; the syndrome that the government suffers from is that it waits for donors to come with funding and with conditions. We need a radical change in this mindset […]. Government and ministers are NOT interested in coordinating. They have learned that Burundi is a poor country and they just wait for donors to come with their funding. The fact is donors are not providing charity!" (ITW23N09, group 5, local)

8.5.2 Lack of vision

To develop a vision for a country needs time for reflection and freedom from constraints. The pre-electoral climate seemed to be an obstacle to moving forward (which was especially strong in the first round of interviews conducted one year before the 2010 elections). Generally, the uncertainty over continuity undermined the possibility of having a vision for the country or the health system. Since highly positioned decision makers were constantly in fear of being internally moved to lower positions, they did not have the necessary time and space/freedom to build a proper vision. In a country freshly out of conflict and still in a transitional stage, the future of the country was so fragile that it did not allow it to build a vision either in consultation with its inhabitants in general or from its policy makers in particular.

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8.5.3 Lack of commitment and sense of responsibility

While coordination seemed to be accepted as an issue by all interviewees within the MoH, clear identification of who should lead /coordinate whom in the health sector was rather vague or non-existent. It was not even clear whether the need for someone to coordinate aid and programs was ever questioned.

Many times, the pronoun 'one' was used by interviewees, blurring definition and perhaps showing unwillingness to take such responsibility, or showing a willingness to dilute the responsibility. Indeed, it was impossible to know if 'one' had to apply to Burundi, to the government, to a unit in the MoH or even to one individual. There was only one person who showed some leadership, using the pronoun 'I' and mentioning

regulatory statutes, and showing willingness to modify/ apply them. The only person who talked about coordination responsibility (allocated to the partnership framework as an entity and not to a person in particular) was an expatriate:

> *"In Rwanda, the policy put forward by the government must be followed strictly. They say 'it is our policy', they tell you where to put the money, and otherwise donors have just to leave. They don't care. This is what is missing in Burundi in contrast to the precise ideas put forward by a strong government. In spite of all that can be said about democracy in Rwanda, we must admit that everything follows the right direction in health field, with a strong leadership." (ITW5N09, group 1, expatriate)*
>
> *"NGOs come to the MoH with their proposals, while it should be the contrary" (ITW7N09, group 1, local)*

This chapter on MoH's organizational power analysis showed that the MoH's power was overall low, in terms of capital (cultural, material, social, symbolic), but also in terms of ability to mobilise capitals and leadership. Even if a clear cause-and-effect relationship is difficult to prove, we can hypothesize that the civil conflict in Burundi had not only damaged the four forms of capital of the MoH (which is easier to demonstrate), but also heavily altered the ability to mobilize its capitals and its leadership. Individuals' experiences of the conflict were embodied as post-conflict habitus in different behaviors and attitudes, leading to low leadership: they were more 'surviving' than 'living' during the conflict and their capacity to believe in the future and therefore to plan was severely hampered, due long lasting day-to-day insecurity; they were carrying a heavy sense of guilt and horror leading to a loss of the meaning of life and of self-esteem; they had disappeared as an individual but also as a member of a society in which they could not believe anymore. These alterations of individuals reflected in turn in organizational behavior. Moreover, the aid for development context had complicated the development of independent vision and clear leadership.

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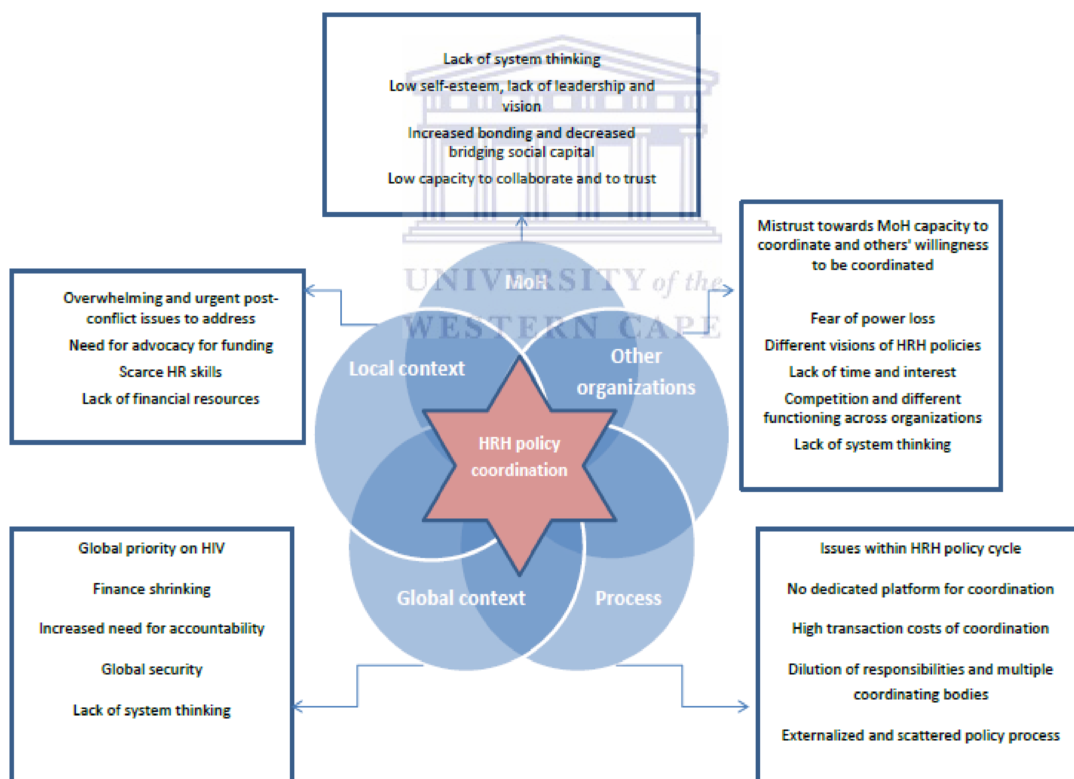
CHAPTER 9: DISCUSSION AND METHODOLOGICAL IMPLICATIONS

9.1. SYNTHESIS OF THE STUDY MAIN FINDINGS

This thesis has demonstrated the complexity of aid coordination in a country in an immediate post-conflict period, drawing on the example of HRH policies, and further dissected the concept of 'weak recipient capacity' often cited as being the major barrier to aid coordination. In the synthesis of findings in Figure 25 below, the factors have been categorized according to context, process and actors, while bearing in mind that these factors were all interrelated and intertwined.

Figure 25: Synthesis of findings on factors inhibiting HRH policy coordination



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Factors inhibiting coordination were ordinary ones – encountered in every country receiving aid, but aggravated by the conflict in Burundi – as well as extra-ordinary ones, i.e. were directly subsequent to the conflict, be they related to context or to actors.

Global context-related factors – such as high-level prioritising of HIV, the need for increased accountability and the decreasing availability of funding – hampered coordination. For instance funding was often ear-marked for HIV, which meant it was more controlled, less flexible and thus harder to coordinate.

In theory GFATM funding constituted an exception since its conception was meant to be managed by the recipient. However, even though its usage was supposed to be adapted to the country context and to increase country ownership, the way this funding was implemented in Burundi proved to be the opposite (Findings, section 1 'Creation of a cross-sectoral MoA'). There are other examples in the literature where government was unable to counteract the implementation of GFATM funding via projects. For instance, Cruz and McPake reported on Uganda's government failure to channel GFATM funding in budget support. Instead, GFATM used parallel monitoring system and separate management unit an did not participate to the coordination mechanism, in order to reduce fiduciary risk and to increase project implementation pace (Oliveira Cruz and McPake 2011). This example, together with our experience in Burundi, illustrates the gap between donors' initial intent and the reality on the ground.

The lack of a health system strengthening approach – i.e. a comprehensive approach to the needs of the entire health system, in all its components – was one of the great shortfalls at global level (Missoni et al. 2009). Coordination necessitates taking into account all components of the health sector: the lack of global policy to this end, and the lack of global-level funding attached to this policy, hampered coordination policy implementation at local-level.

A sense of being overwhelmed was present in the local context: everything in the health system had to be rebuilt following the long-lasting conflict and the extent of destruction. All actors repeatedly mentioned the disastrous state of the HRH in the country, as well as of the health sector more generally given poor financial resources and scarce HRH skills. This emergency context at local level, added to the

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emergency of tackling HIV at global level, hampered capacity and ability to coordinate (see Findings section 'Lack of time and resources to coordinate').

In addition to being overwhelmingly deteriorated, the local context was unstable as the sustainability of peace was uncertain. The risk of a relapse of conflict in Burundi was considered by donors and international observers as extremely high, given its supposedly ethnic nature. As a result, they withheld long-term investments, preferring to respond mainly to short-term and emergency issues. Although hardly controllable, the risk of resurgence of conflict was an additional factor which could have hampered the successful implementation of a plan, given that donors were extremely cautious and were not prepared to finance a long-term plan, particularly within a global context of financial crisis. This lack of long-term commitment hampered the investment of time and energy in coordination.

Vertical programs of the MoH also reflected each donor's different vision of development, given their legacy of project-based functioning – and these varied visions were not necessarily coordinated by the MoH. Our policy cycle analysis showed that vertical programs had a narrow and organization-specific way to identify issues, matching their vision of the population's health issues to the focus of their funding e.g. the actual high incidence of TB in the population led the TB Program to hire specific staff for managing that program at national and provincial levels. In contrast the alleged high prevalence of HIV led to the creation of PES-NAC and to dedicating specific clinical and management positions to HIV activities, despite the overall lack of HRH.

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In our findings the meanings given to 'coordination' differed from one actor to another. It was strongly related to a centralization of power into the MoH's hands, however, and all actors feared that they may experience a loss of power vis-à-vis others within the development field, in terms of access to resources. Those actors who had the greatest power were the strongest opponents of coordination, since they perceived coordination as having a possibly significant impact on the loss of power. Indeed, all actors who had a minimum of financial autonomy (e.g. the Reproductive Health Program, the TB Program and PES-NAC, argued that coordination would imply a centralization of resources into the MoH hands, with a subsequent decrease in their ability to mobilise funding, thus leading to lessening their relative power (i.e. decreased material capital and decreased ability to mobilise it). In our findings, the

WB, one of the biggest funders since the independence of Burundi, was perceived as the strongest opponent to coordination by other actors and behaved as such when MAP funding was implemented, by operating in a silo. Similarly, the GFATM principal recipient (PES-NAC) was reluctant to coordinate with the MoH, since it had a hand in the management of a substantial amount of funding (see Findings section 'Coordination synonymous of power loss').

The political nature of aid was very tangible when analysing the operational procedure of funding agencies. There were several examples in our findings to illustrate each actor's particular interests in securing Burundi as a privileged bilateral partner. For example during the conflict, the EC and the WB continued to operate, allegedly in order to secure a return on investment in the post-conflict period. Historical linkage also influenced eligibility to aid, such as for BTC, following a high-level decision to focus development aid (read here 'investment') in Central African countries.

These struggles of power and influence created a context in which information circulated only between two interlocutors, thus creating an asymmetry of information with respect to other actors. These practices encouraged the implementation of non-evidence-based policies based on the donors' preference, and did not favour policy coordination. For instance donors preferred to hire physicians for managerial positions, despite the overall lack of skilled HRH to deliver clinical services, and this was supported by physicians who preferred to be in managerial positions where they could get financial incentives more easily (see Findings section 2 'Program-centred formulation').

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Another finding was the increasing involvement of donors in the policy making process in a so-called fragile state. Indeed, donors not only participated in but dominated policy processes from A to Z – from issue identification (in the national health forum) and priority setting (consultations between embassies, cooperation heads and government), to policy elaboration (grant and action plans elaboration support) and implementation (evaluation and monitoring by international NGOs, by joint donor missions and other donor-driven initiatives). Donors often took the lead in activities (as implementers or as policy makers, or both), to fill the vacuum left by a weak MoH. The government found its supposedly central role of coordination difficult

to perform in the face of the proliferation of donors, among whom there were also difficult interactions and relationships.

All actors agreed that the lack of coordination was partly related to the lack of leadership and vision on the part of the MoH – which was not considered by other aid recipients (such as reproductive health program, TB program or PES-NAC) or by donors as being able to undertake the coordinator role. In none of the interviews did the MoH come out clearly as the 'must be' coordinator in the health sector; rather interviewees considered the MoH as incapable of acting as a leader (see Findings section 3, 'Generalized lack of trust towards the capacity of MoH to coordinate'). That being said, the MoH itself also did not consider itself as a suitable coordinator.

To further analyze donors' and other aid recipients' lack of trust in the MoH's capacity to coordinate, as well as the MoH's own lack of self-confidence to do so, an organizational power analysis was conducted. This allowed us to assess the symbolic power of the MoH (i.e. 'the representation of capital each individual and organization has of a given organization' including its trustworthiness in the eyes of others), as well as its social capital (i.e. the combination of social networks and trust across networks), which together lead to collaboration and coordination capacities.

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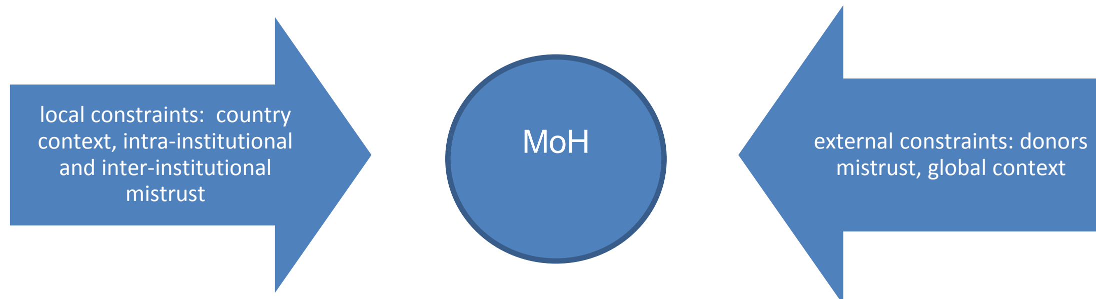
The MoH power analysis suggested complex social capital – which was emphasized in its bonding component and limited in its bridging component. The consequence was a strengthening of negative social capital, with bonding capital accumulating across individuals who shared similar political backgrounds or were from the same ethnic group or, within the same ethnic group, were from similar regions. This complex social capital landscape acted against collaboration between individuals within the MoH resulting from their very low capacity for inter-individual trust.

The symbolic power of the MoH was also low. There was low inter-organizational trust towards MoH, as it was not fully trusted by either its international partners or by the local ones, given past experiences of corruption, nepotism in job attribution, and opportunistic behavior. In addition the MoH was divided internally by intra-institutional distrust which meant it could not act as a single entity to coordinate all actors. This double constraint seriously undermined its task as leader of coordination (see Figure 26 below).

Figure 26: The double constraint faced by MoH



When Bourdieu's framework was further applied to the MoH (Bourdieu 1986), other types of capitals were also identified as low, namely material and cultural capital, as well as what falls under leadership and the ability to mobilize different types of capitals. Behaviors and beliefs of individuals working at the MoH were obviously tainted by the long years of conflict, resulting in a fear of taking responsibility, low self-esteem, and a lack of vision. These behaviors could be hypothesized as having two origins, both ascribed to the consequence of war. As a direct psychological consequence of war, these behaviors constitute symptoms of post-traumatic stress disorder (Somasundaram 2007); while as an indirect consequence of the war, they are an embodiment of seeing the 'other ethnic group' as being threatening and responsible for the current condition of their community. This latter constituted what Bourdieu calls habitus, and this post-conflict habitus constituted the root for negative social capital, by enhancing privileged relationships and collaborations within certain groups only, while leaving aside the 'other group'. Hence, this socially fractured MoH was not able to exert leadership over donors, but nor did donors facilitate MoH leadership, thus failing to stick to the main content of the Paris Declaration. Overall, these factors constituted 'weak institutional capacity' according to the donor's vocabulary and in the literature.

