Agreement for Performance of Work

Support services to enable country level collaboration for improved institutional frameworks in the area of health financing systems

BURUNDI Summary

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by

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2. ANALYSIS :

(i) Constitutional/Legal/Governance Challenges:

● The Burundi's Constitution of 2018 recognizes a "right to health". Article 44 clearly states that "Every child has the right to particular measures to assure or improve the necessary cares for their well-being, health, physical security, and for being protected from poor treatment, extortions, or exploitation" and Article 55 further states that "Every person has the right to access health care".

● However, in practice, the right to heath is still not effective. Legal protection has been jeopardized by years of conflict aggravated by the socio-political crisis that the country experienced in 2015. Burundi continues to be marked by situations of fragility and is characterised by a low score on the human development index, weak institutional capacity, various forms of social inequality, an inadequate infrastructure network and high vulnerability to external shocks.

● From an institutional perspective, there are notable challenges within the structures of Burundi's health system[1]. The central level lacks sufficient

[1] Governance of the health system is organized in a three tiered, hierarchical, pyramidal structure: (i) Central level includes the Office of the Minister, a General Health Inspectorate, two general

human and financial resources, notably, a lack of midwives, while the sharing of duties between provincial and district health bureaux results in the inefficient allocation of resources and lack of adequate supervision. There is high use of hospitals and under-utilization of health centres, due to the fact that health facilities at all levels offer the minimum package of services[2].

● The financing of health services is not as efficient as it could be due to the multiple health system levels (Central, Intermediary/Province, and Peripheral/District). The three main layers of administration and associated administrative institutions for a country of Burundi's size and population density, are indeed relatively costly and inefficient.

(ii) Political and Socio-Economic Challenges:

● Burundi is one of the poorest countries in the world and one of the most densely populated countries in Africa. More than two thirds of Burundian children live in poverty. Socio-political and economic crisis have had a serious impact on the population's access to basic services and the resilience of

directorates, specific institutions, six departments, nine health programmes, and related services. As a result of the merger of the two ministries and an institutional audit in 2009, there is now also a Permanent Secretariat, a general directorate of planning, and monitoring and evaluation, and a national integrated programme to deal with HIV and AIDS; (ii) Intermediate level includes 17 provincial health bureaux, which are responsible for coordinating the health activities of their respective provinces, supporting health districts, and ensuring collaboration between sectors; (iii) Peripheral level includes 45 health districts, with each district covering two to three cities of 100 000 to 150 000 residents each. The health district is the operational unit of the health system and includes the community level health centres, and district hospitals that serve as the first point of contact. In addition to the above governance structure, the care network is organized into four levels: (i) Health centres serve as the point of entry into the health system, offering a minimum package of services that includes treatment and prevention consultation services, laboratory services, pharmacies, health promotion and health education, and in-patient observation; (ii) District hospitals serve as the first reference and offers outpatient consultation, emergency services, hospitalization, specialized techniques, diagnosis and support services. District hospitals offer both the minimum package of services and a supplemental package; (iii) Second-reference hospitals serve to supplement the package of services by offering certain specialized care. The legal framework for operating the second reference hospitals and package of care are not yet well defined. And (iv) National reference hospitals offer care not provided at other levels, such as specialized investigations and treatment. National hospitals offer the minimum package of care, which is also available at health centres.

[2] Nine of the 45 districts lack hospitals, and not all are able to provide the package of services, with 45% of health centres only offering a minimum package. Lack of equipment and supplies, and uneven distribution of infrastructure and personnel (e.g. 50% of physicians and 21% of nurses work in Bujumbura) are also significant challenges.

systems and communities to cope with recurring crises[3]. Burundi actually experiences recurrent humanitarian crises, natural disasters such as floods, landslides and drought and population movements. In 2020, Burundi's fragile health system has to face with multiple health emergencies, including malaria, cholera, measles and COVID-19[4].

● Burundi's disease burden is characterized by a high prevalence of communicable diseases, a growing burden of non-communicable diseases, and the particular vulnerability of mothers, children and adolescents. Numerous social determinants of health remain significant challenges in improving Burundi's health outcomes, including widespread poverty posing a barrier to health-care access, and over 80% of patients incurring debt to pay health expenses[5].

