SOCIOECONOMIC AND INSTITUTIONAL ANALYSIS

USAID ASSISTANCE FOR FAMILY PLANNING IN BURUNDI

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[1] The following is a preliminary analysis of the social context for a potential five-year USAID assistance to Family Planning in Burundi. The assistance would be complementary to and integrated with the maternal and child health program being funded partially by a World Bank Loan, and partially by UNFPA and UNICEF. The author wishes to thank the staffs the Ministry of Public Health, USAID, the World Bank Project in Maternal and Child Health, UNFPA and UNICEF for their warm reception and supportive collaboration in the preparation of this report. The views and recommendations expressed herein are those of the consultant, and in no way be construed to represent those of the United States Government, the government of Burundi or any of their agencies. Many thanks are due the many officials and private citizens who received us and offered their thoughts and information. A list of persons contacted is at the end of this report. Without their help this analysis would not have been possible. Sole responsibility for any errors of fact or perspective which occur here, however, rests with the author.

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MAPS

1. SOCIOCULTURAL FEASIBILITY

Burundi is a landlocked mountainous country of 5 million people in the East African Rift Valley just south of the equator on the northern shores of Lake Tanganyika. The population is growing at a rate of 3.0% per year. It is 94% rural and one of the densest in Africa. The population is concentrated in the highlands, where densities reach 270-350 p./km². In the overpopulated central plateaux farm sizes have declined, and now average half a hectare per family of five. The eastern and southern plains are less intensively cultivated and offer some opportunities for agricultural colonization. Burundi is one of the least urbanized countries in the world, with only 6% of the population in towns, and three quarters of them in the capital, Bujumbura (pop. 230,000). The country is divided into 15 provinces, 114 communes, and 2400 "hills" for administrative purposes, and 11 historic natural regions. Maps of these are at the end of the report.

The economy is dominated by subsistence agriculture plus coffee, tea and cotton for export. Agriculture comprises 60% of GDP and 85% of employment. The 1986 GDP was FBU 150.91 billion (1986 US$ 1.3 billion). There is little integration with the world economy; exports equal 11.5% of GDP, and imports 19.4%. Coffee exports provide over 85% of foreign exchange.

1.1 VALUES AND BELIEFS

Burundi society is strongly pronatalist, in rural as in urban areas, among rich and poor families, whether Catholic or Protestant or Muslim. Children are valued in and for themselves, as well as for the help they provide at home and on the farm. They represent wealth, just as cattle do. When Barundi (s. Murundi) are asked which are poor families, they point to those with no or few children. When they see a large family, they assume it is rich, regardless of the level of material possessions.

A woman is valued according to her procreative capacity, her sense of organization in the home, her ability to grow, store and prepare the family food supply, and her good relations with the husband's family. She normally organizes the children, ranked according to age, to help her with this. Children are typically spaced two years apart--any closer spacing or pregnancy while nursing a baby less than fifteen months old being scandalous. When a new baby is born, on the eighth day it is brought out and presented to the other children, who participate in a little feast in its honor. Within a few weeks the second child older than the newborn--normally about four years old himself or herself--begins carrying the baby on its back and takes on the role of mother's helper vis-a-vis that baby. The two--carrier and carried--develop a lifelong bond, and the role of the carrier

in raising the baby may be as great as that of the mother. The intermediate child is left out, and tends to develop a rivalry with the baby. It is he, with the help of the older children, who will tease the young one into the various stages of growing up--leaving the breast and mother's bed, bladder and bowel control, work roles and the rules of respect for rank and authority.

Despite the lack of farm land on which to settle today's children, despite a belief in the social value of family planning, many Barundi cannot imagine a family of "only" three children in which the above organization is not possible.

A new reality, however, impinges increasingly on this traditional image of family life. The harsh terms with which many Barundi families have to cope are that they do not have enough land to grow what is needed to feed their existing children; school attendance is becoming compulsory; parents pay school fees (200 FBU per elementary school child) and contribute work for the school. In short, children used to be purely an asset, but the economics of subsistence have changed. Now they are both an asset and a financial responsibility. They need to be planned.

1.2. THE POLICY CONTEXT

The idea of family planning as a beneficial technology for healthy families is still new in Burundi. Doctors and nurses have had only minimal mention of it as part of their medical training, and most maternal and child health care has been delivered by Catholic mission health centers. Only in the last few years, in an effort to arrive at a mutually tolerant relationship with the government of the 2nd Republic, did the mission centers agree to teach their patients what modern family planning methods exist and where they can be obtained (at government health centers).

The government became aware of the urgency of the rapidly growing population problem through the difficulties it has in providing schools, health facilities, land for settlement, and jobs. The 1979 census catalyzed awareness of the problem, and in the early 1980s RAPID presentations based on its statistics became a focus of policy change. After much debate in government and party circles, the Party announced in 1983 a new policy firmly endorsing voluntary family planning and calling for its availability nationwide. The Ministry of Health was given overall responsibility, but it was recognized from the start that the family planning should be introduced into the school curricula, the armed forces, and the message reinforced by other ministries.