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Still at the level of the MoH, structural organizational factors dating back to the pre-conflict period passively inhibited HRH policy coordination. Even after independence, the MoH continued to function in similar ways as had been the case under colonialism, with vertical programs and funding based on projects and funded by

previous settlers; an absence of a proper coordination structure; and an absence of an HRH directorate and Directorate General for Resources. Some process-related factors also inhibited coordination. Difficulty in identifying the starting point of rehabilitation work was clearly reflected in the lack of prioritization in the policy and planning processes. The emergency context was palpably evident in the absence of certain plans or in the rush for certain policies, rendering coordination impossible. While the need for coordination seemed to have been taken into account, this was in an uncoordinated way leading to multiplication of coordinating bodies (CCM, IACC, UN coordination groups, CPSD, etc.). In addition the high transaction cost linked to coordination task (loss of energy, no financial incentives attached to the task of coordination) did not favor coordination at all.

Nonetheless, and despite the lack of overall coordination, this study identified two examples of different types of partial, implementation-level coordination (see types 4 and 5 in Figure 18, in Findings part 2). The first was a case of partially coordinated policy formulation and implementation. Here BTC aligned with the MoH HRH Directorate to not recruit new staff at provincial level, while other donors continued to provide incentives to recruit nurses in other provinces. As a formal ruler, the BTC had had a longstanding relationship with the MoH, and recruited a technical assistant to address institutional reforms. This person communicated well with the HRH director at MoH level, and the BTC staff at provincial level (BTC project in Kirundo) communicated well with the provincial director of health.

The second case was one of uncoordinated policy formulation but coordinated implementation. The implementation of P4P showed some level of geographical zoning, following the donor coordination platform in which at least the EC and member states were participating.

These coordination types depended on the quality of inter-individual relationships, however, as this influenced the extent of information sharing between actors. This again emphasizes the importance of trust and social capital in coordination.

9.2. LITERATURE COMPARISON

Walt et al. clearly synthesized factors hindering aid coordination into three categories, based on experiences in five countries in Asia and Africa (Walt et al. 1999a). These are context and timing, negotiations over power and influence, and institutional capacities.

The 'context and timing' category covered unstable political contexts unfavourable to governments and donors commitments, and an overwhelming number of issues to be addressed within a limited time. 'Institutional capacities' included issues around unequal relationships between donors and recipients, with recipients being unable to require donors to reform, and an MoH often internally divided by diverging interests instead of being unified around one unique goal. The 'negotiations over power' category included the unwillingness of donors to negotiate funding arrangements with other donors (for instance SWAPs), in order to perpetuate their own influence on the recipients, as well as a conservative attitude towards even the least risky behaviour.

Our findings may also be classified into these three categories, together with evidence arising from other research. In addition a fourth category arose from our findings and the more recent literature, which is about the complexity of the coordination process, mainly comprising practical difficulties. What follows details how our findings differ from, or add to, previous literature.

9.2.1 Context and timing

Post-conflict context: Unstable, volatile and a lack of systems thinking

The post-conflict nature of a country is generally considered by donors as a major risk factor for a conflict relapse (Mills and Fan 2006). In our findings, donors in Burundi were reluctant to provide long-term commitments or budget support. This reluctance is supported by evidence in the literature regarding post-conflict countries. While the development of a long-term vision and planning are essential pre-requisites to tackling HRH issues (A. Green 2007), the extreme dependence on external funding and uncertainty about its sustainability, within a fragile global and national economic context, did not allow for the emergence of a systems development approach in Burundi. Had it done so, and in contrast to vertical disease approach, it would have made the coordination process easier.

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Moreover, the literature echoed that a global reduction in the financing of health had a detrimental effect on funding countries in other post-conflict and unstable contexts (Leach-Kemon et al. 2012).

Globalized context

Globalization resulted in a tremendous change in the number and quality of actors in the development field, as shown in the literature review. Not only do these actors have conflicting agendas, some go beyond the health sector and touch on geo-strategic interests, which can undermine coordination (Waters, Garrett, and Burnham 2007). The more actors there are, the more heterogeneous they are, and the more difficult the coordination process is (Buse 1999).

In our findings, there was a multiplication of coordination bodies and structures, all created as a condition of different donors or GHIs. For instance, an application for GFATM funding and its disbursement were conditional on the existence of CCM in order to coordinate and evaluate HIV activities, whereas GAVI required the creation of the IACC. This is one illustration of how different actors interpret coordination tools and processes, according to their own internal procedures and stated objectives. Similarly, Spicer et al. noted that heterogeneity of actors at global level, all of whom have different governance and accountability structures, led to the creation of independent and parallel coordination structures, which effectively undermined overall coordination (Spicer et al. 2010).

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9.2.2 Negotiations over power and influence

Interference of donors with the country macro and micro policy process

Donors interfered with all levels of policy development, in an un-coordinated way, as is commonly the case in settings where negotiation capacities over aid are weak (Whitfield 2008). The control of the policy agenda by donors has been well described in other country case studies by Whitfield et al. [(Whitfield 2008), chapter 12, ‘aid and power’]. While recipient countries behaved differently from one another, in general donors’ influence in policy processes increased significantly from the structural adjustments period. Some countries were so deeply entangled with donors that in some cases it was not possible to even differentiate donors and recipients (e.g. Mali, Tanzania, Ghana, Mozambique and Zambia).

In contrast, governments in Botswana, Ethiopia and Rwanda were found to exert strong control over the policy agenda. While in the first two countries this control might be attributed to favourable socio-economic and institutional contexts, the fact that the government in Rwanda managed also to exert some degree of control was surprising, given the recent genocide in this latter country (see Context section).

Authors noted a combination of notable political, geo-strategic and ideological factors in Rwanda, which might have led to this positive outcome. The first was a sudden break-away from Francophone influences after the genocide, favouring the introduction of new donors from the UK and USA. The second was America's interest in securing this region against the growing influence of Sudan, thus forming an Anglophone bloc (together with Uganda and Ethiopia). The third factor was Rwanda's 'de-legitimatisation' of donors, citing their passivity or responsibility during the genocide. Other authors have described Rwanda as being well on its way to reconstruction, acting as a model of local leadership despite an authoritative model of governance which does not exactly match the democracy cherished by Western donors (Thomson and Wilson 2005; Logie, Rowson, and Ndagije 2008). Donor coordination was described as being successful, with donors increasingly shifting towards budget support (Logie, Rowson, and Ndagije 2008).

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In contrast to Rwanda, and despite the two countries sharing a mirrored and similar history, the process to end the war in Burundi was led by external actors during the Arusha peace negotiation process (Boshoff, Vrey, and Rautenbach 2010). Not only was Burundi of less geo-strategic interest than Rwanda, but there was also no real 'winner' or 'loser' in the conflict, thus leaving a vacuum of power when the conflict ended. This political void was largely occupied by those who had been given power through international agreements or internationally agreed processes as well as by foreign aid actors who intervened actively in the policy process. While at macro policy level, they imposed democratic elections, for instance, at micro policy-level, they interfered with the elaboration of most policy documents (see policy elaboration process in Findings part 2).

In such a context of complex entanglement between recipients and donors at every level of the policy-making process, the question of the recipient's ownership is of concern, despite being largely advocated in the Paris Declaration (see Box 1).

Whitfield et al. speculates that the definition of 'ownership' as used in the Declaration is more about 'commitment' than about 'control' [(Whitfield 2008), chapter 12]. Similarly, Goodhand, exploring the peace-building process in Afghanistan, concluded that the concept of ownership, though central to the Declaration, was vague (Goodhand and Sedra 2010). He also argued that in fragile and post-conflict states in particular, ownership remains unattainable because of the overwhelming influence on recipients' policies of donors' perceptions and goals.

Coordination and power struggle between donors and between recipients

An interesting study was conducted by Aldasaro et al. in the economics field (Aldasaro, Nunnenkamp, and Thiele 2010). Authors assessed the evolution of aid proliferation and aid coordination between 1995 and 2006, using disaggregated sector-specific data and indicators which measured fragmentation/ overlaps between donors in recipient countries and across aid sectors. The authors' findings were worrying, showing that overall, indicators for donor specialization (i.e. donors focusing on one or other sectors) remained low and stable, with the exception of France and the Netherlands which improved. Moreover they indicated that aid coordination had decreased, resulting in increasing overlap between donors within recipient countries; the USA had the worst results in this regard. According to authors, struggles between donors over influence is one of the roots of this "wide gap between words and deeds" around coordination (Aldasaro, Nunnenkamp, and Thiele 2010).

In 'fragile' countries such as Burundi, partners rather than the government were often seen as being at the forefront of coordination (Dodd and Olivé 2010; Buse and Walt 1997). Despite their outward willingness to collaborate or coordinate their efforts, they tended to flag their own targets and agenda, as is usually the case (Aldasaro, Nunnenkamp, and Thiele 2010; Buse and Walt 1997).

While several authors identified the commitment of all actors as central to coordination (Buse 1999; Lake and Musumali 1999; Pavignani and Durão 1999), this is difficult to obtain when there are hidden agendas and development visions are different. Moreover, Whitfield et al. reported some cases of collusion between Bretton Wood institutions and members of government who were most favourable to a certain policy (Whitfield 2008).

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Walt et al. noted that the MoH cannot be regarded as one sole actor, given the internal divisions following individuals' affiliation to units or their own interests (Walt et al. 1999a). In this deep case study of Burundi, the same applied to the MoH's 'central' and to its 'vertical programs' whose dedicated funding undermined any interest in coordination (see Findings part 1, 'Complex financial and accountability channels'). Coordination, therefore, needs to take place not only across donors and other country-level recipients, but also within the MoH.

9.2.3 Coordination: a complex process

In our findings even where there was general agreement to coordinate, it seemed difficult to actually do so, especially when financial and management procedures and timelines differed from one donor to another. There were clashes between a need for a comprehensive and long-term plan with health systems thinking, and the practical constraints of having to comply with the burdensome financial procedures imposed by each donor which prevented, for instance, common basket funding (Dodd and Olivé 2010).

Dodd et al. point out that while agreeing on general terms of aid coordination was easy, its detailed implementation seemed difficult in settings where skills were already very scarce, due to high transaction cost (i.e. in time, energy, money) (Dodd and Olivé 2010). Our findings clearly showed that few actors grasped the benefits of aid coordination, when a program was functioning well on its own. Dodd described similar trends in Lao: while actors agreed broadly on general terms of coordination, when it came to harmonizing HRH incentives for instance, no agreement could be reached (Dodd and Olivé 2010).

The question remains whether actors did not understand the benefits of coordination – which would suggest a deficit in stakeholders' policy thinking – or whether stakeholders did not *want* to understand, for fear of losing the individual benefits of not coordinating. This loops back to issues of power and interests. It may well be a combination of both.

9.2.4 Institutional capacity and usefulness of Bourdieu equation

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The lack of coordination which was shown in this thesis to partly relate to the lack of leadership in, and vision of, the MoH, has largely been described in the literature (Buse and Walt 1997; Dodd et al. 2009; Spicer et al. 2010).

Despite publications largely referring to a lack of capacity / leadership / commitment / power of MoH and of local government, to our knowledge, none has analysed the root cause of the lack of capacity or lack of leadership beyond their origins in conflicts and trust within and between institutions.

Bourdieu's framework allowed us to get beyond the classic labels of "lack of capacity", "lack of leadership" and "weak institutional capacity" that MoHs are usually given in fragile states and helped to throw light on the roots of the MoH's low institutional power.

Findings might be summarized as a vicious circle which gathered around the MoH and its habitus, as illustrated in Figure 27. Starting at the easiest funding point in the circle, material capital in relation to salaries level is low due to post-conflict status; then the cultural capital is lowered due to the brain drain; and symbolic capital decreases since trustworthiness from MoH partners will be low towards an MoH emptied of its HRH or with unstable HRH; in turn, the MoH will not be able to attract funding. This first layer of relationships alone already explains the low levels of capitals.

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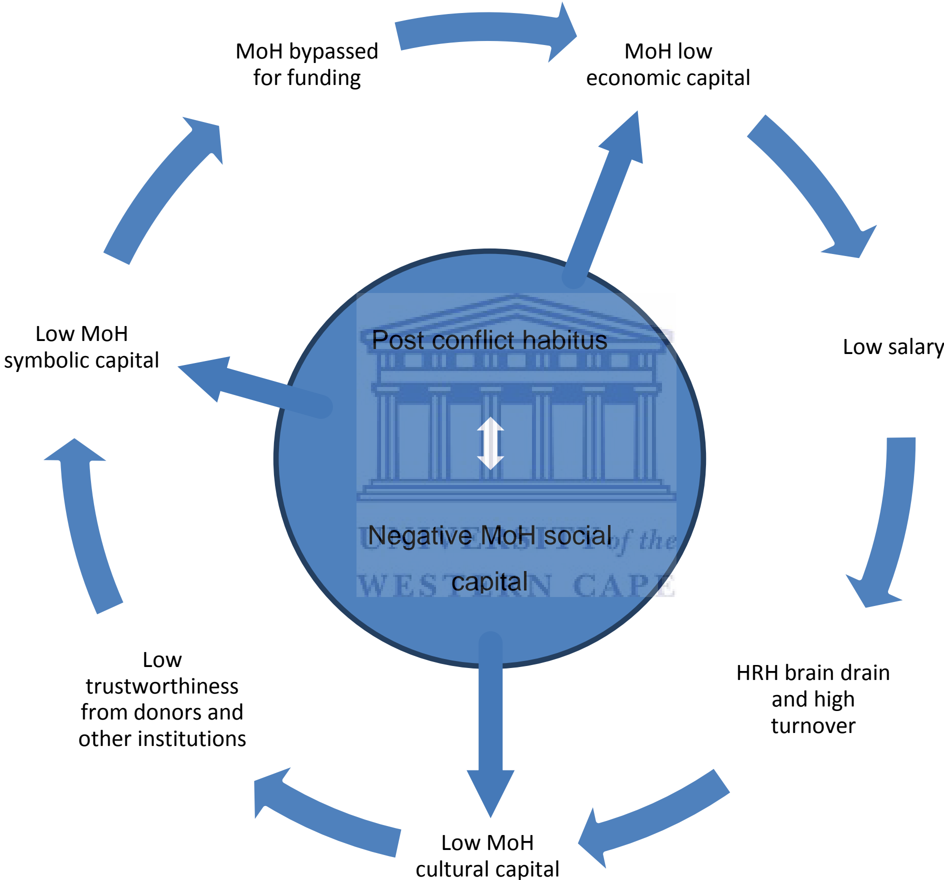
The second, deeper layer, however, explains the persistence and pervasiveness of low levels of capitals. The interaction between negative social capital and post-conflict habitus negatively influences the other three types of capitals, while also exerting an influence on each other. Post-conflict habitus, such as mistrust towards others, will increase negative social capital, which will be embodied in turn into habitus. These two inter-related factors will impact negatively on three other forms of capital. These are economic capital – which either will be accumulated inequitably by one or other social group, or wasted by a lack of global vision for the whole society; cultural capital – since again the extreme reliance on bonding social capital will prevent collaboration and intellectual pollinization across social groups; and eventually, symbolic capital – since MoH partners will be reluctant to work with an organization where social and cultural capitals are so negative or low. Other post-conflict habitus, such as low self-esteem, lack of vision over future (or only partial

vision for its own group), and a lack of sense of responsibility will impact negatively on the MoH's ability to mobilise its already low capitals.

Figure 27: Circle of relationships between capitals and habitus (own creation)



This vicious circle exists within the field of development, in Bourdieu's sense; indeed, "the field is a relatively autonomous social universe set with its own laws, rules and challenges" (Bourdieu 1986). All fields share common properties according to Bourdieu, amongst which is that each field has its dominant actors and its dominated actors, its struggles over control of resources etc. Within this field of development, there are struggles over control of resources, over imposition of own visions of

development, own rules, own influence according to own power, between stakeholders, constituted of donors and recipients of aid.

