Organisation	Date	Reporting period
Embassy of the Kingdom of the Netherlands, Bujumbura, Burundi	June 2016	2015

Activity		2015	Implemented by		Result area	Rio marker		Gender marker
Number	Name	Actual expenditure	Name organisation	Channel	Result area	Mitigation/Adaptation	Significant/principal	Significant/principal
24751	SEXUAL & REPR HEALTH & RIGHTS	944.972	HealthNet TPO	NGO	Rights and respect	Not applicable	[…]	Significant
25428	Expanding Family Planning and Integrated Health Services in Burundi	884.547	PSI (Population Services International)	NGO	Health commodities	Not applicable	Not applicable	Significant
25770	Biraturaba Project for Youth and SRHR (Kirundi of "It concerns us all")	1.134.016	CARE International Burundi	NGO	Youth, information and choice	Not applicable	Not applicable	Significant
26887	SRHR commodity support (II)	0	UNFPA	Multilateral organisation	Quality healthcare services	Not applicable	Not applicable	Significant
27903	Joint program for Youth with a focus on Comprehensive Sexuality Education	1.486.868	Consortium CARE- UNFPA- Cordaid-Rutgers	PPP or network	Youth, information and choice	Not applicable	Not applicable	Significant

Result Area 1	Youth, information and choice
Result question 1a: To what extent are young people better informed? What evidence is there that they are making healthier choices regarding their sexuality?	Young people comprehensive knowledge on HIV/Aids are being translated into practice and positive behavior change: an increase of 18,6% is noticed on condoms use: 11.335.000 condoms (compared to 9,5 million in 2014). 31% of these are contributed by NL supported private sector (26,6% from PSI; 3,1% through community based distribution). Female condoms are still very little used (0,57% through Link Up project) . As a result of our support, Comprehesive Sexuality Education (with HIV component) now starts to reach schools (5% of schools in 2015), including teachers and parents, and out of schools. Health centers are prepared to offer quality of (info and) services to young people to adress teenage pregnancies in primary school (still 3% higher compared to 2014), resulting 9,4% young girls school drop outs. As a result of our support, 849 new kiosks (131 in 2014) are selling subsidized condoms, this brings the total number of private condoms kiosks to 3940.

Indicator	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Result 2015	Results 2016	Source
Indicator 1: Percentage using condoms at last high-risk sex, by age group (MDG indicator 6.2)	Age 15-24: M: 4% (HIV),1.3% not F: 12%(HIV);1.7% not	NA	NA	NA	Age 15-19:17,6%. Age 15-24 (M: 25.4%, F: 8.7%)	general increase of condoms use of 18,6% compared to previous year		MoHealth data
Indicator 2: Percentage of young people (15-24) with comprehensive correct knowledge of HIV/aids (MDG indicator 6.3)	Age 15-49: M: NA F: 30.2%	"HIV new infection reduced to 60%"MoH	Age 15-49: M:47% F: 45%	NA	Age: 15-24 M:46% F: 28.4%	All age: 48% (Age: 15-24 NA)		MoH/ CNLS
Indicator 3: Adolescents fertility rate, Teenage unwanted pregnancies	11% of under 19y girls started their procreative life (national)	8 % MoH + (UNFPA slogan: "zero pregnancy at school")	2300 pregnancies in primary school in year 2012. National,	2356 in year 2013; ("21597 early pregnancies with 434 school drop out" Cordaid provinces)	2351 in year 2014 (1"7184 early pregnancies with 969 school drop out" Cordaid provinces)	2424 pregnancies in primary school , and 60% of sexually abused are girls under 20		UNFPA

