REPUBLIC OF BURUNDI

MINISTRY OF PUBLIC HEALTH
Minister's Office

To: Dr Toré
Executive Secretary - GAVI

Date: Bujumbura, 28/11/2003

Ref: 630/2813/ CAB/2003

Re : Financial Sustainability Plan of the Expanded Programme on Immunization of Burundi

Dear Dr Toré,

Please find herewith the Financial Sustainability Plan of the Expanded Programme on Immunization of Burundi, together with the minutes of the ICC meetings held in connection with the production of the plan.

Yours sincerely,

Minister of Public Health

Copies for information to :

- UNICEF representative
- Special representative of the Director General of the WHO and Regional Director of the WHO
- Inspector General of Public Health
- Director General of Public Health
- Director of Health Programmes and Services
- Director of the EPI
- All members of the ICC

REPUBLIC OF BURUNDI

MINISTRY OF PUBLIC HEALTH

GENERAL DIRECTORATE OF PUBLIC HEALTH

DIRECTORATE OF HEALTH SERVICES AND PROGRAMMES

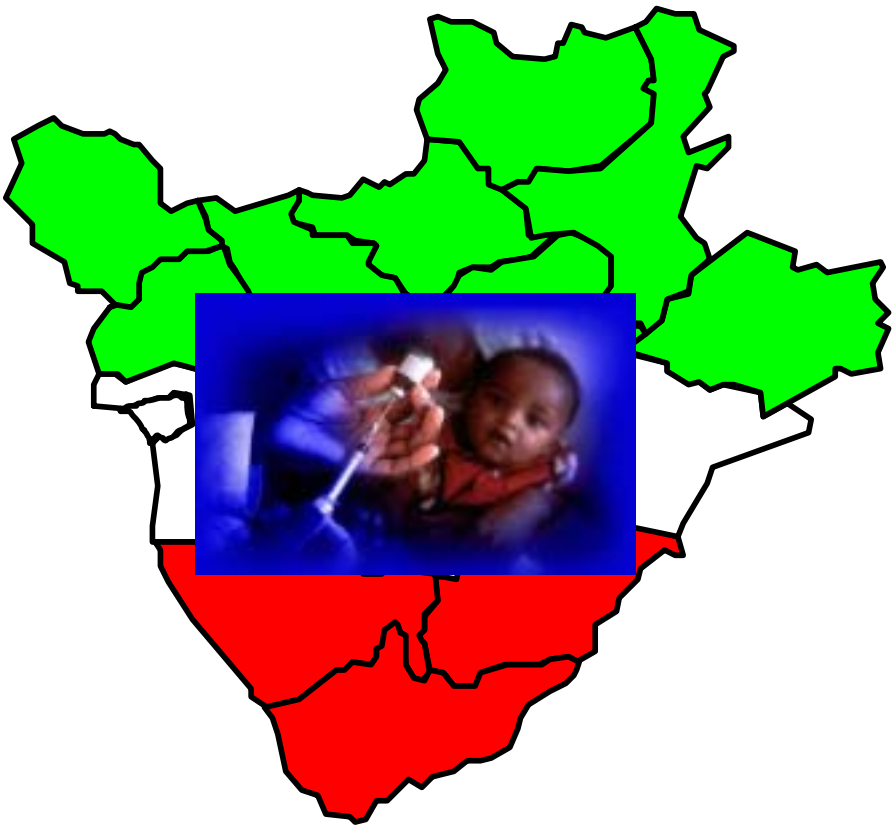
EXPANDED PROGRAMME ON VACCINATION

FINANCIAL SUSTAINABILITY PLAN OF THE EXPANDED PROGRAMME ON IMMUNIZATION OF BURUNDI

Final version of November 2003

REPUBLIC OF BURUNDI

MINISTRY OF PUBLIC HEALTH



EXPANDED PROGRAMME ON IMMUNIZATION

ABBREVIATIONS

AFP	: Acute Flaccid Paralysis
BCG	: Bacille de Calmette et Guérin
DCC	: Disease Control Centre
DPSHA	: Department for the Promotion of Health, Hygiene and Drainage
DTP	: Diphtheria, Tetanus, Pertussis
ECHO	: Humanitarian Aid Office
EPI	: Expanded Programme on Immunization
EPISTAT	: Epidemiology and Health Statistics Department
FSP	: Financial Sustainability Plan
GAVI	: Global Alliance for Vaccines and Immunization
GDP	: Gross Domestic Product
Gvt	: Government
HC	: Health Centre
HepB	: Hepatitis B
Hib	: Haemophilus influenzae type b
HIPC	: Heavily Indebted Poor Countries
ICC	: Inter-Agency Coordinating Committee
IEC	: Information Education Communication
LID	: Local Immunization Day
MEAS	: Measles vaccine
MPDR	: Ministry of Planning for Development and Reconstruction
MPH	: Ministry of Public Health
NGO	: Non-Governmental Organization
NID	: National Immunization Day
NPP	: National Planning Programme
NRHP	: National Reproductive Health Programme
OPV	: Oral Polio Vaccine
SNID	: Synchronisation National Immunization Day
Rotary C.I.	: Rotary Club International
TT	: Tetanus Toxoid Vaccine
TT2+	: Tetanus Toxoid Vaccine 2+
UNDP	: United Nations Development Programme
UNICEF	: United Nations Children's Fund
USD	: United States Dollar
VF	: Vaccine Fund
Vit A	: Vitamin A
WHO	: World Health Organization

List of members of the technical group responsible for drawing up the Financial Sustainability Plan of the EPI/Burundi

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Dr SEHEYE Emmanuel	Director – EPISTAT	Vice-Chairman
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Members of the ICC

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UNICEF Representative : **Vice-Chairman**
Special Representative of the Director General and Regional Director of the WHO
UNDP Resident Representative
World Bank Representative
UNFPA Resident Representative
Director General for Europe, North America and the International Organizations
Ambassador of France
Ambassador of Belgium
USAID Representative
Rotary Club International Representative
ECHO Representative
Chargé d'affaires to the European Union Delegation
Head of Mission of CED-Caritas
Head of Mission CORDAID
Director General – Public Health
EPI Focal Point / UNICEF
EPI Focal Point / WHO
Director - EPISTAT
Director - EPI
Assistant Director – EPI

CONTENTS

Annex VII **:** Spreading of GAVI funding over 8 years
Annex VIII **:** Increase in the government contribution

SUMMARY

Ever since the EPI was established in 1980, it has pursued its mission of protecting children against the target diseases of the programme, namely diphtheria, tuberculosis, pertussis, measles, poliomyelitis and tetanus. With effect from 2004, the programme's list of target diseases is to be extended, with the introduction of vaccines against the hepatitis B virus and haemophilus influenza type b.

The EPI strategic plan for the period 2002-2006 has set the following targets:

- to increase immunization coverage for infants of 0-11 months to 90%
- to increase immunization coverage for pregnant women to 85%.
- to increase immunization coverage for women of child-bearing age to 20%.

The strategies envisaged to achieve these ambitious targets are as follows:

- intensifying immunization activities
- strengthening staff capacities
- strengthening the health management system at all levels
- introducing new vaccines
- monitoring the EPI target diseases
- mobilizing resources.

If this mission is to be carried out, the government and its traditional partners will need to increase their respective contributions to the EPI. Other partners both internal and external will have to be approached and made aware of the need for them to contribute to the financing of the programme.

At the present time the government's share of EPI financing (overheads and vaccine independence) is low, representing only 4.4% of the total EPI budget in 2001 and 3.7% in 2002. The EPI budget accounted for 0.40% of the MPH budget in 2001 and 0.46% in 2002.

Support from external partners in the form of donations represented 95.6% of the EPI budget in 2001 and 96.3% in 2002. This is clear proof of Burundi's heavy dependence on outside assistance for the activities of the programme.

The forecasts for necessary resources show that the new vaccines account for the bulk of the EPI budget. In 2004, the cost of the new vaccines represents 92% of the total cost of vaccines and 52% of the total budget of the programme. Conversely, the cost of the traditional vaccines represents only 8% of the total cost of vaccines and 4.5% of the total costs of the programme.

The purchase of new vaccines and the renewal of equipment will increase the cost of the programme and this trend will continue from year to year throughout the period of GAVI support. The same will apply after GAVI support ceases, at which time there will be a funding gap of around USD 3 million.

To bridge this gap, the government will need to apply strategies to mobilize resources and improve the management of the EPI. The strategies envisaged are as follows:

- advocacy to persuade the government to honour its commitments under the Abuja agreements by increasing the budget of the Ministry of Public Health to 15% of the national budget so that the EPI budget can be revised upwards
- advocacy to persuade the government to grant additional financing to the EPI once the benefits of the HIPC initiative become available
- review of the procedures for the disbursement of funds
- persuading various elements of the local economy to support the immunization services
- persuading the community to contribute to the financing of the immunization services
- increasing the contributions received from traditional partners
- making other external partners aware of the needs of the programme
- strengthening the management of the programme

The priority indicators for monitoring the implementation of the EPI financing strategies are as follows

- percentage increase in the financing of the EPI
- percentage of financing covered by the taxpayer
- percentage of financing covered by the community
- rate of increase achieved by the traditional partners
- share of HIPC financing allocated to the EPI
- reduction in the wastage rate
- reduction in the drop-out rate.

INTRODUCTION

The immunization programme can improve child health only if it has secure and appropriate financing, combined with a judicious and efficient use of resources. Secure long-term financing will ensure the continuity of the services and their performance in terms of immunization coverage, quality and access to the new vaccines recently introduced into the EPI.

The countries which receive support from the Global Alliance for Vaccines and Immunization (GAVI) are required to submit a Financial Sustainability Plan (FSP) within two years of being granted financing by the Vaccine Fund. Burundi has been receiving GAVI funds since 2002 and is to introduce the new vaccines DTP-Hib and two-dose HepB in 2004 and the pentavalent form in 2005.

A training workshop on the preparation of the financial sustainability plan was held in Douala (Cameroon) during the period 26-30 May 2003. The workshop, which brought together the representatives of the countries benefiting from GAVI financing, laid down guidelines for the preparation of a financial sustainability plan making it possible to provide an in-depth picture of the current financial situation and the future needs of the EPI, as well as the identification and implementation of financial strategies permitting the achievement of its targets.

Five officials of the administration of Burundi took part in the workshop. In July, a technical group responsible for drawing up the FSP was established, including officials of the Ministry of Public Health, the Ministry of Finance, the Ministry of Planning and Reconstruction, UNICEF and the WHO. This group began working on the FSP in August and, with effect from October, enjoyed technical support from two consultants for the consolidation and finalization of the document.

The main object of the plan is to permit the country to ensure the financial solidity of the immunization programme and to express to its financing partners the need for their support in continuing and improving the programme.

