

Burundi: a population deprived of basic health care

CIVILIANS in Burundi have lived through years of conflict and are currently in a state of chronic crisis. Although a ceasefire was agreed at the end of 2003, in certain areas of Burundi peace still remains a hope rather than a reality and the effects of war are still very much present.¹ The country's civil war has compounded the economic crisis, and severely damaged the health sector. The government's capacity to invest in the health sector is limited. Medical staff are lacking, infrastructure has been destroyed, and ongoing insecurity in certain regions has increased the inaccessibility of health care for many.² At the same time, infectious and parasitic diseases, especially malaria, remain huge health problems. Despite the beginnings of political stability in Burundi, the mortality rates are alarming and well above those associated with even an emergency situation.³ The violence has led to a scarcity of goods and services, supply and transport problems, an increase in violence and the destruction of family belongings causing generalised vulnerability of the population.

The link between poverty and health is now well known, and health is recognised as an essential requirement for economic development.⁴ Yet there are hundreds of thousands of Burundians who have no access to basic health care as a result of their inability to pay for it. This is because since February 2002, the Burundian government have implemented a policy of cost recovery for health services. The cost-recovery system is part of a revived health reform planned before the war. It aims to mobilise extra resources for health care. Faced with only a small part of the national budget allocated to the health sector, the Ministry of Health had no other choice but to impose the burden of healthcare costs on the patient. The cost-recovery system means that the patient has to pay the full price for medicines as well as tests and medical consultations. The system has been applied in 12 of 17 rural provinces — covering 5 million people. In some areas non-governmental organisations (NGOs) subsidise essential care and user fees are lowered for some 750 000 people.

The average price for a basic consultation at a primary healthcare centre under the cost-recovery system is around €2–3. This is equivalent to about 12 days pay for a Burundian. No effective system exists to protect the destitute, or those unable to afford treatment. In spite of high levels of vulnerability, less than 1% of households obtain a full waiver of the fees. We met Simeon — a man with no money, no job, and a family to feed. He presented to the clinic with a young girl, age 3 years, with second degree burns:

'I was very worried and I brought my little girl to the health centre in my district in the south of Bukumbura. But the nurse wouldn't see us as I didn't have any money

to pay for the consultation. So I had to take my girl back home without having received any care. Then I had no choice but to borrow 2000F (Burundian francs) (€2) from my neighbours for the consultation. I also bought a few medicines on the black market. Every day I pay back 150F (€0.15) of the 250F (€0.25) that I earn every day carrying bags. I have 100F (€0.10) left to feed my family. It's not a lot.'

Increasingly, humanitarian relief agencies have expressed their concern over the introduction of cost-sharing mechanisms in complex emergencies or post-conflict situations such as in Burundi. It seems unfair to many that a population struggling to survive in a war situation should have a further financial burden imposed on them. According to Poletti,⁵ the rationale for introducing cost-sharing in complex emergencies has not been well articulated, and the arguments in favour of it are largely ideological. Although the introduction of user fees is seen by donors as a necessary step in building a sustainable health system, there is sufficient evidence to date to suggest that user fees should not be introduced in complex emergency settings as they can have a dramatic effect on the health and social status of the population.⁵

Against the background of the precarious situation of the majority of Burundians, Médecins Sans Frontières (MSF), who has worked in Burundi since 1992, initiated a nationwide retrospective epidemiological survey from November 2003–January 2004, to assess the effect of nearly 2 years of the cost-recovery system on the Burundian population.³ The results of the survey were alarming: 17% of the population said they had no access to a straightforward consultation, with 82% of these sick people stating that the reason for this was because they didn't have any money to pay. Our findings from the survey translate to almost 1 million people in Burundi, like Simeon, being excluded from basic health care at this time.

