1. Executive summary

This report is the product of an interagency team health and nutrition evaluation in Burundi, conducted from 21 March to 29 April 2005. The evaluation is part of an international initiative "Interagency Health Evaluations in Humanitarian Crises".[1]

The aim of the inter-agency evaluation in health and nutrition was to review processes in-country in order to provide strategic and practical information for the humanitarian programme design and implementation. At the same time, the evaluation attempts to address general questions with regard to humanitarian assistance in the context of transition. Intended end-users include UN and international humanitarian organizations, representatives of donor agencies in Burundi, as well as policy makers and planners at the central level.

The main reference for the evaluation was the health and nutrition sector strategy of the CHAP 2005. The priorities formulated in that strategy were the basis against which progress and quality were reviewed, and to identify bottlenecks for achieving these objectives. While not all stakeholders were familiar with the 2005 strategy for health and nutrition, the priorities were generally considered to be still valid. Monitoring against indicators that were proposed in the strategy was not consistently introduced. The list of indicators is too comprehensive and some indicators need further specification. It is proposed that this takes place during the coming CHAP workshop, in early September.

General context,

Since the signing of a peace accord in Arusha, August 2000, and the ceasefire in November 2003, which was agreed to by all but one party (FNL) to the conflict, the security situation in the interior of the country has improved, allowing better access for humanitarian agencies. Most of the 16 provinces outside Bujumbura town are now visited by international NGO staff, although Cibitoke, Bubanza, Bururi and Bujumbura Rural are still phase IV in the UN security system.

Approximately 230,000 of the 500,000 refugees in the Tanzanian camps have been repatriated with the assistance of UNHCR since 2002. There are upwards of 200,000 remaining in the camps as well as another 470,000 residing in Tanzania and other countries. The complex emergency has also left approximately 116,799 Burundian internally displaced on 160 sites and has stressed the already fragile health system. The repatriation of refugees is one of the essential factors that assisted in establishing humanitarian priorities. Special programs are undertaken to anticipate cross border health issues.

Official sources confirm that the public health system in Burundi was well developed and functioning satisfactorily before 1993. After more than 10 years of conflict and despite local and international efforts to assist the civilian population, people's health and nutritional status continues to be severely affected by environmental deterioration and lack of access to services. In political terms, Burundi is a country in transition, moving towards democratic elections later this year, with a shift in the policy of international assistance from emergency to development.

The most recent estimates (2004, based on a national survey) found that mortality figures, overall as well as in the under-five age group, were higher than the emergency threshold (estimated

[1] The IHE initiative is steered by a Core Working Group including the following members: ACF-France/AAH-UK, CDC, Epicentre, London School of Hygiene and Tropical Medicine, Merlin, MSF, SCF-UK, UNFPA, UNHCR, UNICEF, WFP and WHO.

Crude Mortality Rate 1.3-1,9/10,000/day-; estimated under-5 Mortality Rate 3.3/10,000/day in 2004). The main causes of morbidity and mortality in children are communicable diseases, with malaria reported as the first cause of hospital deaths, while one of the most urgent problems in adult health services is the elevated maternal mortality (855/100,000 live births), mainly due to a lack of timely referral and of access to emergency obstetric services.

The most recent national data, July-August 2004, on nutritional status in children showed prevalence of 52% for stunting (H/A) and 7% for wasting (W/H); oedema was present in 2.7%. The public health importance of these indicators ranges from high (more than 40% of children stunted), over severe (more than 5% of children wasted) to catastrophic (oedema present in at least in 2% of children). Acute malnutrition is currently under the emergency threshold of 10%. New surveys were being carried out at the time of the evaluation.

