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Accelerated fragility: exploring the supply–demand nexus in health facilities in rural Burkina Faso

Helle Samuelsen

Lankoanda and his two colleagues at Tenga[1] health dispensary were deeply engaged in completing the monthly activity report, when I passed by one afternoon in December 2015. Tenga is a village located in the south-central part of Burkina Faso, around 225 kilometres from the capital of Ouagadougou. Lankoanda and his colleagues were sitting in one of the consultation rooms, vigorously discussing which data to put into the report's tables. The atmosphere in the room was one of concentrated activity. The monthly report was to be completed the following day and sent to the district health office. The report is preformatted and includes a number of tables that need to be completed. The dispensary staff report on completed mother and child services, including the number of deliveries, vaccinations and admissions, and they also fill out a table on 'new consultations'. More than forty rows with different diagnoses are listed in this table, with sex and age groups in columns. The health officers at remote dispensaries, such as this one in Tenga, complete the form by hand. At the district level, all data from the incoming monthly dispensary reports are entered into a database for further analysis. The monthly report takes its points of departure from the World Health Organization's (WHO's) International Statistical Classification of Diseases and Related Health Problems (ICD).[2] Lankoanda and his colleagues must enter each new consultation, from the whole month, in the correct row and column. He explains that they have to be meticulous when completing the report, as he was assigned to this dispensary because the chief district medical officer had identified problems with the reports submitted by his predecessor. Following the reporting standards by filling out the rows and columns on a range of activities conducted during the previous four weeks is an important part of Lankoanda's work, and submitting the reports on time is an important performance measure here in Burkina Faso, just as it is in many other healthcare systems around the globe. Close reading of the monthly reports from Tenga and a neighbouring dispensary in the village of Keru shows that the diagnosis called '*paludisme simple*' (uncomplicated malaria) accounts for a very large proportion of the total

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[1] I use pseudonyms for most names and places.

[2] This diagnostic system has been adjusted a few times since I first looked at these reports back in 1996–97. Some of the disease names or groups of diseases have thus been changed; however, the two diagnoses 'uncomplicated malaria' and 'severe malaria' were part of the reporting system during the period for which I looked at the reports.

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number of 'new consultations' and that the proportion has increased over the years.

At first glance, Lankoanda and his colleagues seem to be good citizens doing their duty to the state by making visible health conditions and needs. A closer look shows that these monthly reports, with their overwhelming focus on malaria, are in fact part of a technology of invisibility that contributes to accelerating fragility in citizen–state relations. For people living in rural Africa, health facilities, along with schools, constitute the most important point of encounter with state authorities and therefore a strategic location for exploring relationships between citizens and the state. Drawing on several periods of fieldwork in this area since 1996, I am particularly interested in examining ordinary citizens' formal and informal encounters with the state and how the everyday *grammars* of the state are determined by both national and global processes as well as by local (dis)engagements with state authorities (Adebanwi and Obadare 2010; MacLean 2011; Von Schnitzler 2008; Obadare and Adebanwi 2010).[3] As formulated by Gupta:

> If … we are to understand the paradoxical relation of different groups of poor people to the state, which simultaneously articulates inclusion and care with arbitrariness and structural violence, then we need to pay close attention to the routinized practices of different branches and levels of the state. (Gupta 2012: 41)

This article contributes to the debates about state–citizen relationships by connecting local health-seeking practices to global trends of datafication and a strong focus on the fight against malaria in this part of Africa. I show that the routinization of diagnostic procedures combined with a strong national and global political focus on the fight against malaria create a 'supply–demand nexus' in which citizens selectively ask for the health services that they know the system can supply. The monthly reporting from rural health facilities shows how a discernible focus on malaria, which is based on disputable data, reinforces the cumulative tendency to prioritize the fight against malaria as *the most* important health problem to be addressed in Burkina Faso. I argue here that the combination of limited health service capacity, political unrest and growing insecurity weakens the already fragile relationship between state and citizens in Burkina Faso. I use *fragility* here as a notion to characterize the state–citizen relationship. According to the *Oxford English Dictionary*, fragility refers to an object that is easily broken or damaged.[4] In what follows, I first briefly reflect on the socio-political situation in Burkina Faso in order to provide the context for my discussion of the state–citizen relationship as exemplified in the high number of malaria cases registered in the monthly reports.

Political commotion and paradoxes of the state

In 2014, the ruling president for twenty-seven years, Blaise Compaoré, was dismissed and sent into exile in Côte d'Ivoire after a very short and intense period

[3]The 'everyday grammar of the state' is defined by Adebanwi as the ways in which languages, symbols and discourses of the state shape and are shaped by practical experiences, expressing a concreteness of the state in the everyday lives of people (Adebanwi forthcoming n.d.).