The identification of issues, for instance, results from a certain vision of the field, itself part of the habitus and the capital of an organization and of individuals constituting this organization. The habitus and capital determine the way an individual or an organization perceives the field – and therefore the type of problem they identify. For instance, UNAIDS will perceive and identify HIV as an issue of health and well-being, whereas the WB will perceive HIV as an issue of development and economics. The differing habitus and capital between organizations will necessarily result in different visions and thus in different issues being identified. The same applies to the rest of the policy cycle.

In this field of development, as in a battle arena, the Paris Declaration refers to the necessity for improved aid coordination by recipients' countries. In the health sector, it is assumed that the MoH should be the aid coordinator. When the equation of Bourdieu ([(capital) (habitus)] + field = practices) is applied to the MoH, its organizational capital and the habitus of individuals constituting the organization, both shaped by its history, within the field of development, will prompt a certain practice in terms of coordination. In other words, the combination of habitus and capitals of a given organization could be used as a proxy for organizational power, in a given field.

As organizations are constituted of individuals, their habitus influences their organizations. Organizational power therefore needs to take into account the capitals owned both by the organization and by each individual constituting the organization, as well as the habitus of these individuals. This is illustrated in Figure 28 below, in the equation of habitus-field-capital, adapted to the MoH and coordination as a practice in the field of development.

Alterations of psychological human constituencies, due to individuals' personal past experiences and the way they incorporate these experiences and translate them into present life, is similar to Bourdieu's idea of habitus, which shapes the way an individual regards the future and influences their behavior. The degree of self-esteem, the ability to make decisions and to commit, to build a vision and be

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optimistic, to lead others, to defend an interest which is beyond its own social network and interests are all outcomes of habitus.

The habitus of the MoH was reflected in perceptions, attitudes and behaviours of individuals within MoH (self-esteem, leadership, commitment, vision), in light of their individual and common past experiences (conflict, colonization, long-lasting relationship with donors after independence, chronic political instability). While it was difficult to distinguish the habitus itself from its outcome, Lahire explained that habitus is both a "principle generating classifiable practices, and the classification system itself" [(Lahire 2001), pp.159]. I believe that this impossibility of distinction does not alter the meaning of the findings *per se* nor does it decrease its significance.

Low levels of trust, or even high levels of mistrust, prevailing within the MoH in Burundi, was a result of decades of recurrent civil conflicts, by turns political or ethnic (Lemarchand 1994). Moreover, centuries of slavery and colonial rules might also have deeply affected the capacity of Burundian people to trust others (Nunn and Wantchekon 2011). Frantz Fanon undertook an intensive study of the embodiment of decades of colonialism in institutions and populations in North Africa and the reproduction of domination after independence over the weakest parts of the population (Haddab 2007). The history of Burundi, both from colonial and post-independence era, is therefore likely to have deeply eroded its population's capacity to trust, especially by decreasing its bridging social capital.

Habitus *per se* is not studied in the literature of development, but items related to habitus might be found in some publications. For instance, Alonso and Brugha, reporting on a positive experience of post-recovery in East Timor, highlighted specific positive factors which they found, such as strong social cohesion (similar to a high social capital); local institutions which gained legitimacy rapidly in the eyes of the population and donors; and a smooth post-colonisation period, with the emergence of a non-contested local leadership (Alonso and Brugha 2006). This favourable terrain for coordination by a national institution is directly shaped by the population's common past experiences, i.e. their habitus.

Negative social capital has seldom been studied in the literature, with one of the few articles referring to it being found in the field of economics (Beugelsdijk and Smulders 2009). This study's primary question was whether the two types of social capital,

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bonding and bridging, might influence the constitution of other types of capital, especially an economic one. The findings suggested that bonding capital acted against the cohesion of the society as a whole and therefore acted against its harmonious economic growth, whereas bridging capital enhanced it. A similar concept, the 'dark side' of social capital, has also been developed in the economics and politics fields, as a capital that excludes outsiders, by contrast to the positive view of social capital as conceptualized by Putnam (Coyne 2006).

In Burundi, the post-conflict habitus emphasized accumulation of bonding capital throughout generations, inducing the constitution of an unbalanced and negative social capital. The finding on the impact of negative social capital on economic growth could be extrapolated beyond the economics field. We can hypothesize that accumulation of negative social capital in Burundi, particularly at the MoH level, led to an inhibition of individuals' capacity within the MoH to collaborate towards a common goal for population health improvement.

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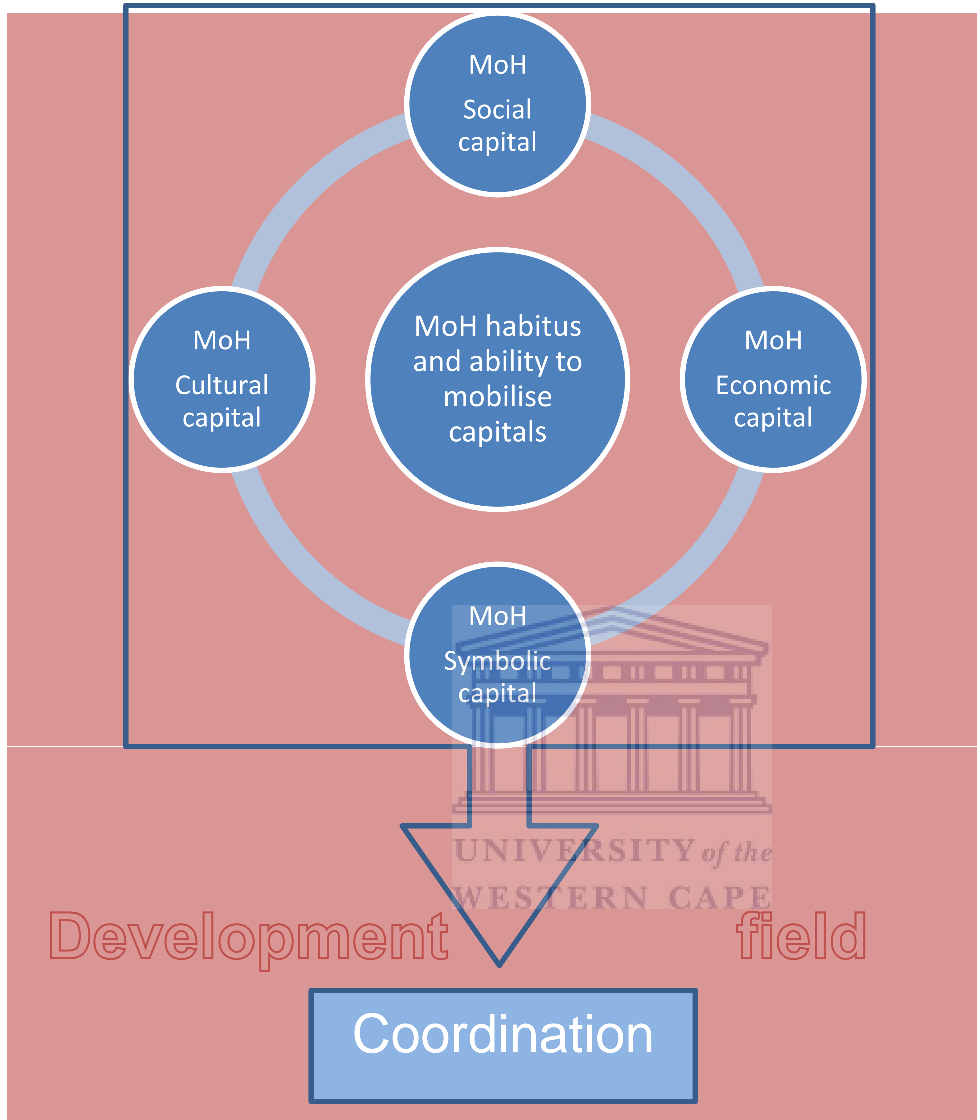
Figure 28: The equation of Bourdieu,

adapted to the Ministry of Health (MoH)



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9.3. METHODOLOGICAL IMPLICATIONS

9.3.1 Personal challenges encountered in defining power and assessing it

As has already been explained in the Methods section, becoming acquainted with numerous theories of power and selecting one theory appropriate for this research as well as finding a practical tool to assess power were difficult tasks.

Power: a concept difficult to grasp

Coordination has a great deal to do with power relationships between actors. In the public health and development literature, notions of power were very prone to perceptions, especially when viewing them from an epidemiological background. Power definitions were not precise enough to be assessed and compared, with a few exceptions of authors such as Brinkerhoff and Hydén. In the literature review, it appeared that angles for conceptualizing power depended on the field in which the research was located: the field of philosophy dealt with power's roots and sense; the sociological and social psychological fields were interested in understanding the structure and functioning of society and power within it; the organizational sciences dealt with power within and between organizations and sought ways to practically manage power in order to make organizations more productive and efficient; while the political science field tried to understand how to best exert power; and so on. There were as many different theories of, and angles on, the concept of power as there are different disciplines – although none of the concepts seemed to be comprehensive enough.

The first challenge was, therefore, to choose the most appropriate field in which to analyse power in the context of this study. As the topic of this thesis dealt mostly with the behaviour of aid organizations (recipients and donors) regarding their willingness to collaborate, be coordinated, and/or to lead, the field of organizational sciences appeared to be of paramount importance. After choosing this field, the next step was the selection of a suitable definition of power, in order to be able to assess it.

Power as a non-quantifiable entity, comprising multi-disciplinary components

None of the methods assessing power was purely quantitative, while the objective of this research was to demonstrate the lack power at institutional level. While some

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components of power – material capital for instance, or cultural capital, to some extent – could be converted into financial terms and were therefore quantifiable, other components such as social capital were hard to measure.

The definition of power devised by Brinkerhoff ("combination of resources, the ability to mobilize these resources, and leadership"), with a practical tool to assess its components, appeared to be the most suitable, since it included the notion of leadership. However, even in this clear definition, the delineation of leadership was not satisfying, and some types of resources or capital which fall outside of material / economic and human ones remained vague. Here, the management field provided the widest literature on leadership and the field of social sciences provided more appropriate definitions of capitals, such a Bourdieu's definitions.

Eventually, the need to incorporate psychological traits such as trust became obvious, as well as the need to find a concept to express the embodiment of individuals' past experiences and history in their current behaviours and attitudes, which led to the use of the concept of habitus. These latter concepts are drawn from the fields of sociology and psychological sociology.

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Hence, analysing an organization implied multiple levels of analysis across multiple disciplines: an understanding of how individuals collectively act and why they act in such way, of how organizations struggle for power between them, of how and why power is lessened or increased at individual and organizational levels, and of what constitutes organizational power.

9.3.2 Importance of social sciences in policy research in low- and middle-income countries

Importance of organizational science (management/ political sciences) in health policy research

Organizational science might be of interest in the development field, with respect to studying the lessening of tensions between individuals and between organizations, both of which undermine coordination policy and collaboration towards a common goal, as this study has demonstrated. According to Olivier de Sardan, development actors are divided between the defense of their own interests and their own institutions' interests which, when these are contradictory, might generate tensions. A

third task comprises the mediation of other actors' interests [(Olivier de Sardan 1995) pp.160]. These contradictions were described by Crozier and Friedberg with regard to organizational settings. According to them, human beings are not naturally fit to act in a collective way; instead they believe that collective action is a social construct which needs to be maintained but which also carries an inner tension, precisely because it is not a natural human behaviour (Crozier and Friedberg 1977).

Development is one type of social change, as Stiglitz said (Stiglitz 1998). Aid for development is therefore aid provided by external actors to support social change in a country; in our context, in the health sector. But individual interests and/or organization's interests might not be aligned to the interests of the system and country, especially in unstable contexts where risks of conflicts relapse are high or where resources are scarce. Therefore, organizational theory could help to disentangle some of the unresolved issues in health policy research. These could be the reasons for the existence of organizations (what exactly is meant by 'development' in each organization's own language); their strategy and hidden agendas to gain power within the field; and their geo-strategic positions and interests, at regional and global levels, beyond the health sector.

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Importance of social sciences in health policy research

This study has also shown the centrality of social capital and trust in an organization's capacity to coordinate – whose determinants have deep roots in historical events and in the way these events have been embodied by individuals (habitus).

As Tzanakis has noted, the study of social capital is difficult since its accumulation is not linear and is rather time and context dependent (Tzanakis 2013). Because power relationships are dynamic and fluid, longitudinal observations are needed in order to understand the formation and destruction of social capital.

Implications in terms of methodology for any future enquiries into this topic, might consider a need to combine quantitative and qualitative studies, as well as observational and interactional studies.

The insider and outsider approaches (such as the one praised by the ethnographer Germaine Tillion) are of special interest if a country's history and its links to individuals behaviours are to be fully grasped – in this case in terms of collaborative work, social capital and trust (Todorov 2009). Corbin-Dwyer analysed advantages and inconveniences attached to both approaches and found complementarity between them (Corbin Dwyer and Buckle 2009).This implies that interactional studies, as in vivo action research is the best method to assess relationships, given that knowledge, attitude and action may vary substantially.

Buse emphasized that policy analysis is inter-disciplinary, drawing on theories from multiple disciplines (Buse 2008). The disciplines of history, ethnography and anthropology should therefore be used more often with regards to the need for a comprehensive understanding of individuals' behaviors and habitus in a given country, which are then reflected in organizations' behaviors. The impact of policy research may increase if it incorporates an analysis of the socio-historical context of the individuals and organizations concerned, in the comprehensive and multi-dimensional way proposed above.

9.3.3 Personal challenges encountered with the topic of this research (power) and ethical implications

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One of the preliminary conclusions from the first round of data collection conducted in 2009 for the WHO study was the fact that the institutional capacity of MoH was low, while at this stage, there were no details provided on what exactly "institutional capacity" meant (World Health Organization 2009). When reporting these preliminary findings to national-level stakeholders, I received a strong critique (which could be named a rejection) of this particular finding, by one of the elite-interviewees, followed by others. The elite-interviewee blamed the donors' community in general to have been unable to build institutional capacity despite their presence in Burundi for more than half a century after the end of colonisation (personal communication). This illustrates very well the fraught atmosphere in which this research had to be conducted, notwithstanding all the ethnic and political issues raised by different interviewees. Interviewees had all some interest in having their opinions listened to, especially since academic institutions are high-located in terms of symbolic power. They could have conveyed rumours and false accusations, or could have used the

interviews to make open their resentment against such or such actor. This post-conflict research terrain was hence particularly full of individual resentments and expectations, making it challenging to find the objective path across them. But in fact, this terrain constitutes the everyday reality within which donors, policy-makers, recipients, service-providers and implementers need to work all together, to deliver services. The real challenge was therefore to find another prism / framework of analysis of individual and institutional behaviours, which went beyond true or supposed embezzlements, personal resentments and sensitivity.

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CHAPTER 10: CONCLUSION AND RECOMMENDATIONS FOR IMPROVING AID COORDINATION

10.1 CONCLUSION

Our findings showed that relationships between different organizations within the field of development are complex and governed by their relative power, their vision and objectives. The broader context, especially a post-conflict context which is by definition fragile and fast-changing, critically impacted on organizations' relationships, positions and abilities to act and direct actions.

The crux of aid coordination in the health sector was constituted by the MoH, whose power might, or might not, be used to coordinated aid. While holding the delicate position of coordinator, then, the MoH may position itself on the same level as the donors, or on a subordinate level. The coordination capacity of the MoH is necessarily influenced by its capitals and by the habitus of the individuals constituting it. Coordination was also affected by interactions between organizations, deeply enmeshed with relationships of power (Norman and Liu 2009).

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10.2 RECOMMENDATIONS

Several complementary options for improving aid coordination arise from our findings. New coordination mechanisms will not be considered here, since these are the means of coordination, and we are focusing here on the process.

A first option entails giving explicit legitimacy to the MoH to coordinate, using a new definition of 'aid coordination' in the health sector. To obtain commitment from donors and recipients, this definition could be proposed at the highest forum on aid effectiveness, in the form of an amendment to the Paris Declaration. Its effective application should be monitored and evaluated according to transparent criteria attached to them, and by a panel of independent assessors, including representatives of civil society.