The present report consists of five sections, followed by a section containing the comments of the ICC partners:

Section 1 : Impact of the context of the country and the health system on the costs, the financing and the management of the EPI

Section 2 : Characteristics, targets, performances and strategies of the programme

Section 3 : Costs and financing for the years preceding the support of the Vaccine Fund (2001) and the year of Vaccine Fund support (2002)

Section 4 : Estimate of future costs and financing of the EPI during and after GAVI support

Section 5 **:** Strategic plan for sustainable financing

Section 6 : Comments of the partners

SECTION 1

IMPACT OF THE CONTEXT OF THE COUNTRY AND THE HEALTH SYSTEM ON THE COSTS, THE FINANCING AND THE MANAGEMENT OF THE EPI.

1.1. MACRO-ECONOMIC CONTEXT OF THE COUNTRY

Geographical situation : Burundi is a land-locked country situated in the eastern part of Central Africa. It has an area of 27 834 km². It is bounded to the north by Rwanda, to the south and east by Tanzania and to the west by the Democratic Republic of Congo.

Demographic situation[1] : Burundi is one of the most densely populated countries in Africa. The population was estimated to be 6.7 million in 2000, with 91.6% living in rural areas. The population density is 266 inhabitants per square kilometre. Population growth is estimated to be 2.9% and life expectancy at birth 40.8 years (source NPP-MPDR). Men represent 49% and women 51% of the population. The breakdown of the target population is as follows:

infants of 0-11 months	: 3.94%
children of 0-59 months	: 18.2%
women of child-bearing age	: 22.3%
pregnant women	: 4.8%
gross birth rate	: 46 o/oo

Thus, the population of Burundi is generally young and the number of children and women of child-bearing age able to benefit from the activities of the EPI is both very high and increasing rapidly.

Social and health situation: The situation of socio-political conflict has led part of the population to leave the land for security reasons and either to settle in camps for displaced persons inside Burundi or to seek refuge in neighbouring countries. This destabilization has made it difficult to organize and provide access to basic health care in general and to conduct the routine immunization programmes in particular. For this reason, maternal and infant mortality are high (800 per 100 000 live births and 129 per 1 000 in 2001).

Political and administrative situation: Burundi is a republic with an administration decentralized down to grass roots level. It consists of 17 provinces, 117 communes and 14 urban zones. The communes, which are autonomous entities, are subdivided into rural zones, sectors and hills. The urban zones are subdivided into districts. This organization facilitates social mobilization.

Since 1993, the country has been going through a socio-political crisis which has rent the fabric of society and engendered institutional instability. This situation has had negative repercussions on the health system.

The negotiations which have been held between the Burundian parties in Tanzania and South Africa since 1998 have resulted in a peace agreement and national reconciliation.

[1] Source: EPISTAT, Report on health in the world 2002

In addition to the progress achieved in the establishment of transitional institutions, the negotiations with the armed groups – which have already resulted in the beginnings of a settlement – presage a general and durable ceasefire in the near future and this is the prerequisite for the establishment of stable institutions.

Economic situation: Burundi is one of the four poorest countries in the world, with a human development index of 0.321 in 1998 and 0.337 in 2002. The economy is based on agriculture and animal husbandry, which together account for 90% of national production. Burundi's main exports are coffee and tea. Its balance of trade is structurally in deficit. This means that the country is in a difficult position with regard to economic growth and external dependence.

The socio-political crisis has resulted in a worsening of the economic indicators, a freeze on external financing and a slowdown in economic activities. Thus, growth in GDP declined from 4.5% in 1992 to 2.5% in 2002.

National income has fallen sharply and the reduction in financial resources has led to a heavy debt burden, constantly rising inflation, negative growth in GDP and a budget deficit (see Table 1 below)

Table 1 : Performances of certain macro-economic indicators

	2000	2001	2002
Nominal GDP (BIF billions)	511.1	550.0	584.6
Average inflation (%)	24.3	9.3	-1.3
Public income (BIF billions)	98.3	110.2	118.4
Public expenditure (BIF billions)	123.5	149.8	151.6
Primary balance (BIF billions)	11.4	-4.6	12.9
Public debt (USD millions)	1183.2	1172.96	1366 .2

Source : Database of the Ministry of Planning

The public debt rose from USD 1172.9 million at the end of 2001 to USD 1366.2 million at the end of 2002. The latter figure consists of an internal public debt of USD 104.7 million and an external public debt of USD 1261.5 million. Thus, for the fiscal year 2002, the public debt represented 180% of GDP.

The servicing of the external debt (principal and interest) constitutes a heavy burden, estimated at USD 28.7 million in 2002, as against USD 21.852 in 2001.

The socio-economic and political crisis and the squeeze on financial resources resulting from the high cost of war and security spending have forced the government to restrict budget credits to the most vital priorities.

Macro-economic targets : The targets are as follows: to increase the average rate of growth in GDP from the figure of 2.5% in 2002 to around 5%; to achieve a surplus of 3.5% of GDP on the primary balance by 2006; to confine the growth of money supply within limits compatible with the inflation target, while making available the resources needed for the recovery of the private sector and maintaining foreign currency reserves sufficient to cover more than three months' imports of non-factor goods and services.

The achievement of this macro-economic framework will require an increase in the investment rate from 8.2% in 2001 to more than 16.8% in 2005, as well as debt relief to limit the deficit on the current account balance of payments (Annex 1).

To this end, Burundi will adopt a policy of renegotiating its multilateral and bilateral debts with the various creditors inside and outside the Paris Club and proceed to reduce the debt by conversion, repurchase, cancellation and rescheduling operations. The country also intends to define a policy of negotiating new loans and to proceed with a regular debt sustainability analysis. One of the results already obtained is that Burundi now enjoys the benefit of a multilateral debt fiduciary fund (USD 6.5 million in 2003). The country expects to have a sum up to a limit of USD 32 million per annum until 2006 to meet urgent debt servicing needs while awaiting integration into the HIPC initiative (see *aide-mémoire* on support for the budget and balance of payments, June 2003).

Involvement of the EPI in economic development

As far as economic development is concerned, immunization is a good investment. Early vaccination protects children from illnesses due to vaccine-preventable diseases, allowing them to grow up in good health and so play their part in national production.

Impact of the macro-economic framework on the EPI

The situation that the country has been going through has had a disastrous impact on the programme, with the destruction of health infrastructures and equipment, the displacement of populations and personnel, the diversion of funds to security rather than the social sectors, and the heavy cost of air transport necessitated by a landlocked position.. The EPI is constantly having to readjust its targets because the denominator are forever changing and the budget allocated by the State is insufficient to cover needs. The result is perpetual dependence on external aid.

Conclusion.

Burundi hopes to return to a situation of peace in the near future and to re-establish its credibility with the international community, the specialized institutions of which (Bretton Woods) may permit the country to enjoy the benefits of the HIPC initiative. If external public debt is forgiven, this will free up additional resources which could be allocated to the social sector and particular public health, with special emphasis on the struggle against disease and the reduction of rates of maternal and infant mortality through the EPI.

1.2. IMPACT OF THE HEALTH SYSTEM ON THE FINANCING AND MANAGEMENT OF THE EPI

The socio-economic and political changes which the country has experienced since the establishment of the EPI in 1980 have put pressure on the State budget and consequently on the support available for the health sector, including the EPI. Fortunately, external aid has increased through support within the framework of rehabilitation and the carrying out of mass immunization campaigns, as may be seen from the following tables relating to recent years.

Table 2: Changes in the budget of the Ministry of Public Health (USD thousands)

1998			1999			2000			2001			2002		
MPH budget	Nat. budget	% health	MPH budget	Nat. budget	% health	MPH budget	Nat. budget	% health	MPH budget	Nat. budget	% health	MPH budget	Nat. budget	% health
5538	**172752**	**3.21**	**4686**	**164376**	**2.85**	**4282**	**154316**	**2.77**	**4536**	**176476**	**2.57**	**4343**	**172158**	**2.52**

Source : National budgets

Table 3 : Changes in external aid to Burundi (USD millions)

	1998	1999	2000	2001	2002
Total external aid	98.751	88.674	164.723	139.102	150.000
Health	9.408	12.375	23.788	36.580	40.553
% health	9.50%	13 .96%	14.44%	26.30%	26.66%

Source : Database of the Ministry of Planning

As in the past, the percentage of the annual State budget allocated to the Ministry of Public Health depends on the discussions between the officials of the Ministry of Public Health and those of the Ministry of Finance. It is never based on the budgets drawn up and approved by the various care services and the health departments and programmes, including the EPI, which is obliged to accept the carry over of inadequate budgets from previous years. In contrast, the resources granted by the donors to the Ministry of Public Health are always in line with the plans and budgets drawn up in advance by the experts.

The EPI and the other health programmes have always enjoyed the benefit of substantial financing from UNICEF, the WHO, GAVI and others for the implementation of activities planned and approved by the competent authorities. The experts' reports and audits on the implementation of the programme have been favourable.

Since the end of 2001, the sectoral policy of the Ministry of Health has laid down strategies for the improvement of the health system, namely:

- increasing administrative decentralization to give more responsibility for planning and resource management to the provincial health offices and the management committees of the health centres
- granting autonomous management to the care structures and health programmes in order to streamline their operations and mobilize additional resources
- increasing the integration of the health services at the intermediate and peripheral levels
- coordinating the national programmes at the central level.

These strategies should satisfy the current requirements of the donors with regard to the mobilization of funds, namely the establishment of the budget process, the provision of information tools for health, finance and bookkeeping, and clarification of the supply channels and the internal and external audit procedures.

1.3. CHANGES IN THE FINANCING OF THE EPI

After the Expanded Programme on Immunization (EPI) was launched in 1980, it achieved one of the highest rates of immunization coverage in Africa and continued to do so until the crisis in 1993. This performance was the result of the efforts of the government and its partners (UNICEF, WHO, ECHO, Rotary C.I, etc.) to mobilize society and raise funds for the organization of the activities of the fixed and advanced strategies, including mass immunization campaigns. In accordance with the health policy in force, vaccination services remain free of charge. The government's share of the financing of the EPI (overheads and vaccine independence) is low, accounting for no more than an average of 1.4% of the total EPI budget in 1998 and 3.7% in 2002. Support from external partners in the form of donations represented 98.6% in 1998 and 96.3% in 2002. This is clear evidence of Burundi's heavy dependence on outside assistance and means that the autonomy and continued survival of the programme cannot be guaranteed in the short and medium term.

The external funds serve mainly to cover the costs of vaccines, the cold chain, staff training, the organization of NIDs for polio and measles and activities for the monitoring of AFP. The EPI budget accounted for 0.24% of the budget of the Ministry of Public Health in 1998 and 0.46% in 2002.

Table 4 : Changes in the budget of the EPI per source of financing (in USD)

Source	98	99	00	01	02
National budget	172 752 346	164 376 220	154 316 303	176 475 984	172 157 684
MPH budget	5 537 987	4 685 779	4 281 571	4 536 486	4 342 708
EPI budget /Gvt[2]*	13 392	14 209	20 804	28 253	20 139
EPI budget from donors	1 006 165	1 494 000	1 664 054	1 828 338	2 509 192
% external support	98.6%	99%	98.7%	95.6%	96.3%
% national budget	1.4%	1%	1.3%	4.4%	3.7%
% of EPI budget (Gvt) in relation to MPH budget	0.24%	0.30%	0.50%	0.40%	0.46%
% of EPI budget (Gvt) in relation to national budget	0.007%	0.008	0.013%	0.010%	0.011%

Source : Ministry of Finance 03, EPI 2003

The restoration of peace and security will provide Burundi with the opportunity to move from an emergency phase, through an intermediate rehabilitation/reconstruction phase (infrastructure, equipment, staff redeployment), to a development phase. There is no doubt that the reforms now in progress (decentralization, financing and establishment of community health and management committees) will help to improve the overall performance of the health system, as well as the financing and management of the programme through the strengthening of logistical capacities and human resources.