● Despite substantial efforts made by the Government over the years to reduce inequalities in the health system, notably through the introduction of free health care and improved access to basic care, a lot remains to be done. In particular, inequalities and poor use of available resources do persist.

(iii) Financial Challenges:

● The Government of Burundi has made major efforts to raise the health of the poor and most vulnerable groups. A key milestone was the removal of user fees for children under five and deliveries implemented in May 2006. Burundi also piloted Performance-Based Financing (PBF) in three

[3] According to the Humanitarian Needs Overview, 2.3 million people in Burundi, including 1.3 million children are in urgent need of humanitarian assistance in 2021. Health indicators are low: (i) life expectancy, which was 57 years in 2014, dropped to 52.6 in 2017; (ii) the under-five mortality rate is 42 per 1000 live births; (iii) the incidence of malaria is 156 per 1,000 people at risk and that of tuberculosis is 114 per 100,000 people; (iv) HIV prevalence stands at 1,1%.

[4] Since 2018, the country has mobilized efforts to prevent and prepare for a potential spill over of the Ebola outbreak from the Democratic Republic of Congo. The threat of an Ebola outbreak remains significant, and Burundi still needs to continue to strengthen its capacity to respond. Burundi is still facing the COVID-19 pandemic. The country has already taken measures to contain the spread of the disease but must make greater efforts to assist those who are sick and to protect professionals on the frontline. The Ministry of Health and Fight Against Aids - *ministère de la Santé et de Lutte contre le SIDA* (MSPLS) has elaborated a national emergency plan to respond to the pandemic, with a budget of US$58 million.

[5] Lack of food security has led to malnutrition, with deficits in food production felt by the most vulnerable households. Lack of sanitation and potable water also affect health outcomes, both directly and indirectly through compromised quality of care at health centres that do not have access to running water.

provinces in 2006[6]. The strategy rapidly gained popularity and in April 2010, PBF was scaled up to the whole country[7].

● The institutional mechanisms of the national PBF system in Burundi are determined by a series of nine contracts. In collaboration with the Ministry of Public Health and Fight against AIDS - MSPLS (*Ministère de la Santé Publique et de la Lutte contre le SIDA*), the *Comité Provincial de Vérification et de Validation* (CPVV) is responsible for strategic purchasing, verification and coaching of health facilities. The CPVV contracts base level organizations to conduct community client satisfaction surveys under performance-based frameworks. Administrative structures are paid on a quarterly basis, depending on their performance results. Civil society and non-state actors are engaged at the central and provincial levels for technical assistance and capacity building, and at the base level for the community client surveys.

● Through the establishment of a budget line dedicated to Performance Based Performance for Free Health Care (PBF-FHC), the Government is seeking to contribute to the reliability and stability of financing. Despite encouraging results, PBF-FHC is faced with an important financial gap. In addition, health facilities are faced with cash shortages – placing them at risk of stock outs of both drugs and other inputs – caused by important reimbursement delays. Challenges to address financial sustainability include the reduction of PBF-FHC implementation costs, the mobilization of

[6] Performance-based financing is a strategy to improve the performance of health care providers through the use of explicit financial incentives for reaching targets on predefined performance measures related to the quantity and quality of health care services. Under performance-based financing, health care facilities are reimbursed retrospectively after verification of the quantity and quality of provided services. PBF is increasingly emerging as a vehicle for large reform of public health systems broader than just a modification of the provider payment mechanism.

[7] Burundi became the second country in Africa to implement PBF in the health sector after Rwanda. All public and most private non-profit health facilities in the country - Health Centres (HCs) and hospitals - are covered by the national PBF scheme. The program is governed by the *Cellule Technique FBP*, a technical group of the MSPLS. The Burundian PBF system reflects the main health priorities of the country and rests on contractual arrangements involving different parties: every month health facilities report their activities related to the incentivised indicators; these reports are reviewed and validated at the province level and then sent to the *Cellule Technique FBP* which approves transfers of subsidies to the health facilities. The completion of this process takes between two and three months. In addition, these activities are semi-annually randomly checked by community based organizations contracted to verify (via community surveys) the truthfulness of activities reported by HCs. Besides, qualitative indicators are used quarterly to assess the quality of the working environment and taken into account as bonuses or penalties for the amount of PBF subsidies transferred to each facility. The national PBF program is financed from several sources, with the Government and the World Bank (WB) being the largest and second largest sources of funding respectively.