A second option is to propose some solutions to circumvent practical difficulties which might arise in the coordination process.

A third option comprises addressing the MoH’s coordination capacity issues, intrinsically related to trust issues within the institution.

10.2.1 Giving the MoH symbolic power to coordinate

The method section presented Buse and Walt’s definition of aid coordination in the health sector as “any activity or set of activities, formal or non-formal, at any level, undertaken by the recipient in conjunction with donors, individually or collectively, which ensures that foreign inputs to the health sector enable the health system to function more effectively, and in accordance with local priorities, over time” (Buse and Walt 1996).

After analysing HRH policy coordination in Burundi, and in light of our findings, a new definition of aid coordination might be proposed as follows:

> **Aid coordination in the health sector is a process used by a MoH to lead donors and other organizations working with similar broad objectives within the country, in an efficient and collective way, towards an equitable improvement of the population’s physical, mental and social well-being, according to population needs, with a systems thinking and long-term approach.**

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This definition would be applicable not only to Burundi, but all countries receiving health-related aid. Indeed, after analyzing the literature on aid coordination, it is clear that even though countries’ MoHs have different levels of power, and therefore of coordination capacity, all countries struggle to some degree to assert their legitimacy vis-à-vis donors, in a complex and globalized development field.

a) Need to give clear mandate to the MoH as the coordinator

There is a need to appoint one leader to head up the process of aid coordination. This coordinator should lead all organizations in charge of health, not only international ones but also local ones. Indeed, the notion of recipients and donors seems to have become too dichotomist, especially since in the era of globalization during which aid has infused all levels of the policy cycle, and during which actors take on numerous roles.

Buse and Walt's definition refers to the notion of "action undertaken in conjunction with" (Buse and Walt 1996). The definition of "in conjunction" is "the action or an instance of two or more events or things occurring at the same point in time or space" (Oxford dictionary). In this sense, coordination might be a random process and this formulation does not truly reflect the actively sought process it should constitute. The notion 'in conjunction with' seems also too consensual, too politically correct and too passive, in a context where so much power is at play.

This study has demonstrated that each aid organization endeavours to dominate the field and works towards its own organization's interests, hence illustrating the ambivalence of actors within a given system. A coordination process therefore needs a leader who is able to guide organizations towards a common objective while, at the same time, making them leave aside their individual interests. This leader cannot be appointed by aid organizations, as each organization will have different views according to their perceived loss of power relating to the appointment of a particular coordinator, and according to their perceived loss of freedom vis-à-vis their own interests if a coordinator exists at all (see Findings theme 'Coordination synonymous of power loss or power centralization').

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According to our findings, not only did such coordinator not exist (see Finding theme 'Lack of consensus over who should coordinate whom'), but power (and responsibilities) was diluted across coordination bodies, the donor's platform, and the lead donor. Hence power was scattered instead of being concentrated in a coordinator's hands.

Sufficient power to coordinate should be given to the central authority which should be in charge of coordination, namely the MoH. To explicitly give the MoH the mandate to coordinate will increase its symbolic power by reinforcing its legitimacy in the eyes of donors and other organizations working in the health sector. Increasing symbolic power could be attempted as one way of breaking the vicious circle as presented in Figure 27 above. Thereafter, other types of capital might be progressively increased.

b) Need to consider broader actors of the health system

Buse and Walt's definition assumes many donors and one recipient, whereas in Burundi several recipients coexisted in the health sector. Within the MoH, various

vertical programs operated independently, funded directly by external partners – e.g. the TB Program received and managed funds from GFATM-TB, whereas the Immunization Program directly received and managed funds from GAVI (see Findings section 1, 'Complex financial and accountability channels'). These multiple recipients therefore need to be taken into account in terms of coordination.

There are also implementers, who could be operating in the country with their own funding, and who would also need to be coordinated. In our findings, for example, the international NGO Cordaid operated at a large scale implementing P4P without proper coordination (case study 1 in Findings section 2).

c) Need to emphasize population health improvement as the aid coordination outcome

While the growing interest in health system and policies from global policy makers and researchers is remarkable and is a first step, the local population should be reasserted as being at the heart of the health system's concerns, given that health systems exist for the population, according to the WHO definition ([…] (ii) the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, […]). Reference to population well-being was a significant and surprising absence from this research findings – as if coordination was established by aid organizations as an outcome or an end in itself (precisely what Buse and Walt warned against), and not as a process towards a desirable goal, namely the improvement of the well-being of the population. 'Population needs' could therefore be used instead of 'HS effectiveness' as in the previous definition.

In addition, however, the concept of equity could be added to the definition to emphasize the need to avoid inequity in health within the population, while retaining the notion of efficiency which is also included in the standard definition of coordination. Uncoordinated policies, especially HRH policies, might lead to non-equitable provision of care between certain categories of the population (Samb et al. 2009). Indeed one of the secondary findings of this research was an inequitable geographical coverage of the country by HRH as a consequence of uncoordinated

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HRH policies, as well as an inequitable provision of care across diseases which depended on the availability of funding[1]. Coordination has been assumed to increase both aid effectiveness and equity, this latter being improved by, for instance, setting incentives for local HRH at common rates across donors (Buse and Walt 1997).

Eventually, the health definition of WHO was included, in order to give the same weight to all three aspects of health, including its social aspects, and to emphasize the final goal of aid coordination in the health sector.

10.2.2 Rendering the coordination process possible in practice

Our findings showed that there were practical difficulties attached to the coordination task – most visible in the tension between attending to urgent matters related to post-conflict reconstruction while taking into account the long-term and time-consuming building of coordination capacity within the MoH. Indeed, rebuilding symbolic power and improving intra-organizational trust within the MoH (see section below) is not a short process - and the provision of health services cannot wait.

One practical strategy probably lies in a two-paced and two-tiered process: one short-term process for emergency needs and one long term for capacity-building, both at individual and at organizational levels. For instance Waters et al. proposed that NGOs be allowed to continue to provide health care provision during the transition phase (since they were already in charge of this task during the conflict) while the government focused on rebuilding its management capacity (Waters, Garrett, and Burnham 2007). This was echoed in our findings, as NGOs were outweighing government facilities in terms of health provision coverage and quality (Findings section 1, "Multiplicity of NGOs, outperforming MoH") and, as such, could be used on a contractual basis during the transition phase (which has been the case with P4P implementation since 2011).

Some countries seem to have supported the reduced MoH capacity by appointing a temporary leader for the post-conflict phase. Shuey et al. in Kosovo described the successful role the WHO played in the health policy reform process, while

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[1] These results are not shown in this study as they are beyond the topic.

government legitimacy was still nascent (Shuey et al. 2003). The authors pointed to the necessity of having one lead policy organization, even if this was temporarily undertaken by an external one such as the WHO, as well as having a policy framework with a clear vision. According to the authors, these two conditions were the pillars of coordination which if unmet, would likely result in each organization acting on its own. Still in Kosovo, Waters et al. also described the implementation of an interim health authority during the phase in which the MoH recovered its capacity as central authority (Waters, Garrett, and Burnham 2007).

These transitional strategies all imply close collaboration between actors external to the country and the MoH. In this situation it is essential that all policy analysts, consultants and technical support experts who might be involved in the policy process have an excellent knowledge of the roots of conflict in the country and the types of social capital in place. Newbrander proposed that "tutors" be placed within the MoH, equipped both with technical skills but, most importantly, with a thorough understanding of the country context, in order to participate in organizational capacity-building (see examples below) perfectly fitted to the country context (Newbrander, Waldman, and Shepherd-Banigan 2011).

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Another important finding in this study, and shared with other publications, was that the coordination process must to be incentivized (Findings section 3 'Lack of time, resources and skills to coordinate'), given the high transactions costs associated with it (Buse 1999). In our data, a recurrent critique of the partnership framework monthly meeting was the absence of a financial incentive to attend the meeting, while attendees had many other duties. Another concern was that there was no sanction for non-attendance at the meeting. This lack of a positive incentive or sanction made attendance at the meeting a low priority for the majority of actors. Goodwill and principles are rarely sufficient, given people's natural tendency towards doing activities that take the least time and are least energy-consuming and towards individual actions rather than collective ones (Crozier and Friedberg 1977). According to Severino, "as in any collective action problem, part of the solution therefore lies in developing the right system of incentives – sticks and carrots – for actors to make their practices converge [and coordinate]" [(Severino and Ray 2010), pp.36]. The authors proposed a series of positive and negative incentives at global and country

levels, as well as, interestingly, the creation of an independent platform at global level which would evaluate policy impact and coherence more broadly.

10.2.3 MoH empowerment and trust repair

In Burundi, the root of the MoH's organizational power, which ultimately influences the MoH's capacity to coordinate, was lowered by post-conflict habitus and negative social capital and, inherent in both, by a low level of intra-organizational trust. These last three components are largely ignored by the so-called capacity building programs undertaken in post-conflict settings. Eade argued that capacity building is a "buzzword" in the aid and development fields, being left sufficiently vague in grant applications to fit to projects' needs and visions (Eade 2007). We also found a vagueness of policy formulation around capacity building in the document analysis (Findings section 2 'Devil's in the detail'). Capacity building programs for HRH were mainly comprised of technical cooperation (i.e. the hiring of external consultants, salary top-ups and incentives, as well as training) (Piva and Dodd 2009).

Currently, then, aid for development focuses on fixing/ rebuilding economic, and to a certain extent cultural, capital at organizational level. As cultural and economic capitals increase, an increase in symbolic capital might automatically follow. In rushing in to reconstruct the most visible damages, donors and countries have a tendency to forget the conflict itself, together with its deepest and mostly invisible consequences. The need to rebuild at organisational level the soft values damaged by the conflict, which constitute other and complex forms of capacity, is overlooked by post-conflict programs.

While in general it is known that it takes a long time to accumulate capital (Bourdieu 1986), cultural, economic and, to a lesser extent, symbolic capitals might be transferred or created relatively more quickly than social capital and habitus which are difficult to rebuild as they deal with complex individual characteristics and inter-individual relationships. Organizational social capital is very different from the three other types of capital, in the sense that it is built through a deep transformation of behaviour, perceptions, and attitudes, linked to habitus. As organizations in post-conflict settings are constituted of individuals who survived the conflict and whose social capital has been damaged, this leads to negative social capital at the level of

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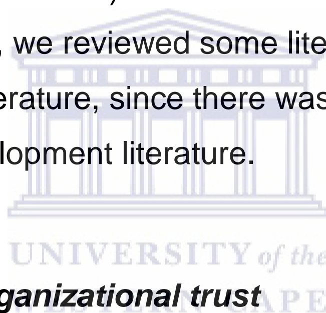
the MoH. While individuals within MoH are required to interact with each other on a daily basis, independently of their opinions, these interactions might precisely not happen because of negative social capital.

In the definition of 'capacity' proposed by Brinkerhoff ("the evolving combination of attributes, capabilities, and relationships that enables a system to exist, adapt, and perform" (Brinkerhoff and Morgan 2010)), the notion of relationships fits the social capital of the MoH well, as it influences both inter-institutional and intra-institutional relationships.

There are several examples of eroded bridging trust in the literature on post-conflict countries (Rohner, Thoenig, and Zilibotti 2011; Somasundaram 2007). Organizational effectiveness and capacity to cooperate within organisations is recognised to be based on both inter-individual trust and collective trust and these need to be addressed properly (R M Kramer 1999). While discussing inter-individual trust is beyond the scope of this study, we reviewed some literature on intra-organizational trust, mainly in the business literature, since there was hardly any reference to organisational trust in the development literature.



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Improving collective intra-organizational trust

Organizational collective trust was conceptualized by Kramer as a diffuse and cognitive form of trust, arising from expectations over trustworthiness of other members of a given organization (Roderick M Kramer 2010). Emphasis is put on social context, largely believed to act as a very important factor in which trustful or mistrustful behaviour of individuals within organizations is embedded. Kramer reviewed several qualitative studies conducted in the field regarding the building of intra-organizational collective trust (Roderick M Kramer 2010). While these examples of collective trust enhancers were tested mostly in USA or Japan (countries with very different settings compared to Burundi) over the longer term mechanisms of intra-organisational collective trust building may not be so different, as it might be expected that people within a system (organization) are likely to behave in a similar way, especially if rules are set and incentives are attached to these.

I selected two examples based on their potential applicability to the organizational context in Burundi, starting with the MoH. They follow Severino's suggestion of the

‘carrot and stick’ necessary to deliver collective action, with one being linked with reward, and the other with sanction The first example was the “rule-based trust”, from which three concrete examples of rules were extracted. Here, rules were defined as “a set of formal and informal understandings that govern how individuals within the organization interact” [(Roderick M Kramer 2010), p.87]. The first example of rule was that members of an institution are hired according to the fitness of their values to collective activities and trust-based work within small teams. The second example was the rule of “awarding trust”, i.e. awarding trust to a person who is not *a priori* trustful in order to induce a virtuous circle. For instance a novice in an organization would be pushed to trust other members of the organization during a given event, despite the fact that the context (recently hired) is not immediately favourable to trust generation. Thus, the novice, who was in a sense coerced to trust, will perceive other members of the organization as trustworthy. The third example of rule was “transforming trust”, which is the way collective trust originating within an institution, about expectations over other’s trustworthiness, is gradually incorporated as self-perception and expectations over its own trustworthiness (which is analogous to habitus in the sense of Bourdieu). This last rule could be understood as an outcome of other rule-based trust generated within organizations. This last form of transforming trust was believed to have a spill-over effect from macro-organizational level to micro-organizational level (individual), due to the reciprocal nature of trust.

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The second example regarded as collective trust-building comprises imposing sanctions in cases of failure to respect rules which, it proposes, will enhance collective trust and trustworthiness. Indeed, if trustworthiness is guaranteed by sanctions, then trust is easier to build, especially in a country such as Burundi where impunity for crimes has prevailed for a long time and remains a root of pervasive distrust.

These two sets of examples constitute only a snapshot of procedures that might be implemented, and it is important to bear in mind the specificity of each context before importing any given strategy

Moreover, strategies to rebuild intra-institutional trust in Burundi may only be successful and sustainable if inter-individual trust repair is implemented before or in parallel to organisational developments. For example, in a context where violent events continuously undermine trust between individuals effectively decreasing the

bridging social capital (across ethnic groups or political affiliations), one way proposed to repair trust is the establishment of a truth and reconciliation committee. Several countries such as South Africa and Rwanda had such commissions, though with mixed results. This type of inter-individual trust repair might be much more context-dependant than intra-organizational trust repair.

These examples constitute concrete examples of actions which might be undertaken at organizational level, starting with the MoH. Such MoH intra-organizational trust repair would allow a fair amount of social capital to be rebuilt within the MoH and would contribute to empowering the MoH, enabling it to lead collaborative activities such as coordination. In order to support this MoH empowerment process, flexible and long-term funding is essential. Trust is easy to break but long and difficult to fix (R M Kramer 1999). This lengthy process partly explains why the consequences of conflict take at least one or two decades to be addressed (Rubenstein 2011).

Impact on society of intra-organizational trust repair in the health sector

It is hypothesized that undertaking such measures of trust repair at organizational level would have positive spill-over effects at micro-level*, as per* the virtuous circle suggested in the literature by Putnam (in Kramer 2010). Putnam based this assumption on the reciprocal nature of trust: trust creates reciprocity and reciprocity strengthens trust.

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Where the roots of conflict reside in a country's social and economic failures, good service delivery and an equitable health system may restore the population's lost trust in the state (Organisation for Economic Co-operation and Development 2008b; Kruk et al. 2010; Naudé, Santos-Paulino, and Mcgillivray 2008). Trust built within health organizations might be exported to the communities they serve and enhance bridging trust in the society in general, as suggested in the literature. In this way, a functional health system might act as an enhancer of societal values, including trust, by acting as a platform for reflective learning and communication between health service providers and health system users (Gilson 2003). Efficient health policies may also act to disentangle social tensions and mitigate relapses into conflict (Naudé, Santos-Paulino, and Mcgillivray 2008; Ranson et al. 2007). Moreover, a

virtuous circle of increased revenue mobilization and an increased ability of the state to provide core services might enhance state legitimacy.