* Government budget for vaccine independence and other overheads, excluding salaries.

SECTION 2

MISSION, CHARACTERISTICS, TARGETS, PERFORMANCES AND STRATEGIES OF THE EPI

2.1. MISSION

Ever since the EPI was established in 1980, it has pursued its mission of protecting children again the target diseases, namely diphtheria, tuberculosis, pertussis, measles, poliomyelitis and tetanus. With effect from 2004, the programme's list of diseases is to be extended, with the introduction of vaccines against the hepatitis B virus and haemophilus influenza type b.

2.2. CHARACTERISTICS

2.2.1. Organization of the service

The Expanded Programme on Immunization forms part of the Directorate of Health Services and Programmes, which itself forms part of the General Directorate of Public Health, a body which in turn reports to the office of the Minister of Public Health. The organization chart of the EPI shows that it is headed by its director and his assistant and consists of the following departments: secretariat, management, logistics, cold chain maintenance (see Annex 2: Organization chart of the EPI).

The organization of the EPI mirrors that of the Ministry of Public Health, being divided into three levels – central, intermediate and peripheral. As the activities of the EPI are integrated at all levels, there is no specific manager for the intermediate and peripheral level. With regard to the management of funds, all disbursements must be authorized by the Minister of Public Health. These pose no problem because all activities are programmed.

2.2.2. The cold chain

Just as the health pyramid is subdivided into three levels, so too is the organization of the cold chain. At the central level, the positive cold chamber consists of two cold rooms, one of which is new and the other more than twenty years old. They are backed up by 11 freezers which take the place of the negative cold room for vaccines that have to be frozen.

At the intermediate level, the cold chain consists of a 320-litre refrigerator and a 172-litre freezer, with emergency back-up from a Sibir mixed refrigerator in the event of power cuts. At this level, there are 17 appliances of each kind.

At the peripheral level (i.e. the health centres), vaccines are stored in mixed Sibir and Electrolux refrigerators. Some of these refrigerators are over ten years old and need to be replaced. Immunization is conducted at around 500 health centres and more than 136 of their refrigerators are either over or close to ten years old and so will need to be replaced within the next two years. Each refrigerator uses 30 litres of paraffin per month, making a total of around 15 000 litres per month, which adds to the cost of the programme.

2.2.3. Supplies

Orders for vaccines and injection equipment are sent to UNICEF. As Burundi is a land-locked country, vaccines have to be supplied by air in order to avoid deterioration and this is, of course, an expensive method of transport. The injection equipment is dispatched by sea and road.

At the intermediate level, supplies of vaccines, injection equipment and fuel are the responsibility of the health provinces. As each category is supplied on a monthly basis, the health province offices need to visit the EPI three times a month. A switch from monthly to quarterly supplies would improve the system and reduce costs.

At the peripheral level, the organization of supplies is mixed. Either the health centres send someone to the health province office to fetch supplies or the supplies are sent from the provincial level.

2.2.4. Vaccine management

At the central level, distribution is based on the target population of each province. This system has improved the distribution system but problems remain with some provincial doctors who have not yet established the system.

At provincial level, this type of distribution has not yet been established, with the result that stocks may run out in one health centre while there is a surplus in another one. Training in vaccine distribution could help to overcome this problem, particularly as all the health centres have already determined their own catchment areas.

2.2.5. The transport fleet

The central transport fleet of the EPI consists of only four vans for monitoring purposes, one car and five motorbikes for the technicians. The car and two of the vans are over ten years old and need to be replaced.

At provincial level, the health sectors which used to have a van are no longer similarly equipped. Of 31 health sectors in operation, only 12 still have a vehicle and this is over eight years old. Practically the whole of the transport fleet at intermediate level needs to be replaced. At the present time, the health centres have no means of transport available to them, though bicycles are to be supplied in the near future. Thus, one major challenge facing the EPI is the replacement of its transport fleet at all levels.

2.2.6. Personnel

The central level has a staff of 22 – the director, his assistant, a doctor, two middle management officials, four technicians and thirteen support staff. Though this is insufficient for the activities to be carried out, the present situation of the EPI does not permit the recruitment of additional staff.

No increase in staff can be envisaged until the EPI switches over from centralized administration to independent ("personalized") administration.

As all activities at the intermediate and peripheral level are integrated, the programme does not need any special additional recruitment.

2.3 TARGETS OF THE EPI

2.2.1 General target

To reduce the morbidity and the mortality due to the target diseases of the EPI and so contribute to the millennium development targets.

2.2.2 Specific targets

- to increase immunization coverage for infants of 0-11 months to 90% by 2006
- to increase immunization coverage for pregnant women to 85% by 2006.
- to increase immunization coverage for women of child-bearing age to 10% by 2005 and to 20% by 2006.

To achieve these targets, we have drawn up an immunization timetable and a five-year forecast for the development of immunization coverage (see Tables 5 and 6).

Table 5 : EPI immunization timetable and antigens used at national level

Antigens	Immunization periods					Years		
	At birth	6 weeks	10 weeks	14 weeks	9 months	2003	2004	2005
BCG	X					X	X	X
OPV	X	X	X	X		X	X	X
DTP		X	X	X		X		
DTP+Hib		X	X	X			X	
Hep B		X	X	X			X	
DTP+Hep B+ Hib		X	X	X				X
MEASLES					X	X	X	X
Vitamin A					X	X	X	X
TT pregnant women	TT1 on 1st contact, TT2 after one month, TT3 after							
	6 months, TT4 after 1 year, TT5 after 1-3 years					X	X	X
TT non-pregnant women	TT1 on 1st contact, TT2 after one month, TT3 after					X	X	X
	6 months, TT4 after 1 year, TT5 after 1-3 years							

Source: EPI strategic plan 2002- 2006

Table 6 : Forecast for development of immunization coverage per antigen 2002-2006

Year / Antigen	2002	2003	2004	2005	2006
BCG	80%	85%	90%	90%	90%
DTP3	65%	70%	-	-	-
DTP-Hib-HepB3	-	74%	80%	85%	90%
OPV	65%	74%	80%	85%	90%
MEASLES	70%	75%	75%	80%	90%
TT2+ pregnant women	65%	70%	75%	80%	85%
TT2+ women of child-bearing age	-	-	-	10%	20%

Source: EPI strategic plan 2002- 2006

Note: In view of the non-availability of DTP-HepB-Hib tetravalent vaccine after the endorsement of the strategic plan for the period 2002-2006, national policy changed to DTP-Hib and HepB in 2004 and DTP- HepB- Hib in 2005.

Table 7 : Revised forecast for the development of immunization coverage per antigen during the period 2002-2006

Year / Antigen	2002	2003	2004	2005	2006
BCG	80%	85%	90%	90%	90%
DTP3	65%	70%	-	-	-
DTP-Hib3			75%	-	-
HepB3			75%	-	-
DTP -HepB-Hib3	-	-	-	80%	85%
OPV3	65%	74%	80%	85%	90%
MEASLES	70%	75%	75%	80%	90%
TT2+ pregnant women	65%	70%	75%	80%	85%
TT2+ women of child-bearing age	-	-	-	10%	20%

Source: EPI strategic plan 2002- 2006

2.4. PERFORMANCES

Immunization coverage increased from 64% in 2001 to 94% in 2002. This impressive performance - recorded despite the crisis – has been achieved thanks to the efforts of the government and its partners in raising funds and social mobilization in favour of the EPI. The current trend shows that coverage will remain above 90%. Emphasis has been placed on the organization of routine immunization activities under the fixed and advanced strategies, as well as on mass immunization campaigns (NIDs, LIDs).

It will also be noted that there has been a steady decrease in the drop-out rate, though the problem of wastage has still not been overcome. During the period 1997-2001, Burundi organized five national immunization campaigns (NIDs) against poliomyelitis in which a coverage rate of over 90% was regularly achieved. In 2002, local immunization days (LIDs) were organized.

In 2000, 2001 and 2002, the country organized mass immunization campaigns against measles in conjunction with the administration of vitamin A. The anti-measles campaign achieved a coverage of 91% and more than half the provinces attained over 80%. The vitamin A coverage was 98%.

In 2002, the programme achieved an immunization coverage of more than 80% for certain antigens. The challenge now is to maintain these high levels of coverage. A further challenge is to increase the rate of immunization against measles and tetanus for women of child-bearing age.

Table 8: Change in national coverage rate for routine immunization

Year / Antigen	1998	1999	2000	2001	2002
BCG	58	72	73	70	99.6
DTP3	50	64	68	64	95
OPV3	55	64	69	61	89
MEASLES	44	47	61	54	67
TT2+ pregnant women	23	30	27	32	42
TT2+ women of child-bearing age	2.95	4.63	3.82	3.96	4.37

Source : EPISTAT

Table 9 : Immunization coverage per health province in 2001-2002

Antigen / Health province	2001				2002			
	BCG	**DTP3**	**OPV3**	**MEAS**	**BCG**	**DTP3**	**OPV3**	**MEAS**
Bubanza	75	67	63	55	95.5	81.6	80.6	56.4
Bujumbura - city	123	110	109	90	112.3	100.3	98.9	80.1
Bujumbura - rural	64	52	52	42	87.2	70.3	70.0	49.8
Bururi	58	50	45	43	98.7	83.5	76.8	64.4
Cankuzo	72	69	70	62	98.5	87.5	83.0	76.8
Cibitoke	121	102	98	68	140.4	112.5	109.1	68.3
Gitega	60	59	57	55	125.0	93.0	92.0	68.3
Karuzi	44	45	41	32	135.8	111.7	104.3	64.7
Kayanza	69	72	70	71	109.2	90.2	90.5	79.9
Kirundo	65	53	40	41	139.5	112.9	93.0	72.8
Makamba	76	65	62	52	110.0	98.0	97.9	74.0
Muramvya	66	64	65	55	101.0	84.4	78.4	69.3
Muyinga	61	54	52	45	122.8	97.5	91.4	62.0
Mwaro	61	62	60	57	97.8	101.0	95.0	74.4
Ngozi	63	67	66	58	98.7	103.5	97.2	60.2
Rutana	79	75	72	69	113.5	83.5	76.8	58.9
Ruyigi	79	59	55	51	118.8	83.8	70.9	63.0
BURUNDI	**70**	**64**	**61**	**54**	**99.6**	**94.5**	**89.2**	**66.7**

Source : EPISTAT

Nearly all of the provinces achieved a coverage of over 80% for DTP3 and OPV3 in 2002. The substantial progress in 2002 was due to concentrated efforts on reducing the drop-out rate, improving logistics (particularly maintenance of the cold chain and the transport fleet), and training and supervising the service-providers and communicators. The national immunization campaigns also played an important role.