Result question 1b: (1) With which results has your programme contributed to comprehensive sexuality education for young people in and outside of school? **Result question 1b: (2) With which results have programmes contributed to opportunities for young people have their voice heard and stand up for their right?**	1) Effective adaptation and use of the World Start With Me (Comprehensive Sexuality Education) curricula in the country. More than 76 schools reached. Collaboration with UNICEF made " life skills training manual" available. Start of longer term 5 year CSE program. 25 "master trainers" on the "World starts with me" are now available; (2) 32 youth friendly center were newly supported (bringing the total to 202). Various approaches have been utilized: dance/ drama, community theatre, football game, cinema, competitions, SRHR informations sharing via SMS, TV show and group focus exchanges (male and female groups). Radio provide opportunity where youth could ask questions and through these programs they were able to address their worries regarding their sexual and reproductive health. Youth fora, international day of the African Child are used to make their voices heard and their rights known. Subsidized (and recyclable) sanitary pads were made available alleviate girls' challenges on managing menstruation. "Social cohesion approach" is used to prevent (all forms of) violence and to address youth SRHR. EP-NUFFIC supported capacity building of a youth led organisation to combat sexual- and gender based violence through contemporary dance. Young people (m/f) demonstrate positive behavioural change on SRHR and a large number of men and boys are now considered as positive role models.. No significant increased case of sexual violence was reported by UNFPA/ UNWOMEN in community level, despite of Burundi post electoral turmoil and crisis. National (and International) SGBV Partners indicate that the worst scenario has been avoided in term of "SGBV used as weapon of intimidation in time of crisis".

Indicator	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Result 2015	Result 2016	Source
Indicator 1: Number (or %) of youth-friendly (health) centres	5 (2008) IPPF	60% of existing health facilities	10 (national)	157 (from NL funded programme)	170 (from NL support)	202 (with 32 newly eqquiped)		NL partners (Hnet+Care+ Cordaid+ ABS+ PSI)
Indicator 2: Number of youth (10-24) using sexual and reproductive health services by organisation supported. (Ref. Total number of 10-24 Burundian youth =34%= 3.349.000)	13% (MoH, UNFPA) 12% (HNetTPO)	NA	NA	33% youth (from NI funded programme)	55.6% youth (Male 34%, Fem 21.6%)	69,6%		H Net TPO (sample of 3 provinces/ 18)
Indicator 3: Number of youth that receive sexuality education in school.(Ref. Total number of 10-24 Burundian youth =34%= 3.349.000)	M:97%, F: 86% (Cordaid Survey 2014 in limited number of provinces)	34% of all 10-24 youth (2020)	NA	1.7% (NL funded programme contribution)	39% (NL funded programme contribution)	45% (NL funded programme contribution)		Cordaid
Indicator 4: Number of youth (10-24) out of school reached with information on sexuality, HIV, STIs, pregnancy, contraceptives. (Ref. Total number of 10-24 Burundian youth =34%= 3.349.000)	M:25%, F:11.3% (Cordaid Survey 2014)	34% of all 10-24 youth (2020)	NA	2% (NI funded programme)	3.5% (NL funded programme)	5,2%		Cordaid
Indicator 5: Engaging men and boys in SRHR and promoting positive manhood as expressed in no. of male role models	NA	NA	NA	500 adult couple officiating marriage	120 role models (men and boys)	7600 role models (men and boys)		HNet TPO (sample of 3 provinces/ 18)
Indicator 6: Number (and %) of teenage girls (<20) that are pregnant or have a child	NA	NA	NA	NA	NA	9,4% girls drop out because of pregnancy		HNet TPO (sample of 3 provinces/ 18)
Indicator 7: Number of schools that adopt comprehensive sexuality education	NA	Target 2020: 33% of schools wil be directly targeted.	NA	NA	NA	76 schools out of 1475 (5%)		Care (9 provinces/ 18)