The initial announcement of the new policy, and its rapid passing as a "mot d'ordre" down the chain of command of party committees to the "hill" level provoked some sharp backlash, and a more cautious approach was settled upon. It was decided that family planning needed to be preceded by a more comprehensive public health system offering full maternal and child health care. Until that point the emphasis in the health care system had been on curative medicine, and urban areas had been heavily favored. In the last five years the public health care system has been rapidly expanded, and vaccination, prenatal and infant consultations, and family planning are offered in all facilities.

2. SOCIAL ORGANIZATION

The social structure is based on monogamous nuclear families, living in dispersed homesteads on hillsides, not in villages. In the past peasant and craftsmen's families were linked to cattle-keeping nobles by feudal ties based on land, cattle and labor, but these gradually eroded the vestiges were finally legally suppressed in 1977. Individual family land tenure is now the rule, and ethnic discrimination based on previous family status is illegal. The Barundi have a single national language (Kirundi), which is the basic language in the school system at all levels. French is taught as a second language.

There is traditionally a sharp sexual division of labor, with women growing food crops, raising children and tending the home, while men concentrate on large livestock, construction, cash crops (coffee and bananas), and public affairs. As men migrated in search of salaried work starting during the colonial period, rural women have been taking on traditional male tasks. The sex ratios in rural areas show female predominance, while in the city men predominate. Children play an important part in raising their younger siblings, and take on household tasks from the age of 4.

2.1. GOVERNMENT SOCIAL POLICY--A HISTORY

Under German occupation (1896-1917) and the Belgian League of Nations mandate (1917-1962), modern education was introduced in a way that accentuated the traditionally subservient role of women. Schools were both sexually and ethnically segregated, and the curriculum was designed to reinforce traditional roles. Health care facilities were similarly segregated. The political structure of the kingdom gradually lost its representational composition until subordinate chiefdoms were all held by persons of royal ancestry.

Since World War II social reforms have come in two great sweeps. The first came during after the War when democratic

ideals began to circulate. From 1949 on girls' enrollment in primary school increased, and education was offered to all social classes. During the struggles for independence the right to vote became an important factor. Universal suffrage was introduced for the 1962 elections, and the women's vote proved decisive. Burundi won independence as a kingdom, however, and it was not until the Second Republic (1976-1987) that women's and landless people's legal rights were redressed.

The second wave of social reform came in a campaign of national reconciliation beginning in 1977 that followed the severe civil conflicts of the early 1970s. The 1982 Family and Personal Law declared equal status before the law and equal educational and employment opportunity regardless of sex or social origin. The traditionally male inheritance of real property was not touched, however, and married women still are under the authority of their husbands in key areas such as choice of residence, and access to employment and banking. Women now participate in politics at all levels, and are gradually increasing their numbers in the administration and other salaried employment.

In 1981-1982 the government began a concerted campaign to improve the situation of rural families by extending health and education services. There has also been an effort to improve living conditions, and incomes through provision of potable water, credit for housing improvements, and large-scale rural development projects. Since then the primary school enrollment increased 217%, and the proportion of 7 year-olds enrolled in first grade has jumped from 38% to 86%. Health care coverage has increased from about 30% to 61%. Potable water reaches 34% of the population, compared to 10% in 1979. Credits for rural housing improvement were extended to 18,250 families, 14,937 through government financing and another 3,313 through Belgian and Luxembourgois assistance.[2] Yet without family planning, progress in these areas is an uphill struggle. At three percent per year growth, the population to be served doubles every 23 years. Just keeping up with population growth requires rapid expansion, and actually improving the proportion of beneficiaries is a daunting challenge.

2.2. THE CHURCHES

Christian churches are important in Burundi social life. The political hierarchy of the kingdom converted to Catholicism in the 1920s, and the colonial government used the established

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[2] Statistics cited are from, Analyse de la Situation des Enfants et des Femmes au Burundi, UNICEF/Republique du Burundi, draft, November 1987, chs. 5 (education), 2 (health), and 4 (living conditions).

ırch to provide state-subsidized education and health care. A ıber of Protestant missions also have long histories and ɔstantial followings. It is estimated that 80% of Barundi are holic, 15% Protestant, and 5% Muslim or traditional religions.

The government of the Second Republic tried gradually to cularize social services, closing church presses, radio tions, and prayer-literacy classes. It declined to renew the as of many of the missionaries in the country.

Since a bloodless coup d'etat inaugurated the Third Republic September 3, 1987, church and mission sponsored activities ve been authorized to resume.

