CROSS BORDER HEALTH MEETING KIBONDO TANZANIA

June 28-29, 2005

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The Cross Border Health meeting is the third in a series of meetings held in Tanzania and Burundi to share information between the two countries concerning the health situation of the Burundian refugees in Tanzania returning to Burundi as a result of the process of voluntary repatriation of Burundian refugees organized by UNHCR starting in 2002. During the process of repatriation it is often difficult to transfer patients to Burundi who are under treatment for various maladies in Tanzania or who have diseases that need follow up upon arrival in Burundi. It is to this extent that the services were compared between the two countries according to the following objectives:

**Objective 1:**
Exchange information on the current health situation in the refugee camps in Tanzania and in Burundi

**Objective 2:**
Establish mechanisms for Hand Over of patients from Tanzania to Burundi

The meeting is within the scope of the joint project of Repatriation Health supported by the WHO, UNHCR, UNICEF and recently UNFPA in Burundi.

**Participants**

**Burundi:** Director of Programs ministry of health (MOH), Responsible for National Program for HIV/AIDS, Responsible for the National Program for Reproductive Health, Responsible for the National Program of Communicable Diseases, WHO, UNHCR, UNICEF, UNFPA, OCHA, WFP, Cordaid, GVC, Handicap International France and SWAA.

**Tanzania:** UNHCR, UNICEF, WFP, Tanzanian Red Cross, International Rescue Committee and Norwegian Peoples Aid.

**Issues Covered**

The third cross border meeting was intended to consolidate the results from the last 2 meetings and to elaborate on the follow up of chronic diseases. A visit to the camps NDUTA and MTENDELI was conducted in 4 groups consisting of Maternal Child Health (MCH) and Nutrition, HIV/AIDS and Sexual and Gender Based Violence (SGBV), Chronic Diseases and Malaria in order to elaborate on the availability of health care interventions and treatment protocols in the different domains available in Tanzania. Presentations were made on the available services and protocols available in Burundi for the repatriating refugees including reproductive health (including the display of various contraceptive devises used in Burundi), malaria, chronic diseases (hypertension, diabetes, asthma and tuberculosis), HIV/AIDS, Nutrition and SGBV.

Comparisons were made according to the different domains and recommendations were made to hand over patients.

**Key Recommendations**

**Malaria:**
- Women under intermittent presumptive therapy should take the second dose of sulfadoxine-pyrimethamine with them to Burundi if they have started the first dose in Tanzania due to differing protocols.
- Sensitize families to bring bed nets with them to Burundi,
- Distribute bed nets at the transit sites for pregnant women with a system of follow up within the community.

**Maternal Child Health:**
- Sensitize mothers to bring health cards with them
- Family planning clients should take a one months supply with them,
- For immunizations the child should start with the pentavalent vaccine that is available in Burundi after starting the vaccination program in Tanzania (in Tanzania hepatitis B and Hib are not included). UNICEF will consider the children who have completed their vaccination in Tanzania but have not received hepatitis B and Hib.

**Chronic diseases:**
- For hypertension: continue with Aldomet started in the camps in Tanzania to Burundi due to the availability in both places,
- For diabetes: For the health centers add Glibenclamide and for hospitals add insulin to the drug list for the project of repatriation health, upon repatriation one months supply should be given,
- For tuberculosis: complete phase I of DOTS in Tanzania and continue with phase 2 in Burundi. Bring a one months supply upon repatriation.

**HIV/AIDS and SGBV**
- For women under preventing mother to child transmission (PMTCT) or antiretroviral: send a sealed report for the provincial health officer in Burundi and send medications for 2 months.
- Sensitize in the camps in Tanzania to the accessibility to services in Burundi for HIV/AIDS and SGBV
- For SGBV: Before repatriating: Encourage persons under post exposure prophylaxis to finish treatment and to remain in Tanzania to complete the legal process.

**Conclusion**

The working group for Repatriation Health in Burundi will meet to assess the recommendations and make concrete plans for action including ordering medications for chronic diseases for Burundi and ensuring the follow up of patients with specific maladies in Burundi.
The Cross Border Health meeting is the third in a series of meetings held in Tanzania and Burundi to share information between the two countries concerning the health situation of the Burundian refugees in Tanzania returning to Burundi. The process of voluntary repatriation of Burundian refugees organized by UNHCR started in 2002 with the repatriation thus far in total of 242,000. There are still upwards of 190,000 remaining in the refugee camps and another 470,000 residing in Tanzania and neighboring countries. The meeting is within the scope of the joint project of Repatriation Health supported by the WHO, UNHCR, UNICEF and recently UNFPA in Burundi.

1. Participants

**Burundi:** Director of Programs MOH, Responsible for National Program for HIV/AIDS, Responsible for the National Program for Reproductive Health, Responsible for the National Program of Communicable Diseases, WHO, UNHCR, UNICEF, UNFPA, OCHA, WFP, Cordaid, GVC, Handicap International France and SWAA.