Assessment of results achieved by NL across the entire Result Area 1	Youth, information and choice
Assess achieved results compared to planning:	B. Results achieved as planned
Reasons for result achieved:	Despite of the 2015 post electoral crisis in Burundi, 3month interruption of 2015 school year, results are achieved as planned. Dutch Strategic partners with different expertise (Health, Education, Youth and Community) worked together to effectively institutionalize Comprehensive Sexuality Education (CSE). Availability of 26 master trainers on the "World Starts With Me" (WSWM) indicates a promising start. Availability and improved access to condoms and contraceptives (public, private, community level) helped addressing the Youth needs. The synergy of programs maximized the impact of Dutch support in SRHR. All programs used a combination of gender sensitive strategies and economic empowermentt (Village Saving and Loans) to better reach/ attract youth, in particular adolescent girls. Mix of school based -and community based (social cohesion approaches, groupe de parole etc) approaches that are socially attractivewere used as entry points to discuss relevant issues of SRHR/HIV-Aids and SGBV.
Implications for planning:	Further intensive & coordinated training, using a cascade approach, with the 3 themes and network of School- Community- Health structures will follow to complete the package of "strategic and multi-sectoral pool of CSE trainers. More "influential community members" (including parents, religious leader etc), health providers, including peer educators will be trained on CSE. Close cooperation between the Dutch strategic partners and consortium members (Care, Cordaid, UNFPA, Rutgers) with MoH, MoE, MoY and Gender Ministries etc) will be strengthened. The new joint program on CSE will be the backbone of support to stimulate the "demand side" for the coming 5 years. With regard to the "supply side", continuation of support to private sector (possible 2nd phase with Population Services International (PSI) to increase access to quality of SRHR services, making "Tunza private clinics" more attractive and youth friendly is foreseen. International HIV Alliance will continue supporting HIV/ Aids local partners with more focused Youth approach to address needs of key populations in community level. EKN, PSI and UNFPA will negociate MoH to include "contraceptive Prevalence Rate - modern methods- all girls 15-19" in the national routine data. Dialogue with influential community members (religious leaders and parents/ educators etc) on SRHR remains a challenge and a necessity.

Result Area 2	Health commodities
Result question 2a: To what extent do more people have access to anti-retroviral drugs, contraceptives and other commodities required for good sexual and reproductive health?	Contraceptives are available in the country. Acceptants for vasectomy increased, in collaboration with UNFPA. Contraceptive Prevalence Rate is 3,1% higher compared to the previous year. As a result of our support, contraceptive use has significantly doubled in some of NL working province: Bujumbura Rural from 18% (2014) to 36% (2015). 43 private clinics (called "Tunza") were accredited by PSI to offer quality and non- stop SRHR care. Through Cordaid, 20 "Post Secondaire" have been maintained complementing SRHR services provision next to religious health centers; 180 young entrepreneurs conducted house to house visits to provide SRHR information (and to sell health products). Via PSI, 849 new kiosks (131 in 2014) are selling subsidized condoms, this brings the total number of private condoms kiosks to 3940; Link Up project and Pathfinder International (PSI field partner) are active at community level. All with an aim to increase access to condoms and contraceptives in all level. 2015 planned Demographic Health Survey did not take place because of Burundi instability and post electoral crisis that affected planning,funding and implementation. Unmet need for family planing of girls 15-19y, 20% poorest and 20% richest is not available. Different source indicate different data (projection) population density [342 to 413/ Km2], official data wil be confirmed by the 2018 general population census. Dutch SRHR support does not explicitly provide HIV drugs or care. HIV/Aids information is addressed as an integral part of SRHR. Access to HIV care is improving, according to MoH routine data.

Indicator	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Result 2015	Result 2016	Source
Indicator 1: Contraceptive Prevalence Rate - modern methods- all married women 15-49 in developing regions	13%	Initially 40% (2015), changed to 40% in 2017 50% (2020); 60% (3 child/woman) 2025	25,30%	30,80%	National 34.3%, with weakness in Bujumbura Rural 18%	national 37,4% , with a significant increase (doubling) in Bujumbura Province 36%		MoH 2015 / Bilan PNSR . Only 297 731 new users of contraceptives en 2015, 3,9% decreasee compared to 2014
Indicator 2: Contraceptive Prevalence Rate - modern methods- all girls 15-19	2%	NA	NA	NA	16.2% both male and female aged 15-19 use FP meth	" 6% of clients benefiting from contraceptives are15-19y" PSI supported clinics.		This is not a routine data for MoH. DHS III delayed.
Indicator 3: Unmet need for family planning of married women 15-49 years old	31%	25% (2195)	NA	NA	26% (average in 3 provinces)	NA.		This is not a routine data for MoH. DHS III delayed
Indicator 4: Unmet need for family planning of girls 15-19 years old	19%	NA	NA	NA	Age 15-24:M:12% F: 16% ONLY use FP methods	NA		This is not a routine data for MoH. DHS III delayed
Indicator 5: Demography, population density (hab /Km2)	310 hab/Km2 = 8 053 574	decreased fertility rate from 6 to 3 kids /women(2015)	327 hab /Km2	NA	348 hab /Km2 (projection by local research institute); 388 hab/Km2 according to the World Bank	342 hab /Km2 (Data used by MoH= 9507983 pop); 413 hab /Km2 (other source= 11 510 000 pop)		Source are different, data are different. Most of them are just a projection. DHS III (delayed) will confirm. World Bank data NA in 2015
Indicator 6: Proportion and number of the access to antiretroviral therapy of people living with HIV (MDG indicator 6.5), in developing regions	NA	HIV Aids death related reduced to 50%, New infection reduced to 60%	NA	NA	21,95% < 15 y; 62,1% adults	74,35% < 15y; 90,59% adults		MoH