2.3. *THE GOVERNMENT*

The political structure of Burundi has been a one-party ate since the 1st Republic ended the monarchy in 1965-66. The rty and its affiliated youth wing, womens' union and labor ion touch every area of community life. The Chief of State esides over its central committee and political bureau. The esident of the Third Republic (September 1987-) is Major Pierre yoya. The central party organs and the National Assembly are rrently being reorganized, and the Military Committee for tional Salvation has temporarily taken over their functions.

The Ministry of Health is responsible for coordinating nily planning policy and activities. Other ministries involved clude: the Ministry of Education, the Ministry of Defense hich is responsible for medical care for the armed forces), the nistry of Family and Women's Affairs, the Ministry of Social fairs, the Ministry of Information, the Ministry of Labor mployers pay all medical costs), and the Ministry of the Civil rvice (whose affiliate, the Civil Service Mutual, insures blic employees).

2.4. MARRIAGE AND CHILDBIRTH PRACTICES

Monogamous marriages are the rule, polygamy having been scouraged throughout the colonial period and finally outlawed 1977. The average age at first marriage for women is 21 ars, in both urban and rural areas.[3] Traditional taboos ainst premarital pregnancy are still strong, particularly in ral areas where most of the population lives. Therefore the oblem of teenage pregnancies is far smaller than in many untries.

The following table shows fertility rates by age group:

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[3] Recensement national de la population, analyses profondes, partement de la Population, Ministere de l'Interieur, 1979.

TABLE 1.1 FERTILITY RATES BY AGE GROUP

AGE	FERTILITY RATE	NO. OF WOMEN IN 1987	NO. OF LIVE BIRTHS, 1987
15-19	0.076	245110	18628
20-24	0.300	231877	69563
25-29	0.304	218124	66310
30-34	0.290	167670	48624
35-39	0.199	121420	24163
40-44	0.078	96437	7522
45-49	0.040	84075	3363
Total		1084980	238173

Completed fertility 6.44 live births per woman.

This pattern of fertility suggests that among the health issues the IEC campaign should emphasize the dangers to older women and their babies. Pregnancies in Barundi women over thirty often entail high risks for more than one reason:

--the age of the mother is itself a factor, with mortality of both mother and baby increasing after thirty and sharply after thirty-five[4]

--most of the births in women over thirty are also high parity, the mother typically having born her first three or four children in her twenties.

--large families, particularly those with more than one child under five, have higher rates of young-child malnutrition. Large farm families have less land per person than small and medium-sized families.[5]

There are no national statistics on maternal mortality or perinatal infant mortality in Burundi, as only live births must be registered. The UN estimates maternal mortality in East and

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[4] WHO, "Risk approach for maternal and child health care," World Health Forum, 3, (1981), 413. This was confirmed with local statistics from the main referral hospital in Bujumbura, in a presentation by Dr. Ntareme to the Colloque National sur l'Enfance, sponsored by the Parti UPRONA and UNICEF, November 1986.

[5] Bernard LeMaire, Systeme de production et analyse de la situation alimentaire et nutritionnelle dans la region du Buyenzi, vol. I, Ministere du Plan/FAO/FAC, August 1986, p. 9.

Central Africa as a whole to be about 4 per thousand, but Burundi has one of the higher infant mortality rates in the region and one of the lowest rates of medically assisted deliveries. The maternal mortality rate may be as high as ten per thousand, which was the rate found in Northern Nigeria, where a similar high proportion of home deliveries occur.[6] The World Bank estimates that 3% of births would require Caesarian sections for safe delivery, yet only 0.5% of births in Burundi are so done.

Only 16% of deliveries in Burundi are medically assisted; 84% of women deliver at home with the help of an older woman, usually a relative. Such women consider themselves traditional birth attendants (TBAs), but are not paraprofessionals as they only assist a delivery when a birth occurs in the family or immediate neighborhood. A recent study of their practices shows that complications of childbirth rarely receive an adequate response and infection rates are high for both mother and child.[7] Twenty-seven percent of the women interviewed reported an infection following her most recent delivery. Neo-natal tetanus has been estimated at 8 per thousand live births in 1985, which is very high considering that vaccination would easily prevent it. Faced with hemorrhaging, prolonged labor, breach presentation, multiple births, placental retention or other serious complications, less than 15% of TBA respondants referred the patient to medical personnel. Few TBAs knew to clear the mucous from a baby's mouth and nose if it failed to cry. The most common response to emergencies was to wait and see. In many cases the patient would have to be carried by bearers for an hour or more over mountain terrain, so referral would come too late in any case.

Efforts to remedy these conditions began at the same time as the studies were taking place. Prenatal and infant monitoring programs were introduced into government health centers starting in 1982. They were to include monitoring for health, growth or nutritional deficiencies, vaccination, family planning and health education. By 1986 it was estimated that 57% of pregnant women came for prenatal consultations, and 47% brought in the baby afterward. Vaccination coverage improved from about 1/4 to over half in five years. By the end of 1987 it is expected 56% of 1-2 year olds will be fully vaccinated, as against 46% in 1986. Family planning was introduced in 1984, and in three years has

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[6] Kelsey A. Harrison, Child-bearing, Health and Social Priorities: A Survey of 22774 Consecutive Hospital Births in Zaria, Northern Nigeria. Special issue of the British Journal of Obstetrics and Gynaecology, suppl. no. 5 (Oct. 1985).