**Tanzania:** UNHCR, UNICEF, WFP, Tanzanian Red Cross, International Rescue Committee and Norwegian Peoples Aid.

2. The agenda of the meeting included

**June 28:** Opening welcome from the Medical Coordinator UNHCR Kibondo Tanzania, Coordinator of Repatriation Health WHO Burundi and the acting head of office UNHCR Kibondo Tanzania; Visit to the camps NDUTA and MTENDELI in 4 groups consisting of Maternal Child Health (MCH) and Nutrition, HIV/AIDS and Sexual and Gender Based Violence (SGBV), Chronic Diseases and Malaria; Group work to record the information on available health services from the camp visits.

**June 29:** Presentation by the MOH members from Burundi on Reproductive Health (including the display of various contraceptive devices used in Burundi), Malaria, Chronic Diseases and HIV/AIDS; Presentation by WFP on Nutrition and by the WHO (presentation prepared by UNICEF Burundi) on SGBV; Key points from a recent survey on SGBV in Burundi were presented by UNFPA; Copies of the recent training module for management of SGBV in Burundi was given to the Tanzanian team; Presentation of the situation in the camps in Tanzania from each group; Group work to compare services in both countries and make recommendations for hand over; Presentation of recommendations and discussion.

3. Acknowledgements

We would like to thank the participants of the Ministry of Health (MOH) in Burundi including the Director of Programs and the responsible for the National Programs for HIV/AIDS, Reproductive Health and Communicable Diseases. The participation of the MOH has allowed for the elaboration on the situation of the health situation in Burundi including the services available for Burundian refugees.
Situation in Tanzania

Statistics

- Population 30,000 with 6129 under 5 in NDUTA camp
- Total consultations for May: 8300
- Malaria cases for May: 5889 with 2802 (1/3) under 5 accounts for 75% of consultations
- 4 deaths from malaria in May
- Rare complications from malaria because patients arrive early
- 10% of patients are from Tanzania

Case management

- Uncomplicated: First line: sulfadoxine-pyrimethamine (SP), Second line: Amodiaquine, Third line: Quinine
- Severe cases: Quinine
- Intermittent Presumptive Therapy (IPT) for pregnant women: SP at 20 weeks 3 tablets and at 28-32 weeks 3 tablets
- Treatment is free of charge
- Medicines ordered from IRC Kibondo and there is no rupture of stock
- There has been no study on resistance patterns

Laboratory

- Microscope exam only
- Out of 633 slides in May 291 were positive for malaria with an approximately 40% positive rate
- On the job training only
- Certificates given to staff to help continuation of work in Burundi
- 15/42 transfusions were for malaria (for Tanzanians)

Bed Net Distribution

- Distributed at prenatal clinics at the first visit and in the inpatient ward
- Distributed on Africa Malaria day to vulnerable: HIV, albinos, elderly, diabetes, sickle cell, mentally ill
- Free of charge
- Sufficient supply for pregnant women
- 2027 nets were distributed in 2004
- Community sensitization before distribution

Bed Nets follow up

- Survey in 2000 showed that 70% of bed nets were sold
- In 2004 contracts were signed with women and their husbands and now there is a 91% retention rate
- Have not yet started a community based re-impregnation program
- Monitoring committee of CHWs to follow up use in community
- 95 nets went with repatriates and 81 sold

Situation in Burundi

Statistics

- Burundi has a population of about 7.0 million
- Malaria is the commonest disease
- 40.13% of patients are under 5 years of age
- Stable perennial transmission
- Fifty percent (50%) of all outpatient
- 77% of anemic children have malaria
- Mortality about 48% in children under five
Case Management

- Increased parasite resistance to chloroquine and SP, 50-73% for chloroquine and 9-49% for SP (studies, 2001)
- Studies on ACT (amodiaquine-artesunate, Coartem) in 2001-2002: ACPR (clinical and parasitic rate) of 95.3% for AQ + ASU, ACPR of 99.3% for Coartem
- Uncomplicated: 1st line treatment: amodiaquine + artesunate, 2nd line treatment: quinine
- Severe malaria: quinine
- Intermittent preventive treatment for pregnant women (IPT): no protocol
- Procurement of ASU + AQ from Sanofi Aventis (UNICEF-ECHO, MSFs): stock for 6 months, Drug supply to provincial health offices
- Routine supervisory visits to public health facilities in a quarterly basis
- Technical committee set up to deal with all issues related to implementation of the new protocol (worked up to July 2004)
- Setting up mechanisms for financial accessibility: 100 fbu (0.1$) for patients under 5 years, 200 fbu (0.2$) for others
- Knowledge of health workers about management of uncomplicated malaria with first line Combination therapy is quite impressive, 78% of them are treating with amodiaquine-artesunate (32% are treating with quinine for pregnant women and at missionary establishments)
- A half of HWs interviewed have received formal training on ACT
- Presence of wall charts and treatment guidelines
- Few facilities provide direct observation therapy for the first dose of AQ+ASU
- Anti malarial drugs are affordable to all patients
- The majority of patients are satisfied with the care given
- Inadequate Information, education and communication (IEC) materials for the community
- Only 5% of health workers (HW) are providing health education on malaria prevention