Result question 2b: (1) With which results have programmes contributed to a greater choice in and sufficient availability of contraceptives/medicines? **Result question 2b: (2) With which results have sociocultural barriers preventing women from using contraceptives been addressed?**	1) Through supply of contraceptives (implants, anesthethics to the public sector; pills, IUD, injectables and condoms to private sector), post abortion care (medecine and equipment) a greater choice in, and sufficient availability of commodities and SRHR care are in place. Health providers (including community health workers) are trained on contraceptive technology. Health Districts staff were capacitated to improve the supply chain management of commodities and avoid stock out. NL contribution to the national CYP is 54%, in which 8% contribution from NL supported private sector. Access and availability of SRHR services were improved via Secondary Health Posts (adjacent to confessional clincs), Tunza (accredited/private) clinics and supported community based distribution of commodities and condoms. (2) Various interventions have been undertaken and intensified at different levels with the involvement of different stakeholders through "community strengthening systems" approach: community networks were set up, training and mobilization of influent community members, door to door/awareness raising on the FP methods. Radio is airing a very popular soap (Agashi) with 90% of listening rate, key message focus on the importance of family planning. Economic empowerment mechanism is put in place to address girls and women's basic needs and increased self esteeem, resulting in better decisionmaking on the use of modern contraceptives.

Indicator	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Result 2015	Result 2016	Source
Indicator 1: Number and type of new, user-friendly products / medicines on the market for improved sexual and reproductive health	1 ("prudence class" condom)	5: Implants, "Confiance" (pill), IUD, misoprostol, MVA	1 ("prudence class" condom)	1 ("prudence class" condom)	3: Implant, IUD, Confiance	6		Supported Private sector (PSI) with 2 new molecules/ products: misoprostol and post abortion care equipment (MVA)+ CYP new from NL: tbc (25,4% en 2015 against 25,8% en 2014), with 42,000 from the Dutch supported priovate sector (8%)
Indicator 2: Number of couples protected by various contraceptives (Couple Year Protection = CYP)	359102 (National)	Increased nb/ year to reach 3 child/ women in 2025	438276 (National)	152042 (NL contribution= 22,7% of the national)	100294: NL contribution is 17% of national number	285,000: NL contribution is 54% of national number		
Indicator 3: Number of legal marriage taking place after SGBV raising awareness event	NA	Increased number	NA	500 (as result of our programme)	NA	NA		HNet TPO. Data not available on time
Indicator 4: Contraceptive abandoning rate	13% of women	Decreased percentage	NA	11,9% of women	Age 15-19: F: 20% Age 20-24: F 34%	Decrease of 14,6% of Implants use, Decrease of 23% of IUD. Some withdrawal are due to expiration date. (But increse of vasectomy)		MoH (withdrawal of Implants and IUD are known because clients has to go to health structures. Other form of abandon not).
Indicator 5: Number of single mother empowered	NA	NA	NA	NA	868	Up to 50.000 women (including adolescent girls) economically empowered and informed (SRHR, business skills)/ total 50.000		Hnet TPO, Care, Cordaid
Indicator 6: Number of people reached with information on sociocultural barriers regarding family planning	M: 66% F: 44% (DHS 2010)	M: 90% F: 85%	NA	NA	NA	90%		PSI/ Agashi listening rate
Indicator 7: Number of male and female condoms distributed	NA	13.860.000 (2015)	NA	10.020.000 national	9.780.000 National (NL contribution 50%)	11.335.000 national (NL contribution of male condoma M: 31 % ; Female condoms: 0,57%)		MoH versus [PSI + ABS]