Government and external resources, guaranteed regular payment of health facilities' invoices and the integration of PBF-FHC in the national health financing strategy.

● In addition, concerns recently emerged as to whether PBF is a cost-effective intervention and whether its effects outweigh its additional administrative burden. To answer this question, it would be necessary to identify the effects of PBF on health outcome measures such as maternal and child mortality. Also, further clarification is required on the issue of whether PBF mainly affects health care use and quality through expanded facility resources or through a change in provider incentives.

● The heavy reliance on out-of-pocket (OOP) expenditures from households is a problematic and inequitable aspect of the health system in Burundi, especially in the light of the extreme poverty of the majority of Burundian households. Despite some efforts to introduce exemption schemes for the poor by the Government (Medical Assistance Card or *Carte d'Assistance Maladie, CAM*) and by some Non-governmental Organizations (NGOs) in the provinces (for example, *Médecins Sans Frontières* in Karuzi), there are still serious concerns about the effectiveness of these schemes.

● The health budget is dominated by wages and salaries, as well as transfers and subsidies[8]. Representing almost 80% of budget allocations and of THE in 2010-2014, salaries, transfers, and subsidies increased throughout the pre-crisis period. The increase in transfers and subsidies has been heavily driven by the Government's contribution to the PBF program. The high level of PBF funding reflects the country's strong commitment to financing the free health care (FHC) program. The budget execution performance in the health sector has been strong overall but declined in 2015 and 2016 as a result of the crisis[9]. Budget execution by type of expenditure shows that salaries and transfers and subsidies were the best-performing types of expenditure.

- **Revenue Raising:**

● Domestic Revenue Mobilization (DRM) is led by the Burundi Revenue Authority (OBR)[10]. The health sector is the second top priority of the

[8] Budget allocations to MSPLS for fiscal year 2020/2021 consist of salaries, goods and services, transfers and subsidies, and investments.

[9] Releasing the budget in a timely manner is essential as an increase in the budget alone will not be sufficient if these resources are not spent.

[10] The introduction of the OBR has helped to create additional fiscal space to partially compensate for the declining budget support that accounted for 3.7 percent of GDP in 2010-2014 (annual average). In addition, to improve budget management in the MSPLS a General Directorate of Resources (DGR)

authorities[11]. On an average annual basis, it receives approximately 10% of the total domestically-funded budget. Donor aid is the main source of health sector, making Burundi particularly vulnerable to the fluctuation and unpredictability of aid flows[12]. For fiscal year 2020/2021, the share of external resources in the Total Health Budget (THB) represents 53.2%, against 46.8% for domestic resources. If domestic revenue mobilization has become more important over the last decade, tax efforts have not been enough to offset the effect of decreasing donor aid[13].

● Expenditure on health in Burundi remains low, mainly due to very low Government expenditure in the sector. Total health expenditure (THE) per capita in Burundi is estimated to be less than half the sub-Saharan Africa (SSA) average, below the World Health Organization (WHO) norm of USD $44, and lower than THE in other post conflict countries like Rwanda. Resources allocated to MSPLS increased in nominal value between 2011 and 2015. The share of the total state budget allocated to MSPLS is 13.6% in 2020/2021, compared with 10.8% in 2019/2020. Despite the Government's efforts to prioritize health, this budget share remains lower than the Abuja commitment[14]. Most of this expenditure is financed by foreign assistance which is the source of about 50% of it[15]. Government expenditure on health is

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was created in 2006. The DGR has strengthened the capacity of the MSPLS to manage resources, but weaknesses still remain. The MSP faces many challenges concerning budget planning, monitoring, and execution.

[11] An increase in the budget for peripheral health structures (health centres / hospitals), and in particular the strengthening of community health structures in the most resource-constrained zones, is necessary.