[4]See <https://www.lexico.com/definition/fragility>.

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of *insurrection populaire* (popular uprising) led by a grass-roots organization called *Balai Citoyen* (Citizens' Broom) in collaboration with trade unions and a range of non-governmental organizations, including women's organizations. The popular protests were triggered by a proposed new electoral code whereby the ruling president would be eligible for re-election more than twice; this would have allowed Compaoré to stand for another term as president (Hagberg *et al*. 2018; Zeilig 2017). After a short-lived military coup in September 2015, elections were held in November 2015; Roch Marc Kaboré, an ex-member of the old regime, won in the first round with 53.49 per cent of the vote (Zeilig 2017: 159). During this period, the Sahel region, including Burkina Faso, was being challenged by an increasing number of attacks by various jihadist groups such as AQIM (al-Qaeda in the Islamic Maghreb) and Ansaroul Islam (Hagberg *et al*. 2019). These organizations moved their battle zones from the border areas of Mali, Burkina and Niger to launch violent and spectacular actions against military, government and civilian targets inside these countries. In January 2016, there were two bomb blasts at a hotel and a café in Ouagadougou. Both places were known as hubs for Western tourists, aid workers and well-off Burkinabe citizens, and kidnappings of both Western and national citizens have occurred in Mali and Burkina Faso in recent years. New attacks, including attacks on health facilities, schools and Christian congregations, followed, and 600,000 people had fled their homes and were living in refugee camps inside the country in 2019.[5] In parallel to the escalating insecurity caused by the many terrorist attacks, organized crime has also increased over the last few years (Hagberg *et al*. 2018). Most recently, the Covid-19 pandemic has reached Burkina Faso, presenting another huge challenge to the government, which is under pressure due to a weakened economy, increasing poverty and a growing critique of its capacity to fulfil the promises it made during the elections. In other words, the current political, economic, social and health situation is extraordinarily tough and the population's trust in the state is particularly challenged by serious security issues and a looming pandemic.

Looking at the Burkina state over recent decades, we see at least three types of paradoxes. First, Blaise Compaoré's presidency, which lasted twenty-seven years, was quite strong for a long period yet also weak. Second, the state is both absent and present at the same time (Masquelier 2001; Law 2002; Street 2012), something that is particularly visible in rural areas. Third, governance is both stable and fragile. The first paradox relates to the fact that Compaoré's presidency was surprisingly strong until 2014. He was elected and re-elected several times, and, during his rule, he navigated many conflicts between various ethnic groups inside the country, he balanced the power of the government with that of the traditional chiefs, and he succeeded in negotiating 'peace deals' with the northern jihadist groups by offering them certain privileges. In addition, the economy grew at an average annual rate of more than 5 per cent between 1991 and 2016. However, the notion of 'Africa rising' (Zeilig 2017; Mbembe 2016), which has been used to characterize the impressive economic growth rates of many African countries, would not apply if we looked at living conditions in the rural areas of the country. The Compaoré government never managed to improve the

[5]See <https://www.internal-displacement.org/countries/burkina-faso>.

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living conditions of the poor and Burkina Faso is consistently ranked at the bottom end of the United Nations Development Programme's Human Development Index. In 2016, the country was ranked 185 out of 188 countries and 46 per cent of the population lived below the poverty line (Zeilig 2017). The period after the insurrection in 2014, when Blaise Compaoré was forced to resign, and since Roch Marc Christian Kaboré won the elections in 2015 has seen a further weakening of the state (Hagberg *et al.* 2015; Hagberg 2019; Samuelsen forthcoming n.d.). The second paradox, which relates to the absent–present state, is very visible in the rural parts of the country. Government institutions are visible (the school, the dispensary and the prefecture) with their distinct architecture, but they are remarkably empty, in terms of both people and equipment. I unravel this paradox in more detail below. The third paradox relates to governance and the country's health policy, which has been characterized by a long-standing focus on district-based primary healthcare as a fundamental element since the signing of the Alma-Ata Declaration in 1978. The government has steadily worked towards an increase in the number of dispensaries in rural areas and a reduction in the average distance to a public health facility in order to promote 'health for all'. Despite the increased availability of health facilities, the healthcare system continues to face huge challenges in terms of quality of care (Melberg *et al.* 2016), and, as we shall see below, the strong emphasis on malaria treatment may be taking the focus away from other important health problems.