[7] Centre Universitaire d'Etudes Socio-economiques/Min. de la Condition Feminine/UNICEF, Pratiques d'accouchement traditionnel au Burundi, Bujumbura, February 1985.

reached 13,000 acceptors. There is an estimated 3% acceptance in cities and 1.6% in rural areas.

3. THE INSTITUTIONAL CONTEXT

3.1 HEALTH CARE DELIVERY

Burundi's health infrastructure is relatively good for a country of 5 million people with an annual per capita GDP of only $240. There are:

- 32 hospitals
- 75 health centers
- 114 rural dispensaries

The quality of health care needs to be improved, however. Overall staffing levels are less than half what is needed to adequately staff existing facilities: there are less than 4000 employees in the system, as against an estimated 9000 for which the facilities were designed. There are 241 doctors, of whom 96 are foreign. The most competent, established health personnel in rural areas are greatly overworked, while some of the newer personnel are inadequately trained, equipped and/or motivated.

Health personnel are distributed as follows:

Bujumbura Hospitals (serving 5% of the population, plus referrals)	798	22%
Interior Hospitals	1383	38%
Health Centers and Dispensaries	1481	40%
Total	3662	100%

The emphasis is on curative medicine, in both the overall staffing pattern and the activities of the health centers visited by the consultants. This has historically been the case with the Burundi health-care system, but the government determined to change that orientation beginning in 1982. It undertook to extend health care to all, specifically to rural areas, and to change the emphasis to public and preventive health. It has been since 1982 that most of the government health facilities in the interior were constructed.

Due to understaffing, training biases, and fiscal pressures, however, medical personnel in rural areas as well as urban tend to place the greatest priority on treating the sick. Consultations by sick people are paid for; preventive medicine and family planning are free. The charges are:

--For the first visit FBU 30 to see a nurse and FBU 100 to see a doctor in a government center, variable (generally higher) rates in NGO clinics.

--Subsequent daily visits for the same problem (medicines are usually doled out daily) FBU 15

All of the centers visited by the consultants were equipped with FP flip charts and adequate contraceptive supplies (injectable noristerat, condoms, Blue Lady pills). Personnel reported that there had been occasional stock-outs of injectables and condoms, but the supply system seems fairly reliable.

As is the case with records keeping, however, the supply system needs to be integrated with the center's other activities. Currently vaccines, contraceptives, and other medicines are supplied by three entirely independent networks even though they start at the same center (the Ministry of Health depot, or for NGO clinics, CARITAS) and end at the same outlets. Similarly the vaccination, nutrition, health monitoring and family planning components each have separate patient forms that the nurse is expected to fill out, and on which he/she is to compile monthly reports. The respective sponsors and administrators of these programs have agreed upon a common form, and await the implementation of a new integrated and computerized MCH/FP supply and reporting system to smooth out these problems.

No FP counselling or education was actually being conducted during our visits. In some centers it was reported that a ten minute presentation on FP takes place in the morning before prenatal consultations begin. Most centers had personnel specifically assigned to health education and FP, but they did not seem busy. Some centers reported that they conducted FP talks on specific days, once or twice a week.

3.2 TRAINING OF HEALTH PROFESSIONALS

Nearly all medical and paramedical education takes place in-country. The Faculty of Medicine has graduated 83 doctors since 1982, about 20 per year. Medical technicians (the equivalent of nurses or paramedics, with 6 yrs. primary school, 4 years junior secondary, and 4 years Medical Technicians School) are trained at Gitega, in a newly equipped school on the old nurses' training school grounds. It has an enrollment of 452 students and graduates about 100 per year. Nurse's assistants are trained in two new schools, one at Ngozi and one at Bururi, with a combined enrollment of 102 students.

Family planning is touched upon briefly in the curriculum outlines during a few hours of lectures on obstetrics, gynecology, and family/community medicine. The emphasis in all

of the schools is on lectures; there are few or no textbooks, and libraries and laboratories seemed not to be functioning.

For this reason, short-term supplemental training of in-service personnel is badly needed, as are enhancement of the teaching, curriculum development, and provision of teaching materials.

3.3. FUNDING HEALTH CARE

The problem of understaffing was in the past partly due to lack of trained persons, but the medical and paramedical schools are rapidly filling that need. Unfortunately the government has been obliged to cut operating costs, and there is little prospect of rapidly expanding government health staff in the immediate future. The structural adjustment agreement which Burundi negotiated with the World Bank in July 1986 calls for a freeze on the government budget for salaries, which are the core of recurrent costs in the health field. Instead, better self-financing mechanisms are being explored.