[12] Donor funding represents the main source of funding for four major national programs, including HIV/AIDS, vaccines, reproductive health and nutrition. A sizable portion of this aid is off-budget, adversely affecting aid predictability and monitoring.

[13] In 2016, external aid decreased by 86% and only the World Bank, Belgium and UNICEF are listed in the financial law as contributing Development Partners (DPs). However, regular exchange with DPs and with the Government reveals that not all external support is reflected and listed in the financial law. Most notably, the vaccine alliance GAVI and the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria are both actively scoping for alternative ways of continuing their support to Burundi's children and their families. Although the financial law may lack complete accuracy, it is an important indicator on how suspension and/or withdrawal of donor resources will impact the Government's ability to ensure access to essential health care services. Particularly, the PBF system which ensures free health care for pregnant women and children under 5, is heavily externally supported and depends on a few donors – in 2014, 48% of contributions come from donor-side.

[14] In terms of the national economy, budget allocations to MSPLS represent 3.3% of gross domestic product (GDP) in 2020/2021.

[15] Most foreign aid for the sector is extra-budgetary which makes it difficult to keep track of the levels and uses of these funds. There are many challenges surrounding foreign aid which limits its effectiveness. For instance, donor funds are unpredictable and highly volatile. It is therefore difficult

only about US$ 1 per capita, one of the lowest in SSA. The private sector finances the rest, mainly through household out-of-pocket (OOP) expenditure whose percentage is higher than WHO's recommendation of 15-20 percent[16]. This large OOP on health together with high poverty rates results in large financial barriers to access health care.

● More resources for the sector are needed to significantly progress towards the MDGs. However, the options to increase fiscal space for health are limited. Besides, since there is no pre-set amount earmarked for any sector, the share that will go to health will depend on the Government's commitment to this sector[17]. Likewise, increasing resources to the sector will not necessarily improve health outcomes, especially for the poor, unless the inefficiencies in the allocation of resources, and the weaknesses in public expenditure management (e.g. weaknesses in budget planning, monitoring, and execution [18]) are lessened. Besides, budget preparation is still fragmented [19]. It is also important for planning purposes to generate a consolidated account of all donor funds supporting the sector and progressively institutionalize National Health Accounts. The development of a Medium Term Expenditure Framework (MTEF) will facilitate this process. Finally, there is a need to build capacity for budget planning at different levels of the MSPLS, particularly at the provincial level.

- **Pooling[20]:**

● The financing of health and in particular access to health care in Burundi is made up of several financing mechanisms / schemes, the most important of which are financed by public expenditure. More than 60% of the

for the sectoral ministries to plan and budget activities. Similarly, this unpredictability and volatility coupled with the low maturity of external assistance to health also introduce major challenges to the sustainability of activities that are being financed as is the case of HIV/AIDS funding.

[16] More than 80% of the rural population could not afford to pay more than US$16 per year.

[17] It will be not just reflected in the original budget allocation but also in the total amounts that will be finally disbursed.

[18] The long delays of the Ministry of Finance to disburse HIPC funds limit considerably the execution of the budget.

[19] There is thus a need to consolidate the budget preparation not just in terms of recurrent and capital expenditure but also in terms of sources of funds.

[20] Pooling is the function of health financing which consists of pooling and managing the various funds collected by an organization to purchase services, with the aim of spreading the financial risk associated with the use of health services over a large number of people and by disconnecting the amount of payment from the costs of services consumed by households, hence the implicit insurance function. Pooling is the accumulation of funds for health care on behalf of a population before they get sick. The main rationale for pooling of funds is that health care costs are unpredictable.

Total Health Expenditures (THE) in 2018 goes through public administration schemes and compulsory contributory healthcare financing schemes, including free healthcare for children under five and women in maternity[21], free priority health programs, the Civil Service Mutual Insurance Fund (MFP)[22], the CAM[23] and the subsidy regime to the indigent[24].