Datafication and health policy

Before examining the rural residents' encounters with local health facilities and the reporting system in more detail, it is important to note the increasing global demand for metrics and the modern state's need for systems of quantification. These trends have been widely discussed in political anthropology and beyond (Foucault 2012; Scott 1998; Porter 1996) and more recently within critical global health (Adams 2016; Merry 2011; Merry *et al.* 2015; Erikson 2016; Moats 2016). As emphasized by Gupta: 'Foucault's biopolitical order depends upon the normalizing power of statistics.' He continues: '[I]f one does not critically analyze how those statistics are collected and employed, then the relationship between biopower and issues like sovereignty and violence is likely to be misunderstood' (Gupta 2012: 42). Today, as pointed out by Vincanne Adams, the eagerness to quantify and categorize populations is not restricted to nation states; global health agencies and institutions are also committed to forms of (global) knowledge that are based on universals and that become visible only through forms of data production grouped together as 'metrics' (Adams 2016: 6). With the increased use of metrics comes standardization, which makes it much easier to formulate comparable indicators and goals at national, international and global levels (Brunsson and Jacobsson 2000: 1; Timmermans and Epstein 2010). The disease classification system, ICD, is in itself a standardization of disease categories. WHO highlights the advantages of the ICD system as follows:

> [I]t provides easy storage, retrieval and analysis of health information for evidence-based decision-making; it facilitates sharing and comparing of health information between

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hospitals, regions, settings and countries; and it facilitates data comparisons in the same location across different time periods.[6]

Decisions about what to standardize and what to count are obviously political, yet somehow it is still assumed, both in national administrations and among global health stakeholders, that numbers are unbiased and apolitical and that they reveal the truth (Hacking and Hacking 1990; Merry 2011; Jerven 2013; Adams 2016). Claire Wendland's analysis of maternal mortality metrics in Malawi provides an excellent example, demonstrating that the regression equation used to assess maternal mortality rates is based on six *estimated* numbers defined by WHO, not actual counts.[7] Wendland formulates her concern in the following way:

> The product of an equation looks like a number and works like a fact, but it is more the moral of a story. In this case it is the story that bolsters the shaky foundations of a presidency. It is a story that hides uncertainty under layers of numbers, even when those numbers are estimates based on approximations based on intuitions. (Wendland 2016: 78)

In Botswana, as observed by Julie Livingston, a cancer surveillance system was not developed until cancer emerged as an epidemic, because cancer was never thought of as a problem (Livingston 2012). The government of Burkina Faso is following this trend of datafication with a Health Information System that includes a large number of quantifiable goals and indicators and a meticulous concern with the timely flow of data from rural dispensaries to the district level.

The diagnostic repertoire

The dispensary in Keru is staffed by two government-trained nurses: '*le major*', who has overall responsibility, and '*la matrone*', who is in charge of maternity and childcare activities, including vaccinations. The nurses have two years of training, while the third staff member, the assistant midwife (AIS), has only one year of training. A village volunteer is in charge of the medical depot. On most days, the atmosphere at the dispensary is quiet, with only a few patients waiting for consultation during the morning hours. The consultation rooms are sparsely furnished with an absolute minimum of equipment and instruments. A few fading educational posters hang on the walls and papers lie piled up on the desk and the examination bed. The dry and dusty weather conditions leave all surfaces covered with a fine layer of red dust. Without running water, it is difficult to keep the health facilities clean.

As in many other dispensaries in sub-Saharan Africa, clinical encounters at dispensaries in rural Burkina Faso follow a standard procedure: the patient (or

[6]See <https://www.who.int/classifications/icd/en/>. The first edition of the International Classification of Diseases was adopted by the International Statistical Institute in 1883; since 1943, WHO has been entrusted with updating and revising the list.

[7]Malawi, like many other sub-Saharan countries, does not record vital statistics (the registration of births, deaths, etc.). Most of the health statistics are therefore based on the demographic and health surveys conducted every five years by ICF (Inner City Fund) Macro. Some of these statistics are also based on estimations rather than counts (Wendland 2016: 66).

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mother with a sick child) enters the consultation room, where the nurse in charge is sitting behind the table. A few questions are asked about the condition and specific symptoms such as fever or coughing. In some cases, the nurse examines the patient, lifting the eyelids to look for anaemia or checking for fever. In cases of fever, a rapid diagnostic test (RDT) for malaria is often conducted. After a short conversation and examination, the nurse writes a prescription and asks the patient to go to the medical depot to get the medicines (including needles and syringes if injections are needed); when patients need injections they are asked to return to the nurse. The consultation process itself is routinized in the sense that the main component in the consultation is a short exchange between the patient or the mother of a sick child and the nurse, with the purpose of diagnosing the illness and deciding on the treatment. Front-line health workers have to depend on their clinical experience, the RDT[8] for malaria, a thermometer (if it is not broken) and a weighing scale.