In order to pay for health care, 81.5% of patients consulted said they were obliged to go into debt or sell a proportion of their harvest, land, or livestock. Running up a debt with a health centre is a common practice in Burundi. In order to recover debts, centres confiscate identity papers, or some of the patients' belongings. Another measure reported by MSF was the imprisonment of patients, which may leave them inside the health centre, but with no care. Some NGOs and other civil bodies have been known to reimburse all or part of the debt contracted in order to obtain the patients release.

18-year-old Clémentine, from a desperately poor area called Cibitoke, had recently given birth in the health centre.

'After the delivery I was presented with a bill for 30 900F (around €30). I didn't

References

1. Human Rights Watch. *Everyday victims: civilians in the Burundian war*. New York: Human Rights Watch, 2003.
2. Médecins Sans Frontières. *Burundi: vulnerable population deprived of access to healthcare*. Brussels: Médecins Sans Frontières, 2004.
3. Médecins Sans Frontières. *Access to health care in Burundi: results of three epidemiological surveys*. Brussels: Médecins Sans Frontières, 2004.
4. World Health Organisation, CMH Support Unit. *Investing in Health: a summary of the findings of the Commission on Macroeconomics and Health*. Geneva: World Health Organisation, 2002.
5. Poletti T. Cost-recovery in the health sector: an inappropriate policy in complex emergencies. *Humanitarian Exchange* 2004; **26**: 19–22.
6. Hansard (House of Commons Debates). Westminster Hall Debates for 5 May 2004. London: HMSO, 2004. http://www.parliament.the-stationery-office.co.uk/pa/cm/200304/cmhansrd/cm040505/halltext/40505h04.htm#40505h04_spm0 (accessed 5 Jul 2004).

have money enough to pay that much. I am an orphan ... [My husband] left me when he learned that I had to pay 30 900F for the delivery. As I didn't have anything to pay that amount of money, I was imprisoned in the health centre ... I remained there for a week, in detention, without care and without food. It was the other women in the room who shared their food with me and helped me to wash. I was suffering from anaemia and my baby had respiratory and digestive problems.'

Besides the exclusion and the risk of further impoverishment, the delays in attending a consultation for a health problem are a concern. Since the introduction of the system, the survey highlighted that attendance rates at the health centres have fallen off sharply. Mainly for financial reasons, most households postpone seeking health care. This means that patients may be presenting later to services, possibly to the detriment of their health. This practice could be one of the factors explaining the significantly higher mortality rates for malaria that have been observed in regions affected by the cost-recovery system.

The population of Burundi is living in extreme poverty and the expenditure on health care is further exacerbating this precarious state. To impose a cost-recovery system on a population emerging from 10 years of civil war is unjust. It is imperative that an effective and free healthcare system is urgently restored in Burundi, and that services are accessible to all. The human price of this cost-recovery system must provoke a reaction among the relevant bodies, with dialogue needed around alternative ways of financing health services to avoid exclusion.

During a Westminster Hall debate on Burundi,⁶ in response to questioning on whether appropriate exemptions from the cost-recovery scheme could be made for vulnerable elements of the Burundian population, the Parliamentary Undersecretary of State for International Development stated that DFID's priority was, 'to ensure that the poorest of the poor are able to access medical services and for the moment the best way to achieve that is through health services being provided free of charge'.⁶ MSF is currently in dialogue with DFID Africa Desk to review alternatives to the cost-recovery system in a humanitarian situation.

Burundi today faces a great many challenges. In addition to the real difficulties in guaranteeing access to health care due to the high cost of consultations in public health facilities, aid agencies are still having major difficulties reaching the most vulnerable people. Aid agencies are also searching for ways to handle the massive return of refugees expected later this year.

Mit Philips, Gorik Ooms,
Sally Hargreaves and Andrew Durrant

From the Journals, June 2004

New Eng J Med Vol 350

2362 The American medical press is deeply worried about the epidemic of obesity in children, with good reason: the 'metabolic syndrome', which is used to describe obesity, insulin resistance and hypertension in middle-aged adults is now increasingly seen in teenagers, some of whom show an almost limitless capacity for eating fast food (see *JAMA*: 2828).