Insecticide treated Bed Net (ITN) Distribution and Follow up

- ITN Strategic plan 2003-2007
- ITN coverage is still low: 22% pregnant women, 23% children under five (target 60% 2005)
- Mixture of long lasting (LLIN) and ordinary ones, Rely mainly on importation
- Commercial sector less developed
- Tariffs and taxes on ITN to be removed
- Not perceived as priority by ITN distribution scheme
- Health facilities: routine reproductive health: ITN distributed free of charge to pregnant women at antenatal care clinic (ANC), delivery and post partum care and at routine expanded program for immunizations (EPI) service: ITN distributed to children attending measles immunization
- Social marketing: ITN given at subsidized price (1.5$); PSI
- ITN availability and access for returnees: Partners: Global Fund, UNICEF, NGOs, WB, bilateral cooperation, About 500.000 ITN in 2004, No specific distribution plan for returnees

Recommendations

- Do not transfer patient under malaria treatment: complete treatment first. Temp >38 delay repatriation for 1 week.
- Advocate for a change protocol in Tanzania according to the MOH
- If women is repatriated after the first dose at 20 weeks; give her the 2nd dose and instruct her to take it at 28 weeks.
- Refresher course for lab technicians in Tanzania camps and Burundi
- Increase distribution to under 5 in the Tanzanian camps
- Instruct families to bring bed nets with repatriation (pregnant women and under 5)
- For refugees in the camps sensitize them that they will receive a bed net in Burundi at the ANC and EPI services.
- Distribute bed nets to pregnant women at transit sites with sensitization.
- Programs for re-impregnation of bed nests in Tanzania and Burundi.
- Follow up bed nets with CHW, UNHCR and NGO partners
- In Burundi set up a mechanism to follow up in community: use the experience from Tanzania to make a contract with the women and her husband to use the net.
- Sensitize communities on environmental control
- Exchange IEC material and treatment protocols
Reproductive Health and Nutrition

Situation in Tanzania

Statistics and services

- MCH Clinic: Antenatal Clinic (ANC) services 4 days/week, Postnatal: Once a week, Family planning (FP), EPI, prevention of mother to child transmission (PMTCT) and voluntary counseling and testing for HIV (VCT)
- Maternity: Antenatal, intra-natal, delivery and post delivery care/unit
- Approximately 120 births/month with 99% at the hospital
- MMR: 0/100,000 live births since 2004
- Neonatal mortality rate: 14-15/1000 mostly late neonatal and due to pneumonia and sepsis

Antenatal Care

- Coverage 100% with good male involvement
- Prevention services: mebendazole, multiple micronutrients and sometimes ferrous, tetanus (TT), ITNs, Supplementary feeding
- Lab: hemoglobin, syphilis (RPR), urine for albumin
- Proper referral of obstetrical emergencies
- 3-5 OB emergencies/month mostly from CPD, distress (<18 years old)

Family Planning

- Prevalence rate 5%
- Method preferred: injectables
- Others: pill, male condoms, female condoms, intrauterine devises, tubal ligation

Expanded Program of Immunizations (EPI)

- Immunization coverage 100% for BCG and polio 0
- DPT, polio, measles < 80% due to repatriation
- Good recording in EPI room
- 100% pregnant women had a minimum of 2 TT

Child Growth and Monitoring

- From Monday to Friday
- Integrated Management of Childhood Illnesses (IMCI) in place (in Swahili)
- Proper referral of children who need nutritional support according to protocols and guidelines
- Link between MCH and nutrition unit
- Safety boxes in place and used
- Good use of human resources: refugees manage most of the MCH services

Areas for growth

- ANC offered 4 days a week
- Poor coverage of post natal care
- Improper recording in the registers for FP and ANC
- No DPT-HB in place (UNICEF)
- Statistics not well presented on the walls
- Some FP methods not available (microval)
- Inadequate space for svc delivery and wall not conducive
- Soak instruments for 15-20 versus 10 minutes (proper way)
- Improper packing of delivery kits with appropriate equipment
- No follow up mechanism for defaulters
- No pelvic exam equipment in FP room (speculum)

Nutrition

- Proper referral of sick patients for medical treatment
- Protocols and guidelines adhered to
- Therapeutic Feeding Center (TFC) and Supplementary Feeding Center (SFC) in place
- HIV and chronically ill patients included in SFP
Situation in Burundi