As Table 1 illustrates, the proportion of malaria diagnoses among all new cases of sickness registered in the month of January increased from 28.4 per cent in 2001 to 46.4 per cent in 2013. At the neighbouring dispensary in Keru, the malaria diagnosis was applied in more than half of all 'new consultations' during a large part of the year. Although there are seasonal variations, the figures show that even in the month of January, which is not the peak season for malaria, more than 50 per cent of all diagnoses in the category 'new consultations' were categorized as 'uncomplicated malaria'.

Amadou, the nurse in charge at the dispensary in Keru, commented: 'Our diagnostics are essentially based on the clinical signs, the physical signs, and simple examinations as for example the rapid diagnostic test. As we are not well equipped in terms of material and personnel, there are examinations that we cannot do.' The limited availability of medico-scientific equipment clearly restricts health professionals' diagnostic repertoire,[9] leaving staff at this level of the healthcare system to rely on their experience and their 'clinical gaze' (Foucault 2012).

The supply–demand nexus

Child fevers are extremely common in rural communities in Burkina Faso and the majority of visits to the local dispensaries in Keru and Tenga are translated into a malaria diagnosis, as the monthly reports show. Many other diagnostic categories listed in the form, such as anaemia and malnutrition, are hardly ever used, despite the fact that dispensaries in this area distribute food supplements to malnourished children between six months and five years of age. Other illnesses, such as sexually transmitted diseases, mental health problems and dental problems, are generally absent from the monthly reports. We do not know how frequent these other diseases are as they are never counted, and we do not know whether they are not

[8]The National Malaria Control Programme (NMCP) guidelines in Burkina Faso recommend that all suspicious malaria cases should be confirmed using either the RDT or light microscopy (if available) (Kiemde 2019).

[9]A repertoire is defined as a 'stock of plays, dances, or items that a company or a performer knows or is prepared to perform' (<https://www.lexico.com/definition/repertoire>).

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TABLE 1
Diagnosis of patients at CSPS Tenga and Keru in January 2001, 2010 and 2013

	CSPS Tenga						CSPS Keru			
	Jan. 2001 (%)	Jan. 2001 (no.)	Jan. 2010 (%)	Jan. 2010 (no.)	Jan. 2013 (%)	Jan. 2013 (no.)	Jan. 2010 (%)	Jan. 2010 (no.)	Jan. 2013 (%)	Jan. 2013 (no.)
Uncomplicated malaria	28.4	38	35.4	177	46.4	434	51.8	195	55.7	241
Complicated malaria	3.7	5	3.0	15	0.4	4	4.3	16	0.9	4
Undetermined fever	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0
All cases		134		500		936		376		433

Note: CSPS = Centre de Santé et de Promotion Sociale (Centre for Health and Social Advancement).
Source: Monthly reports (2001, 2010 and 2013) collected from Keru and Tenga dispensaries.

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counted because they are never raised in the consultation room at primary healthcare facilities or because health workers tend to translate diseases involving fever (with or without a positive RDT) into a malaria diagnosis. The brief, routinized consultations and the limited diagnostic repertoire result in malaria being the most frequently diagnosed disease.

The routine consultation process combined with standardized diagnostic procedures make the outcome of a visit to the dispensary rather predictable if we look at it from a patient's perspective. Rural citizens have a kind of certainty in knowing what is offered at the clinic, particularly in cases of fever: a quick conversation, a prick of the fingertip and a prescription, which is 'cashed' at the medical depot. Patients and the mothers of sick children do not complain if they do not get exact information about the diagnosis itself; they are more concerned about 'doing' away (Mol 2002) with the symptoms by getting a prescription for medicines, which hopefully will improve the condition of the patient (Østergaard *et al*. 2016). As Mogensen (2005) describes for rural clinics in Uganda, the little piece of paper with the written prescription becomes a token. The main aim is to take pragmatic action in response to the disease. As described above, often days will have passed before the mother of a child with symptoms decides to go to the dispensary, and often other methods will have been tried before contacting the public healthcare facilities (Olsen and Sargent 2017). In Tenga and Keru, sick people, and particularly mothers of sick children, try to be hopeful and look for certainty. In one sense, they do find certainty at the dispensary: parents know that their child will be looked at and given some medicine, and their experiential knowledge tells them that this will happen in cases of fever. This is what I call the supply–demand nexus: sick people mainly go to public health services with afflictions for which they know treatment is supplied. The standardized diagnostic procedure and treatment of fever cases becomes an important means for both health professionals and patients in their joint efforts to take care of the sick. In this way, the ill child is taken care of rather than cured, if the fever is not due to malaria. I suggest that we can look at this supply–demand nexus as a form of 'technology of invisibility', similar to Joao Biehl's analysis of the non-registered AIDS deaths of marginal groups in Bahia, Brazil (Biehl 2005).[10] The three short cases below show how mothers of sick children pragmatically navigate the medical field and how strongly they associate the services at the public dispensary with fever/malaria treatment. The narrow focus on malaria and the incapacity to diagnose many other diseases exemplified here demonstrate the fragility of the state–citizen relationship.