The recent change in health policy, to emphasize public health for all, has just begun to involve major funding reallocations. Public health is being integrated into the curative health system. The keystone to new funding is a US$ 10 million World Bank Loan, to fund a five-year maternal and child health project. The Bank hopes to fund mainly capital improvements (rehabilitation of thirty existing health centers) with the loan money, and has asked UNICEF, USAID and FNUAP to collaborate in funding the consumables, IEC, training and operating costs.

Funding for health care totalled US$ 18 million in 1985, or 1.7% of GDP. Of this 45% came from the government; 26% from user fees, employers and insurance; 18% from external assistance; and 9% from religious donations and non-governmental organizations.[8] Religious missions and other NGOs built and maintain about a third of the facilities. An unevaluated contribution to government health facilities and schools comes from communal labor provided by the population on Saturdays to build and maintain local facilities.

Burundi's health system already has an unusually large proportion of cost recovery from user fees and insurance, compared to other African countries. This tradition needs to be further strengthened. Current existing mechanisms include:

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[8] UNICEF/Republique du Burundi, Analyse de la situation des enfants et des femmes au Burundi, ch. 2.

--about 70,000 civil servants and their families have 80% of their health care costs covered by the Insurance Mutual.

--about 60,000 permanent employees in the private sector have all of their family medical costs covered by the employer, by law.

--the other 65,000 temporary and daily workers in the private sector, and 189,000 informal sector workers have to pay for their health care, as do the 857,800 farm households.

The latter groups can buy a health card for FBU 500 ($4.16) to FBU 1500, depending on profession, which entitles them to consultations and medicines in local government clinics, rural government hospitals, or the main referral hospital in Bujumbura. It is not accepted by NGO clinics, as there is no provision for benefit sharing. Sales of such cards have not been very significant, and various reforms of the system are being studied. One of the reforms being studied, that of allowing health centers to fund themselves at least partially from their receipts, has an important potential to improve the motivation of health care providers in government centers. At present there is no incentive system for good service delivery.

4. PARTICIPANTS AND BENEFIT INCIDENCE

A portrait of family planning acceptors in Burundi is difficult to draw, as there have been no studies of the subject. Burundi did not participate in the World Fertility Survey, and the one major demographic study undertaken recently, known as the Westinghouse study, has not yet been released. The 3% acceptance rate in towns vs. 1% in rural areas does not even tell us that urban dwellers are more likely to participate, as the program has been concentrated in urban areas until recently.

The few FP providers whom it was possible to interview give a picture similar to what is found elsewhere in Africa:

--educated women are more likely to participate, particularly if they are employed outside the home.

--socioeconomic motivations are the most important factor leading people to seek FP;

--health problems and fatigue of mothers come second.

Family planning benefits may accrue first to urban, educated families, but this does not make it an elitist program. The educated elite is first to adopt all good ideas, and no amount of social planning can change that. The difference between family

planning assistance and other imported technologies is that the cost per family ($2-$6 per year if the full cost were not subsidized) is much less than doing nothing--continuing with uncontrolled fertility, and raising the children who result.

Every effort is being made to offer family planning to the poorest of the poor. In Burundi the poor are mainly rural farm families, who have an average annual income of FBU 67,504 ($562, with an average family size of 4.93 persons). This figure includes the market value of home-grown foods. Yet the poorest of the poor, urban and rural are the hardest to reach. Even when contraceptives are free, as is the case currently, the time spent walking to a clinic and waiting for attention can be a major hidden cost to participants.

Non-users of family planning will also benefit from higher contraceptive prevalence and declining population growth rates. There will be more places available in the schools and less pressure generally on social services, housing and infrastructure.

5. OBSTACLES AND OPPORTUNITIES

5.1 POLITICAL

There is always a possibility of political backlash from a new FP program, perhaps particularly so in Burundi with a history of ethnic and church/state tension. In fact, Burundi seems to have experienced some repercussions and learned a lot from them. There was some backlash when the decision to encourage FP was first announced in 1983. This seems to have taught everyone some sensitivity in dealing with FP issues. The government repeatedly stresses the voluntary nature of the program. The Catholic missions agreed to teach about modern methods if they were not made to offer them themselves, and if discretion were used in the IEC campaign.

Any new expansion of FP activities will have to carefully build on the political consensus and sensitivities that have been established.

5.2. RELIGIOUS

Religious opposition to modern methods of family planning is a factor in Burundi, chiefly among Catholics, but also among some Protestants and probably also Muslims and followers of traditional religions. Pro-natalist values run deep and are enshrined in rituals of everyday life.

It is important to keep a good modus vivendi with the churches and mission-supported clinics. They can be involved in the IEC program, and organize Christian family classes to teach natural child spacing methods. The pressures of poverty and land shortage on large families, and the drama of the spread of AIDs have led Catholics to think carefully about the value of contraceptives.