Statistics

- Maternal mortality is estimated at 855 in 100,000 live births (ESD/SR, 2002). In 1992: 800 in 100,000 live births (the survey was made in the province of Muyinga).
- In the health structures: the reporting varies between 541 in 100,000 live births in 1998 and 335 in 100,000 live births in 2003 (with regional disparity).
- Causes of Maternal Mortality: Primary cause: Hemorrhage (post-partum, ante-partum); Secondary cause: Infections; Third cause: Eclampsia; Fourth cause: obstruction of labor
- Secondary causes: anemia, malaria, HIV/AIDS
- Aggravating Factors: Geographic inaccessibility for obstetrical emergencies, The absence of a referral system for obstetrical emergencies (except in 3; Karuzi, Muyinga and Makamba); Insufficient resources (human, financial and material); Lack of motivation for health personnel can be the basis for the poor services available; Poverty; Socio-Cultural barriers; Poor status of women; Insecurity for personnel and beneficiaries.
- Neonatal mortality rate: 32 in 1000 live births in the health structures in 2003 with regional disparities ranging from 11 and 57 in 1000 live births according to the provinces.
- Rate of still birth is estimated at 73, 6/1000 in the hospital and at 59, 9/1000 in the health centers (needs assessment for maternity risk carried out in 2003).
- The price paid for delivery services varies between 1500 and 150000 FRBU (1.36-136 $) for normal delivery and a cesarean.

Family Planning

- The contraceptive methods available in Burundi: microgynon 30 and microlut, injectables (noristerat and depo provera), IUD, Female and Male condoms, Spermicides, Voluntary contraceptive surgery

- Where can one find the contraceptives: In all of the public health centers, Male condoms are also distributed through community based programs; Community based distribution of the pill, spermicides and condoms in the provinces of Gitega, Kirundo, Kayanza, Ngozi and Muramvya.
- The contraceptives are provided Free of Charge
- Contraceptive utilization rate has varied from 1.7 in 1994 to 5.4 in 2003, in 2004 it was at 4.7
- Causes of under utilization of modern contraceptive methods: Insufficient qualified human resources, Weak power of women concerning their reproduction, Poverty, Pro-natal mentality, insufficient information on FP, Weak integration of services for FP within the other primary health care services.

Prenatal Consultation (PNC)

- Recommended Calendar: at least 3 PNC: 
  - PNC 1: 0 – 3 months
  - PNC 2: 5 – 6 months
  - PNC 3: 8 – 9 months
- The 1st PNC is late: Rate of PNC: 98.9% (PNC1 in the 1st trimester is 8%, 2nd trimester 31.4%, 3rd trimester 58.7%)
- Percentage of PNC visits was 98.9 in 2004 up from 53.2 in 1994
- All the health structures offer services for PNC (public and religions based).
- During the PNC, the woman receives: Tetanus vaccination, Iron tablets, Impregnated bed nets, Voluntary counseling and testing for HIV is suggested, Syphilis test for women coming for the 1st PNC
Reduction of Maternal Mortality

- Avoid the 3 delays:
  - First Delay: Delay in the decision to go and seek appropriate care at a health structure; Information/sensitization on danger signs; Preparation of the individuals, families and the community to deliver with assistance (TBA, community relays)
  - Second Delay: Delay to arrive at the appropriate health structure; Provision and installation of means of transport in 3 provinces
  - Third Delay: Delay in provision of adequate treatment at the health structure; Strengthen capacity of the health personnel, Provision of equipment, medicines and other necessary material to ensure the 6 functions at the health center and 8 at the hospital, Motivation of personnel, Subsidy for emergency obstetrical care
- Make available qualified health personnel to assist women during pregnancy, birth, at all the levels of the health system;
- Strengthen the capacity of the individuals, families and the community to improve the health of the mother and the newborn

Current principle Actions

- Referral system for obstetrical emergencies in 3 provinces (ambulance, radio communication at health centers and 1st referral hospitals)
- Emphasis on cost recovery and responsibilities;
- Implication of all actors;
- Supplementation for pregnant women, those who are breastfeeding and those coming to deliver in the health structures.