1 Improve the access to primary health care through the access to the MCP including curative and preventative care in 100% of the priority areas in 2005;

The project Access/Use of an Essential Care Package (ECP) has been implemented within the framework of the Memorandum of Understanding (MOU) on *Voluntary Repatriation and Reintegration of Refugees to Burundi: Health Interventions and Health System Reinforcement* programme that was signed by WHO, UNICEF and UNHCR in 2004. The project is strengthening the health system in 10 priority provinces and should improve access to health care during the transition period towards development with particular attention to returnees, displaced and most vulnerable population. The project should improve access to health care and is an opportunity to support the MOH in the transition between emergency and development to reinforce the functionality of the health system according to national policies, with particular attention to returnees, displaced and most vulnerable population. The delayed distribution of supplies and medicine due to a strike made it difficult to assess the adequacy of the procurement system. Fine-tuning of support to specific health facilities need to be further coordinated at provincial level to reduce overlap with support given directly by NGOs. EPI coverage is reported to be high

Cost- recovery is applied in most public health centres and hospitals, with parallel systems of cost-sharing (NGO takes over part of the cost attributed to the patient) in some parts of the country, and minimal flat fees to free services in health centres receiving NGO support. The cost recovery system places a heavy financial burden on the user, which acts as a deterrent and barrier to access. A special policy is developed so that refugees have free services for the first three months, but this is not yet fully applied. Returning refugees receive health screening and targeted health information in special transit sites. This functions well. A cross border initiative facilitates information and resource sharing between Burundi and Tanzania.

- Financing of the health sector needs to be reviewed for all vulnerable groups. While people living in below the absolute poverty line, in a humanitarian context, should not have any financial barrier to access services, the least harmful policy seems to be the introduction of minimal flat fees per episode of illness.
- Development of technical skills, particularly with regard to management of communicable diseases, pharmacy management and improved laboratory services, as well as adherence to general principles of hygiene need to be given more attention.

2 Strengthen access to health care at the second reference level notably for severe cases, urgent obstetrical care and the management of victims of sexual violence

To a large extent, elevated maternal mortality is due to late referral, which is related to the high cost of emergency obstetric care. The cost of hospitalisation, including caesarean section can amount to the average annual income of a rural family. The referral system for emergency obstetrical cases is being strengthened in three provinces (Karuzi, Muyinga and Makamba) with the installation of radio VHF, solar panels coupled with ambulances, and with a strong involvement of the community for the implementation and to ensure the sustainability. The lack of qualified and experienced staff in rural health centres and provincial hospitals is the second major obstacle. In 2 provinces now receiving support for emergency obstetric care, health centre managers and hospitals doctors have been trained in appropriate skills; training is ongoing in the 3rd province. In the pilot province Karusi, most of the personnel trained in 2003 have already left their position. Adequate salaries and an attractive benefits package, such as free or low-cost housing, as well as future career options, should be offered to health workers in the provinces.

- Short-and long-term solutions are needed to address the shortage of qualified, experienced and motivated staff in the provinces
- The program to improve the referral system should be expanded to the other provinces
- Costs for secondary care should be fully subsidised by external donors

3. Improve the access to prevention and effective treatment for malaria

Almost three quarters of all health centre consultations in Burundi are due to malaria, acute diarrhoea and acute respiratory infections. Especially for malaria, a new treatment protocol (Artesunate+Amodiaquine) is currently implemented countrywide. A recent evaluation on the implementation shown that the ACT is available in the health infrastructures in 75% and is prescribed in 78% and patients know very well how to use the new treatment protocol in 90.6%. However the private sector is not yet fully involved the implementation process and the pharmacovigilance activities need to be reinforced for case confirmation and aside effects reporting. Sentinel surveillance records (EPISTAT) show no significant change yet in case fatality rate since the introduction of the new treatment scheme. Bed net distributions are limited; the population coverage is estimated at less than 6%. Distribution of bed nets had not yet started this year in some of the provinces visited, nets were said to have arrived in the provincial warehouse recently.

The management of communicable diseases is at present carried out without a comprehensive reference toolkit. The newly developed "Toolkit on Management of Communicable Diseases in Burundi" is under revision and should be validated by the MOH in June 2005. Laboratory capacity of most health centre is very limited, in most cases only malaria and stool parasites may be laboratory confirmed. There are no guidelines on when to use malaria testing before treating patients for malaria.

- Intensified free distribution of bed nets to target groups, and social marketing by a variety of agencies, together with effective low-cost treatment, should result in a reduction of morbidity and case-fatality over time.
- Clear guidelines on when to use laboratory confirmation for suspected malaria cases are needed, in order to make more efficient use of the more expensive ACTs.