The emergence of this virtuous circle might be hampered or helped by the nature of the aid policies put in place by donors (Goodhand and Sedra 2010). Increased trust in government will also increase its legitimacy, and vice-versa (Alonso and Brugha 2006). According to this literature around “health as a superordinate value” and “health system as a social institution” a virtuous circle of increased health service delivery, trust in government and decreased risk of conflict relapse might be established. This potential virtuous circle around health systems and conflict relapse should constitute a significant, if not the biggest, incentive for donors who fund post-conflict states to take trust and social capital rebuilding programs into account.

Even though such capacity development takes time and might go against aid effectiveness in the short-term, in the long-term aid will gain in effectiveness if capacity is to be developed (Brinkerhoff 2010). Kruk et al. insisted on the role of health systems in restoring the state, since “health is the face of the state” (Kruk et al. 2010).

We need to acknowledge that trust repair and trust building are nested in broader socio-historic and political contexts, however, and that context is also, in turn, shaped by dynamics of individuals and groups of individuals as illustrated by cyclic conflicts in Burundi. Factors independent of individuals and even organizations, however, such as regional instability, may undermine a full recovery by introducing uncertainty over the future (such as the events surrounding the upcoming elections in Burundi) thus emphasizing the importance of being sensitized to geo-strategic issues behind conflicts.

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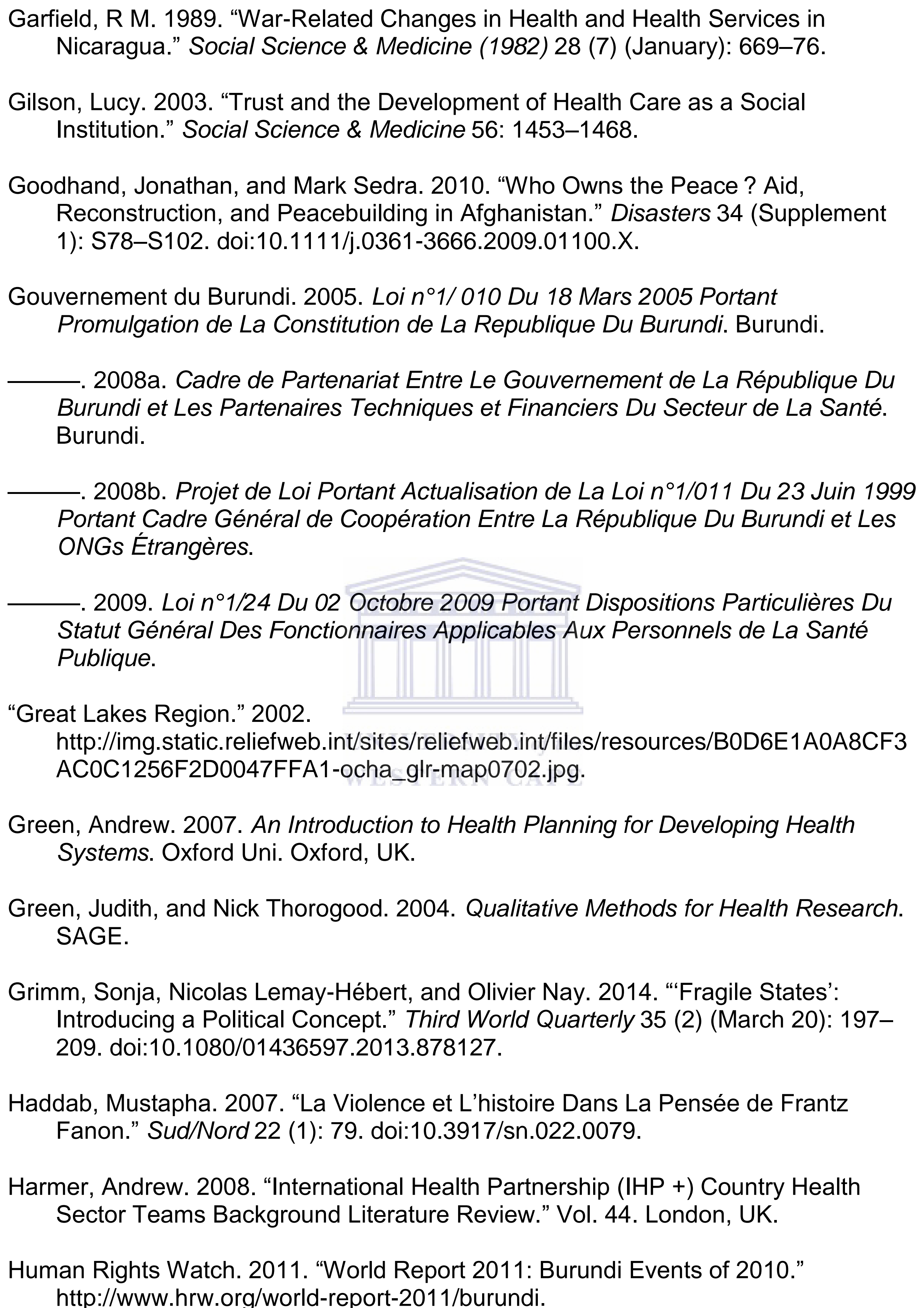

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APPENDICES

APPENDIX 1: EXAMPLE OF ONE SEMI-STRUCTURED QUESTIONNAIRE FOR THE WBG, AT NATIONAL LEVEL (THEN ADAPTED TO EACH PARTICIPANT)

National Level Interview

⇒ What is your position in the WB?
⇒ What are the main responsibilities of your post?
⇒ In general, how does WB work in Burundi?

A Aid effectiveness

1) How does WB compare with other funding mechanisms that donors use to provide aid? In what ways? Advantages / disadvantages of each?
2) Does WB work towards harmonisation with other aid mechanisms?
   ⇒ In what way? What aid instruments do they use?
3) How do partners work together aid effectiveness and coordination?
   ⇒ What structures/platforms exist to harmonize actions of donors?
4) Does the WB work towards aligning themselves with government systems?
5) How do you see the government input in coordinating aid?
6) Do you see any tensions in the new aid approach?

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B National policy development

7) How do you think WB and MAP interact with **national policies, plans and priorities for health**? Please give examples.

8) To what extent is their '**ownership**' in Burundi – by NGOs and other country stakeholders – of the different donors and GHIs operating in this country?
   ⇒ *What are the reasons for different degrees of country ownership of the GHIs?*
9) What effects have these donors and GHIs had on **intersectoral collaboration?**

C Financial flow

10) How do MAP funding flow in Burundi?
11) Are MAP funds channelled through existing mechanisms such as through government ministries or pooling mechanisms such as common fund of the CNLS or SWAp?
12) Is the WB providing **additional funds** in Burundi? Or do you think MAP funds **substituted** for other funds by Government and donors with reduced government commitment to health/HIV/AIDS?
13) Do MAP and WBG utilise existing financial management systems or have they established new mechanisms?

14) To what extent do the different partners, including your organisation, get access to funds so as to deliver services?

D Coordination and planning

15) What do you see as the major effects of MAP and other donors/GHIs on Government **national planning structures and processes** in Burundi?
    - ⇒ *Do donors and GHIs utilise existing planning and coordination structures such as CNLS, SWAp committees and Interagency Coordination Committees (ICCs), or have they promoted the establishment of new structures (such as CCMs)?*
16) Have donors and GHIs strengthened the functioning of existing structures such as CNLS, helping to focus partner efforts?
    - ⇒ *Explore the balance of positives and negatives – costs and benefits – due to the effects of donors and GHIs on national planning structures and processes*
17) Coming from your national perspective, what do you see as the major effects of these donor initiatives on **district planning structures and processes**?
18) What effects, if any, have donors and GHIs had on **decentralisation policies?**
    - ⇒ *e.g. do they strengthen districts through providing funds to implement district plans?*
    - ⇒ *or are they promoting top-down vertical planning, thereby undermining decentralisation policies*

E Monitoring and Evaluation

19) What are reporting mechanisms for MAP? Are you using **existing** reporting and monitoring systems or **separate** reporting requirements? What effects do this have?
20) Are there different effects at national and district levels?

F Human resources

21) What effects have the five different GHIs (Global Fund, World Bank, GAVI) had on Burundi's Human Resources for Health (HRH) policies?
    - ⇒ *HRH policy formulation for National, Provincial/state, and District levels*
    - ⇒ *Policies for (i) health worker training, (ii) distribution, (iii) remuneration, and (iv) performance management?*
22) What has been the degree of involvement of donors including GHIs on the development of Burundi's HRH policy and plans?
23) To what extent has the Government (MoH) been pro-active in developing HRH policies (and/or to what extent has it been responding to the effects of GHIs)?
24) How has MAP affected **health worker availability and performance** in the public health sector?
25) Does MAP actually support **national training capacity**?
    - ⇒ *Training capacity (*number of training institutions and staff)
    - ⇒ *Location of training (rural-urban, tertiary-primary)*
    - ⇒ *Curricula (content and orientation of training: eg selective vs comprehensive; clinical skills vs management/implementation skills)*
26) What **strategies or incentives** does MAP use to attract health workers to work on programmes that you fund? What are levels of motivation of public sector staff compared to non-public staff?

- ⇒ *Salaries and bonuses*
- ⇒ *Training opportunities, continuing education, career development*
- ⇒ *Recognition and appreciation/ hospital- clinic management*
- ⇒ *Availability of necessities/ hospital infrastructure*

Concluding question

27) How could MAP improve the way they work in Burundi?
- ⇒ *In what ways? Explore and probe responses*

What important documents/ reports would you advise me?

Who else should I be talking to?

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APPENDIX 2: ORIGINAL APPROVAL FROM THE NATIONAL ETHICS COMMITTEE OF BURUNDI (FOR ROUND 1)

Comite National d'Ethique pour la protection des êtres humains participants à la recherche biomedicale et comportementale

Bujumbura, le 19 / 1 / 2008

N/Réf : CNEB/ 002 /2009

Au Dr Johann CAILHOL

A Cap Town/ Afrique du Sud

Objet : Décision du Comité National d'Ethique sur l'étude « Synérgies positives entre initiatives santé globale et systèmes de santé »

UNIVERSITY of the WESTERN CAPE

Docteur,

Le Comité National d'Ethique s'est réuni en date du 16/1/2009, en vue d'une analyse de votre projet à haut mentionné.

Après avoir analysé les aspects éthiques et conformément aux reglementations internationales dans ce domaine, le Comité National d'Ethique du Burundi, a approuvé ce projet.

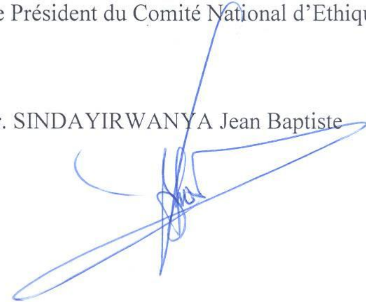
Cette approbation est valable pour une année renouvelable du 19/1/2009 au 19/1/2010.

Toutefois, si des modifications du protocole devraient y être apportées (notamment l'inclusion d'autres unités de recherche), une demande préalable devra être adressée au Comité National d'Ethique avant application.

Veuillez agréer, Docteur, l'expression de mes sentiments les plus respectueux.

Le Président du Comité National d'Ethique

Pr. SINDAYIRWANYA Jean Baptiste



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APPENDIX 3: APPROVAL OF THE NATIONAL ETHICS COMMITTEE OF BURUNDI, TRANSLATED IN ENGLISH (FOR ROUND 1)

National Ethics Committee for the protection of human beings participating to biomedical and behavioural research

- Bujumbura, 19/01/2008

N/Ref:CNEB/002/2009

To Dr Johann CAILHOL

At Cape Town/South Africa

Subject: Decision of National Ethics Committee on the research entitled <positive synergies between health systems and global health initiatives>

Doctor,

UNIVERSITY of the WESTERN CAPE

The National Ethics Committee analysed your project, quoted above, on the 16 of January 2009.

Considering the project is fulfilling the international rules and ethical criteria, the Committee has approved this project.

This approval is valid for one year, from the 19 of January 2009 to the 19 of January 2010. However, should any change be implemented, especially regarding the inclusion of additional facilities, a further approval will be required.

Sincerely,

The president of the National Ethics Committee

Pr SINDAYIRWANYA Jean-Baptiste

APPENDIX 4: INTERVIEW REQUEST LETTER IN FRENCH (ROUND 1)

Bujumbura, le X/Y/2009

A l'attention de XXXXX

Objet : sollicitation d'interview dans le cadre d'un projet OMS

Nous vous informons que le Burundi a pris part à un projet OMS intitulé Synergies Positives entre Initiatives de Santé Globale et systèmes de santé.

Les objectifs du projet sont d'analyser les impacts des nouveaux financements internationaux appelés Initiatives de Santé Globale, tels que le Fonds Global, PEPFAR, GAVI ou le projet MAP de la Banque Mondial, sur le système de santé au Burundi.

De par votre rôle dans votre institution, vous êtes en première position pour observer et analyser les influences que peuvent avoir les Initiatives Globales de Santé sur les ressources humaines dans le domaine de la santé au Burundi.

C'est pour cette raison que nous aimerions vous inviter à participer à une interview approfondie thématique.

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L'interview sera réalisé par le Dr Johann Cailhol, médecin, chercheur en santé publique, à l'université de Western Cape, Afrique du Sud.

Nous espérons que vous serez en mesure d'accorder un peu de temps à cette étude.

Nous nous permettrons de vous contacter par téléphone quelques jours après le réception de ce document afin d'organiser l'interview, si vous en êtes d'accord.

Je vous prie d'agréer XXXX, mes expressions distinguées.

Dr Johann Cailhol

CNR/ Burundi

University of the Western Cape/ South Africa

Téléphone: Burundi: +257 79 410 432 / South Africa: + 27 79 100 4366

Email: johann.cailhol@gmail.com

APPENDIX 5: INTERVIEW REQUEST LETTER TRANSLATED IN ENGLISH (ROUND 1)

Bujumbura, X/Y/2009

Dear Mrs/Ms/M XXXXX

Purpose: interview request

We have the pleasure to inform you that Burundi is involved in a WHO project, entitled Positive Synergies between Global Health Initiatives (GHIs) and Health System.

The aim of the project is to analyse how these new financing mechanisms, called GHIs, such as the Global Fund for the fight against AIDS, Tuberculosis and Malaria, PEPFAR, GAVI or the Multi-country AIDS Program of the World Bank interact with the health system in Burundi.

Given your position in your institution, we think that your point of view, especially on Human Resources for Health would be very useful.

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We would like therefore to know if you would agree to be interviewed you for the purpose of this study.

The interview will be led by Dr Johann Cailhol, researcher at the University of Western Cape, in South Africa.

We hope that you will have some time to for this project.

We will contact you in few days by phone to set a date for the interview, if you agree with that.

Best regards

Dr Johann Cailhol

CNR/ Burundi

University of the Western Cape/ South Africa

Téléphone: Burundi: +257 79 410 432 / South Africa: + 27 79 100 4366

Email: johann.cailhol@gmail.com

APPENDIX 6: INTERVIEW CONSENT FORM IN FRENCH (ROUND 1)

Formulaire de consentement

Projet: Synergies positives entre Initiatives de Santé Globale et systèmes de santé

L'étude m'a été décrite dans un vocabulaire clair et compréhensible et je consens à y participer volontairement et librement. J'ai obtenu des réponses à mes questions concernant l'étude. J'ai compris que mon identité ne sera pas divulguée et que je pourrai me retirer de ce projet à tout moment, et cela sans aucune conséquence ultérieure.