- The Government has started to set up the two following mutual health insurance schemes: the MFP and the CAM. The MFP covers Government employees and their dependants, which comprise 10% of the population[25]. The CAM covers certain low-income populations, providing for 80% of the costs of laboratory tests, consultations and hospitalizations. However, the CAM does not cover medications. In addition, it should be pointed out that the Government has failed to reimburse certain providers,

[21] In order to facilitate access to health care and services for its population, the Government of Burundi has instituted since 2006 by Presidential Decree n°100/136 of 16 June 2006, revised by Decree n°100/38 of 16 March 2010 the subsidizing of health care for children under five and childbirth in public and associated health care structures.

[22] The Public Service Mutual Fund (MFP) was created by the Decree of June 27, 1980, and at the same time a Decree-Law has instituted a health insurance scheme for public and associated employees. Public administrative establishment (EPA) having administrative and financial autonomy, the MFP was tasked with organizing and administering this scheme.

[23] To improve access to healthcare for populations in the informal sector, the Government of Burundi has instituted by Ministerial Order No. 620/57 of March 20, 1984, a Medical Assistance Card (CAM) whose voluntary acquisition was open to any Burundian aged 21 whose activities were in the informal sector. This CAM covered initially the entire household (parents and all children under 18) for an annual contribution of 500 FBu (equivalent to 0.6 USD in 2001). Faced with the dysfunctions of the CAM during the period 1984-2012, the Second Vice-President of the Republic signed on 01/25/2012 Order No. 01/VP2/2012 reorganizing the medical assistance system in Burundi, aiming the populations of the informal and rural sector which represent approximately 2/3 of the Burundian population.

[24] The healthcare scheme for the indigents was introduced in Burundi simultaneously with the introduction of the CAM. Article 5 of the Decree instituting the CAM provides that "healthcare provided to indigents in possession of a certificate of indigence issued by the municipal administration will be supported by the State". This provision was clarified in 2003 by a ministerial ordinance which sets the conditions for the medical and health care expenses of indigent people and defines at the same time "indigents" as the following persons: "indigent children holding a certificate of schooling; any person deprived of everything without any assistance, unable to produce income and recognized as such by the local community". 20% of the financing is supported by the municipality and 80% by the central State. In 2012, a Decree of the second Vice-Presidency reorganized the healthcare scheme for the indigents, pointing out that "the indigent recognized as such by the community via the health committee (COSAN) and validated by the municipalities are fully supported by the Ministry having the national solidarity in its attributions".

[25] Specifically, the MFP covers 80% of the cost of services and pharmaceuticals and represents 15% of public expenditures.

discrediting the CAM as a means of payment and causing reluctance to offer care to CAM beneficiaries. Private insurance funds are so far undeveloped.

● There are also community and private funding mechanisms including community health mutuals (MCS - *Mutuelles de santé communautaires*)[26], private insurance and vouchers for private sector employers[27]. The health financing system is therefore very fragmented and does not promote disease risk sharing or efficiency gains due to the multiplicity of financing agents/structures and management costs. According to the *Enquête Démographique et de Santé au Burundi* (EDSB) III 2016-2017, the majority of Burundians remained without medical insurance (78% among women and 79% among men), i.e., coverage of only 22% of the population.

● Two progressive strategic options should be considered to improve the health coverage of the population in the informal and rural sector in the short term, and for the entire population in the medium term : (i) to set up a compulsory common fund/scheme for the informal and rural sector which would capture the financing and mechanisms intended for this target, in a first phase; (ii) Pooling funds from the two sectors into a single fund to improve national solidarity, cross-subsidies “from the healthy to the sick” and equity of access to care.

[26] Community Health Mutuals (MCS) are community-based health insurance systems intended to provide health coverage for rural and informal populations. These schemes are defined as “any scheme where communities organize themselves (spontaneously or by stimulation) into mutual aid and solidarity associations for the payment of health care. Payment, risk pooling and universal health care coverage are the main pillars. The first steps of the MCS in Burundi dated from 1999 and were supported by the Belgian Christian mutuality and revitalized by the Catholic confessional development structures of the Archdiocese of Gitega. The other mutuals were gradually set up until 2012.