Nutrition

- With the crisis, the nutritional situation completely depredated: Population displacement, Destruction and looting, Epidemics
- The program of supplementation was started in 1995
- Each health province has at least one TFC and many SFCs.
- 80% of the nutritional programs are carried out by the provincial health bureau

- 20% are under the responsibility of the NGOs
- Existence of a nutritional staff at each health center
- Personnel trained in management of nutrition
- Support from UNICEF to the MOH for supply of micronutrients and WFP for food supplementation
- Family rations for the beneficiaries that frequent the nutritional centers: Muyinga, Kirundo et Buja Rural
- Supply of food at the health center by WFP

Recommendations MCH and Nutrition

- Educate mothers to return with ANC, TT and child growth and monitoring cards
- EPI: UNICEF to follow up on DPT-HB and DPT-Hib vaccine
- Pregnant women should be advised that IPT and de-worming for prophylaxis are not available in Burundi
- FP clients should be supplied with at least one month supply for repatriation and a document showing what she was on in Tanzania
- PMTCT: clients should be advised on PMTCT centers available in Burundi
- Pregnant women under PMTCT program should be given a document on progress and encouraged to present it to the PMTCT centers in Burundi (voluntarily)
- Deliveries: pregnant women should be sensitized and aware that there are maternity services in Burundi free of charge for 3 months (after that they are assessed in the same system as Burundi if they will be considered as indigent or will have to pay), ANC, EPI, FP is free in public health facilities
Follow up on the possibility of giving injectable FP method for clients under depo provera 2 weeks prior to repatriation
For those with BOH, they should have a special document showing their risk factor for follow up and further management
Follow up for TBAs repatriating with TBA kits
International organizations in Burundi should continue to advocate for maternity services (deliveries) to be free of charge
Continuation of TT for women of childbearing age
Services offered for malnourished children (moderate) should be indicated for continuation in Burundi
At least one months supply at the time of repatriation

Chronic Diseases

Situation in Tanzania

- Types of chronic diseases seen: Hypertension, Tuberculosis, Diabetes mellitus, Asthma, Sickle cell, Malignancies, HIV/AIDS and Mental illnesses
- Services provided: Curative, Inpatient department (IPD) and outpatient department (OPD), Feeding program (Selective), Clinics (Eye, dental and mental), 2 Health posts
- 40% of admissions are Tanzanian (especially children)
- Leading mortality and morbidity is malaria
- Home based care services are available
- Chronically ill patients are referred by home based care (HBC0 providers and Community heath workers to OPD or heath posts after governmental hospital Kibondo, Bugando or Muhimblili national hospital
- IRC covers the referral cost
- MTENDELI camp: established in 1993; population 32,400

Hypertension

- Drugs available: Methyldopa, Propanolol, Hydralazine, Nifedipine
- Complicated cases and treatment failure are referred.
- On transit to Burundi: Patient is given a document on treatment and medication for a month

Tuberculosis

- National program in place
- Diagnosis based on sputum: Examination done three times, Chest X-rays
- Treatment guidelines: 4 categories in place
  - **Category I:** Sear + : Rimactazid+Pyrazinamid+ Ethambutol /2 months daily (DOT): Ethambutol+ Isoniazid /6 months
  - **Category II:** Relapse, treatment failure, return after default: Streptomycin+ Rimactazid+ Pyrazinamid+Ethambutol/2 months (DOT) Rimactazid/1 month then 6 months of treatment
  - **Category III:** New smear negative, extra pulmonary tuberculosis, less severe forms of Tuberculosis: Rimactazid+Pyrazinamid/2 months (DOT), Ethambutol+Isoniazid/6 months
  - **Category IV:** Multiresistant tuberculosis: No drugs available for multiple drug resistance

Diabetes

- **Diagnosis:** Random blood sugar test and Urine for sugar test
- **Treatment:** Diet, regular food available+ supplementary feeding program, patient education; Oral hypoglycaemic drugs: Diabinese & glibenclamide (Daonil); Insuline (soluble), lente
- Insulin injections are made at Mtendeli hospital only
- Insulin is available all the times
- Diabetic emergencies are referred to governmental hospitals
Asthma

- **Available drugs:** Aminophylline injections & tablets; Salbutamol tablets and inhaler; Hydrocortisone injectable; Prednisolone tablets; Adrenaline injection
- Oxygen therapy
- There are many cases of asthma particularly among the middle age group.

Mental Illnesses

- There are many mentally ill patients
- Mental health officer is available (1 for Mtendeli camp: not sufficient)
- Adequate drugs are available

General major problems

- Chronically ill patients need close follow up and team work throughout their treatment
- Additional non medical needs not available (food, clothes)

Situation in Burundi

Hypertension (HTN)

- It is a pathology of which the breadth is in constant increase due to changes in dietary regimes and the sedentary lifestyle of the Burundians.
- The reporting of the statistics of this disease are partially available. In fact, in the course of 2004, 146 cases of HTN have been diagnosed at the level of 12 Hospitals out of the 45 in the country.
- The principle medicines are: Aldomet, Nifedipine, Captopril, Inderal, Lasix, Atenolol
- These medicines are available throughout the level of the Hospitals and the pharmacies but rarely available at the level of the health center.