Assessment of results achieved by NL across the entire Result Area 2	Health commodities
Assess achieved results compared to planning:	B. Results achieved as planned
Reasons for result achieved:	Key support on contraceptive (and other commodities) supply, the strategic combination of public, private and community approach that improving access to contraceptives & other commodities. Capacity building of the decentralized level of the Health System was key to improve quality of SRHR service provision. Mix of approaches including community mobilization, information campaigns and use of media and training healthworkers to adapt more youth friendly SRHR services contributed to positive results. Some other (basic but very useful) elements such as production of subsidized recyclable sanitary pads were put in place by supported local Partners (SaCoDe) to help young girls and women addressing their menstruation, as this was identified among reasons that decrease girls' school attendance and performance.
Implications for planning:	For better impact of SRHR programmes in Burundi it is essential and a critical condition for success that there will be peace and stabillity in Burundi and that donors will continue to fund the health sector. Performance of private sector needs to be boosted. How to increase the willingness to pay for healh commodity from the population-remains as a challenge. Focus will be put on strategic balance and mix: Public and Private sector, Supply and Demand side, Health & Education, Gender & Social protection (economic empowerment. etc). Mobilisation campaign coupled with capacity building of health providers will be continued to attract more new users of contraceptives as although the contraceptive coverage increased (due to switch to more clients to vasectomy), new users of implants and IUD indicated 3,9% decrease. Feasibility of smaller projects that will put together proven best practices (such as Sociotherapy etc) are under analysis by the Embassy as 3 main projects will end in 2016. Technical support will be given to the national supply chain management system (close coach to Health District) to avoid over stock, expiration of health products as only 61% of public health strucures could offer all ranges of contraceptives in 2015. Build capacity of medical professionel to increase access to contraceptive surgeries. 48 referral hospitals (out of 64) will be capacitated in 2016 and 2017 to be able to offer these services. Dialogue with community leaders will be intensified to help minimizing negative impact from confusing messages on family planning (eg. negative rumors invited contraceptives users to withdraw their implants as they were tagged to be "spy device/ GPS"). On a strategic and policy level we will support MoH to update the SRHR Strategic plan 2016-2020. This remains a challenge as the Plan National de Developpement Sanitaire is expired and will not be updated before 2018, the DHS III (and PRSP III) delayed.

Result Area 3	Quality healthcare services
Result question 3a: To what extent has the use of sexual and reproductive healthcare services in the public and private sector improved?	Pregnant women still tend to start antenatal care late (i.e. only 16.5% of women start their first antenatal visit during the first trimester of their pregnancies): Four antenatal care visit per pregnancy is low 34,7%, Three visits are 66,4%; Two antenatal visits are 86,6%, and one single visit has been reported as 100% (i.e all Burundian women). Despite of the " delay of start", 2015 data is improving. In cooperation with NL supported partners (private sector and NGOs), the quality of integrated health messages has been improved and expanded, to contribute to this better attendance. Access to anti-retro viral therapy for pregnant mothers is increasing. GoB committment to contribute to vaccine supply was always good compared to contraceptives. The GoB committed in 2014 to increase the budget for contraceptive commodities supply with 10% from 2015 onwards. This comittmment was honored via purchase of male condoms in 2015. Government's budget allocated to health sector however decreased from 12,92% to 5.1% while local currency seriously suffered from devaluation/ depreciation.