Un dictaphone sera utilisé pour enregistrer l'entretien, de manière à capter le plus précisément possible les informations dont vous ferez part. A tout moment, le chercheur gardera la confidentialité de la source d'information et se référera à vous et à vos propos avec un pseudonyme ou avec un nom fictif et le contenu de l'enregistrement sera effacé au terme du projet. L'accès aux informations qui seront retranscrites sera limité aux chercheurs associés au projet. Les transcriptions de cet entretien de seront pas divulgués.

___ Je consens à être enregistré pendant l'entretien.

___ Je refuse d'être enregistré pendant l'entretien.

Nom du participant………………………

Signature du participant……………………………… Date………………………

Nom de l'interviewer………………………..

Signature de l'interviewer……………………………… Date………………………

Si vous avez des questions relatives à l'étude, n'hésitez pas contacter le chercheur principal de ce projet:

Dr Johann Cailhol
CNR/ Burundi
University of the Western Cape/ South Africa
Téléphone: Burundi: +257 79 410 432 / South Africa: + 27 79 100 4366
Email: johann.cailhol@gmail.com

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APPENDIX 7: INTERVIEW CONSENT FORM TRANSLATED IN ENGLISH (ROUND 1)

CONSENT FORM

Title of Research Project: Positive synergies between health systems and Global Health Initiatives

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Participant's name………………………..

Participant's signature……………………………….Date………………………

Researcher's name………………………..

Researcher's signature……………………………….Date………………………

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An audiotape will be used to record the interview so as to capture accurately all the information that will be given. At all times the researcher will keep the source of the information confidential and refer to you and your words by a pseudonym or invented name, erasing the taped material on completion of the study; and limiting access to the interview transcripts to his co-researchers who will assist in the data analysis. The transcripts of the actual interview will not be released.

___ I agree to be **audiotaped** during my participation in this study.

___ I do not agree to be **audiotaped** during my participation in this study.

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Dr Johann Cailhol

CNR/ Burundi

University of the Western Cape/ South Africa

Téléphone: Burundi: +257 79 410 432 / South Africa: + 27 79 100 4366

Email: johann.cailhol@gmail.com

APPENDIX 8: ETHICS CLEARANCE FROM UWC (ROUND 1)

OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT

Private Bag X17, Bellville 7535
South Africa
Telegraph: UNIBELL
Telephone: +27 21 959-2948/2949
Fax: +27 21 959-3170
Website: www.uwc.ac.za

13 March 2009

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and the ethics of the following research project by: Prof D Sanders (School of Public Health)

Research Project: Experiences of three African Countries with Global Health Initiatives

UNIVERSITY of the

Registration no: 09/1/12

WESTERN CAPE

Peter Syster
Research Development
University of the Western Cape

APPENDIX 9: ETHICS CLEARANCE FOR ROUND 2, ORIGINAL IN FRENCH FROM BURUNDI NATIONAL ETHICS COMMITTEE

Comite National d'Ethique pour la protection des êtres humains participants à la recherche biomédicale et comportementale

Bujumbura, le 06/12/2010

Au Docteur Johan Cailhol

University of the Western Cape

Objet : Décision du Comité National d'Ethique
Sur le projet thèse « Coordination des aides et partenariats dans le secteur sanitaire et leur impact sur les ressources humaines dans un pays post-conflit, le BURUNDI »

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Docteur,

Le Comité National d'Ethique s'est réuni en date du 24/11/210, en vue d'analyse de votre projet ci-haut mentionné.

Après avoir analysé les aspects éthiques du projet et conformément aux reglémentations internationales dans ce domaine, le Comité National d'Ethique du BURUNDI a approuvé ce projet.

Cette approbation est valable pour une année renouvelable du 24/11/2010 au 24/11/2011

Toutefois, si des modifications du protocole devraient y être apportées (notamment l'inclusion d'autres unités de recherche), une demande préalable devra être adressée au Comité National d'Ethique avant application.

Veuillez agréer, Docteur, l'expression de ma considération distinguée.

Le Président du Comité National d'Ethique

Pr. Jean Baptiste SINDAYIRWANYA

APPENDIX 10: ETHICS CLEARANCE FOR ROUND 2 FROM UWC

OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT

Private Bag X17, Bellville 7535
South Africa
Telegraph: UNIBELL
Telephone: +27 21 959-2948/2949
Fax: +27 21 959-3170
Website: www.uwc.ac.za

23 August 2010

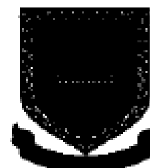
To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and the ethics of the following research project by: Dr J Cailhol (School of Public Health)

Research Project: Aid co-ordination, partnerships and their impact on the health workforce in post-conflict states – the case of Burundi

Registration no: 10/6/6

Peter Syster
Manager: Research Development Office
University of the Western Cape



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APPENDIX 11: INFORMATION LETTER, TRANSLATED FROM FRENCH (ROUND 2)

INFORMATION LETTER

Title of Research project: Aid coordination, partnerships and their impact on the health workforce in Burundi

The Universities of Pretoria and Western Cape, with funding from the European Commission, together with the University of Burundi, are conducting a study to assess how the rise of Global Health Initiatives (GHIs) such as The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the Global Alliance for Vaccines and Immunization (GAVI), and the US President's Emergency Plan for HIV/AIDS Relief (PEPFAR) have impacted on the architecture of development partnerships and country-level health systems' functions at national, provincial, district and sub-district levels.

There are differing views on the consequences of GHIs for the development and functioning of recipient countries' health systems. This study is a multi-country study in South Africa, Lesotho, Burundi, Angola and Mozambique to document the exact impact of these GHIs.

In Burundi, this study will be part of a PhD research (Dr Johann Cailhol) and will be focused on the implementation of donors' coordination mechanisms (including GHIs) and their impact on the human resources for health.

The study will first examine the implementation of a new coordination mechanism at central-level, the partnership framework for health and development. The study will then evaluate the evolution of selected human resources indicators since the coordination mechanism was implemented. Eventually, the probable impact of the coordination mechanism on the human resources for health will be assessed.

The research will combine quantitative and qualitative methods, at each level of the health system, from national to facility. Three provinces will be included, Bujumbura-Municipality, Ruyigi and Kirundo and four facilities per province will be included. Qualitative methods will include semi-structured interviews of key-informants in each

relevant donor's related institution and government bodies, as well as at provincial, district and facility-level and focus-groups at facility-level. Quantitative methods will include questionnaires and reports review at facility-level.

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Dr Johann Cailhol

CNR/ Burundi

University of the Western Cape/ South Africa

Téléphone: Burundi: +257 79 410 432 / South Africa: + 27 79 100 4366

Email: johann.cailhol@gmail.com

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APPENDIX 12: INFORMED CONSENT FORM, TRANSLATED IN ENGLISH (ROUND 2)

CONSENT FORM

Title of Research Project: Aid coordination, partnerships and their impact on the health workforce in Burundi

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

An audiotape will be used to record the interview so as to capture accurately all the information that will be given. At all times the researcher will keep the source of the information confidential and refer to you and your words by a pseudonym or invented name, erasing the taped material on completion of the study; and limiting access to the interview transcripts to his co-researchers who will assist in the data analysis. The transcripts of the actual interview will not be released.

___ I agree to be **audiotaped** during my participation in this study.

___ I do not agree to be **audiotaped** during my participation in this study.

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Participant's name………………………..

Participant's signature……………………………….

Date………………………

Witness' name………………………..

Witness' signature……………………………….

Date………………………

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Dr Johann Cailhol
CNR/ Burundi
University of the Western Cape/ South Africa
Téléphone: Burundi: +257 79 410 432 / South Africa: + 27 79 100 4366
Email: johann.cailhol@gmail.com

APPENDIX 13: ISSUES RAISED IN THE CANADIAN CONSULTANT DOCUMENT, CLASSIFIED ACCORDING TO THE MARTINEAU&MARTINEZ FRAMEWORK

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- In terms of production and distribution, there was no HRH planning process. There was no proper recruitment, which used to happen upon references from political authorities. The MoH seemed to be reactive rather than proactive (in general).
- In terms of management, HRH used to be contracted by different programs within MoH, funded by different donors. Therefore, they were ruled by different policies, creating parallel groups of HRH at facility-level. There was no HRH management policy and there was even no individual HRH file. The MoH and the HRH unit managed everything on a daily basis, without any planning or projection and functioned in reaction to a situation or to a need/offer (*ad hoc* basis).
- In terms of education, there was no training plan. In-services trainings happened on the ground, without being coordinated by central level. The MoH had an opportunistic behaviour, acting according to situations and not according to a proper planning. Trainings organized by donors did not fit within an annual training framework. There was no record of trainings provided. Trainings provided were only assessed in terms of participants' satisfaction but never in terms of mid or long-term change in practices on the ground. If a health program organized some training, participants to the training had to get an authorization / invitation for participation from 1) the facility manager, 2) the health program director and 3) from the Minister of health. The HRH director was not involved at all in the process. Its direct budget was very limited.
- In terms of working conditions, remuneration did not respect internal nor external equity. The MoH did not have any control on its remuneration policy, since the civil servants legal framework has been regulating it. This framework did not provide any flexibility and in particular, was not adapted to the specificities of the health sector. There was no protective factor of remuneration against the effects of inflation (both in MoH and MoF).

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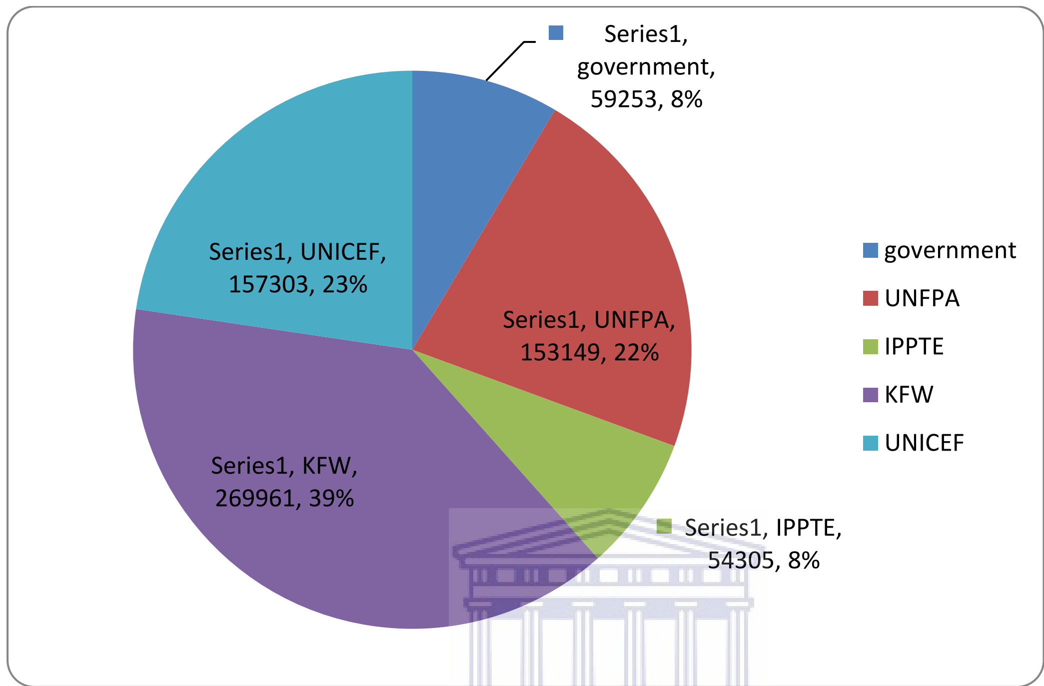
APPENDIX 14: SOURCES OF REPRODUCTIVE HEALTH PROGRAM BUDGET IN 2006

(USD, converted using 1000 BIF = 1 USD)



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APPENDIX 15: CHRONOLOGY OF EVENTS AROUND THE BEGINNING OF HEALTH AND POPULATION PROJECT 2 (FROM PROJECT IMPLEMENTATION AND RESULTS REPORT, PP.7)

This Project was financed by an IDA Credit 27310 in the amount SDR 14.3 million approved on 05/25/95 and a supplemental grant H0180 of SDR 7.2 million. The total project financing amount is SDR 21.5 equivalent to US$30.8.

The Projet was conceived as part of a comprehensive donor program of over US$100 million for five years prepared by the Burundian Ministry of Public Health (MOPH) in the late 1980s, and agreed with most donors by 1992. The Program was to be financed by USAID, EU, KfW, UNICEF, WHO, the Government of Belgium, and IDA. The Project was to follow-up a successful First Health Project (implemented December 1987 to June 1995). The Project was first appraised in May 1993 and negotiations were scheduled three months after the 1993 elections. The assassination of the President elected and the subsequent civil crisis modified the time table and partially changed the Project's design and conditions. The following chronology of events provides contextual background for the Project:

- October 1993 assassination of president-elect. Massacres and massive migration of refugees until spring 1994. In this period, the population's nutritional and health status deteriorates (chronic malnutrition among children under five rises from 26% in 1987 to around 40% in 1994). A substantial percentage of health personnel abandons the country or is killed; the MOPH's health facilities are vandalized and most equipment stolen. Most rural hospitals stop functioning.
- October 1994 interim Government constituted, situation stabilizes.
- Early 1995, newly formed Government endorses an IDA-financed Emergency Recovery Program (ERP) to further stabilize the situation, including the Second Health Project, which is re-appraised. USAID parallel financing (US$50 million) and KfW Project co-financing total amount are confirmed.
- May 1995: Project approved.
- January 1996: Project declared effective.
- 1996 coup d'etat, situation deteriorates, economic embargo imposed, all donors leave the country, IDA interrupts disbursements in October 1996.

August 1997: IDA reinitiates disbursements, making it the only active donor in the sector. Sporadic emergency aid comes in. Regional disturbances throw the country into open civil war.

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APPENDIX 16: ELIGIBILITY CRITERIA FOR MAP FUNDING IN 2000

- "Satisfactory evidence of strategic approach to HIV": evidences consisted of the elaboration of a national strategy and an action plan against HIV 2002-2006 (participative process, validation by NAC and by the UN thematic group on HIV)
- "Existence of a high level HIV coordinating body": actually, government of Burundi (GOB) created 2 coordinating bodies, the NAC, in the President's office and the MoA, both in 2001. NAC replaced the special unit to lead the HIV program, formerly created within MoH in 1996.
- Agreement of GOB to channel fund directly to implementing agencies, to contract out activities whenever appropriate and to simplify admin procedures.
- Agreement of GOB to fund multiple implementation agencies (other ministries, NGOs, CSOs, private sector….)

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APPENDIX 17: COUNTRY COORDINATION MECHANISM COMPOSITION, AS OF 2002, ITS CREATION DATE (FROM RBM ORIGINAL PROPOSAL 2002)

- President: the Minister of the Presidency in charge of HIV/AIDS
- Deputy-president: The Minister of Health
- Permanent executive secretary: executive secretary of the NAC
- Members: Minister of social action and women promotion, 1 UN representative (at that time president of the UNAIDS thematic group), 3 faith groups representatives, 3 HIV-related CSOs representatives, 1 academic, 2 representatives of MoH, 1 youth and 1 private sector representatives

The CCM composition was progressively diversified, so as to include NGOs and bilateral/multilateral representatives.

APPENDIX 18: OVERVIEW OF MAIN EXCLUDED ORGANIZATIONS

1. The USAID resumed its aid only from 2007, and slowly; in the health sector, USAID worked mainly through NGOs, such as the international NGO Family Health International, in 3 provinces in the Northern part of Burundi.
2. The Swiss cooperation project for public sector HRH policies development started in April 2009, with a special emphasis on mapping HRH in the country.
3. The Dutch cooperation was not active in the health sector but took on an intersectoral role, through their involvement in the national committee for aid coordination (CNCA). They also supported the international and Dutch NGO Cordaid in their P4P implementation (pilot-project) since their beginning, though at a very low proportion (10%). Cordaid has been active in Rwanda in the P4P implementation, in Burundi during the war and started a pilot project for P4P in some provinces. The involvement of the Dutch cooperation will be expanded in an extended context, in the discussion section.
4. The Japanese International Cooperation Agency provided since 2008-2009, a District Health System (DHS) support in one province (Buja-mairie) and a support for hygiene in one hospital
5. The Italian cooperation was supposed to provide DHS support in Cibitoke (but nothing happened, see interview Leo nov 2009).
6. The French cooperation was not supposed to provide aid in the health sector, according to the EU rule of non-duplication of activities. The French cooperation partly funds a governmental organization, Esther, which strictly operates in the HIV domain in Burundi.