Diabetes

- A frequent pathology throughout the urban community
- A prevalence study of this pathology was carried out in Bujumbura in 2002 that showed a prevalence rate of approximately 7%
- It is a pathology that is currently considered as a genuine problem of public health in BURUNDI
- A Diabetic Center exists in the city of Bujumbura
- The reported statistical data are currently to be integrated in the statistics provided by EPISTAT
- In the course of the year 2004, the data divided from 12 Hospitals have notified 137 cases of diabetes.
- But this is only the tip of the iceberg because the notification of cases in the hospital and health centers is still insignificant
- The most part of health centers and hospitals in the interior of the country do not have the diagnostic means available for this pathology (Glucose testing), so the treatment is often started late
- The most utilized medicines are: Daonil, Human Insulin
- These medicines are not available at the health centers but can be found at the level of the Hospitals and private pharmacies.

Tuberculosis

- Tuberculosis is a common disease throughout BURUNDI with the pandemic of HIV/AIDS
- In fact, close to 7,000 cases of all forms of Tuberculosis are detected each year
- The national objectives for the fight against tuberculosis and world wide objectives are the following:
  - Detection rate of 70% of smear+
  - Cure rate of 85% of smear+ tested
- In 2004 the number of all detected cases was 6886, smear + cases 3087, detection rate of 40% and cure rate of smear+ 35.9%
The treatment protocol of tuberculosis used in BURUNDI:

- **Short term regime of 6 months for all new cases of tuberculosis:**

  This regime is divided into 2 phases; the first last for 2 months and the second for 4 months summarized as the following: 2RHZE 7/7  4RH 3/7: 2 months of Rifampicin + Isoniazide + Pyrazinamide + Ethambuthol (daily) followed by 4 months of Rifampicin + Isoniazide 3 times a week.

- **Regime for a repeat of treatment lasting for 8 months (failure and relapse):**

  2SRHZE 7/7  1RHZE7/7  5 RHE 7/7: 2 months of Streptomycin + Rifampicin + Isoniazide + Pyrazinamide + Ethambutol (daily) followed by 1 month of Rifampicin + Isoniazide + Pyrazinamide + Ethambutol (daily) followed by 5 months of Rifampicin + Isoniazide + Ethambutol (daily)

- **The regime for multi-resistant TB lasts for 15 months:**

  3 KCOPHZE 7/7  12OPHZE 7/7; 3 months Kanamycin + Clofazimin + Ofloxacin + Prothionamide + Isoniazide + Pyrazinamide + Ethambutol (daily) followed by 12 months of Ofloxacin + Prothionamide + Isoniazide + Pyrazinamide + Ethambutol (daily)

- In the National Guidelines, sputum tests are free in the public sector. However, this gratuitousness is theoretically only in the hospitals with autonomous management. These tests also remain to be paid in the private sector. Pulmonary radiology tests are paid for in all of the health establishments with the exception of the Tuberculosis Center in Bujumbura and the Sanatorium of Kibumbu.

- Note that the anti-tuberculosis medicines are free of charge in all of the national territory.

**Integration into the system:**

- The activities of detection and treatment of TB are integrated into the centers for testing and treatment (CDT and CT) installed in the health structures at the intermediate and peripheral levels (hospitals and health centers).

- The country at the moment has 98 centers for detection and treatment (CDT) and 268 centers for treatment (CT).

- The integration is limited to these 2 activities. The other activities such as: Routine follow up of TB activities, the supervision and supply at the CDT and CT as well as the collection of data is assured by the Technical Supervision Teams found at the regional level.

- The collection, analysis of data and the elaboration of reports are made by the National Program to Fight Leprosy and Tuberculosis.

- In the course of this year, workshops and training have already begun to decentralize all activities for tuberculosis to the intermediary and peripheral levels.

**Availability of Treatment:**

- BURUNDI continues to benefit from the support of traditional partners: The Danien Foundation and the Belgium Technical Cooperation to allow for the availability of anti-tuberculosis medicines.

- Since 2003, the National Plan to Fight Tuberculosis benefited from a support of the GDF with a contract of 3 years. The third line drugs for multi-drug resistant TB are financed entirely by the government.

- The supply of medicines in the peripheral centers is made by the Technical Supervision Teams from the central level at the same time of the round of supervision.
Recommendations

Hypertension
• ALDOMET is available at peripheral health centers in Burundi which is also the case in Tanzania
• It is preferable to give ALDOMET as first line drugs in the Tanzanian camps
• When repatriated, a one month supply of drugs should be given

Tuberculosis
◆ National guidelines are different (6 Months in Burundi, 8 Months in Tanzania; and the drugs are also different)
◆ Patients in category I, Phase I should not be allowed to repatriate
◆ Then, patients will be given a 2 week supply of drugs, after they will continue with the second phase in Burundi according to the regime in Burundi
◆ If the patients have already begun with the second phase in Tanzania, they should be advised to continue the treatment regime of Tanzania and should get the drugs for the remaining period?
◆ OR, patients will be advised to stay and complete the treatment in Tanzania