Odette lives in Keru with her husband and their seven children. They subsist from tending their fields, like most other inhabitants in the village, and Michel, Odette's husband, also works for a latrine project, constructing pit latrines in households where owners are willing to invest in such a facility. Whereas most adult women in Keru have never attended school, Odette completed six years of schooling and uses her skills when she occasionally assists the Catholic mission in the village. In addition, Odette is also a *dolotière*, a producer of the local

[10]In 1997 the Bahia state in Brazil reported a decrease in AIDS cases; however, when counting the AIDS cases at the state hospital in the period 1990–96, Biehl found that only 26 per cent of AIDS deaths were officially registered. The rest of the cases were absent from the AIDS statistics.

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millet beer, and she runs a 'cabaret' (a millet beer tavern) every third day. Odette was one of fifty women interviewed about their therapeutic itineraries when their children fall ill. She invited my field assistant and me into her compound, finding small stools for us to sit on while she continued her millet beer preparation. Her youngest child, who was three years old, suffered from *ying-wingre*,[11] she told us. The sickness had started with a sudden fever and loss of appetite twelve days before our visit, but, after treatment, he was now slowly recovering. She emphasized to us that she took the decision herself to consult the dispensary located in the village and had asked a female neighbour if she could borrow her bike. Many women in this part of Burkina would have to ask their husband for money and permission before seeking treatment, but Odette has her own small income from her cabaret. The local *dolotières* are usually allowed to keep the profits for themselves (which they mainly use for their children's medicine and healthcare). At the dispensary, the child was prescribed some paracetamol and a course of malaria treatment, and he was given one injection at the consultation. Odette explained to us how the nurse instructed her to give the child the malaria medicine twice a day for three days and half a tablet of paracetamol three times a day for three days. She does not know what caused the disease, but said that *ying-wingre* is very common, adding that *pug zabre* (stomach problems/diarrhoea) and *palu* (malaria) are also common among small children. Odette did not use any herbal medicine for home treatment or consult any of the local specialists during this episode of sickness. She prefers to go straight to the dispensary in such cases, as 'the local medicines do not cure this disease. Besides, visiting the traditional healers would take a lot of time and drag the sickness. It is better to go to the dispensary, it is quicker.'

Thirty-five-year-old Alimata, another of our interlocutors, lives alone with her three children, aged seven years, five years and ten months. Her husband, Idrissa, works at a plantation in Côte d'Ivoire, sending money home to her once a year. Her youngest child fell ill with the '*palu*' (malaria) three days before our conversation. He had '*corps chaud*' (a warm body) and was coughing. Alimata uses the local term '*sobgo*' for malaria. She explained to us that she first bought some herbal plants at the market, which she boiled and gave the child to drink every morning for three days. On the second day, she also took him to the dispensary. Here they tested for malaria, which gave a negative result. Yet, he was prescribed treatment for malaria, artesunate/amodiaquine, as well as paracetamol and some medicine for the cough, and was given one injection at the consultation. Alimata's child is part of the malaria diagnosis statistics, although the test was negative. The child recovered after a couple of weeks following the herbal treatment and another visit to the dispensary. Many women told us about similar therapeutic pathways in cases of child fever, mixing home treatments with visits to local herbal experts and consultations at the dispensary.[12] As Alimata explained: 'I only go to the dispensary if the disease does not finish [with home treatment], if it is grave, because I

[11]Mooré for fever.

[12]During my fieldwork in this area, I have interviewed more than twenty-five different traditional healers in and around Keru and Tenga, including bonesetters, sorcery specialists, marabouts, diviners and different types of herbalists who specialize in treating a few specific symptoms or diseases.

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don't have money. My husband is in Côte d'Ivoire, he only rarely sends me 5,000 CFA [US$8.50].' 'Warm body' or fever appeared as the most frequent symptom or sickness in our series of interviews on therapeutic trajectories.