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APPENDIX 19: DETAILS ON HISTORY, MISSIONS AND GOVERNANCE OF THE SELECTED 19 ORGANIZATIONS

Group 1: Ministry of Health (MoH), central level (excluding its vertical programs)

General history

The functioning of the MoH has changed several times during the course of its recent history, but its operating system remained very much traditional, heavy and centralised, inherited from the pre-colonial era. The latest decree setting its organization dates back to 2006. The organization as described in this section was inspired from this latest decree.

The Minister is nominated by the President as part of the government, at each presidential election, but also each time a change in government composition occurs.

As displayed Figure 23, the Ministry has two general directorates, in addition to some units directly managed by the Minister cabinet. The five directorates of interest in this study have been highlighted: the Directorate General for Resources, the Directorate General for Health, the HRH Directorate, the Health Programs and Services Directorate. The planning and programming unit has not been selected for the analysis, since its establishment was recent (post-2008).

Governance and missions of the selected entities of the MoH

The Directorate General for Resources

The Directorate General for Resources was created in 2005 and manages the 3 types of resources of MoH: human, financial and equipment. This directorate is also in charge of preparing the budget for the MoH, in collaboration with the planning unit since 2008, and negotiates this budget with the Ministry of Finance (MoF).

HRH Directorate

Before 2006, there was only a virtual unit dedicated to HRH (Andre Cote HRH management consultancy document). As part of the second health and population project of the WB, a

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Canadian consultant was hired in 2005 to support the HRH management process at MoH. The HRH Directorate was created in 2006, under the authority of the Directorate General for Resources, following recommendations of the consultant (Appendix 13). Since 2006, the Directorate's mission has been HRH management.

The Directorate General for Health

The Directorate General for Health is in charge of planning, supervising and coordinating all activities in the directorates under his direct authority. This is also in charge of supervising provincial health offices, as well as coordinating and monitoring NGOs and DPs' activities. Its mission is to promote an equitable health care and an effective decentralization of the health system. It also contributes to formulate and implement health policies and collaborate technically with other relevant ministries and international agencies.

Programs and Health Services Directorate

All the national health programs are only partially self-governed, falling under the authority of the Programs and Health Services Directorate. The national reproductive health program is the only health program fully self-governed, falling under the cabinet's authority (explicit in the organogram). Main roles of this Directorate are: to provide an integrated supervision of all programs and health services activities; to organise and coordinate in-service trainings in collaboration with the HRH Directorate; to promote the technical coordination of all projects and programs in order to ensure their 'harmonious collaboration'.

Policy and planning documents and their elaboration processes

National health policy 2005-2015

The policy document *per se* was elaborated by a technical multisectoral team, which worked under the supervision of the MoH and according to priorities raised in a national health forum held in June 2004 (PNS 2005-2015 pp 37).

National health and development plan 2006-2010

The national health plan elaboration was described as a bottom-up process, starting with provincial plans and vertical programs strategic plans, and ending at national level. However, it was not the case in most cases, as explained further. Four objectives emerged

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from this process: reduction in maternal and neonatal mortality; reduction in child mortality; control of morbidity related to communicable and non-communicable diseases; strengthening of health system performance (preface PNDS, pp.6).

These 4 general objectives were a consensus between 4 pre-existing key documents: the national health policy 2005-2015, the poverty reduction strategic paper (interim version August 2003 and final version September 2006), the Millenary Development Goals and the health strategies of NEPAD (PNDS, pp35).

The financing plan of the national health plan was elaborated by an international consultant, hired by the WHO. He spent 2 weeks in June 2005 in Burundi and the document was produced in August 2005.

Other policy documents and plans

A performance-based funding (P4P) policy document was finalised in December 2006. The document was entirely elaborated by an international consultant from the WHO, expert in P4P (Jean Perrot).

The first HRH policy and the national annual health plan were first elaborated in 2010 and 2009 respectively.

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Group 2: MoH vertical programs and health sector HIV unit

National TB program

History, missions and governance

The national program of TB and leprosy was created in 1984, initially as a department and transformed into a program in 1992. The program was financed by 6 different sources, with each source financing specific items (from the 5 year plan pp.8): MoH, WHO, BTC, GFATM-TB, Global Drugs facility and Damien Foundation.

Policy and planning documents and their elaboration processes

The TB strategic plan 2001-2005 was halt due to the civil war. The second strategic 5-year plan was finalised in December 2006, for the period 2007-2011. The plan was elaborated after the national health plan 2006-2010, by opposition to the bottom-up approach which is mentioned in the national health plan. The plan fitted with the MDGs and was aligned with

the global partnership plan 'Stop TB 2005-2015'. The document was elaborated by a team of 3 consultants, amongst whom one was a national and 2 were international.

HIV sectoral unit of the MoH (USLS-health)

History, missions and governance

In 2001, each minister was asked to create a sectoral HIV unit (USLS, for "unite sectorielle de lutte contre le SIDA") within its ministry, to tackle the multisectoral aspect of HIV (Poverty reduction strategic paper). Following this, the sectoral HIV unit of the MoH (USLS-health) was created in 2002, replacing the previous national HIV program, created in 1986 (MAP1 project appraisal pp6). The mandate of all HIV sectoral units across ministries was to formulate, to implement and to evaluate the sectoral HIV action plan, elaborated by the NAC.

The USLS-health was placed under MoH authority in order to support the implementation of the sectoral action (HIV action plan 2002-2006, chapter 8, pp68). Since USLS-health did not own funding, it needed to send funding applications and authorizations to NAC-PES.

Policy and planning documents and their elaboration processes

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No specific policy document existed, and USLS-health followed the national HIV plan, elaboration to which USLS staff participated. Annual activities plans were established, mainly divided into two sections: a table of pre-financed activities and a table of activities without funding, both of them developed according to strategies of the HIV national annual plan.

National malaria program

History, missions and governance

From 1980 to 2008, there was no national malaria program, but malaria activities were included in a program entitled 'Program against transmissible and malnutrition-related diseases'. The program was jointly funded by the BTC and the MoH. In 1993 the BTC stopped its funding because of the conflict and since then, the program managed to survive using WHO and UNICEF funding (ITW10N09). Within this program, malaria activities were implemented on a project-based approach.

In 2008, a series of institutional reforms reshuffled the MoH, and amongst others, the national malaria program was created.

The malaria project and the later national malaria program were only one amongst the numerous sub-recipients of the GFATM-malaria funding, along with local and international NGOs. The project/program used to send a disbursement request to the principal recipient of the GFATM-malaria funding (project health and population of the World Bank –PSP2 until 2006 and then the PES-NAC).

A unit for GFATM-malaria funding management was created (physically apart from the national malaria program). The management unit's role was to coordinate all the sub-recipients (amongst which the national malaria program) and their activities. The national malaria program applies to the GFATM malaria unit for funding according to needs and activities planned.

Policy and planning documents and their elaboration processes

There was no national program policy or planning document before 2008. The draft strategic plan 2008-2012 was elaborated in July 2007 with the technical support of the WHO.

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National reproductive health program

History, missions and governance

Historically, this program has been directly linked to the cabinet of the Minister (as shown in the organogram above), and did not fall under the rule of the Directorate General for Health or Directorate of Services and Programs, by contrast to other programs. The program was fully self-governed, with its own governing body. Before 1998, there was a national-level coordination body for family planning. After an advocacy and a policy adopted at regional level (East Africa) by the International Planned Parenthood Federation, this body was transformed into a national program (ITW27N11). The reproductive health program managed its own funding and was free to disburse funding.

In terms of budget, the program depended mainly on external partners, the main one being Kaiser Family Foundation (Appendix 14).

Policy and planning documents and their elaboration processes

There was no national policy or plan before 2008. There were only annual activities reports, built according to items of maternal and neonatal mortality reduction objectives presented in the national health policy (2007 report), or according to activities achieved over previous years (2005 and 2006 reports).

The elaboration of the national strategic plan 2008-2012 was described as a participative and collaborative process between government and its partners (plan stratégique PNSR pp.5). It benefited from the 'joint' technical assistance of the WHO, UNFPA and UNICEF.

National immunization program

History, missions and governance

Immunization program started in Burundi in 1980. In addition to MoH funding, it was also supported by UNICEF and WHO, mainly for activities related to outbreaks.

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Since 2002, the program operated mainly with GAVI (in charge of funding the new vaccines). The program was also 'integrated' at facility-level, as was the malaria program, with no staff dedicated to its activities.

Policy and planning documents and their elaboration processes

A multiannual plan 2006-2010 has been developed, from which annual plans were developed. The general objective was the same as one of the MDGs and the specific ones were adapted from the national health plan 2006-2010. The plan included activities of 3 types, classified according to their probability of getting funded: those with secured funding such as GAVI and the government; those with mostly probable financing, such as WHO and UNICEF; and those with less certain funding from other sources. The annual plan contained only activities with secured funding.

Group 3: Non-disease specific donors

Most of the donors (bilateral, multilateral) suspended their aid during the conflict, from 1993 onwards and resumed slowly their activities in early 2000’. Some donors were not major actors in the immediate post-conflict period and were not taken into account in this organizational analysis, even though their influence might have grown throughout the years (e.g. USAID and JICA).

The 2 major bilateral donors were Belgian Technical Cooperation (BTC) and the UK Department for International Development (DfID) and the major multilateral donor was the European Commission (EC).

Belgian Technical Cooperation (BTC)

History, missions and governance

As a former settler (after Germany capitulated in 1918), BTC has been the largest bilateral donor as well as the oldest one. Globally, BTC provided 3 types of aid, direct bilateral, indirect bilateral and indirect multilateral, the latter being channelled mainly through 3 organizations, UN agencies, GFATM and the WB. The BTC concentrated its aid on some countries, according to criteria set by the development cooperation law and on some sectors, amongst which health. Criteria comprised for instance former experience of BTC with the country and the type of governance in the country.

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Burundi was one of the 3 former colonies where cooperation was further focused, beside Rwanda and DRC. During the civil conflict, direct aid volume decreased significantly, while indirect aid through NGOs and UN agencies remained. Direct aid slowly resumed after the signature of Arusha agreement in 2000.

No data on volume of aid and its affectation was retrieved for the period between 1996 and 2003 (OAG).

Between 2003 and 2004, aid channels shifted back from direct aid to predominantly indirect aid, due to the improving country-context. Indeed, an internal strategy document of aid in fragile states warned on not using general budget support when government channels were too weak. Indirect aid has been mainly allocated to humanitarian aid, debt cancellation and infrastructure rehabilitation (health and water / sanitation) (OAG).

The first indicative cooperation project 2003-2005 (PIC) was signed between BTC and the government in 2003. Priority areas for investment were health, beside agriculture, education, infrastructure development and security (rapport annuel 2003).

03).

Projects for the health sector from the PIC 2003-2005 were mainly a support to the general hospital in the capital (Prince Régent Charles) and support to 2 provinces (Kirundo and Mwaro) (OAG). A number of new bilateral agreements were signed: in 2007, support to districts implementation in one province out of 17 (Kirundo), and support to infrastructure rehabilitation in Prince Charles hospital in Bujumbura; in 2008: institutional support to the MoH, and support to nurses' schools reform. These projects were later incorporated in the PIC 2010-2013, since they have not started yet at the date of the PIC elaboration.

The signature of the following PIC seemed to have been postponed until 2009.

Policy and planning documents and their elaboration processes

Within the Belgian aid for development system, functional and hierarchical links between the political arm (embassy) and the technical arm (cooperation) are very close but also very structured. In the aid policy process, the embassy identifies priorities to be funded and the cooperation elaborates policies and strategies and implements them. However, the PIC documents seem to be relatively flexible, since projects might be started without being agreed in the PIC.

UK department for International Development

History, missions and governance

DfID was set up in 1997, as a product of transformation of the previous department of technical cooperation set up in 1961. Its priority is the fight against world poverty. Its objectives are to make global development a national priority and to foster a new aid relationship with governments of developing countries.

DfID started its activities in the health sector in 2004-2005 in Burundi, in the drugs supply area, mainly for emergency supply. When the removal of user fees for children under 5 and pregnant women was implemented in 2006, high risks of out-of stocks were foreseen. EC

emergency program (ECHO) then provided a financial and technical support to the drug supply and DfID took over from UE.

DfID was a major supporter to the IHP+ initiative in Burundi, along with the WHO (see background section). DfID became the lead donor amongst the technical and financial partners group in the health sector from 2008, when sectoral coordination groups were created. Its inputs to the health sector financing in Burundi in 2009 was for bridging support to essential medicine, IHP+ catalytic funds and co-funding of the DHS and national polio campaign. An exit strategy from the health sector is in place for year 2012.

Policy and planning documents and their elaboration processes

DfID in Burundi operates via 2 main modes: via technical assistance to the central drug purchasing agency (CAMEBU) and via international call for project proposals, the latter one arriving to its end.

European Commission (EC)

History, missions and governance

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The EC first started its activity in Burundi in 1962. EC, like other countries, suspended its cooperation with Burundi in 1996 (except for ECHO), during the economic embargo. The aid was resumed in 1999. EC was a strong supporter of peace negotiations and the 2 special 'envoyés' of EC to the great lakes region played an important role in the resolution of the conflict. EC, as other bilateral donors, shifted its aid mechanism from loans to grants in recent years (IDA grant and structure document).

Its main aid mechanism is through EDF (European Development Funds), ECHO (humanitarian emergency funds) and the community budget.

ECHO operated without interruption since 1994 and spent more than 250 Million USD. The strategy of ECHO was to provide emergency humanitarian assistance but also to prepare, whenever possible, the terrain for EC rehabilitation and development projects. In 2003, the national indicative program was signed, to implement the 9th EDF (2003-2007). The 10th round of EDF started in 2011 in Burundi, while ECHO closed down their projects progressively. EDF funded project for district support started in 4 provinces in the Eastern part of Burundi in late 2007, where ECHO projects used to operate.

Policy and planning documents and their elaboration processes

The National Indicative Program (PIN) is elaborated at global and national level, jointly between EC global and country representatives and national level stakeholders. EDF projects are usually elaborated by international consultants, after a call for consultancies has been released. The content of each project is jointly decided between EC local representative and GOB, according to EC general orientations and national priorities. For instance, for the Santé Plus project, needs in geographical areas where EC was previously operating through ECHO were identified, as well as potential partners. This is how support to P4P policy was chosen and how it was decided that the project would be sub-contracted to Cordaid for its implementation, since this NGO was experienced in P4P in Rwanda.

Group 4: Disease-specific organizations

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The World Bank Group and its Multisectoral AIDS Projects (MAP)

History, missions and governance

The WBG (IBRD + IDA) was a traditional supporter of Burundi in many sectors. Since 1963, the WB invested about 1 560 billion USD in Burundi, in all sectors (WB website, country portfolio). The WBG mission is poverty reduction. IDA is now also operating through grants and credits, and not loans anymore.

Policy and planning documents and their elaboration processes

Usually a macro-level dialogue, every 5 years, between the Bank and a given government determines priority areas to be funded.

During the decade before the beginning of the civil war in 1993, the WBG had implemented a first project in the health sector, called health and population project, from December 1987 to June 1995. A second health and population project followed, but its continuation was somehow affected by the conflict. It was supposed to be a joint financing system gathering major aid organizations active in Burundi (Appendix 15).