Diabetes
• No oral hypoglycemic drugs at the health centers in Burundi. GLIBENCLAMIDE should be added to the repatriation health drug list
• If patients are already under insulin treatment, They should be addressed at the hospital and insulin should be added to the essential drug kit given to the hospitals in Burundi
• When repatriated, they should be given 1 month supply of drugs Patients should be trained on self administration of insulin

Asthma
• To continue with the current medicines (They are the same in the 2 countries)

General Recommendations
◆ To develop a common hand over document for all chronic illnesses. UNHCR should be the responsible agency
◆ Languages that should be used are English and French
◆ All chronically ill should continue with nutritional support
◆ Feed-back system between UNHCR Tanzania and Burundi should be initiated

HIV/AIDS and SGBV

Situation in Tanzania

HIV/AIDS

Prevention services:
• community awareness and sensitization, VCT, PMTCT, STI, condom promotion and use, universal precautions

Facilities:
• 1 hospital with 5 wards 24 hours
• 2 health posts
• consultation clinics
• RH services: SGBV, HIV/VCT, STI, PMTCT, EPI, FP

Adolescent RH services (youth ages 10-24)
• services at the 2 youth centers
• combine leisure and RH services
• peer health educators and peer parents

Management
• record keeping is in place
• protocol and guidelines are in place
• services: VCT, PEP, PMTCT, STI management using syndrome approach , HBC, Laboratory, treatment of OI, supplementary feeding for PLWA

Challenges
• Stigma: PLWA do not come forward for SF (15/288), can lead to domestic violence, separation and poor follow up of patients, PLWA are isolated
• Lack of proper referral mechanisms for repatriates

Future Plans
• In 2005 IRC will conduct a survey to assess the magnitude of stigma and discrimination on HIV/AIDS among community members and to come up with strategies
SGBV

Overall management
- Prevention; community awareness and sensitization, community forums
- Types of cases: sexually related and domestic violence (DV)
- Protocols from UNFPA in place
- Drop in center open 24 hours: counseling, legal aid, local tribunal
- Support: psychosocial, referral services, food and non-food items

Medical care
- Medical exam
- Laboratory tests
- STI prophylaxis
- PEP
- Emergency contraceptives
- Filling in police forms 3 (PF3)
- VCT
- Coordination and collaboration with other SGBV actors

Data collection tools
- Survivor reporting to DIC
- Meeting with key community people
- Parents in the case of child abuse
- Outreach services with SGBV counselors

Challenges
- Clients refuse to take legal action
- Child abuse in the family goes unreported
- No provision of child counseling (esp DV)

Future plans
- an assessment on the level of child abuse will be conducted
- come up with strategies to address the problems

Situation in Burundi

HIV/AIDS

Statistics
- Sero-prevalence in the age range of 15-49 years
- Urban: 9.5%
- Semi-Urban: 10,5%
- Rural: 2,5%
- Predominantly female in all context
- Sex ratio=1,5 (3,8/2,5)
Management

- 27 Centers for ARV in 12 out of 17 provinces
- A National Treatment Protocol has existed since 2004: 5050 people are under ARV at the end of 2004 versus 600 in 2002
- Treatment is free of charge
- Cost: Around 40 US$/person/month
- First Line: Stavudine (d4T), Lamivudine (3TC) and Niverapine (NVP) that exists in a tri-molecular form
- Alternative to the first line treatment if: complications, Intolerance, Co-infections (HB, TB)

Opportunistic infections (OI)

- Not a unique protocol
- Protocol available for most common OI: Pneumocystis, TB, esophageal candidiasis, Cerebral Toxoplasmosis, Meningial Cryptococus, GI parasites
- Co-infections (HB, TB)

Preventing Mother to Child Transmission (PMTCT)

- 990 HIV+ women included in the program
- A national protocol exists
- Services for the beneficiaries are free of charge
- Available in 9 provinces

Voluntary Counseling and Testing (VCT)

- VCT centers increased from 89 in 2002 to 115 in 2004
- 71 729 tests conducted in 2004, 50 303 in 2002 and 30 412 in 2000

Policy of Decentralization

- Implication of People living with AIDS (PLWA): Associations of PLWA, National Network for PLWA
- Community Participation: Committees to fight HIV/AIDS up to the level of the collines
- Implication of private sector: 9 centers of ARV are in the private sector

Multi-sectoral approach

- Participation of the civil society: OAC (Community based civil society organization) in the organization of coordination national and provincial, OAC to carry out activities

Perspectives

Pass from 5000 to 12500 under ARV by the end of 2005 and to 25000 by the end of 2006. by:

- Increase in VCT, EPC (management teams) and centers for ARV
- Training of care takers for the global management of PLWA
- Reinforcement of capacity of laboratory interventions and of the health structures at all levels

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SGBV

Statistics (from survey in 2004)

- Of 1575 women surveyed 300 (19%) have had at least one time in their life had an episode of sexual violence
- 39.6% surveyed confirmed to had seen or hear about sexual violence against minors
- Principle actors that are conducting sexual violence: Military (30.6%), administrative authorities (19.3%) and teachers (18.2%).
- Incest: 50.9% father in law, and sister in law-brother in law, uncles and nieces (27.6%) 19% fathers with children of spouses,
- Causes for assault against minors: treat AIDS (40.2%), others (36.7%), they don’t have AIDS (34.8%).