Mariam, a young Mossi woman who had lived for many years both in Côte d'Ivoire and in Ouagadougou, said that the two most common diseases of her eight-month-old child are *palu* and '*pugnondre*' (stomach problems). The *palu* is caused by mosquitoes, she says, while *pugnondre* is related to the 'cycle of the moon'. She attends the dispensary for the *palu* while traditional medicine works better than going to the dispensary in cases of *pugnondre.* Like Odette, she highlighted the importance of consulting the dispensary in cases of child fever, saying: '*Parce que le corps chaud se soigne à l'hôpital* [Warm body/malaria is treated at the 'hospital'/the clinic].'

The three cases above show that mothers consult the dispensary mainly in cases of fever (if they can afford it), knowing that treatment for malaria is provided there. In other cases of sickness – for example with stomach problems – they may rely on home treatments or consult other types of specialists. An examination of rural women's therapeutic trajectories shows that, despite the fact that public health facilities are available in rural areas, the link between citizens and the state is frail when the focus of the supply–demand nexus is limited to only a few symptoms and diagnoses.

In the rest of this article, I discuss some of the implications of the supply–demand nexus, with a particular focus on two aspects. First, I look at the local reporting system within the primary healthcare sector of Burkina Faso as part of a global trend in which current forms of governmentality are based to a large extent on processes of datafication. Second, I discuss how the supply–demand nexus affects the citizen–state relationship in the current political climate.

The labelling of all fever cases as '*paludisme simple*' or uncomplicated malaria, whether as part of the government policy of treating undiagnosed cases of fever as malaria or as the habituated practice of health workers (or a combination of the two), confirms to both the public and policymakers that malaria is *the* main health problem in rural Burkina Faso. Whether all these patients really suffered from malaria is, of course, unknown. Nevertheless, we know from conversations with the inhabitants of Tenga and Keru that they also suffer from a range of illnesses other than fever. The knowledge produced on the basis of the monthly reports from Keru and Tenga dispensaries informs us of a significant and increasing burden of malaria in this particular area. This is the information that government healthcare policymakers are presented with and which continues to shape the overall healthcare priorities of the country. For decades, malaria has been singled out as a high-priority public health problem in Burkina Faso, if not the main problem (Ministère de la Santé 2011; 2012). This prioritization has been supported by global health organizations such as WHO and UNICEF in programmes including the Roll Back Malaria Partnership as well as the Millennium Development Goals Initiative (WHO and UNICEF 2005; WHO 2015; Owens 2015). For decades malaria has been high on the global health political agenda as well as on the funding agenda (Pigott *et al.* 2012; Cueto 2013). The supply–demand nexus thus feeds into a kind of self-fulfilling prophecy where the prioritization of malaria as *the* most important health problem to be addressed is confirmed – a prioritization that to a large extent is based on dubious and disputable data.

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Accelerated fragility

In this last section of the article, I turn to a discussion of how the supply–demand nexus and the strong focus on malaria in the current political context further weaken the link between rural citizens and the state in Burkina. Apart from the public school, the local dispensary is the government institution with which rural residents have most contact. Yet, as described above, the residents of Keru and Tenga use the public health facilities in selective ways. Moreover, the capacity of the nurses at the local dispensary to fulfil their fundamental duties as representatives of the state by providing basic healthcare services to the public is limited. This is a challenge for the rural population, which is not 'serviced' in adequate ways, and, as pointed out by Street in her analysis of Madang hospital in Papua New Guinea, 'institutional poverty weakens the efficacy of bureaucratic and biomedical technologies' (Street 2014: 17). This also applies to the dispensaries (and the hospitals) in Burkina Faso. The capacity to perform medical sovereignty on biological bodies is limited. Government healthcare professionals are equipped with the technology and capacity for only a narrow focus on malaria. As pointed out by Foucault (2012), Rose and Novas (2005) and a number of other scholars (Lock and Nguyen 2010; Stapleton and Byers 2015; Nguyen 2010), in principle government institutions are a locus for biopower, but in Burkina these institutions are relatively weak and characterized by a number of absences. The state–citizen relationship is a two-way relationship. On the one hand, health staff (or other government employees) have the formal legitimacy to be in command of essential technologies to execute their power and manage the medical treatment of patients. On the other hand, health staff also need to be recognized by and visible to patients as professional experts with decisive capacities for action. This 'rights and duties' relationship is taken up by Vinh-Kim Nguyen in his discussion of *therapeutic citizenship* in relation to the AIDS epidemic in Burkina Faso and Côte d'Ivoire, where it became important to recruit HIV-positive patients for various treatment trials. Being part of a treatment trial also implied certain rights, such as the right to medicines and the right to food aid (Samuelsen 2016; Nguyen 2010). In Niger, a country facing similar challenges to Burkina Faso in terms of high rates of poverty, political instability and weak public services, Masquelier explains how widespread resistance to a state-sponsored polio eradication programme was rooted in general perceptions of the state as a vehicle for generating political deceptions and fraudulent deals (Masquelier 2012). She writes:

> [P]eople may not agree as to what they should be entitled to, but they expect the state to do more for its citizens, especially when it comes to health care. These claims about entitlements are grounded in an expectation of free medical care inherited from the brief period of prosperity Niger experienced in 1970s and early 1980s. (Masquelier 2012: 227)

Similarly, Warren *et al.*'s (2015) study in Mali shows how a general mistrust in the state combined with health workers' scolding and mistreatment of pregnant women may explain the low use of maternal healthcare services in rural areas. Rural citizens in Burkina Faso – in my experience – seldom openly criticize the health system when medicine is out of stock or when personnel are absent. They use the services offered in very pragmatic ways, but they do not claim their general entitlements as citizens with rights to the common goods of public

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healthcare as such; rather, they share an ontology of marginality (Das and Poole 2004). In the consultation room, patients present themselves in accordance with a legitimate order, to use Weber's (1978) terminology, where the health worker represents governmental authority and the patients are subordinates. They do not openly call for their rights to public healthcare; their healthcare-seeking practices are pragmatic, knowing that they have access to malaria treatment if they can afford it. The strong focus on malaria and the deployment of the RDT define and materialize the civil link to the state and, more importantly, participate in the construction of a narrative about a malaria-suffering nation with a government that works hard to control the disease.

After twenty-seven years with a 'despotic' president, many people in Burkina Faso had high hopes for real change, where basic needs such as security, healthcare and employment would be fulfilled. However, for the villagers in Keru and Tenga, nothing much has changed. In fact, as mentioned in the introduction, the basic security situation is gradually worsening, with terrorist actions spreading from the border regions to almost all the provinces of the country. Furthermore, armed gangs conducting raids against ordinary people to seize goods is a growing phenomenon in rural areas (Hagberg *et al*. 2018: 59). To mitigate these incidents, the local population has formed self-defence groups called *koglweogo*.[13] The members of these militia-like units are local volunteers. When I asked one of my friends in Keru, Thomas Kéré, what he thought about this development, he said that it was absolutely fine: 'What else can we do?' During a fieldtrip in 2017, we passed a group of *koglweogo*, including ten to fifteen males on their motorbikes with various types of weapons in their hands. Later, we passed a prisoner who was roped to a tree on public display. While these types of vigilance raise a series of ethical and legal questions, they also reveal a huge vacuum in the state's ability to fulfil its sovereign duties to protect its citizens. From the perspective of rural citizens, their experience is that they are left to themselves to take care of their security.

In terms of healthcare, the government of Roch Marc Christian Kaboré, elected in 2016 after the popular uprising, has granted free healthcare for children under five years of age (Hagberg *et al*. 2018: 67). However 'free' healthcare is not always free. Prescribed medicine may not always be available at the medical depot, in which case the patient or caregiver will have to buy the medicine somewhere else. As we saw in the cases above, patients and caregivers in this part of Burkina worry a lot about potential demands for money, both direct payments for medicines or under-the-counter payments (REN-LAC 2018)[14] and indirect payments in terms of transport costs or loss of income while spending time at the health facility. Thus, considerations about the potential cost of a visit to the dispensary continue to play an important role in the healthcare-seeking process. Direct criticisms of specific health services are seldom voiced by individual patients, but the recent history of Burkina Faso shows that in certain situations civil society can mobilize protests (Harsch 1998; Hagberg *et al*. 2015; 2018).

[13] *Kogle*: 'to protect'; *weogo*: 'bush land' in Mooré.

[14] A recent report from the Réseau National de Lutte Anti-corruption (National Network for the Fight against Corruption) documents that the healthcare system in Burkina Faso is characterized by massive corruption at all levels of the system (REN-LAC 2018).

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During a series of strikes among health workers in 2012 and 2013, when people were prevented from accessing biomedical services, we saw incidents in which rural residents both criticized and attacked health facilities (Østergaard 2016). And the insurrections in 2014 were not only an urban phenomenon; a large number of actions and demonstrations took place in the rural areas of Burkina as well. Moreover, the Covid-19 health crisis has also led to public protests against some of the restrictions enforced by the government, and the double layers of security and health crises led to public discussions about possibilities of postponing the scheduled government elections in November 2020.[15]

When the state is not able to deliver basic healthcare and security to its population, 'health for all' is replaced by a 'duty to be well'. The state and public authorities relinquish their obligations and responsibility for the provision of security and well-being, delegating to individuals and communities the responsibility for managing their own insecurities (Rose and Lentzos 2017: 35–6). In the current situation, where political, economic and health crises are escalating, the everyday grammar of the state is under attack. We see this very concretely in the growing number of terrorist attacks, but also in more subtle ways when the state's capacity to care for its citizens is reduced (Trnka and Trundle 2017). This, I argue, accelerates the risk of a further fragilization of the relationship between rural citizens and the state.