Since the 2000', Burundi was classified as a fragile state and intermediate dialogues between governments and WBG were organized, every 2 to 3 years. Since the Peace agreements in 2000, the WB has implemented three interim country assistance strategies (CAS), in 1999 and 2002 "to support economic and political stabilization" and in 2005 "to address social needs and to lay foundation for sustainable economic development" (CAS 2008 p.9).

The first interim CAS put an emphasis on "restoring basic social services" (hence including health services). This strategy could be presented to the WBG board only when debts arrears started to get reimbursed again and when peace agreements process was initiated (project appraisal MAP1 pp3). The second interim CAS (2002) emphasized further on the necessity of "strengthening health services, in particular the struggle against HIV" (project appraisal MAP1 pp3). WBG funding supported the implementation of the poverty reduction strategic paper (PRSP), elaborated in 2006 after a 2 year long participative process.

Simultaneously, Burundi became eligible for MAP funding in 2000, once it had eventually met 4 criteria (see Appendix 16). The MAP1 started in 2002 and contributed, amongst others, to the operational costs of the PES-NAC and of the provincial AIDS committees.

The first non-interim CAS document since 13 years has been produced in 2008 for the FY 09-12 (last one was in 1995 and ceased with the military coup in 1996).

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In parallel, MAP2 started in 2009 (15 USD millions). No MAP3 is planned so far and the GOB is supposed to take over the recurrent cost of running the NAC-PES.

2. Ministry of AIDS (MoA)

History, missions and governance

The MoA was created to ensure political visibility of the fight against HIV and mobilisation of resources, in alignment with the poverty reduction paper, in which HIV was one of the 6 strategic axes. Its creation was encouraged by the WHO and UNAIDS, though the government was not very favourable. The Ministry of HIV/AIDS was created in November 2001, initially in the President's office, after a reshuffling of the government following the Arusha agreement, but its structure changed a couple of times (MAP1 project appraisal document and ITW22N09). Hierarchically, it was placed higher than all other ministries, hence exerting leverage on them. A director general in charge of program coordination and

relationships with partners was nominated in 2005. In November 2007, the MoA became a vice-ministry within MoH, before becoming again a MoA in January 2009. In July 2010, the 2 Ministries were merged into a Ministry of health and fight against HIV.

Policy and planning documents and their elaboration processes

There was no policy document specific to MoA. The MoA participated to the elaboration of national HIV strategic plans.

3. Permanent Executive Secretariat of the National AIDS Council (PES-NAC)

History, missions and governance

The institutional framework for the implementation of the HIV national strategic plan, according to the 3 ones principles of the UNAIDS, was established by a decree in 2002. Two institutions were to coordinate the fight against HIV, one on the political side (Ministry of AIDS) and one on the technical side (PES-NAC, the executive body of the national AIDS council). PES-NAC was created after a joint decision of the WB and UNAIDS on the need of a unique body of coordination against HIV, to respect the 3 ones principles.

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The institutional framework is summarized in the Figure 29 (translated from the HIV strategic plan 2007-2011).

The highest hierarchical body is the Presidency, placed above all other institutions. The NAC, the MoA and other ministries all coordinate and support HIV plan implementation. The PES-NAC is under the charge of the MoA, whereas the executive committee of the NAC is hierarchically below NAC, but above PES-NAC. The PES-NAC coordinates with the provincial NAC and the sectoral HIV units within each Ministry. It also coordinates with CSOs and private sector, for HIV activities implementation. The private sector, CSOs, provincial AIDS committees and sectoral HIV units collaborate all towards the HIV plan implementation.

PES-NAC was created with WB support (out of MAPs) for its recurrent costs, in order to have a coordinating body: its mandate was to have the highest level of visibility (presidential level), to fight against stigmatisation, to enable multisectoral activities scope and to better

advocate in resources mobilisation. PES-NAC was supposed to coordinate activities implementation but not to implement itself activities.

Policy and planning documents and their elaboration processes

An HIV strategy plan 2002-2006 and a corresponding concrete action plan were elaborated in a large participative process led by GOB (but who exactly? MoA? NAC?) at national/provincial and local levels, inclusive of CSOs, FBOs, religious leaders, private sector, government rep, PLWHA representatives and in collaboration with bilateral donors and UNAIDS (project appraisal MAP1 pp4). Curiously, there was no mention of the MoA role in policy document elaboration. A second strategic plan 2007-2012 was formulated, under similar conditions.

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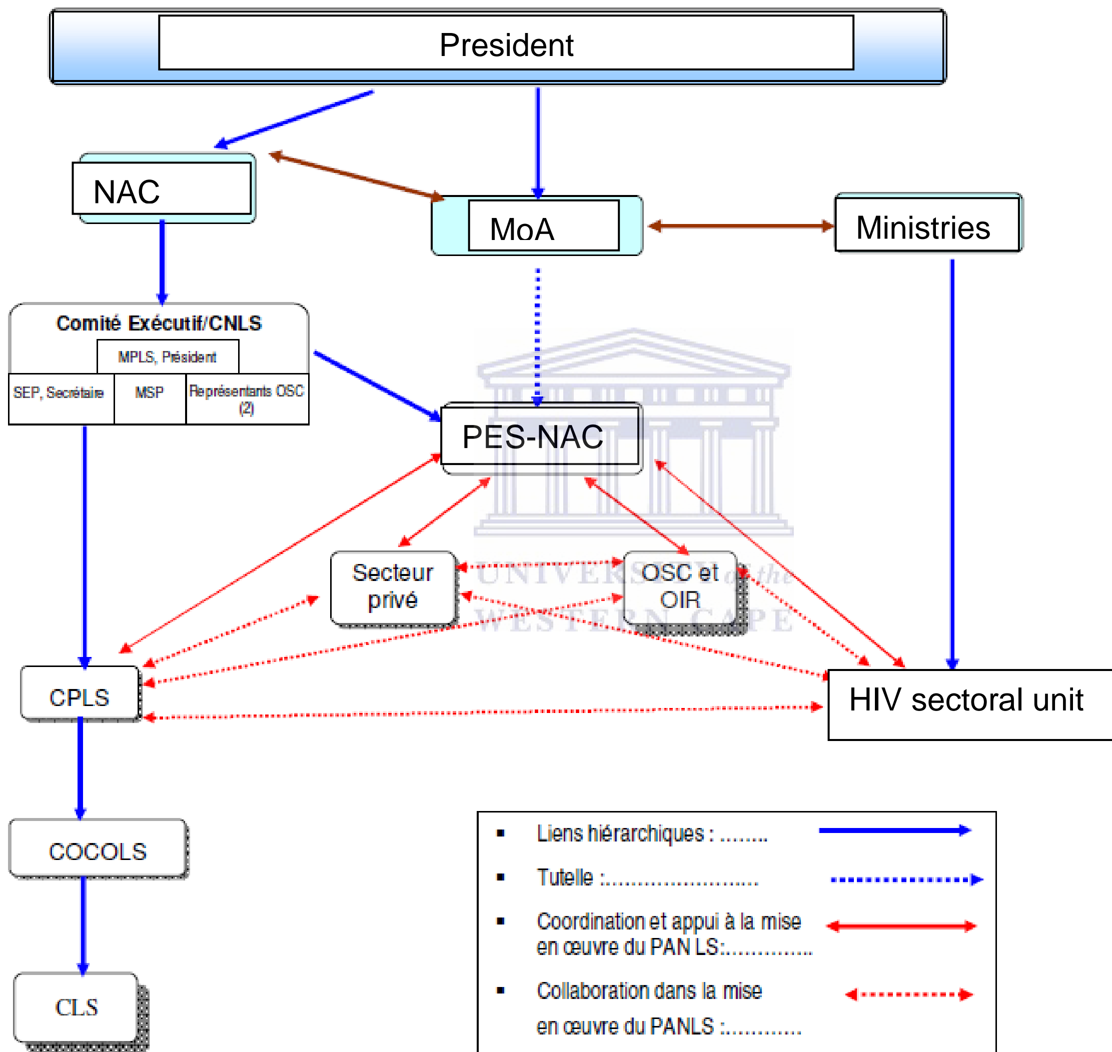
Figure 29. Institutional framework for MoA, NAC and PES-NAC



4. GFATM

Funding applications criteria were similar for the 3 grants of GFATM (malaria, TB and HIV). Call for applications are released each time funding become available (rounds). Applications from countries are reviewed by a technical review panel at global level. The existence of a CCM is one pillar for GFATM eligibility.

In Burundi the CCM was constituted in March 2002, before the country submitted its first proposal to GFATM, for the HIV component. Its functioning is co-financed through the 3 active GFATM grants and by GOB (composition in Appendix 17).

The funding application processes are also similar for the 3 grants. The grant application form is completed by the country team, usually by CCM members and working groups nominated *ad hoc*, supported or not by international experts. There are several conditionalities to the grant elaboration process and content: the process needs to be participative; the GFATM funding has to be additional and not substitutive to other funding; each round has a particular theme which needs to be taken into account (e.g. gender issuefor round 8 of GFATM-HIV),; the country needs to show a political willingness to tackle the disease it applies for (e.g. to have a MoA was a strong political sign for HIV area).

Based on country application, the GFATM selects a principal recipient, in charge of the quarterly financial and progress reports, upon which the disbursement of the following tranches will be based. The applicant needs to justify the choice of the principal recipient and this latter is assessed by a local fund agency, mandated by GFATM.

Specificities for each grant technical and financial management are detailed in the section below.

GFATM-malaria

Burundi was approved in late 2002 for the round 2 of GFATM-malaria, for 5 years (17 million USD). A further extension (Rolling Channel Continuation, 33 million USD), was approved and started in July 2008. From 2002 to 2006, the project health and population 2 (PHP2) of the WBG was the principal recipient of GFATM-malaria. From 2006, when the PHP2 came to its end, PES-NAC became the principal recipient of GFATM-malaria funding since the national malaria program did not pass the local fund agency assessment.

GFATM-TB

The national TB program succeeded in the grant application for round 4 (3.4 Million USD) and became its principal recipient from 2005 to 2010. The national TB program further succeeded in the round 7 application in 2007 (9.6 Million USD), as a principal recipient as well.

GFATM-HIV

Burundi was granted so far 3 grants: round 2 (from 2003, 8.6 Million USD), round 5 (from 2006, 13 Million USD), and round 8 (from 2010, 140 Million USD). The 3 rounds of GFATM-HIV funding have all been managed by PES-NAC. A financial management and coordinator have been hired to this effect. The last proposal to round 8 was a five-year plan to specifically address HIV-related issues in the health care system. The grant was divided, for the first time, between two principal recipients (PR): the NAC and a civil society organization (CSO) representing PLWA.

5. GAVI

Mission and mandates

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GAVI mandates are to "promote equity in access to immunisation services between and within countries", "to make vaccines and related technologies more affordable for poor countries through market influence and innovative business models" and to "contribute to achieving the Millennium Development Goals (MDGs), focusing on performance, outcomes and results". These actions should be achieved while respecting some principles, such as ensuring sustainability, providing for instance catalytic funding, or respecting the Paris declaration and encouraging country-driven approach through absence of earmarked funding. From 2002 to 2008, 32 Million USD were disbursed for Burundi (GAVI alliance report 2008).

Funding application process

The funding process is country-led, on a pre-filled application form and coordinated by the Inter Agency Coordination committee, constituted of: a president (the Minister of health), a secretary (the director of immunization program), and members (representatives of the WB, of the WHO and of the UNICEF, as well as some NGOs, other representatives of the MoH and other Ministries representatives)

The committee's roles are to advocate for resource mobilization, to validate all policy and planning documents, to provide general orientations for HSS and immunization in Burundi (PVF 2004).

The funding application is reviewed by the board of GAVI at global level.

6. GAVI-HSS

History, missions and governance

GAVI-HSS objectives are to help countries to overcome bottlenecks at health system levels, which impede immunization but also prevent other child and maternal health care to be achieved successfully. Those bottlenecks might be for instance limited supervision skills, workforce or infrastructure. GAVI-HSS operates through the same principles as GAVI.

Burundi was approached by the GAVI secretariat in 2006, to become part of HSS pilot countries and GOB accepted. GAVI-HSS funding in Burundi is managed by a specific unit (GAVI-HSS management unit, headed by a coordinator), attached to the MoH. GAVI-HSS coordinator reports to DG health in MoH. The unit follows standard operation procedures for financial management and reporting. Funding has first been transferred to MoH account, managed by MoF, but due to "partly lost funding of GAVI EPI", financial management falls under WHO Burundi since 2009.

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Funding application process

The funding application process was country-led, with procedures similar to the GAVI application process. The application focused on one of the national health plan's priority, to decrease the maternal mortality rate and increase the immunization coverage (GAVI-HSS report).

Group 5: UN organizations

In Burundi, UN funding used to operate through small grants for technical assistance and for institutional capacity-building, via specialized small agencies, such as WHO, UNICEF, UNDP, UNFPA, WFP etc (IDA grant and structure document). UN was also predominant in

humanitarian aid and early post-conflict stage and UN troops are present in Burundi since 2004.

The WHO

History, missions and governance

The global mission of the WHO consisted of “supporting member states in order to increase the health statute of its population to the highest possible point” (general work program, WHO, 2002-2005). The WHO institutional strategy in 2000 emphasized the essential role of countries for WHO action and the need to translate WHO global strategy into more specific strategies, adapted to each member state. This new institutional strategy laid out the foundation for the country cooperation strategy (CCS). To improve its efficacy in Burundi, WHO decided to play a consultative and catalyst roles rather than engaging with routine activities, except for specific cases and for a limited time. Amongst others, the WHO pushed for district health system (DHS) implementation, which started with the support of BTC and EC.

Under the leadership of the country-representative, there were 4 departments or units: health systems; child, adolescent and reproductive health; transmissible and non-transmissible / neglected tropical diseases including HIV, TB-leprosy and malaria; emergencies, catastrophes and epidemics

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The transmissible diseases department/unit included a person in charge of monitoring the 3X5 initiative implementation (an operational plan 2004-2005 was elaborated), beside the UNAIDS operating in the country.

Policy and planning documents and their elaboration processes

Burundi CCS 2005-2009 was elaborated after a participative process involving all levels of WHO (headquarters, regional, country), the MoH, other government bodies, donors etc. The CCS was elaborated in alignment with a total of 10 institutional, national, regional and global frameworks.

UNAIDS

Global mandate and history (adapted from the Lancet, Dec 2008)

On Dec 31, 1995, the WHO global program for AIDS programme shut down, and on Jan 1, 1996, the UN's Joint Programme on HIV/AIDS (UNAIDS) was launched. UNAIDS was

meant to be a unique UN agency, with a complex mandate: “to put HIV/AIDS on the political agenda and to coordinate a global, multisectoral response to the pandemic”. In order to improve aid effectiveness, 3 key principles, which identification was led by the UNAIDS, the WBG and the GFATM, were announced in 2004:

One national AIDS coordinating authority with a broad-based multisectoral mandate

One agreed national HIV framework

One country-level M&E system

Under these principles, “external support agencies commit themselves to coordinate within the action framework consistent with their own mandates”.

UNAIDS governance in Burundi

UNAIDS has been leading 2 working groups in Burundi:

UNAIDS Working Group, which presidency is a roster between all UN agencies representatives.

Extended UNAIDS Working Group, with a mandate of political, strategic and decisional coordination (memo échange mission conjointe 2007). This latter WG was not functional in 2008 due to institutional reshuffling between MoA and MoH

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UNAIDS has also established a coordination group (GTE), co-presided by the Minister of AIDS and by the president of the extended working group described above.

UNAIDS operates with a small budget, used for epidemiological surveys, as well as for advocacy and occasional support (AIDS day …)

Policy and planning documents and their elaboration processes

The global ‘three by five strategy’ was adopted at the UN general assembly in September 2003, by the UN general secretary and the WHO general director. The aim of the strategy was to put on ARV treatment 3 million of PLWA by 2005. This global strategy was adapted into a country 3X5 operational plan for acceleration of access to care for PLWA in Burundi, covering 2004 and 2005. Seven strategic themes were developed, each accompanied by a budget.