Indicator	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Result 2015	Result 2016	Source
Indicator 1: Antenatal care coverage of at least one visit (MDG indicator 5.5)	1 visit: 100%	100%	100%	100%	100%	100%		MoH/ Bilan PNSR 2015
Indicator 2: Antenatal care coverage of at least four visits (MDG indicator 5.5)	3 visits 66,1%	4 visits 50% (2015)	3 visits 61%	3 visits 63,7%	3 visits 62,4%; 4 visits: 23%	3 visits 66,4%; 4 visits: 34,7%		MoH/ Bilan PNSR 2015
Indicator 3: Proportion of births attended by skilled health personnel (MDG indicator 5.2)	54% (2009) 60.4% (2010) 70.9%(2011)	76% (2014) 80%(2015)	64.4%	74%	76%	78,5%		MoH/ Bilan PNSR 2015
Indicator 4: Percentage of HIV-positive pregnant women receiving treatment to prevent mother-to-child transmission of HIV	15% (2010) 38% (2011)	98% (2015)	42%	57.9%	72.3%	75,8%.		MoH/ SEP -CNLS
Indicator 5: Percentage of government's budget allocated to health sector	8.8%	15% (2015)	8.1%	11.1% (equiv 55 mln Eur)	12.92% (equiv 100 mln Eur)	5.1% (equiv 40 mln Euro)		GoV. Operational conversion rate is 1 Euro= 2200 Bif (= BIF devalustion in 2015).
Indicator 6: Percentage of births attended by skilled health personnel	59.9% (2010); 64,4% (2011)	85% in 2015	68%	72,9%.	76,5%	78,7%		MoH/ Bilan PNSR

Result question 3b: (1) With which results has your programme contributed to improved cooperation between public and private healthcare services? **Result question 3b: (2) With which results has sexual and reproductive health care including emergency obstetric care become more affordable and accessible?**	(1) As a consequence of our support to both PSI, Cordaid and HealthNetTPO, MoH more and more recognizes the added value and need for public private cooperation to effectively address the huge needs for SRHR and demographic challenges (i.e. high population growth). Innovative approaches of public private cooperation included "Movercado" (SMS, vouchers, mobile phone), kiosks, social franchising and support to youth entrepreneurs (Healthy Entrepreneurs programme). Synergy building between activities, partners/sectors and between EKN spearheads was among our focus. All NL contracting & strategic Partners have a staff policy in place that contributes to the sustainability, accessibility and quality of the health system. This includes PSI/ Tunza, CARE, UNFPA, Cordaid. Smaller INGO like I Plus solutions is actively investing on quality of health system. For its very first time in Burundi, a National guidelines on Quality Assurance of Drugs and other pharmaceutical products was developed under NL funding in collaboration with I Plus Solutions (Cordaid consortium member). (2) Dutch SRHR support does not explicitly address BEmOC but Burundi 2015 target is reached according UNFPA- MoH data.

Indicator	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Result 2015	Result 2016	Source
Indicator 1: Number of doctors, nurses and midwives per 1000 inhabitants	0.03 doctors, 0.02 nurses & midwives/00	1 MD/ 00, 1 nurse/5.000 1 midwife/5000hab	0.05 doctors, 0.6 nurses and midwives/00	0.054 doctors, 0.7 nurses/00; 0.008 midwife/00	NA	NA		NA because of delayed DHS III
Indicator 2: Access to basic emergency obstetric care (BEmOC) per 500,000 population	0,28	66 health structures offer BeMoc, 45 offer CEmOC (2015)	NA	57 (=7,5%)of health structures offer BEmOC. 46 (=5,4%) CEmOC	NA	65 health facilities offre BEmOC, 46 hospitals offer CEmOC		UNFPA enquete SPSR
Indicator 3: Number of kiosks or Post Secondary service for family planning (FP) services next to the FP restricting health facilities	5 (2010)	15 national, 15 Cordaid, 60 tunza PSI (2016)	9 (national)	9 (from our programme)	20 post secondaire,131 new condom kiosk, 75 new Entrepreneurs	20 post secondaire maintained, 105 new Youth entrepreneurs; 840 new kiosks (bringing the total nb of kiosks to 3940)		Cordaid
Indicator 4: Number of health staff and community health workers trained in ante- and post natal care, safe deliveries and basic health care	NA	NA	NA	NA	NA	275 new trained health staff on contraceptive technology, 300 community agents		NL partners/ programs (20% of training in contraceptive technology in national level is NL funded)
Indicator 5: Partners have a staff policy in place that contributes to the sustainability, accessibility and quality of the health system	This is among NL criteria selection of "strategic Partners"	NA	NA	All NL contracting & strategic Partners have a staff policy in place that contributes to the sustainability, accessibility and quality of the health system	All NL contracting & strategic Partners have a staff policy in place that contributes to the sustainability, accessibility and quality of the health system	PSI/ Tunza, CARE, UNFPA, HNet TPO, Cordaid. Smaller INGO like I Plus solutions invest on quality of health system		Cordaid
Indicator 6: Percentage of maternal health facilities with an increase in satisfaction by women	NA	NA	NA	NA	NA	95% expressed positive satisfaction on cleanliness, time allocated by health providers, confidentiality, family planing service provision		MoH- UNFPA (enquete SPSR in SRHR health facilities- not limited to maternal health)