Conclusion

As I show in this article, the relationship between rural citizens and their local dispensaries is characterized by a *supply–demand nexus*, where citizens mainly demand those services that the system is able to provide. This may be logical and pragmatic from the viewpoint of the citizens. If, however, most fever cases are translated into a malaria diagnosis and many non-fever cases seek treatment with other local specialists or are treated at home, the government's (and the global health community's) policy of focusing on malaria as the most important disease to be addressed in Burkina Faso does not reflect the actual disease pattern of the country. The metrics produced through the system of monthly reporting and the routinized practices at the health facilities indicate that Burkina Faso, unlike many other countries in Africa (WHO 2015), is experiencing a heavy and increasing burden of malaria. However, as discussed here, the data substantiating this policy are fragile. As I suggest here, there is a risk that the routinized diagnostic practices that mainly focus on malaria serve as a 'technology of invisibility' by not capturing other important diseases among the rural population. Furthermore, by exploring diagnostic routines at the dispensaries and following individual cases of illness, we see the various ways in which the social contract between the government's healthcare services and rural citizens is played out in everyday life. The *duties* of the modern state to protect and care for the health of its citizens, as embedded in the term 'public health' (Prince and Marsland 2014), are not fulfilled. To a large extent, the rural citizens of Tenga and Keru

[15]'Burkina: des organisations de la société civile appellent au report des élections', lefaso.net, 1 May 2020 <https://lefaso.net/spip.php?article96570>.

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are left to take care of their own health problems – or at least those ailments that are not directly translatable to a malaria diagnosis. The relationship between the government's health representatives at the village level and the rural citizens appears to be fragile in a number of ways. Lankoanda and his colleagues at the dispensary in Tenga are probably doing their best, but their reporting system and their lack of diagnostic capacity make them translate most fever cases into a malaria diagnosis. Finally, I ask whether the limited healthcare services provided at the rural health facilities in the current context of political insecurity, instability and a global pandemic spur a process of further fragilization of the social contract between rural citizens and the state.

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Abstract

In Burkina Faso, political turmoil, escalating insecurity and a looming pandemic challenge the population's trust in the state. This article contributes to the debates about state–citizen relationships in fragile countries by connecting local health-seeking practices with the global trends of datafication and a strong focus on the fight against malaria in this part of Africa. Drawing on long-term research engagement in Burkina Faso, I examine the health-seeking practices of rural citizens and look into diagnostic routines and reporting in two rural dispensaries. I show how the routinization of diagnostic procedures combined with a strong national and global political focus on the fight against malaria create what I term a 'supply–demand nexus' in which rural citizens selectively ask for the health services that they know the system can supply. I argue that the routinized diagnostic practices that mainly focus on malaria serve as a 'technology of invisibility' by not capturing other important diseases among the rural population. Finally, I ask whether the limited healthcare services in the current context of political insecurity, instability and a global pandemic spur a process of further fragilization of the social contract between rural citizens and the state.

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Résumé

Au Burkina Faso, l'agitation politique, la montée de l'insécurité et la menace d'une pandémie ébranlent la confiance de la population dans l'État. Cet article contribue aux débats sur les relations État-citoyen dans les pays fragiles en reliant des pratiques locales de recours aux soins aux tendances mondiales de mise en données et à la priorité donnée à la lutte contre le paludisme dans cette partie de l'Afrique. S'appuyant sur ses recherches à long terme au Burkina Faso, l'auteure examine les pratiques de recours aux soins des citoyens ruraux et étudie les routines et rapports diagnostiques dans deux dispensaires ruraux. L'auteure montre comment la routinisation des procédures diagnostiques, associée à la priorité politique nationale et mondiale donnée à la lutte contre le paludisme, crée ce qu'elle appelle un « lien offre-demande » dans lequel les citoyens ruraux réclament sélectivement des services de santé qu'ils savent pouvoir être fournis par le système. L'auteure soutient que les pratiques diagnostiques routinisées qui se concentrent essentiellement sur le paludisme servent de « technologie d'invisibilité » en ne capturant pas d'autres maladies importantes parmi la population rurale. Enfin, l'auteure pose la question de savoir si les services de soins de santé, limités dans le contexte actuel d'insécurité politique, d'instabilité et de pandémie mondiale, stimulent un processus de fragilisation accrue du contrat social entre les citoyens ruraux et l'État.

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