5.3. CULTURAL

Barundi are initially very shy about contraceptive methods. There seems to be far more awareness of the potential health dangers of contraceptives than of their health benefits--i.e. the much greater health danger of pregnancy and childbirth.

There is a strong preference for injectable contraceptives, which seems to be culturally determined. Providers say that women favor them because they believe that injections work faster and better. This seems to be by analogy with injected pain killers, antibiotics, and anti-malarial medications. Also women like the fact that the injection lasts three months, and no one has to know about it--family, fellow parishioners, etc.

The government would like gradually to change this preference, as injectable contraceptives cost $6 per year, while other methods are cheaper (from $2 per year for the IUD to $4-$5 for condoms on average). A market basket of contraceptives will continue to be offered, but through education more acceptance of IUDs, pills and condoms may be encouraged.

Condom distribution through health centers is inappropriate to the behavior patterns of potential users. Men do not go to health centers unless they are sick; there are no preventive health programs for them. Women do not handle condoms. Therefore condom distribution through health centers is not a very good approach.

6. INFORMATION, EDUCATION AND COMMUNICATIONS STRATEGIES

The mountainous terrain, dispersed homesteads rather than villages, and low literacy rates (17% for women, ~27% overall), low radio ownership rate (31-49%, depending on the survey), make it difficult to reach families with IEC messages.

It is essential that messages reach women, who in Burundi as in most other African countries, are the primary users of FP, but not the primary recipients of mass media communications. It is also important that men be informed, and encouraged to discuss FP and the prevention of STDs. The most effective messages and media for reaching the two audiences are often different.

UNICEF recently conducted a KAP and communications study relating to child rearing practices, which can serve as a guide in developing a communications strategy.[9] It shows that the main means by which rural families receive health related messages are:

--meetings called by the communal administrator
--Party meetings, (held at least monthly at all levels)
--the school system
--the informal educational system, adult literacy classes on health themes, and health instruction in vocational programs: N.B. the largest of these, the Yaga Mukama schools, with 260,000 enrollment, are organized by the Catholic Church. They can be expected to teach about <u>all</u> legal FP methods although they will surely emphasize natural methods.

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[9] The study was conducted in June-July 1987, and the results are still being analyzed. Coverage included 473 households in a nationwide sample, 25 of the 114 communes in 8 of the 15 provinces were interviewed. Preliminary results are in the <u>Analyse de la situation des enfants et des femmes au Burundi</u>, ch. 6.

--mass media (31-49% of homes have a radio, according to different surveys since 1984). Only 5% of respondants indicated learning anything about FP from the written press. Literacy is about 33% overall, 17 % for women.

The capacities of the different governmental and NGO channels are summarized in the attached tables, together with estimates of the audiences reached by each.

Health center presentations reach only a tiny fraction of the potentially interested audience. Health broadcasts on the radio, however, are listened to regularly by 35% of the respondents to the UNICEF KAP study. A dynamic IEC program might also find a way to insert FP messages into the popular radio sitcom "Ni Nde," or to create similar programming with FP messages.

Printed posters and picture brochures can also reach illiterate mothers and fathers with the help of their literate children. Pre-testing of materials for comprehension and impact needs to be introduced. It has not been used here except on a UNICEF poster project. The FP flip charts that have been issued to all health centers look very much like the pictures of large families in tatters, tears and germs that Africans elsewhere have turned out to interpret exactly the opposite of what was intended. They see <u>it</u> as the "big, happy, wealthy family," while the one with three children is interpreted as "poor."

It is equally important to choose <u>appropriate</u> messages for the audiences addressed. The RAPID presentation, for example, has been very effective among policy makers in Burundi and those who are working to provide social services. The ordinary population, however, could care less about general population growth. They are only interested in using FP methods if this would be good for their personal circumstances. In fact, overuse of the message concerning the problems of population growth contributed to some of the initial backlash in Burundi, as the idea spread that the government was going to make people limit their families. Ethnic paranoia can also be stimulated by such impressions. It is therefore very important to tailor messages to the general population so that they deal <u>only</u> with the advantages to individual families. In University and government circles and the written press a larger scientific and socioeconomic debate is appropriate.

The following guidelines, gleaned from market research elsewhere in developing countries, may be useful:

AUDIENCE	APPROPRIATE MESSAGES	INAPPROPRIATE MESS.
1.Press, Policy makers, Higher Ed.	1. RAPID, Health Impact statistics, Family Economics.	
2. Scientific Publications	2. RAPID, Epidemiology of Childbirth complications and Contraceptive side-effects. Family and corporate economics of FP.	
3. Health Professionals,	3. Health Impact, Family Economics, Side effects management, pedagogical methods.	RAPID
4. Men's Groups and Communities	4. Family economics, promiscuity is a matter of character, not contraception. AIDS and STD protection. Advantages of FP for child health, mother's health. Importance of women's education.	RAPID, Side-effects management (except highly educated groups).
5. Women's	5. Health advantages to children and women. Women's education. AIDS and STD protection. Appropriate FP methods. Side effects management.	Promiscuity, RAPID (except highly educated groups).