Assessment of results achieved by NL across the entire Result Area 3	Quality healthcare services
Assess achieved results compared to planning:	B. Results achieved as planned
Reasons for result achieved:	Training (and coaching of Health Districts) of health providers of both public and private health centres resulted in making SRH services more accessible for especially young men and women. Performance Based Financing approach also has contributed to incentives to improve the quality and availability of SRH services. Close cooperation with both public and private sector at technical AND strategic (policy) level resulted in a growing government understanding and commitment of the benefit of joint cooperation to address the need for better and increased SRHR services more effectively.
Implications for planning:	Cooperation between GoN, GoB (MoH) and PSI (social marketing) is expected to contribute to improved cooperation between public, private and religious based health care services, resulting in better, and more accessible, sexual and reproductive health care.The concept of accredited private clincs, the socalled "Tunza clinics" will be further promoted and expanded to provide better access to reliable SRH services that will include BEmOC, Post abortion Care, cervical cancer testing. Increased number of kiosks at more rural villages- and community level that will provide condoms to address the expressed needs of young people will be enhanced. The focus on better access and quailty SRH services for adolescents and young men and women will further be strengthened. Synergy building via "activity integration between partners/sectors/ between EKN spearheads" will be further explored (through " Bujumbura 2016 portfolio review") to maximize impact.

Result Area 4	Rights and respect
Result question 4a: To what extent have the conditions for women, young people, sexual minorities, sex workers and intravenous drug users improved with regards to their sexual and reproductive rights?	Conditions are improving although the R of SRHR (Rights) ans SGBV remain a challenge. Any report of persons imprisoned because of homosexuality (where criminalised by law), LGBT were received. Through NL support via Link up project (that involve Youth led association RNJ+), sexual minorities do have now a center (including health care and recreational). 15550 key populations (PLHA, MSM, sex workers) received clinical health services in 2015. Taboos linked to socio- cultural norms and policies are slow to change. Sex workers are often abused and assaulted by national security force. LGBTs are still actively discriminated. Female genital mutilation is not applicable for Burundi. Abortion remains illegal in Burundi, except for life threatening issues. Clandestine abortion resulting life threatening complications are numerous but is under reported. Post abortion care are available but remain actively stigmatized (even by health providers). Because of poor status, limited education and economic dependency of youth (mostly girls) and women, they remain vulnerable for sexual and gender based violence (SGBV). Addiction with drugs is not yet reported as public health issue but WHO plans to put in place a law forbiding drugs' use to prevent Burundi from becoming a hub for drug use traffickers.

Indicator	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Result 2015	Result 2016	Source
Indicator 1: Percentage of women married before age 18 in 20-24 year age group	20.4% (with 2.8% under 15y age)	NA	8% (7% urban, 9% rural)	NA	15% (average of 3 provinces)	22%		HNet? (sampling of 3 provinces/ 18)
Indicator 2: Number of persons imprisoned because of homosexuality (where criminalised by law) versus Number of LGBT reported to be assaulted / imprisoned	NA	NA	NA	3 arrests +Meeting in support of LGBTI cancelled.	4 transgenders threatened, 1 lesbian arrest, 2 persecuted and fled out of the country	zero case reported		LGBT association