4. Prevention of malnutrition and proper management of cases of severe malnutrition;

Acute malnutrition is currently under the emergency threshold of 10%. This can be largely attributed to the effect of the large nutritional interventions carried out since 1999. Improved security and increased access to markets are additional positive factors. To deal with the critical

situation that characterised the last years in Burundi, the classical nutrition emergency approach with therapeutic and supplementary feeding centres (TFC and SFC) was followed. Good country coverage was assured with all the provinces equitably covered by nutritional programmes. In 2002, the process of integration of the Nutrition Centres activity in the local health structures was started. The process needs refinements and revisions that should be evaluated at medium/long-term.

In general the performance of the Nutrition Centres (NC) was good, sometimes excellent, with key indicators below the Sphere minimum cut off points and good training of the personnel. Admission rate of severely malnourished children to the NC steadily decreased from 2002 to 2004. However, in 2005, malnutrition rates in the north where found to be above emergency thresholds, confirming that the population is still vulnerable to food-insecurity. A clear seasonality pattern of admission is reported (high in pre-harvest period). The age breakdown of beneficiaries in NC showed that the majority are children under five (from 60% to 75%). Adults are less represented (20%) and most of them are women of child bearing age. In the pre-harvest period, the proportion of children in NC increased. Nutrition surveillance is a specific activity of NC.

At the end of 2003 a "*Projet de Nutrition à Assise Communautaire (PNAC)*" was set up, to improve the nutritional status and food security levels of vulnerable groups of population. Community involvement in the project is the prerequisite for implementation of activities. The project represents the first step of the transition between emergency and development initiatives. While it is too early to provide a conclusive evaluation, the results of the pilot phase of the community-based approach to malnutrition are encouraging. It will lead to an increase of the family involvement and reduce absence of mothers form the family. Further data on nutritional follow up after the admission of children in the programme should be collected. Extreme poverty of the family and lack of motivation of the staff are the weak points of the project. Training of local staff in nutrition is important for the continuation of nutrition activities.

The present nutritional status in Burundi is the result of successive wars and disruption of socio-economic structures, in a context of pre-existing poverty. The management of acute malnutrition has been successful in terms of clinical outcomes and to reduce the prevalence of malnutrition in covered areas. However, high communicable disease prevalence, a weak health system, poor diet quality and chronic household food insecurity could easily lead to collapse of a fragile system. The consolidation of the results achieved should be one of the priorities for future programmes in Burundi. An appropriate mix of relief and development strategies should be pursued. Reduction of malnutrition in project areas should be consolidated through integrated food security interventions.

- The capacity of the PNAC, essentially a preventive approach should be strengthened. Combining this program with Community based Therapeutic Care should be explored, which would lead to a devolution of therapeutic feeding from 100% inpatient to a partially outpatient model.
- Epidemiological and contextual data for comparing and monitoring the effectiveness of the classical and this community approach with a careful monitoring of outcome variables and cost are however necessary.
- Given the vulnerability to food-insecurity, there should be a continued capacity to scale up nutritional programs as indicated by surveys.
- A nutrition policy unit should be established in the MOH with the purpose of data collection from the different institutions, UN agencies and NGOs, and to formulate a plan

of action, which includes a set of longer term approaches to improve nutrition. More details on longer term nutritional recommendations are included in the report.

5. Reduction in the transmission of HIV/AIDS in the priority provinces during 2005

The number of people infected with HIV in Burundi has tripled in the last 10 years, with a significantly higher proportion of cases among women. The national action plan (2002-2006), revised in 2004, puts emphasis on services for adolescents. Efforts to decentralize voluntary counselling and testing, ARV treatment facilities and prevention of mother-to-child transmission have intensified since 2004. Local organizations are receiving international support for IEC and social marketing activities, while mainly faith- based organizations provide home care to people living with HIV/AIDS. A national law concerning the rights of HIV positive individuals has been passed and is ready for implementation. Intensive screening of blood donors and scrupulous testing of donated blood, have minimised the risk of transmission through transfusion.

Health centre staff did not mention testing for syphilis as a routine procedure in pregnancy. Unsafe injections have been reported, and it was observed that used needles were not promptly discarded. In spite of reported widespread availability of condoms, and community-oriented projects to promote their use, actual changes in behaviour take time. Condom distribution and sales have reportedly increased, but the figures vary widely between provinces. Cultural attitude favouring men's liberal sexual behaviour has been enforced by many years of conflict and continuing economic insecurity.