6.1 ALTERNATIVE CHANNELS OF IEC

Alternative channels for FP communications and distribution of barrier methods are a necessary complement to the health centers if FP acceptance is to spread as rapidly as the government desires. The health centers effectively reach only 30-35% of the potential participants, and at least half of the women patients frequent Catholic clinics where modern methods are not available. The following channels have potential for FP program development, with the guidance of and in cooperation with the Ministry of Health, which has been assigned responsibility for overall coordination:

--the Party UPRONA, and its auxiliary organizations
--private firms, possibly employers as a whole
--the armed forces
--the educational system, teachers, administration and pupils

--private pharmacies, possibly linked to a pilot social marketing project
--churches, through Christian family education
--the socio-educational centers of the Ministry of Social Affairs, (one in each commune)
--The Ministry of Agriculture--rural extension
--The Ministry of Rural Development--cooperatives, etc.
--The Ministry of Information (press and radio)
--The Ministry of Family and Women's Affairs has an important advocacy function, in collaboration with the Women's Union of the Party, but has no territorial units

The private sector employs 74% of the salaried personnel in the country, a total of 185,000 persons. About 6% of these are women.

Employers are responsible by law for the full health care costs of permanent employees and their families (46% of their total number of employees). This results in heavy medical bills for employers, who thus may have a natural interest in encouraging family planning.

Private firms are closely regulated by the government and will wait for leadership to come from that quarter. If they are invited by the government to develop FP programs, however, the Chamber of Commerce, the Employers Group (le Patronat), the Rotary, Lions and Table Ronde clubs, and the large firms with their own dispensaries could probably easily be interested in such a project. Research reports on the costs/benefits to employers in other countries would be helpful. A short research project on the costs and benefits of FP to employers in Burundi would be even more influential, as its labor laws put an unusually heavy burden on employers.

Private pharmacies are another potential channel for contraceptive availability. There are 5 wholesalers and 14 private pharmacies. The latter have 26 outlets in the interior, mostly concentrated in five towns. Private pharmacies now serve mainly insured employees, as the prices are high and sale of all medicines (even aspirin, vitamins and condoms) is restricted to licensed pharmacists. The rural outreach of pharmacies is limited partly because of this tight control. A pilot project in social marketing of contraceptives is called for in the government/World Bank project. If done effectively, this could be an important breakthrough in helping the government see the efficacy of private sector distribution. It could help policy makers to consider determining whether there are other medications whose wide dissemination would do more good than harm. With improved consumer and health education, the ground could be prepared for a liberalization of policy in this area.

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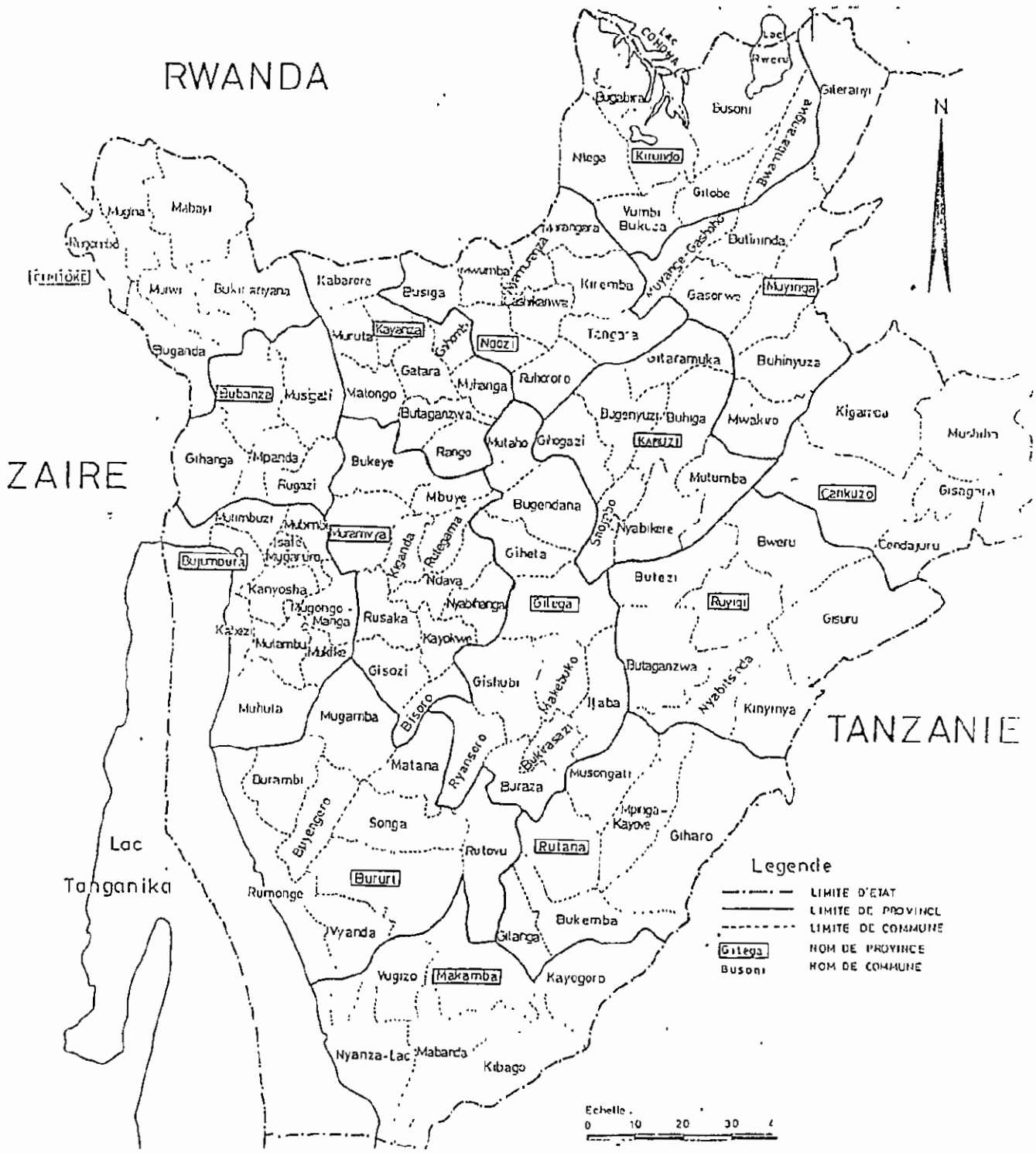

