REPRODUCTIVE HEALTH *at a* GLANCE

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BURUNDI

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Country Context

Burundi was devastated by many years of civil conflict and four wars following its independence in 1962.[1] During the last conflict, GNI per capita (Atlas method) decreased by nearly 40 percent between 1993 and 2005. With a 3 percent average growth rate from 2001 to 2008, and a stagnant GDP per capita (US$110), Burundi is one of the poorest countries in the world.[1] The number of people below the poverty line almost doubled from 35 percent in 1993 67 percent in 2006.[1] Recent estimates based on wealth index comparison indicate that poverty might have worsened from 2005 to 2009.[1] Four-fifths of the population still subsists on less than US $1.25 per day.[2]

Burundi's large share of youth population (39 percent of the country population is younger than 15 years old[2]) provides a window of opportunity for high growth and poverty reduction—the demographic dividend. For this opportunity to result in accelerated growth, the government needs to invest more in the human capital formation of its youth. This is especially important in a context of decelerated growth rate arising from the global recession and the country's high vulnerability to shocks and its rapid population growth.

Gender equality and women's empowerment are important for improving reproductive health. Higher levels of women's autonomy, education, wages, and labor market participation are associated with improved reproductive health outcomes.[3] In Burundi, the literacy rate among females ages 15 and above is 59.9 percent.[2] Fewer girls are enrolled in secondary schools compared to boys with a 71 percent ratio of female to male secondary enrollment.[2] Ninety-two percent of adult women participate in the labor force[2] that mostly involves work in agriculture. Gender inequalities are reflected in the country's human development ranking; Burundi ranks 147 of 157 countries in the Gender-related Development Index.[4]

Greater human capital for women will not translate into greater reproductive choice if women lack access to reproductive health services. It is thus important to ensure that health systems provide a basic package of reproductive health services, including family planning.[3]

Burundi: MDG 5 Status

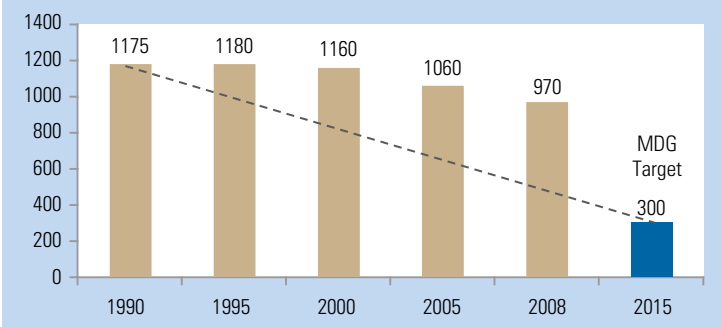
MDG 5A indicators	
Maternal Mortality Ratio (maternal deaths per 100,000 live births) *UN estimate*[a]	975
Births attended by skilled health personnel (percent)	31.8
MDG 5B indicators	
Contraceptive Prevalence Rate (percent)	9.1
Adolescent Fertility Rate (births per 1,000 women ages 15–19)	185
Antenatal care with health personnel (percent)	92.5
Unmet need for family planning (percent)	NA

Source: Data compiled from multiple sources.
[a] The 2005 MICS3 estimated maternal mortality ratio at 615.

MDG Target 5A: Reduce by Three-quarters, between 1990 and 2015, the Maternal Mortality Ratio

Burundi has made insufficient progress over the past two decades on maternal health and is not on track to achieve its 2015 targets.[5]

Figure 1 ▪ Maternal mortality ratio 1990–2008 and 2015 target



Source: 2010 WHO/UNICEF/UNFPA/World Bank MMR report.

World Bank Support for Health in Burundi

The Bank's current ***Country Assistance Strategy*** is for fiscal years 2009 to 2012.

Current Projects:
P109964 BI-Second HIV/AIDS MAP (FY08) ($10.05m)
P101160 BI-Health Project (FY09) ($23m)

Pipeline Project: None

Previous Health Projects:
P071371 BI-Multi Sec HIV/AIDS & Orph APL (FY02)
P078111 BI-Health & Pop SIL 2 Supl (FY03)

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Key Challenges

High fertility

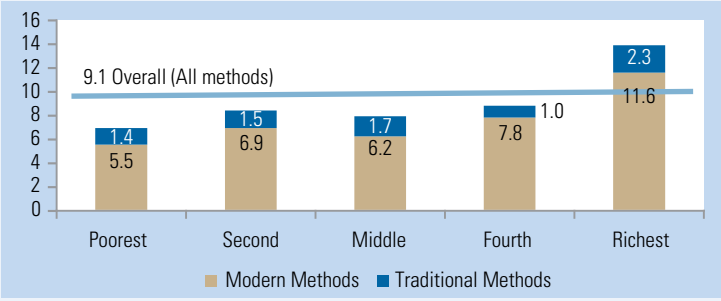
Fertility has decreased over time, although it remains high. The total fertility rate (TFR) has decreased from an estimated 6.9 births per woman in 1987[6] to 4.6 births per woman in 2008.[2] The forthcoming Burundi DHS 2010 will provide more recent information on socio-economic disparities.