2.5 STRATEGIES

2.4.1 Intensification of routine immunization activities

The immunization of children and pregnant women is an integral part of the minimum services offered by the public and private health centres (HCs). This fixed strategy is complemented by the strategy of reducing missed visits by completing the immunization of any child coming to the health centre for whatever reason. In provinces with remote areas far away from the health centres, recourse is had to two further strategies: the *advanced strategy* whereby an immunization team is dispatched periodically and the *mobile strategy* whereby immunization teams are trained to make systematic tours of the remote areas.

As immunization coverage had fallen due to the socio-political crisis, catch-up campaigns were conducted in a number of provinces during the last quarter of 2002 in order to raise the performance of the programme in the health centres.

During the years 1998-2002, Burundi joined with its neighbours in the campaign to eradicate poliomyelitis and, within this framework, organized a number of successful NIDs and LIDs. In view of the excellent results achieved in 2002, the programme is to focus on the fixed and advanced strategies, with an emphasis on community micro-planning and monitoring to reduce drop-out rates under the guidance of the health centre management committees.

2.4.2. Strengthening staff capacities

Apart from the recruitment of staff to strengthen the management of the programme, training was organized in Burundi and abroad to update the managerial knowledge of the health personnel at all levels (central, intermediate and peripheral). Personnel at the central level followed the management course, while staff at the intermediate and peripheral levels received local training. At the intermediate level, the EPI team conducted supervision exercises to train personnel. At the peripheral level, these exercises were conducted by the teams from the provincial health offices, supported by staff from the central administration. This strategy has already borne fruit and will remain one of the main emphases of the programme.

2.4.3. Strengthening management of the programme at all levels of the health system

The following approaches are used to implement this strategy:

- Reduction of vaccine wastage by ensuring the proper operation of the cold chain from the EPI store through to the health centres. Health personnel have been trained in vaccine supply and stock management at the level of the provincial health offices and the health centres. This training has already begun to bear fruit and it will be continued by the programme over the coming years.

- Reduction of drop-out rates in the health centres by reducing the number of missed visits. The programme will shortly be supporting the introduction of community micro-planning and monitoring of activities by the health centre management committees, which will also be responsible for social mobilization.

- Injection safety in the care structures by requiring the use of AD syringes, safety boxes and destruction by incineration from 2001 onwards.

2.4.4 Introduction of new vaccines

One of the priorities endorsed by the country is the introduction of new vaccines in 2004 and 2005 to improve child health through protection against hepatitis B and haemophilus influenza type b.

2.4.5 Surveillance of the EPI target diseases

Surveillance concerns vaccine-preventable diseases, particularly AFP, measles and neonatal tetanus. The investigation of cases is conducted on individual cards for AFP and measles, with confirmation by means of laboratory analysis. The activity of monitoring neonatal tetanus on individual cards has yet to begin.

2.4.6 Strengthening partnerships

To carry out the planned activities, the programme needs to strengthen partnerships for the mobilization of funds. The task of advocacy is effected through the Inter-Agency Coordinating Committee (ICC) which brings together :

(i) our internal partners: the General Directorate, the Directorate of Health Services and Programmes, the DPHHD, the NRHP, EPISTAT, IEC/EPS and PHO)

(ii) our external partners: the Ministry of Foreign Relations and Cooperation, the Ministry of Finance, the Ministry of Planning, Development and Reconstruction, UNICEF, the WHO, the ROTARY Club International, the OFDA and the NGOs.

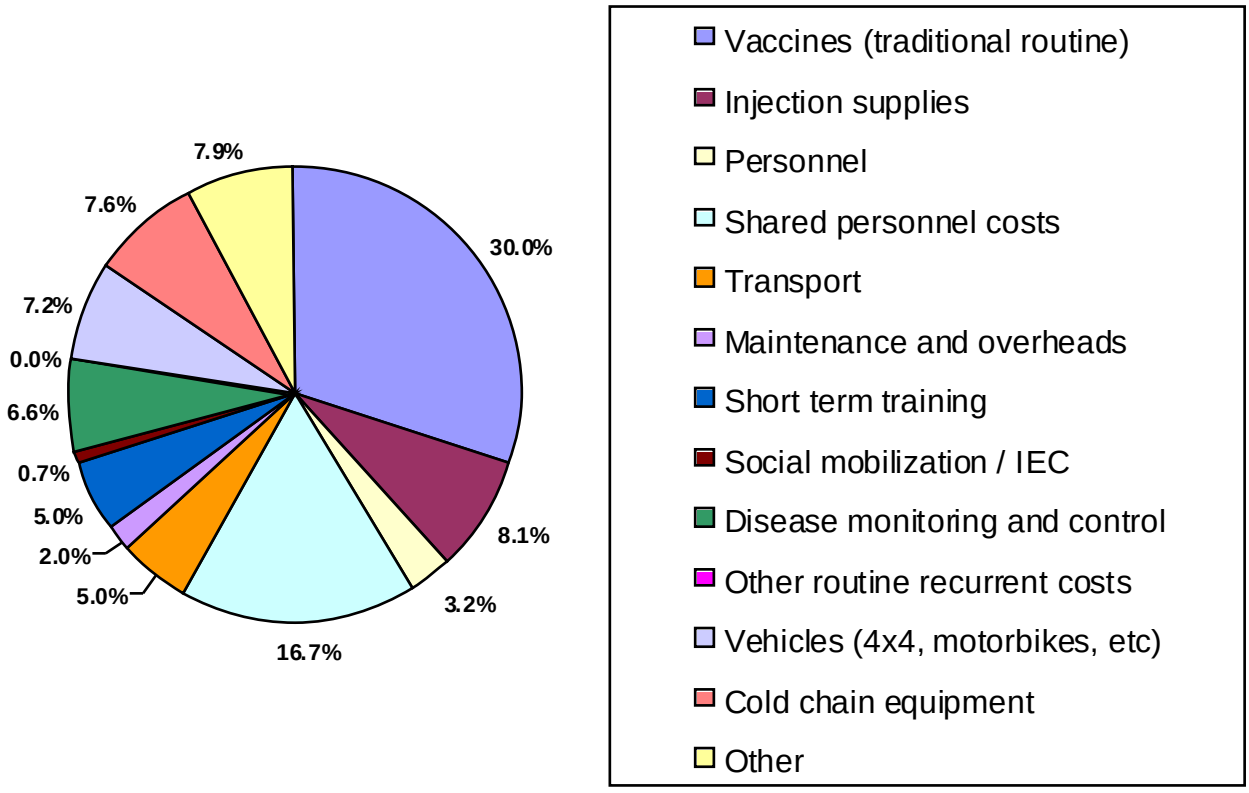
2.6 . CHANGES TO COME

The EPI expects to begin the process of independent management for the coming years. The strengthening of staff capacities through in-service training is also crucial. Computerization will be established to improve the management system of the programme and a monitoring and evaluation section will be set up. Accounting and logistics sections will also be established. The need for more office space will then necessitate the construction of an EPI headquarters building.

SECTION 3
COSTS AND FINANCING OF THE EPI
FOR THE YEARS BEFORE AND DURING GAVI SUPPORT
(2001 and 2002 respectively)

3.1. EPI costs and financing for the year 2001

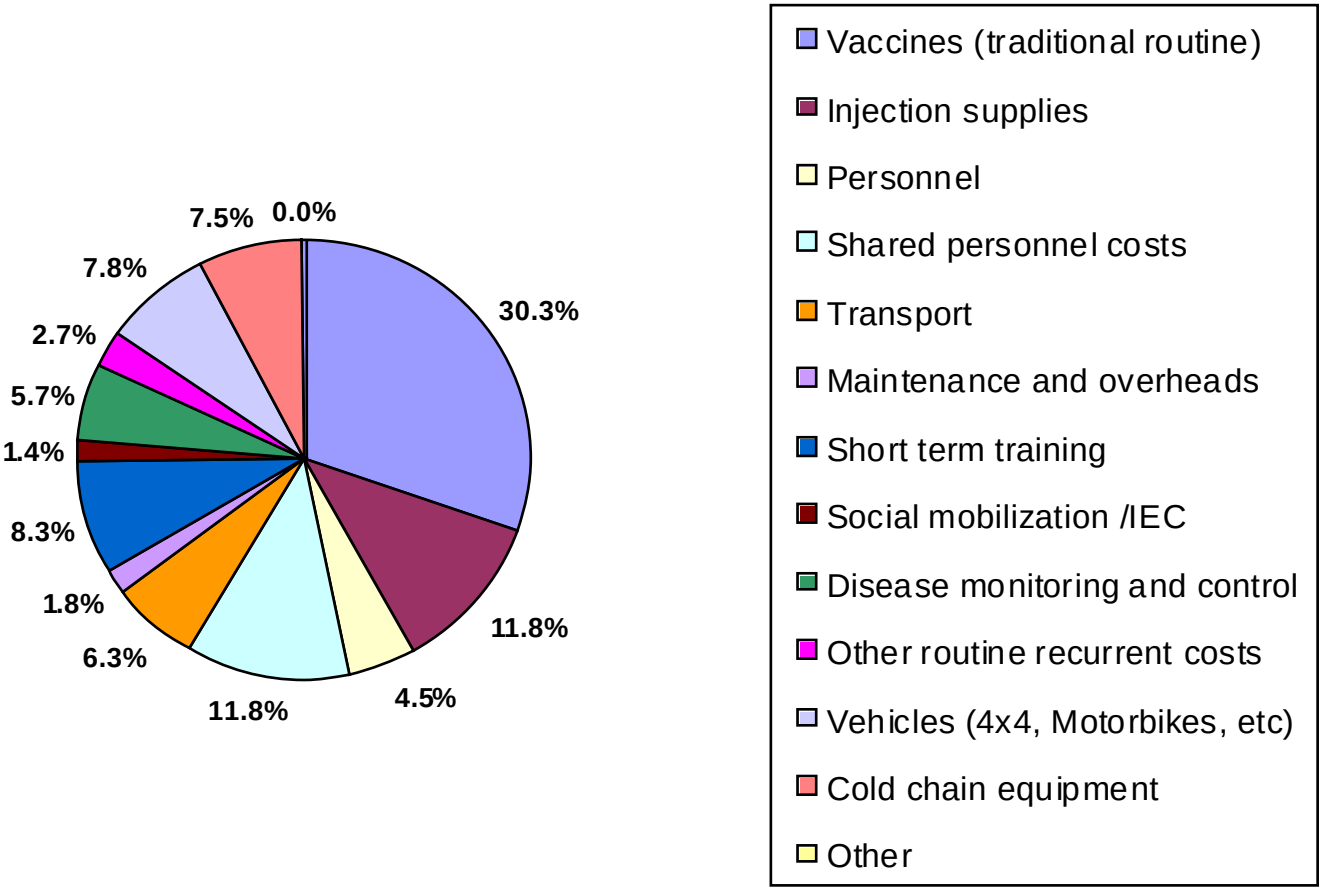
Figure 1: Profile of Routine EPI costs for 2001 (year before GAVI support)



During the year 2001 (i.e. before the effective intervention of the GAVI funds), the EPI cost USD 1 973 348. The various cost categories are shown in Figure 1. The government of Burundi contributed the equivalent of USD 230 187 (11.7%) towards these costs. This covered various recurrent costs (including particularly all salaries of staff at the central, intermediate and peripheral levels) and the total capital cost of building a storage depot (USD 17 441). The main contributor to the programme activities was UNICEF, which allocated USD 1 405 789 or 71.2% of total expenditure. The main activities financed by UNICEF are the purchase of vaccines, vaccination equipment, cold chain equipment, training, cold chain maintenance and transport. For its part, the WHO provided financing of USD 295 632, representing 14.9% of programme costs. Of this sum, USD 223 496 served for additional immunization activities (31.3% of total) and USD 72 000 for operating costs (100%). The detailed figures for the contributions of each partner are given in Annex 3.