Medical Treatment

- FREE medical and psychological care (including ARVs for PEP) is available in the provinces of:
  - MUYINGA, SWAA GBV multisectoral centre (Muyinga town) supported by UNICEF
  - RUYIGI, Hospitals of Ruyigi and Kinyinya (supported by MSF-Holland)
  - MAKAMBA, Provincial Hospital (supported by CS/CORDAID/UNFPA and soon by UNICEF)
  - BUJUMBURA RURAL, 3 health centres (Mubimbi, Rushubi, Gitasa) supported by GVC, UNICEF
  - BUJUMBURA MAIRIE, SERUKA Centre (MSF-B) 2 centers with ABUBEFand SWAA (Supported by CARE)

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Protocol Within 72 hours:

- Emergency contraceptive pill: 1st choice Postinor (2 pills stat), 2nd choice Microgynon30 (4 pills stat and 4 12 hours later), 3rd choice Microlut (25 pills stat and 25 12 hours later)
- PEP: 28 days with D4T or AZT + 3TC + Nevirapine or Efavirenz
- Prophylaxis for STI: Ciprofloxacin 500mg x1, Doxycycline 200mg/day for 7 days
- Tetanus and Hepatitis B vaccinations
- Penicillin IM for syphilis prophylaxis suggested

Average number treated per month:
- MUYINGA: 25,
- RUYIGI: 20,
- MAKAMBA: 12,
- BUJUMBURA RURAL: 14,
- BUJUMBURA MAIRIE (MSF-BELGIUM): 130,
- BUJUMBURA MAIRIE (SWAA, CARE, ECHO): 15

Psychosocial Services

- Muyinga multisectoral centre
- Search For Common Ground, in partnership with local NGOs: THARS, TPO (various provinces)
- Synergie Burundaise pour la lutte contre les violences sexuelles (Bubanza, Bujumbura Mairie & Rural, Cibitoke, Makamba)

Legal Services

- MUYINGA SWAA MULTISECTORAL CENTRE
- APRODH (various provinces)
- LIGUE ITEKA (various provinces supported by UNFPA)
- Generally, the legal response needs to be reinforced

Safety and Security

Generally, all the GBV programmes/projects in Burundi need to improve and reinforce their safety & security activities for GBV survivors
Achievements

- TRAINING MANUAL ON GBV CASE MANAGEMENT FOR HEALTH PERSONNEL”
- Produced by the MOH (PNSR) in collaboration with ICRC, UNICEF, UNFPA and funded by ECHO
- Mass campaigns (JOINTLY organized by ALL the actors involved in GBV)
- Community sensitization and information on available services for GBV survivors through trained community animators (TBAs, Health workers, etc.) Engaged media.
- IEC material (leaflets and posters under production)
- Trained the justice and police
- Advocacy to Government and authorities at all levels
- A research study has been done on GBV in displaced sites
- The PNSR and UNFPA are working on tools for follow up though a registration system
- Progressive integration into the primary health care system

Recommendations

PLWA

- Detailed confidential medical report in sealed envelope addressed to the Provincial Health Officer
- Drug package for 2 months for those under treatment: ARV, AB
- Systematic treatment with ARV in the camps is not in common use
- Concerning the management of PLWs under treatment: Discuss the matter in an internal framework as to which referral channel to follow

PMTCT

- Information
- Follow up form
- Medical confidential report in sealed envelope addressed to the Provincial Health Officer

SGBV

- UNHCR/IP: Facilitate connection between the client and the PHO

Conclusions

The goal of the cross border meeting was to review the protocols in Tanzania and in Burundi, make a comparison and devise mechanisms of hand over for Burundian refugees from the camps in Tanzania to the community of origin in Burundi.

The health domains covered were Malaria, Chronic Diseases, Maternal Child Health, Nutrition, HIV/AIDS and SGBV.

The recommendations made under each domain will be used to improve on the current methods of repatriation of refugees with specific health concerns. The working group for Repatriation Health will meet to assess the recommendation and make clear guidelines for more effective transfer.

For further information please contact:

WHO-Burundi
Dr. Heather Papowitz
Phone: (257) 23 17 02
Mobile: (257) 914522
papowitzh@bi.afro.who.int

UNHCR-Tanzania
Dr Makou
Phone: (255) 748730478
makou@unhcr.ch