Adolescent fertility rate is high affecting not only young women and their children's health but also their long-term education and employment prospects. Births to women aged 15–19 years old have the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother.[3, 7] In Burundi, there are 185 reported births per 1,000 women aged 15–19 years.

Less than a tenth of women use contraception. Current use of contraception among married women was 9 percent in 2005 and more married women use modern contraceptive methods than traditional methods (7 percent and 2 percent).[8] Injectables are the most commonly used method among married women at 5 percent. Use of long-term methods such as intrauterine device and implants are negligible. There are socioeconomic differences in the use of modern contraception among women: it is 12 percent among women in the highest wealth quintile and 6 percent among those in the poorest quintile (Figure 2). Similarly, just 5 percent of women with no education use modern contraception as compared to 26 percent of women with secondary education or higher, and 7 percent for rural women versus 16 percent for urban women.

The forthcoming Burundi DHS 2010 will provide data on unmet need for contraception as well as reasons why women do not use contraception.

Figure 2 ▪ Use of contraceptives among married women by wealth quintile



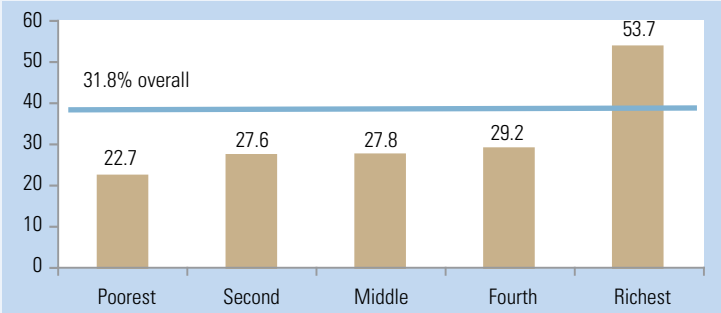
Source: MICS3 Final Report, Burundi 2005.

Poor Pregnancy Outcomes

While majority of pregnant women use antenatal care, institutional deliveries are less common. Over nine-tenths of pregnant women receive antenatal care from skilled health personnel (doctor, nurse. or midwife).[8] However, a smaller proportion, 32 percent deliver with the assistance of skilled health personnel. While 54 percent of women in the wealthiest quintile delivered with skilled health personnel, only 22 percent of women in the poorest quintile obtained such assistance (Figure 3). Additionally, 28 percent of women with no education delivered with skilled health personnel as compared to 84 percent of women with secondary education or higher. Further, 47 percent of all pregnant women are anaemic (defined as haemoglobin < 110g/L) increasing their risk of preterm delivery, low birth weight babies, stillbirth and newborn death.[9]

The forthcoming Burundi DHS 2010 will provide information on women's perception on the barriers to accessing health care.

Figure 3 ▪ Birth assisted by skilled health personnel (percentage) by wealth quintile



Source: MICS3 Final Report, Burundi 2005.

Human resources for maternal health are limited with only 0.03 physicians per 1,000 population but nurses and midwives are slightly more common, at 0.19 per 1,000 population.[2]

The high maternal mortality ratio at 970 maternal deaths per 100,000 live births indicates that access to and quality of emergency obstetric and neonatal care (EmONC) remains a challenge.[5]

STIs/HIV/AIDS prevalence is low but a growing public health concern

The adult population that has HIV is estimated at 1.3 percent.[2] The forthcoming Burundi DHS 2010 might provide information on HIV/AIDS-related knowledge, attitudes, and sexual behaviour

References:

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Technical Notes:

Improving Reproductive Health (RH) outcomes, as outlined in the RHAP, includes addressing high fertility, reducing unmet demand for contraception, improving pregnancy outcomes, and reducing STIs.

The RHAP has identified 57 focus countries based on poor reproductive health outcomes, high maternal mortality, high fertility and weak health systems. Specifically, the RHAP identifies high priority countries as those where the MMR is higher than 220/100,000 live births and TFR is greater than 3.These countries are also a sub-group of the Countdown to 2015 countries. Details of the RHAP are available at *www.worldbank.org/population*.

The Gender-related Development Index is a composite index developed by the UNDP that measures human development in the same dimensions as the HDI while adjusting for gender inequality. Its coverage is limited to 157 countries and areas for which the HDI rank was recalculated.

Key Actions to Improve RH Outcomes

Strengthen gender equality

- Support women and girls' economic and social empowerment. Increase school enrollment of girls. Strengthen employment prospects for girls and women. Educate and raise awareness on the impact of early marriage and child-bearing.
- Educate and empower women and girls to make reproductive health choices. Build on advocacy and community participation, and involve men in supporting women's health and wellbeing.

Reducing high fertility

- Increase family planning awareness and utilization through outreach campaigns and messages in the media. Enlist community leaders and women's groups and emphasize community-based distribution.
- Provide quality family planning services that include counseling and advice, focusing on young and poor populations. Highlight the effectiveness of modern contraceptive methods and properly educate women on the health risks and benefits of such methods.
- Promote the use of ALL modern contraceptive methods, including long-term methods, through proper counseling which may entail training/re-training health care personnel.
- Secure reproductive health commodities and strengthen supply chain management to further increase contraceptive use as demand is generated.