3.2.EPI costs and financing for the year 2002

Figure 2: Profile of Routine EPI costs - 2002 (year with GAVI support)



Total expenditure for the EPI in 2002 amounted to USD 3 275 963. The various cost categories are listed in Figure 2. The main partners of the EPI were the government, UNICEF, WHO and GAVI (Figure 3).

The government of Burundi granted a budget credit equivalent to USD 180 036 or 5% of the total expenditure of the EPI, in order to cover the salaries of programme personnel and part of the overheads.

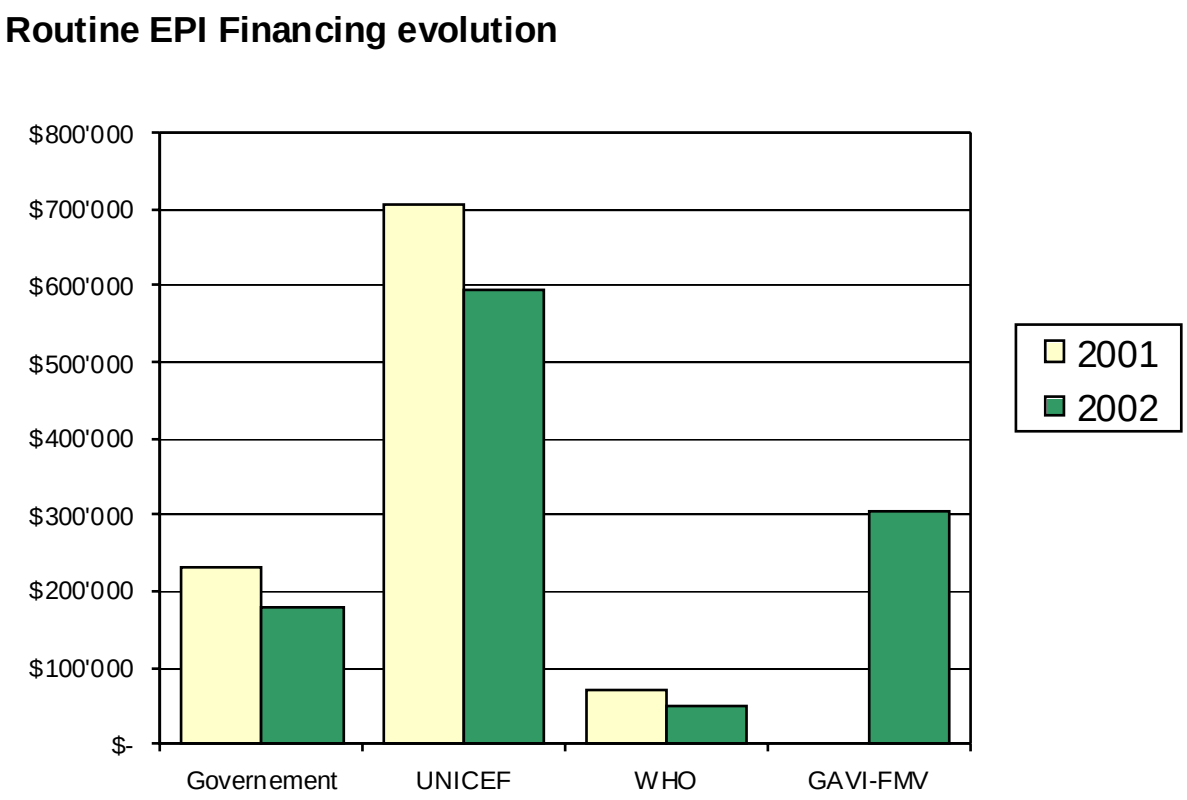
The UNICEF contribution to the EPI expenses in 2002 remained remarkably high at USD 2 685 191 or 82% of total costs. The financing was mainly focused on the vaccines and related materials, the cold chain and maintenance, and the immunization campaigns against measles, poliomyelitis and meningitis.

In 2002, the WHO contributed USD 106 153 (3.2%) towards the cost of programme activities. Of this sum, USD 50 970 was used to cover part of the routine costs (4.5%) of disease monitoring and control (AFP, measles), while USD 55 183 was used for the NID/SNID

supplementary immunization activities (5.1% of campaign costs). In addition, the WHO provided the EPI with significant expertise and technical assistance in the form of training abroad not costed in Annex 3.

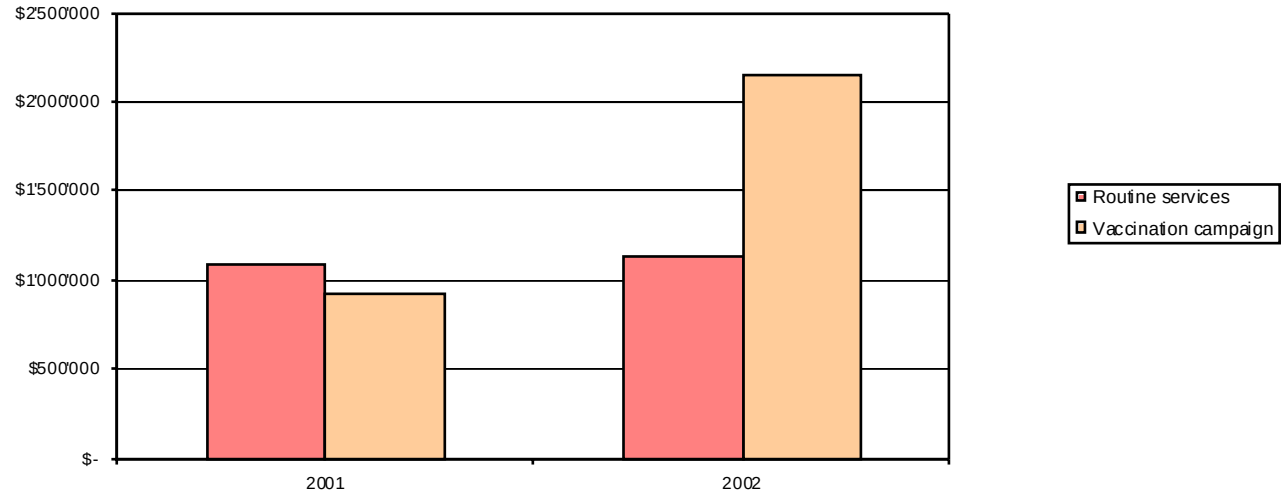
The financial year 2002 corresponds to the first two disbursements of GAVI funds in the total sum of USD 304 583 or 9.3% of total costs. For further details, see Annex 3.

3.3. Figure 3 : Profile of EPI financing



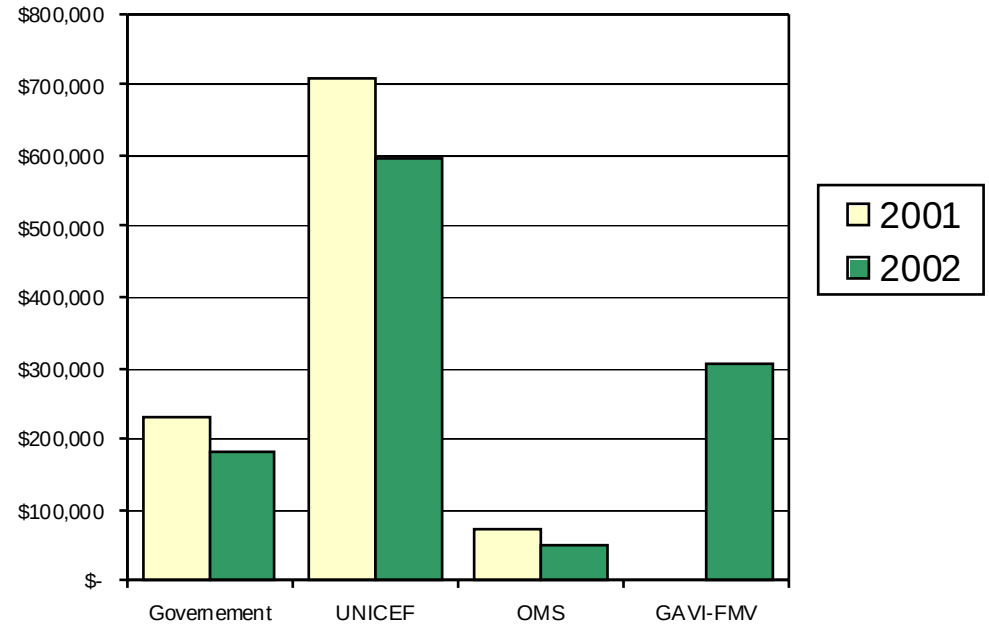
The programme partners in 2001 and 2002 were the government, UNICEF and the WHO. GAVI then intervened in 2002 to reinforce the support of these traditional partners. The contribution received from the government remains low, rarely exceeding 10%. It will further be noted that this contribution was reduced in 2002, despite the fact that there is an annual rate of increase of 3%. This is due to the fact that staff salaries are not linked to the currency inflation rate. The UNICEF contribution on the other hand covers the main costs of the EPI, i.e. routine immunization activities and particularly vaccines. The WHO contribution was somewhat less in 2002 than in 2001.

Figure 4 : Costs of routine services and immunization campaign



Although the campaigns in 2001 and 2002 were short, their costs were often higher than those of the routine programme because of the need to mobilize additional vaccines, equipment and personnel. For this reason, it would be appropriate to strengthen routine immunization and to keep the campaigns to a minimum.

Figure 5: Change in the financing of the routine EPI



With the advent of GAVI financing, UNICEF and the WHO have reduced their contributions. The reduction on the part of the government is due to monetary erosion.

3.4 Sources and difficulties of financing

3.4.1 Internal financing

a. Government financing

The government allocates to the EPI an operating budget which serves essentially to cover staff salaries and part of the recurrent costs. On the capital side, the government has just built a depot for the storage of vaccination equipment.

State financing is subject to the following problems:

- the procedures for forecasting and for implementing the budgets adopted
- the cash flow position of the State for *ad hoc* disbursements
- the situation of poverty and war which restricts the opportunities for action in favour of the programme.