- The importance universal precautions needs to be stressed. While testing for HIV infection may not always be possible, access without financial barriers to diagnosis and prompt treatment of STI should be a priority.
- More technical and financial support is needed to continue implementation of the national strategy to combat HIV/AIDS, and to strengthen its management.

6. Explore the level of the sexual violence and assure medical, psychosocial and legal management for victims;

High levels of sexual violence against women require special multi-sectoral services.
Until now, about 12 specialized centres for appropriate and sensitive management of victims of sexual violence have been set up around the country, each seeing about 15-25 new cases monthly, except one in Bujumbura Town, with 120 women each month. The options for care outside these centres are limited, unless trained personnel and PEP (post-exposure prophylaxis) kits are available at the second line referral hospital. Agencies working with victims at the community level stated that the number of cases seeking help is increasing. Within the public health sector, more work needs to be done to provide comprehensive care for victims of SGBV. Advocacy at the central level needs to be intensified.

- The current capacity to address victims of SGBV needs to be expanded
- The social stigma attached to rape, and its potential economic consequences to the victim, can only be dealt with if the Burundian leaders of society are willing to publicly express commitment and take consequent action.

7. Strengthen the preparedness for epidemics in the priority provinces and the response to epidemics and natural disasters in all of the country;
Burundi has recently introduced a new Outbreak Detection System (ODS), the result of a collaborative effort of Ministry of Health (MOH), WHO and NGOs. It is a weekly, passive, clinic

based system tracking nine diseases with epidemic potential, recording both new cases and deaths. In parallel, a monthly disease surveillance system (Regular Disease Surveillance) exists to track trends of a larger number of communicable diseases. Only new cases are recorded through this system, no mortality data are provided. Many provinces do not participate in the ODS and some of those who started to participate stopped, at present less than 20% of Burundian population is covered and thus occurrence of delays in detection of, or undetected outbreaks is possible. Feedback from ODS is not sufficient: it is limited to distribution of one Excel sheet with no analytical or descriptive interpretation of the data. The level of expertise among the staff of EPISTAT (the MOH data management office) is limited.

The latest outbreaks were malaria in Cibitoke, and dysentery in Ngozi, both December 2004. For both outbreaks free services were offered. No data existed to analyse effectiveness of response (for example through case fatality rates). Contingency planning exists, and plans for preparedness are now elaborated.

At present, there is no protocol among primary health care providers regarding management of communicable diseases. This, combined with often insufficient theoretical base of care providers, may lead to misdiagnosing and over-prescribing of antibiotics and anti-malaria drugs.

- The need for an effective outbreak detection system is clear. Its functioning needs further strengthening to expand the coverage and some improvements on technical components can be considered.
- To ensure that laboratory capacity and prepositioned kits for response are maintained to complement outbreak contingency planning and response plans.
- It is recommended to speed up the process of validation and introduction of the “Toolkit on Management of communicable Diseases in Burundi," to provide training and distribute the toolkit as soon as possible.

8. Strengthen mechanisms of coordination and collaboration between al of the partners intervening in the health sector.

Coordination mechanisms in the health sector are in place and well functioning in Bujumbura. Burundi is a small, densely populated country with a relatively good network of roads and communications. This makes it possible for national and international workers in the provinces to be in contact and exchange information regularly. The security situation is improving.

While there have been several provincial coordination mechanisms set up, formal exchange among implementing agencies in the provinces appears still to be limited. As a result, there may be fragmentation or even overlap of efforts. Interaction between the community and health services has been strengthened through "health committees," with members elected by the community. There was a sense of overload among many humanitarian workers, and an expressed need to reduce the number of meetings and committees, so as to improve results and follow-up in practice. Partners in emergency management can give a valuable input into the process of development. Exchange and coordination among development oriented donors will need to be strengthened. The sectoral sub-groups of the PRSP process provide a suitable forum.

- Sectoral coordination systems at the provincial level need further strengthening.
- Coordination mechanisms at central level may need further rationalisation, links with developmental coordination and policy development need to be pursued.