Reducing maternal mortality

- During antenatal care, educate pregnant women about the importance of delivery with a skilled health personnel and getting postnatal check. Encourage and promote community participation in the care for pregnant women and their children.
- Promote institutional delivery through provider incentives and possibly, implement risk-pooling schemes. Provide vouchers to women in hard-to-reach areas for transport and/or to cover cost of delivery services.
- Target the poor and women in hard-to-reach rural areas in the provision of basic and comprehensive emergency obstetric care (renovate and equip health facilities).
- Address the inadequate human resources for health by training more midwives and deploying them to the poorest or hard-to-reach districts.
- Strengthen the referral system by instituting emergency transport, training health personnel in appropriate referral procedures (referral protocols and recording of transfers) and establishing maternity waiting huts/homes at hospitals to accommodate women from remote communities who wish to stay close to the hospital prior to delivery.

Reducing STIs/HIV/AIDS

- Integrate HIV/AIDS/STIs and family planning services in routine antenatal and postnatal care.
- Lower the incidence of HIV infections by strengthening Behavior Change Communication (BCC) programs via mass media and community outreach to raise HIV/AIDS awareness and knowledge.

BURUNDI REPRODUCTIVE HEALTH ACTION PLAN INDICATORS

Indicator	Year	Level	Indicator	Year	Level
Total fertility rate (births per woman ages 15–49)	2008	4.6	Population, total (million)	2008	8.1
Adolescent fertility rate (births per 1,000 women ages 15–19)	2008	185	Population growth (annual %)	2008	3
Contraceptive prevalence (% of married women ages 15–49)	2005	9.1	Population ages 0–14 (% of total)	2008	39
Unmet need for contraceptives (%)	—	—	Population ages 15–64 (% of total)	2008	58.2
Median age at first birth (years) from DHS	—	—	Population ages 65 and above (% of total)	2008	2.8
Median age at marriage (years)	—	—	Age dependency ratio (% of working-age population)	2008	71.7
Mean ideal number of children for all women	—	—	Urban population (% of total)	2008	10.4
Antenatal care with health personnel (%)	2005	92.5	Mean size of households	—	—
Births attended by skilled health personnel (%)	2005	31.8	GNI per capita, Atlas method (current US$)	2008	140
Proportion of pregnant women with hemoglobin <110 g/L	2008	47.1	GDP per capita (current US$)	2008	144
Maternal mortality ratio (maternal deaths/100,000 live births)	1990	1180	GDP growth (annual %)	2008	4.5
Maternal mortality ratio (maternal deaths/100,000 live births)	1995	1180	Population living below US$1.25 per day	2001	81.3
Maternal mortality ratio (maternal deaths/100,000 live births)	2000	1160	Labor force participation rate, female (% of female population ages 15–64)	2008	91.5
Maternal mortality ratio (maternal deaths/100,000 live births)	2005	1060	Literacy rate, adult female (% of females ages 15 and above)	2008	59.9
Maternal mortality ratio (maternal deaths/100,000 live births)	2008	970	Total enrollment, primary (% net)	2008	99.4
Maternal mortality ratio (maternal deaths/100,000 live births) target	2015	290	Ratio of female to male primary enrollment (%)	2008	95
Infant mortality rate (per 1,000 live births)	2008	102	Ratio of female to male secondary enrollment (%)	2008	70.6
Newborns protected against tetanus (%)	2008	78	Gender Development Index (GDI)	2008	147
DPT3 immunization coverage (% by age 1)	2008	92	Health expenditure, total (% of GDP)	2007	13.9
Pregnant women living with HIV who received antiretroviral drugs (%)	2005	3.3	Health expenditure, public (% of GDP)	2007	5.2
Prevalence of HIV, total (% of population ages 15–49)	2007	2.0	Health expenditure per capita (current US$)	2007	17.3
Female adults with HIV (% of population ages 15+ with HIV)	2007	58.9	Physicians (per 1,000 population)	2004	0.03
Prevalence of HIV, female (% ages 15–24)	2007	1.3	Nurses and midwives (per 1,000 population)	2004	0.19

Indicator	Survey	Year	Poorest	Second	Middle	Fourth	Richest	Total	Poorest-Richest Difference	Poorest/Richest Ratio
Total fertility rate	—	—	—	—	—	—	—	—	—	—
Current use of contraception (Modern method)	MICS3	2005	5.5	6.9	6.2	7.8	11.6	7.5	–6.1	0.5
Current use of contraception (Any method)	MICS3	2005	6.9	8.4	7.9	8.8	13.9	9.1	–7.0	0.5
Unmet need for family planning (Total)	—	—	—	—	—	—	—	—	—	—
Births attended by skilled health personnel (percent)	MICS3	2005	22.7	27.6	27.8	29.2	53.7	31.8	–31.0	0.4

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