It should be noted that the EPI does not draw up its own budget and has no regular bookkeeping system. It is clear, however, that budgeting and general accounting should provide the basis for the establishment of cost statistics and information for the sources of financing. This would greatly facilitate the search for and mobilization of resources.

b. Private sector financing

The private sector does not yet play any role in the financing of the EPI. This is an area that needs to be explored and developed.

c. Community financing

The immunization services are provided free of charge and no contribution is sought from the community.

3.4.2. External financing

The main external sources of funds for the programme are UNICEF, the WHO and, since 2002, GAVI. Other partners, such as the European Union, Belgian Cooperation, DCC, OFDA and Rotary C.I., finance the programme through UNICEF and the WHO.

The difficulties in disbursing the funds granted by the different partners derive from the old-established procedures and the ICC is trying to resolve this problem through consultations organized with the main parties involved in the programme (funding bodies and members of the executive of the EPI).

SECTION 4

ESTIMATE OF FUTURE COSTS AND FINANCING DURING AND AFTER GAVI SUPPORT

This part of the FSP presents a projection of the resources needed to permit the operation of the EPI during the period 2004-2011. The gap between the projected expenses/costs and the financing enables us to envisage other sources of funds and, where applicable, to adjust the targets and strategies. The estimate of resources needed covers two periods, namely:

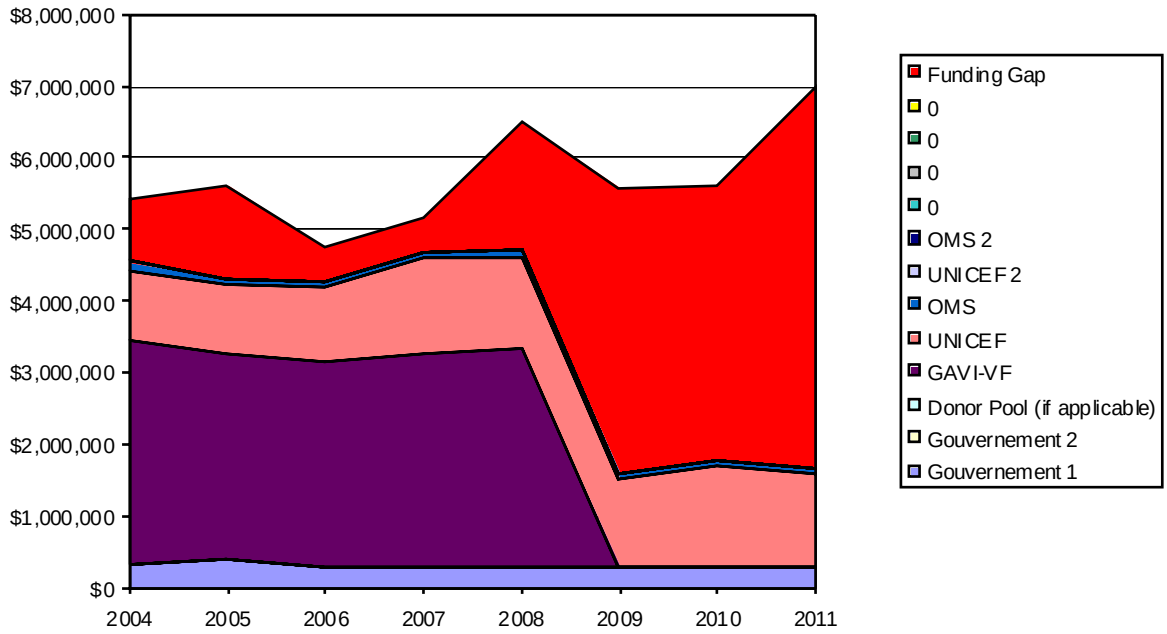
- the period of GAVI support (2004-2008);
- the period after GAVI support (2009-2011).

4.1 The period of GAVI support

The financing projections are based on the EPI targets contained in the strategic plan and application file submitted to GAVI. They take into account the following elements:

- the target population
- the rate of immunization coverage to be achieved
- the introduction of new vaccines
- injection safety
- the unit cost of vaccines and injection equipment
- the dollar exchange rate : USD 1 = BIF 1073*[3]

Figure 6: Projections of Secure Financing by Source and Funding Gap



* Exchange rate from January to August 2003

The proposed scenario envisages the introduction of the DTP-Hib and the two-dose monovalent HepB in 2004 and then their replacement by the pentavalent form in 2005. The target population is projected from that of the year 2000, which served as the basis for the application file submitted to GAVI with the growth rate of 2.9%. The crisis ravaging the country since 1993 has had a serious impact on the population and the programme, with deaths, massive displacements of populations and refugees. These effects have resulted in changes in relation to the census of 1990, especially in certain border provinces, particularly along the border with Tanzania. Accordingly, the population figure used has been corrected on the basis of the data available at provincial level.

The rate of immunization coverage to be achieved takes into account the EPI targets stated in the GAVI application and the performances obtained in 2002. The introduction of the tetravalent DTP-Hib and the monovalent hepatitis B led to some changes in the cost projections as they were to be used for only one year. The new vaccines and under-used vaccines refer to the new protocol adopted in March 2003. The price for the vaccines used is the one communicated by UNICEF. The projections of resources needed for the period covered by GAVI take into account the forecast expenses and the projected financing of the main partners of the EPI, such as UNICEF and the WHO. The following table summarizes the changes in resources projected for the rest of the period of GAVI support:

Table 10 : The projected resources (USD)

Years	2004	2005	2006	2007	2008
Projected expenditure	**5 437 967**	**5 602 452**	**4 737 043**	**5 153 629**	**6 488 412**

The detailed table of resources required (Annex 4 a : Basic Projections) shows that the new vaccines absorb the greater part of the EPI budget. In 2004, for example, the new vaccines account for 92% of the cost of vaccines and 52% of the total cost of the programme. On the other hand, as may be seen from Table 11, the traditional vaccines account for only 8% of the total cost of vaccines and 4.5% of the total cost of the programme:

Table 11 : Comparison between the costs of vaccines and the expenses of the programme (USD)

Basic scenario A	2004		2005		2006		2007		2008	
Vaccines (routine only)	3,052,292	56.1%	3,166,585	56.5%	3,218,416	67.9%	3,380,007	65.6%	3,490,604	53.8%
-6 traditional antigens	243,182	4.5%	279,620	5.0%	316,815	6.7%	394,260	7.7%	418,270	6.4%
-new and underused vaccines	2,809,109	51.7%	2,886,965	51.5%	2,901,601	61.3%	2,985,747	57.9%	3,072,334	47.4%
Total expenses	5,437,967		5,602,452		4,737,043		5,153,629		6,488,412	
Nkvd cost of vaccines		92.0%		91.2%		90.2%		88.3%		88.0%

This increase in the cost stems from the high price of the new vaccines.

Furthermore, the crisis in Burundi since 1993 has resulted in the destruction of much of the immunization equipment, particularly in terms of the cold chain and the transport fleet. The replacement of this material and the purchase of new vaccines will increase the cost of the programme. The same trend is expected to continue in the following years (2005-2008). The analysis also shows that, with effect from 2004, the cost of vaccines is set to increase tenfold

(see Annex 4: Basic Projections, Vaccine Table). During the same period, a significant financing gap remains to be overcome (see Basic Projections, Figures 1-3). It will be necessary for the EPI to put this message across to its customary donors so that they increase their contributions. It will also be necessary to approach other potential partners for contributions.

4.2. The period after GAVI support

The period in question relates to the three years 2009-2011. The forecasts for resources needed take into account the target population estimate based on the projection from the year 2000 and the annual estimated rate of growth of 2.9%. It is assumed that the new vaccines have been introduced, that the injection safety policy has been established and that the cold chain has been renewed at all levels. The cost per dose is that applied by UNICEF, the main partner of the programme. The average exchange rate remains unchanged at USD 1 = BIF 1073.

Table 12 : Projection for resources after GAVI support (USD)

Year	2009	2010	2011
Resources	5 584 105	5 629 507	6 987 931

In this scenario, the expenses take into account the introduction of the DTP-Hib and the two-dose hepatitis B in 2004 and their replacement by the pentavalent in 2005. During this period, the cost of the programme continues to increase from year to year (Tables 12 and 13). This is because of the annual rise in the target population and the high cost of the new vaccines. The result is a significant financing gap which appears with the withdrawal of GAVI funding (see Basic Projections, Figures 1-3). Intensive fund-raising efforts will be needed to bridge this gap.

Table 13 : Comparison between total expenditure and vaccine costs(USD)

Basic scenario A	2009		2010		2011	
Vaccines (routine only)	3,593,014	64.3%	3,716,549	66.0%	3,825,307	54.7%
- 6 traditional antigens	431,582	7.7%	463,436	8.2%	477,854	6.8%
- new and under-used vaccines	3,161,432	56.6%	3,253,113	57.8%	3,347,453	47.9%
Total expenses	5,584,105		5,629,507		6,987,931	
Nx vc/cost of vaccines		88.0%		87.5%		87.5%

4.3 Other substitutes to obtain the necessary resources

The negotiations currently being conducted between the government and the rebel forces offer a gleam of hope that the hostilities will cease and that peace will be restored in the country. Such an outcome will enable the government to establish strategies to kick-start the national economy and to provide finance for the EPI. The strategies which could be applied to the EPI include:

- improvement in the management of the EPI
- reorientation of targets
- spreading the GAVI funding over 8 years

4.3.1 **Improvement in the management of the EPI**

4.3.1.1 Reduction in the wastage rate

The wastage rate is currently estimated at 25% for the DTP and OPV and 50% for the measles vaccine and BCG. The strategic plan aims to reduce the wastage rate for the DTP and OPV from 25% to 10% by 2008 and for the measles vaccine and BCG from 50% to 25%.

The reduction of the wastage rate is one of the priorities of the programme and steps have already been taken to move towards this target.

4.3.1.2 Improvement in the supply system

The present system is for vaccines, material and fuel to be ordered on a monthly basis. As far as fuel is concerned, monthly ordering will have to continue due to the lack of storage capacity. On the other hand, orders for vaccines and material should switch from a monthly to a quarterly basis. The average fuel consumption is 50 litres per vehicle and there is one vehicle for each of the 17 health provinces.