2558 Being male puts you at reduced risk of getting venous thromboembolism, but at 3.6 times higher risk of recurrence compared with women.

2582 Palliative care for patients with non-cancer diagnoses can be very challenging, as shown by this excellent discussion of a man dying from heart failure with Alzheimer's and osteoarthritis.

2663 The wart treatment we have been waiting for: alpha-lactalbumin-oleic acid kills the papilloma virus while leaving healthy skin intact.

Lancet Vol 363

1840 'They don't like it up 'em!' — Corporal Jones was quite right. Men facing transrectal prostate biopsy often find the injection of local anaesthetic as painful as the procedure itself.

1849 Cervical cerclage (the Shirodkar suture) does not prevent mid-trimester miscarriage, even in high-risk women with short cervixes.

1854 A well-conducted UK trial showing that 'Most patients with chronic venous ulceration will benefit from the addition of simple venous surgery.' That's a lot of patients: get referring!

1925 A triumph for general practice — the 40% reduction in stroke seen in the last 23 years, probably due to better control of risk factors such as hypertension and atrial fibrillation.

2015 Chronic inflammation predisposes to cardiovascular events, so rheumatoid arthritis is a coronary risk factor. As one would expect, atorvastatin 40 mg reduces the risk — with the unexpected bonus that it also helps the rheumatoid symptoms.

2022 Blockers of the angiotensin II receptor (ARBs, or sartans) are pleasantly free of side-effects, but unfortunately may also be less good at reducing blood pressure than other drug classes (valsartan compared with amlodipine).

2105 Cholinesterase inhibitors for Alzheimer's disease are very expensive and do not reduce the need for institutional care: this study of donepezil shows we need better drugs. Hurry up!

JAMA Vol 291

2705 A study of the presenting symptoms of ovarian cancer, which are common and non-specific — for example, back pain, bloating, constipation. Only their persistence gives a clue, and by then it is usually too late.

2713 By contrast, prostate cancer these days often presents too early, in the form of an elevated PSA and positive biopsies, which nevertheless cannot predict spread or progression. I read this report of a 21-year Scandinavian study as an argument against PSA screening, as I do a similar one in *Arch Intern Med* (164: 1227), but in both cases the authors use it as an argument in favour.

2746 Never miss an instalment of *JAMA*'s marvellous series, 'The Rational Clinical Examination'. Here it addresses the vital question, 'Is this child dehydrated?' — and the answer is 'yes' if there is poor capillary return, loss of skin turgor and/or an abnormal respiratory pattern.

2947 More bad news about oestrogen replacement therapy (alone or combined): far from warding off cognitive decline, it may increase it.

2978 Interesting insights from an erectile dysfunction study at an obesity clinic in Naples. If the Neapolitan male allows his BMI to get above 28.7, he runs a risk that when things get *dolce*, he will be able to *far niente*.

Other Journals

How many of us know how to assess clinical competence objectively? A large randomised US study is reported in *Ann Intern Med* (140: 874) — essential reading, since we will increasingly train foundation year doctors as well as students and registrars. Primary prevention of type 2 diabetes is discussed on page 951; and the important contribution of depression to outcome in various chronic diseases is the subject of an editorial on page 1054. A paper in *Pediatrics* 113: 1776 caught Theophrastus' jaundiced eye (he has Gilbert's disease), as it praises the role of bile acids in neurovascular protection. Indeed, a further search reveals that having an elevated bilirubin is associated with fewer cardiovascular events in adults.

If your Latin is good, *Folia phoniatica et logopaedica* (56: 182) contains a review about the effects of adenoidectomy and tonsillectomy on speech and nasal resonance. Actually, it is written in English.

Plant of the Month: *Echinacea purpurea*

One of the best and most reliable late summer perennials: quite useless as a cold remedy, though (*Arch Intern Med* 164: 1237).