Result question 4b: (1) With which results has your programme contributed to the identification of or changes in legal and policy barriers for the sexual and reproductive health of women, young (unmarried) people, sexual minorities, intravenous drug users and sex workers? **Result question 4b: (2) With which results has your programme contributed to improving the access of these specific groups to sexual and reproductive health services and commodities?**	(1) The Netherlands supported programmes do not explicitly focus on the identification of, or changes in, legal and policy barriers for the sexual and reproductive health of women, young (unmarried) people, sexual minorities, intravenous drug users. We rather focus on capacity buliding of local partners (CSO, NGO) - still fragiles as not yet recovering from years of older crisis that the country experienced for them to be a voice and actors for positive change. Through policy dialogue, the Embassy always put emphasize on the importance of gender equality, universal health care and joint efforts needed for a greater respect of human rights. We expect that it will take some time before significant changes in attitude and behavior towards these specific groups will take place. (2) All programs report that communities are now more sensitized on issues of sexual- and gender based violence (SGBV), and youth (including girls and women) Rights. With a holistic approach, Link up project and partners are adressing (social and health) needs of sex workers and sexual minorities and people living with HIV. are made available in 3940 PSI kiosks, via 180 Youth entrepreneurs and approx. 400 "franchisers" (small shops). Free condoms (and low price condoms) are accessible through community distribution and within youth club. Community members and community leaders are participating in SRHR awareness-raising activities at community level. More and more community leaders (and parents) are involved in realisation of SRHR in targeted communities.

Indicator	Baseline	Target 2017	Result 2012	Result 2013	Result 2014	Result 2015	Result 2016	Source
Indicator 1: Perceived change in public statements made by leaders / personalities advocating for sexual and reproductive rights	Contradictory msg on family planing from churches	Catholic churches becoming Allies for SRHR	NA	Dialogues held with religious com, Ombudsman	Youth need Comprehensive Sexuality Education	Youth (school, out of school) need Comprehensive Sexuality Education. Health providers and parents need support to contribute in fortering enabling environement		UN agencies and Government speech
Indicator 2: Number of key populations having received sexual and reproductive health services and information	NA	36085 target by Link Up project (2015)	NA: EKN support has just started	307	1.349	15550		ABS/ L:ink up project
Indicator 3: Number of women /men that think it is normal to be punished /beaten if they refuse sex	F: 74%, M: 44% F: 69%, M: 40%	Decreased number which tends towards zero	NA	NA	48% of women (average 3 province/18) 2261 cases of SGBV reported(total 3 prov/18),	42%		HNet TPO (3 provinces/ 18)

Assessment of results achieved by NL across the entire Result Area 4	Rights and respect
Assess achieved results compared to planning:	B. Results achieved as planned
Reasons for result achieved:	The growing synergy among partners and programmes and the strong engagement of civil society, including youth led groups, combined with a variety of approaches have been the main reasons for results achieved. The mix of approaches of community based approaches (economic empowerment), community mobilization, focused group meetings, peer group educators and individual care has proven to be beneficial. Moreover the use of "public diplomacy" , with the support of all EKN staff including the ambassador, is essential to be able to contribute to policy change in sensitive areas of human rights and SRH. Continuous connection with LGBT group is maintained to keep the embassy informed about LGBT situation and their development.
Implications for planning:	The Netherlands Embassy will intensify its focus on support to young people and marginalized groups, who enjoy little social protection, which affects their SRHR overall health and social status. Linkages will be strengthened with the Security Sector Development programme (peace keeping and security) on human rights issues and, Food security (land rights for women) as well as gender issues. Diplomacy and advocacy in these areas will remain as a focus. Given the youth (and adults!) continuous needs of SRHR appropriate information and service, girls dropping out of school due to early pregnancies, greater attention will be given to comprehensive sexuality education through a strategy partnership. This new programme is aimed at impacting positively on behaviour change, fostering an empowered new generation of Burundians and tackle at the same time the high demography challenge. All activities will continue to adress the "endemic gender inequality and gender-based violence". Beyond SRHR, the embassy will do whatever is possible to promote peace, equity& equality of chance and for the respect of (general) human rights in Burundi as this negatively impact SRHR indicators. Contraceptive use in Burundi will hardly increase if thousands of family (225 000 people according to the European Comission) in reproductive age keep on flying out of the country (political persecussion started 2015), hundreds of men died, many disappears/ jailed. Equity/ equality of opportunity will remain a challenge where poverty is endemic, SGBV (resulting early pregnancies) is hard to prevent/ tackle when basic (social/ economic) needs of adolescents girls (and women) are not met, as they are exposed to accept unprotected sex for food or money. High level Policy Dialogue will be continued to improve working environment: NGOs and CSO need to work freely, international technical assistants need secure environment to travel/work, less working restriction with banks is desired, more local capacity building / transfer skills are needed.