Table 14: Savings achieved on improvement in the supply system (USD)

Frequency of orders	**Quantity**	**No. of rounds**	**Litres per rounds**	**UP**	**No. of months**	**Total**	**Exchange rate**	**No. of years**
							1073	5
Monthly	17	3	50	880	12	26928000	25096	125480
Quarterly	17	2	50	880	4	5984000	5577	27884
Saving						**20944000**	**19519**	**97596**

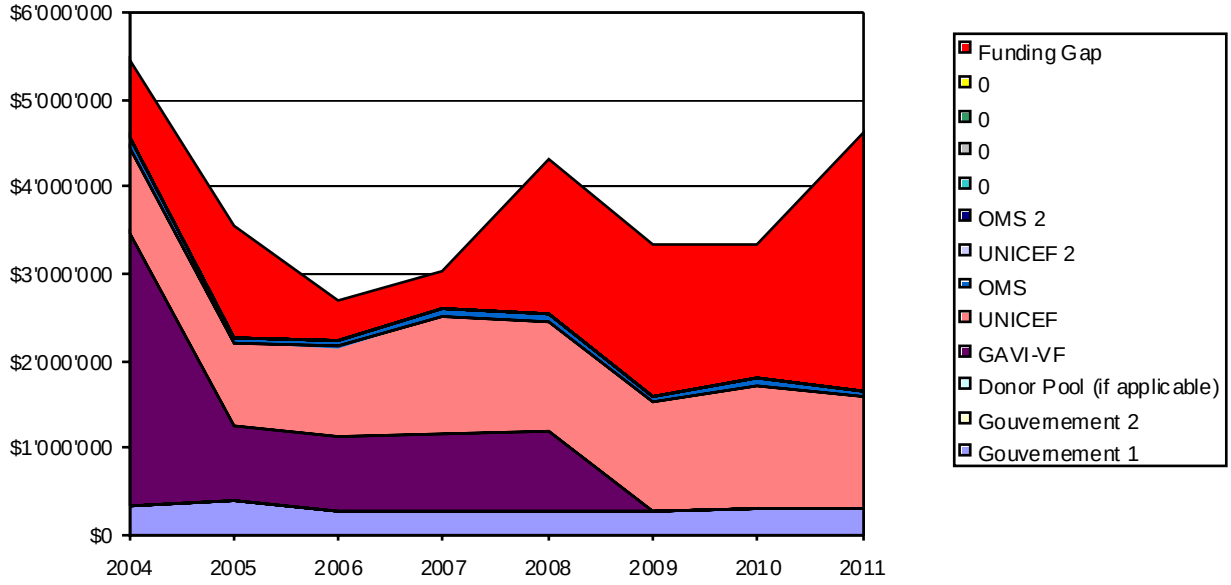
4.3.2. Reorientation of targets

4.3.2.1. Introduction of the DTP – Hib and two-dose Hep B

The introduction of the new vaccines (DTP-Hib and two-dose Hep B) will increase the annual cost of the EPI. This increase is comparable to that of the basic scenario and there is no reduction in the cost of the programme. In addition, the constraint of two doses per visit will lead to an increase in the drop-out rate. The introduction of new vaccines under this option accentuates the need for programme financing, which is already 90% dependent on outside help. This option is not sustainable (see Annex 5: Introduction of DTP + Hib + two-dose HepB).

4.3.2.2. Introduction of the DTP-HepB instead of the pentavalent.

Figure 7: Projections of Secure Financing by Source and Funding Gap



Viral hepatitis B is a public health problem in Burundi, with a prevalence of 12% in the population (1985 survey of seroprevalence of the HBs antigen in Burundi). Given the economic situation of the country and the epidemiological arguments, Burundi could opt for the DTP-HepB vaccine instead of the pentavalent. The savings which would accrue in such a scenario are summarized in Table 15. The introduction of the DTP-HepB rather than the pentavalent would halve the vaccine costs, a reduction which would be more advantageous for the country. The funding gap during and after the GAVI support period would also be significantly reduced. The details of the cost of the programme with this scenario are indicated in Annex 6: Introduction of DTP-Hep B.

Table 15 : Cost of vaccines according to this scenario (USD)

Years	2004	2005	2006	2007	2008	2009	2010	2011
Vaccines	3 052 292	1 136 688	1 178 228	1 280 654	1 330 369	1 370 132	1 429 204	1 471 629
Trad. vaccines	243 182	279 620	316 815	394 260	418 270	431 582	463 436	477 854
New vaccines	2 809 109	857 068	861 413	886 394	912 099	938 550	965 768	993 775
Cost of EPI	**5 437 967**	**3 555 872**	**2 680 088**	**3 037 023**	**4 310 423**	**3 342 955**	**3 323 363**	**4 277 289**

4.3.2.3 GAVI funding spread over 8 years

According to this scenario, the GAVI funds allocated to vaccines are spread evenly over 8 years. The funding gap that results is almost the same as the preceding cases and is spread uniformly over the 8 years. The cost of the programme remains unchanged because it takes into account the relatively low basic projection and the resource gap. The problem of the funding gap will become more serious when the GAVI funds are withdrawn. Annex 7 shows in detail the cost of the programme during and after the period of GAVI support.

4.3.4 The government increases its contribution to 15% up to 2008

In the Abuja agreements, the signatory governments undertook to increase the budget of the Ministry of Health to 15% of the national budget. If the government honours this undertaking and if a quarter of the increase is allocated to the EPI budget, the funding gap is sharply reduced. Indeed, the gap disappears entirely if the whole of the increase is allocated to the EPI. However, this strategy is conceivable only if the war comes to an end and there is an effective economic recovery. Annex 8 presents the changes in the cost of the programme in detail.

Figure°8: Projections of Secure Financing by Source and Funding Gap

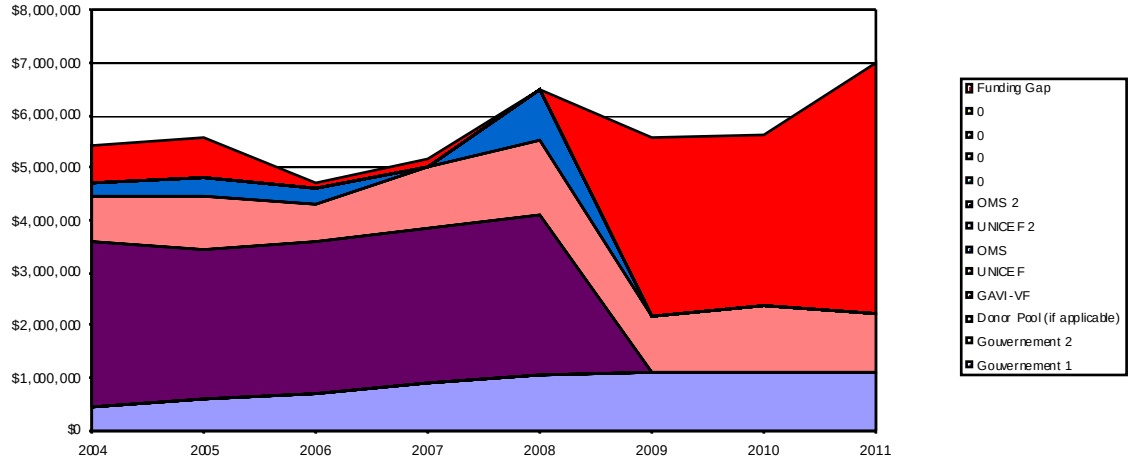


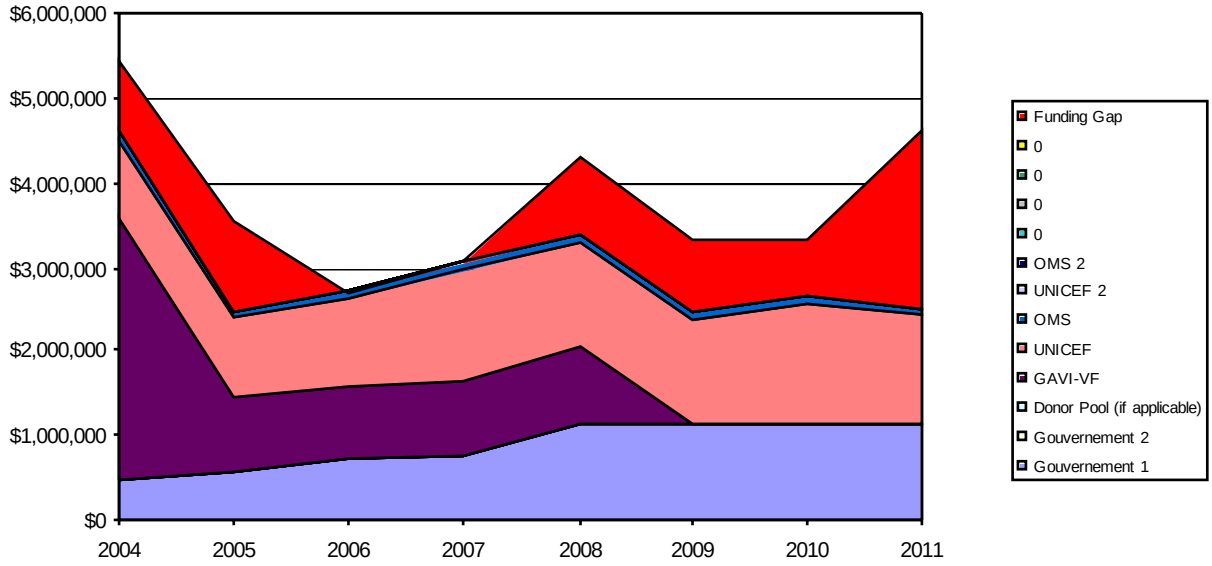
Table n°16: Increase in the government contribution to 15%

Increase in the government contribution to 15%

Years	2003	2004	2005	2006	2007	2008
		3%	6%	9%	12%	15%
Gvt. Budget	172,158,000,000	182,339,841,154	182,339,841,154	182,339,841,154	182,339,841,154	182,339,841,154
MPH budget	4,343,000,000	5,470,195,235	10,940,390,469	16,410,585,704	21,880,780,938	27,350,976,173
EPI	395,426,252	494,282,815	617,853,519	772,316,898	965,396,123	1,206,745,154
Proportion	0.091	1,073	1,073	1,073	1,073	1,073
Amount in USD		**460,655**	**575,819**	**719,773**	**899,717**	**1,124,646**
If EPI is granted 1/4 of the MPH budget						

Combination of scenarios 2 and 3

Figure°9: Projections of Secure Financing by Source and Funding Gap



4.4. Analysis of the gap and assessment of the risk in relation to the sources of financing

The government of Burundi finances 5% of the cost of the EPI. The remaining 95% of the budget comes from external sources.

The introduction of the new vaccines will result in a fivefold increase in the cost of the programme, from approximately USD 800 000 to USD 5 million. During the period of GAVI support, the funding gap will vary between USD 165 539 and USD 1 789 021. As a whole, the routine immunization needs are well covered. The gap which arises is generally due to an immunization campaign.

After the GAVI support ceases, the funding gap varies between USD 3 842 182 and USD 5 327 482 (see Annex 4). This increase is due to the high cost of the new vaccines, which are not yet financed. If no partner comes forward to assume these costs, the EPI will be hard put to continue its immunization activities.

Faced with the poverty of the country and the continuing crisis, the government is unable to embark on strategies to rehabilitate the economy and enable it to increase its contribution to the EPI. This same situation applies both to the basic scenario and to the substitute means of financing.

To conclude, Burundi is a highly indebted poor country ravaged by an unending war. As Burundi's EPI programme depends on outside sources for 90% of its financing, the country will be unable to operate with the new vaccines unless help is forthcoming from external partners.

SECTION 5 : STRATEGIC PLAN FOR SUSTAINABLE FINANCING

Introduction.

Having analyzed in the preceding sections the economic problems connected with the EPI, we now turn to the strategies which need to be laid down in order to mobilize the funds required for the financial sustainability of the EPI, as well as to the related performance indicators. These questions will be considered under four headings:

- Mobilization of internal resources
- Mobilization of external resources
- Mobilization of reliable resources
- Strategies permitting efficient use of resources.