Legende

- LIMITE D'ETAT
- LIMITE DE PROVINCE
- LIMITE DE COMMUNE
- Gitega — NOM DE PROVINCE
- Busoni — NOM DE COMMUNE

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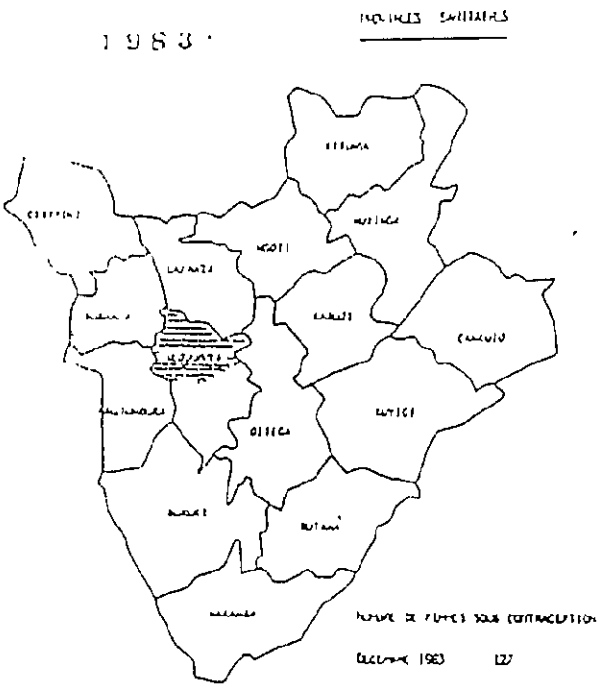
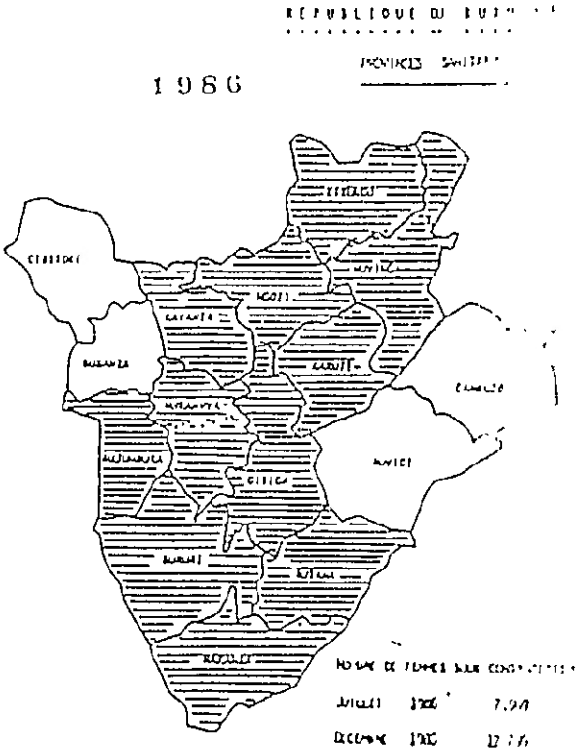
Carte 1.1 LE BURUNDI - CARTE ADMINISTRATIVE

Carte 1.1 Le Planning Familial, 1983



Carte 1.2 Le Planning Familial, 1986



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