5.1. Mobilization of internal resources

"Internal resources" is understood to mean financing provided by the government, the domestic NGOs and the local communities.

5.1.1 .Government financing.

The government currently covers the operating costs of the EPI. Within the framework of the vaccine independence initiative (VII), the State contributes 25% of the cost of purchasing vaccines. The agreement stipulates that the State must progressively increase this percentage until it covers a good part of the purchasing costs. It is essential for this strategy to be implemented so that the State will have achieved and consolidated an acceptable level of self-financing for the purchase of vaccines before the withdrawal of the Vaccine Fund.

The State must take the option of renewing the EPI transport fleet, particularly as external partners are committing less funds.

5.1.2. Financing from internal partners.

The government must set in place a mechanism involving partners from the domestic economy in support of immunization services by establishing a national vaccine fund.

5.1.3. Community participation.

A system of autonomous health centres is being established throughout the country and immunization services are provided free of charge, irrespective of the material supplied. It follows, therefore, that the local communities should establish an immunization support fund with the participation of all the health centres offering vaccination. Though there is no possibility of the communities bearing the costs of the vaccines in the medium or the long term, they could contribute to the financing of local operating costs.

5.1.4. Strengths

- Burundi hopes to emerge from the war in the near future.
- The country will then enjoy political and institutional stability.
- The economy of the country is expected to take off again.

- Immunization remains a priority of the government and of the Ministry of Public Health.
- The traditional donors of the EPI and the Ministry of Public Health remain disposed to support the programme.
- Burundi may be able to enjoy the benefits of the HIPC initiative.

5.1.5. The indicators

- percentage increase in EPI financing achieved
- percentage of financing covered by the taxpayer
- percentage of financing covered by the community

5.2. Mobilization of external resources

5.2.1. The customary partners of the EPI

The customary partners of the EPI are UNICEF, the WHO, Rotary Club International, the CDC and Bilateral Cooperation. These partners provide the EPI with support in two-year cycles. At the end of each cycle, it is necessary to renegotiate the financing for the new period. It would be desirable for the partners to increase their contribution, especially as the introduction of new vaccines will sharply increase the cost of the programme.

5.2.2. Other partners

The cost of the programme is estimated to increase progressively during the period of support by GAVI and particularly thereafter. Accordingly, it will be necessary to raise the awareness of the other partners so that they can intervene in support of the programme and ensure the long-term continuity of its activities.

5.2.3. Lightening the debt burden

As we indicated above in the section on macroeconomic targets, Burundi is one of the world's most heavily indebted poor countries. In 2001, with a view to having its debt reduced or even cancelled, Burundi drew up a case to permit the country to benefit from the advantages of the HIPC initiative. During the period of the negotiations with its development partners, Burundi enjoys the benefit of a multilateral fiduciary fund to finance a part of its external debt.

Burundi's eligibility for the HIPC initiative will permit the country to obtain funds for financing the programmes of the priority sectors. A plan of action for the use of such funds has already been drawn up for information purposes, covering the social sectors, the management of public finances and the debt strategy. The measures to lighten the debt burden will make it possible to finance social rehabilitation, health care, education programmes, basic infrastructures, agriculture, the eradication of the street children problem and the like.

As a health sector programme, the EPI could be able to benefit from these funds. However, the proposed plan of action will need to be improved to include a breakdown of financing per priority sector.

5.2.4. The indicators

- the number of awareness-raising meetings held
- the rate of increase in funds achieved by the customary partners of the EPI
- the rate of increase in funds achieved by the other partners
- the level of the external debt burden lightened
- the proportion of the HIPC financing allocated to the EPI.

5.3. Mobilization of reliable resources

5.3.1. The government contribution

The funds allocated to the EPI by the government depend on the situation at the particular time, i.e. they take into account not the wishes expressed by the programme but rather the carrying over of previous budgets. The government must be made aware of the need to increase the budgeted funds allocated to the programme in order to improve the situation.

5. 3.2. Disbursement procedures

The procedures for the disbursement of funds are so lengthy that the time limits are often exceeded, with the result that the funds are cancelled. The disbursement procedures need to be revised to overcome this problem, which applies not only to government funds but also to those provided by development partners.

5.3.3. Indicator

- the time needed to make the budget allocation available to the EPI.

5. 4. Effective and efficient management of resources

5.4.1. Strengthening of programme management

5.4.1.1. Autonomous programme management

Independent programme management would lead to greater effectiveness and efficiency.

5.4.1.2. Improvement of programme management

- reduction of wastage rate
- reduction of drop-out rate
- reduction in missed visits
- strengthening of the fixed and advanced strategies
- proper estimates of the target population
- improvement in the cold chain
- reduction in stock shortages
- improvement in the system of supply
- increase in staff capacities.

5.4.2. The indicators

- Achieved reduction of wastage rate
- Achieved reduction of drop-out rate

Table 23 : Strategies and indicators

Strategies	Indicators	Party responsible
1. Mobilization of internal resources	- 6.01% GDP ; 15% investment budget; 14.8% of national savings	- Ministries of Finance, Planning and Public Health
1.1 Increase in State budget	- 15 % of MPH budget achieved in the overall State budget	- Ministries of Finance, Planning and Public Health
1.2 Participation of NGOs and private sector	- 3% of financing of local NGOs; number of partners	
1.3 **Participation of local authorities (health centres)**	- 1% of the financing of the local authority	- Ministry of the Interior, health centres
2. Mobilization of external resources.	- 85% of the financing of the health sector achieved	- Government and development partners
	- Number of new partners involved in financing of the EPI	- Government and development partners
	- Alleviation of debt burden within the framework of the HIPC initiative	
3. Mobilization of reliable resources	- % of financing from WHO - % of financing from UNICEF	- WHO - UNICEF
4. Effectiveness and efficiency of resource management	- % of drop-out rate achieved - % of wastage rate achieved - % of coverage rate achieved	- EPI - Provincial Health Offices

CONCLUSIONS

The Financial Sustainability Plan of the EPI has been drawn up on the basis of the development of the socio-political situation currently prevailing in Burundi. A positive outcome to the resolution of the conflict will permit, *inter alia*, the rehabilitation of the national economy and the relaunch of the development programmes. In parallel, the programme for the mobilization of funds endorsed by the government on the occasion of the round tables held in Paris in 2000 and in Geneva in 2001 and 2002 will be continued and will breathe new life into the national economy.

Furthermore, Burundi has entered into negotiations with its creditors inside and outside the framework of the Paris Club with a view to the reduction of its bilateral and multilateral debt through conversion, repurchase, cancellation and rescheduling measures (HIPC initiatives). Thus, the income flows resulting from the relaunch of the economy and the benefit of the HIPC initiative will permit the implementation of the development programmes, including specifically the improvement of the health programmes and, more particularly, the EPI.

SECTION 6 : PARTNERS' COMMENTS ON THE EPI FINANCIAL SUSTAINABILITY PLAN

6. 1. COMMENTS OF UNICEF

Through the EPI and its financial sustainability plan (FSP), the government of Burundi has reiterated its commitment to the reduction of infant and maternal mortality and once again endorsed the millennium development objectives.

Immunization is one of the few medical interventions which, though inexpensive, offers enormous advantages for the health and well-being of the whole population. It represents a long-term investment, as children who grow up in good health are able to contribute to the economic development of the country. For this reason, immunization must be ranked among the strategic priorities in the fight against poverty.

The EPI financial sustainability plan just drawn up by Burundi demonstrates once again the commitment of the government to the protection of such vulnerable groups as women and children. This commitment needs to be manifested by an increase in the government's contribution to the EPI, so that the programme becomes less dependent on external support.

The Ministry of Public Health will also have to start approaching other bilateral and multilateral donors to help in the financing of the EPI. In this regard, the FSP is a valuable instrument, helping both government and partners in the task of advocacy and the mobilization of resources.

The quality of the FSP lies in the fact that it covers the realities of the programme all the way from situation analysis through to strategies. The document will permit a mobilization of resources and UNICEF will have recourse to the FSP in putting across the case.

UNICEF is pleased to have been a member of the multi-disciplinary group which drew up the FSP and it congratulates all concerned on the fruit of their labours. UNICEF will continue to support the Ministry and the programme so as to ensure that the set targets are reached.

Fait à Bujumbura le 27/11/2003

Malick SENE

Représentant de l'UNICEF au Burundi

REPRESENTATION AU BURUNDI

6.2. COMMENTS OF THE WORLD HEALTH ORGANIZATION

The World Health Organization congratulates the government of Burundi which, despite the crisis the country has been going through since 1993, has subscribed to the international targets to reduce infant mortality through the immunization of mothers and children and thus contribute to the Millennium Development Objectives.

The present Financial Sustainability Plan (FSP) is a valuable document for advocacy in raising the funds needed to cover the deficit, especially after the period scheduled for GAVI financing.

The WHO considers the FSP to be a document of quality, particularly in terms of the highly relevant strategies proposed by the multi-disciplinary group responsible for drawing up the plan.

If the Expanded Programme on Immunization is to remain in existence, especially after the introduction of new vaccines, greater financial resources will be needed, on the one hand, from the government with a view to long-term self-financing and, on the other, from the international community so that it is able to assume its responsibility, having regard to the special circumstances of Burundi and of the most economically disadvantaged countries.

The WHO is delighted to have played a part in drawing up this plan.

Done at Bujumbura on 27/11/2003

Dr Abdel Wahed EL Abassi

Special Representative of the Director General

and Regional Director of the WHO in Burundi

REPUBLIC OF BURUNDI

MINISTRY OF FINANCE
MINISTRY OF PUBLIC HEALTH

Memorandum of support for the Financial Sustainability Plan of the Expanded Programme on Immunization of the Republic of Burundi.

The document which has been drawn up is supported by the administration and the government of Burundi. It represents the expression of the will of the authorities and of the internal and external donors to protect the population against the morbidity and mortality due to vaccine-preventable diseases by seeking to improve the socio-economic indicators, including particularly those for health.

The hopes of peace pointing to a horizon auguring confidence on the part of our traditional and potential partners will serve to maintain and strengthen the efforts of all concerned in the Expanded Programme on Immunization, ensuring that all mothers and children, irrespective of social class or ethnic origin, receive the benefits of free immunization during and even beyond the period of support by GAVI.

Given this commitment, a high level of coverage should be expected over the course of time.

BUJUMBURA, le 28 Novembre 2003

Le Ministre de la Santé Publique

Dr Jean KAMANA

Le Ministre des Finances

Athanase GAHUNGU

ANNEXES

Annex I : Table of economic and financial targets 2002-2006

Annex II : Organization chart of the EPI

Annex III : Section 3 tables:

- Table 3.1 : Budget for the base year 2001
- Table 3.2 : Budget for the year in progress 2002
- Figures 1-5 : Profile of cost of EPI (2001 and 2002)

Annex IV : Basic projections

Annex V : Introduction of the two-injection DTP-Hib6HepB

Annex VI : Introduction of the DTP-HepB

Annex VII : Spread of GAVI funds over 8 years

Annex VIII : Increase in the government contribution

EPI ORGANISATION CHART
(Burundi)