[27] Formal private sector insurance mechanisms ensure coverage of occupational disease risks mainly through the National Institute of Social Security (INSS) created for this purpose in 1962. Diseases which are not occupational are covered when they fall under the responsibility of the employer according to the provisions of the Labour Code revised in 1993. The employer fulfills this responsibility through various methods: he/she can provide direct care through the establishment of an infirmary within the company; he/she can provide for direct payment to service providers; he/she can transfer the risk to third-party organizations (private insurance through their health risk branch, or through health micro-insurance institutions). Decree-Law n°1/037 of 07/07/1993 revising the Labor Code specifies the health products and services that are the responsibility of the employer. The creation of a common fund for the private sector is possible to further structure this scheme and improve its coverage. Going further with the integration of the private sector into the already functional public sector scheme (MFP) in order to reduce the fragmentation of the system and better share the risk associated with healthcare expenses is another alternative option.

- **Purchasing[28]:**

● Government's involvement in PBF has been important to ensure that emphasis is put on the strategic purchasing of basic essential health services necessary for reaching the Millennium Development Goals. The PBF program, which is covering the entire nation's population, contracts public and faith-based organizations, and sub-contracts private-for-profit providers to deliver services such as curative care and family planning services[29].

● It is now necessary to further examine how PBF impacts on health care purchasing in Burundi. Preliminary studies already emphasized that PBF did not impact notably on provider accreditation and selection, or on treatment guidelines. However, it did introduce a more contractual relationship for some providers and bring about improvements in provider payment systems, data quality, increased financial autonomy for primary providers and enforcing equitable strategies.

● The system for the procurement and distribution of medicines is not working as intended. Burundi has centralized the procurement of pharmaceutical products by creating a central medical store called the Central Agency for Drug Purchases (CAMEBU). However, the pharmaceutical supply chain is not working, as CAMEBU is systematically unable to fulfil demand for medicines from district pharmacies. CAMEBU's inability to meet demand appears to result from a combination of foreign exchange rationing and institutional inefficiency. In order to try to meet supply shortfalls, district pharmacies and hospitals are therefore forced to purchase supplies from the private sector[30].

[28] Purchasing is the process of allocating prepaid resources from pooled funds to providers for service benefits. Closely linked to purchasing are decisions on benefits (what services, and at what level of cost coverage) and provider payment methods. The way purchasing arrangements are set up has significant implications for provider behaviour and efficiency.

[29] The intervention has been implemented throughout the entire health system: beginning with the community and health center level where a basic package of health services is provided to first-level referral hospitals that provide a complementary package of health services. National (tertiary) hospitals are also included in the performance scheme. A web-enabled database has been created and allows for accurate and transparent data collection, data analysis, strategic purchasing, contract management, and invoicing.

[30] Official authorization from the *Direction de Medicaments et Laboratoires* is required. This system is flawed in two important respects: first, the amount that facilities can purchase from the private sector is capped on a monthly basis at BIF 5 million per month (US$ 2,900), which is insufficient to meet shortfalls and; second, unit prices are much higher in the private sector which results in poor value-for-money, with higher costs passed on to health users at the facility level.

● CAMEBU has recently pointed out difficulties in procuring urgently needed essential drugs due to lack of funding. For many women and children access to health care thus is no longer feasible, since they cannot afford to pay themselves for the necessary medication in private pharmacies. In this context of increasing vulnerability, without additional resources, there is a real risk of rolling back important gains achieved over past years in the area of healthcare.

(iv) Collaborative Challenges:

● The formal mechanism for consultation and dialogue between the Government and the various DPs is functional in Burundi. The mechanism comprises a strategic forum chaired by the Minister of Finance, which is supposed to meet monthly, and a political forum that is supposed to be held quarterly and chaired by the Second Vice President of the Republic[31]. In 2018, the technical and financial partners relaunched a consultation and internal coordination framework. They set up a mechanism comprising a three-tier coordination framework bringing together heads of diplomatic missions and heads of agencies, heads of cooperation and sector groups.

● The policy dialogue enabled by the UHC Partnership, which Burundi joined in 2016, helped the MSPLS to extend its second PNDS until 2018. It serves as a strategic framework to strengthen the health system during the political crisis, in line with Burundi's National Health Development Policy 2016-2025. WHO is playing a brokering role to foster dialogue between the MSPLS and international partners to improve coordination of health aid. WHO played a key role in the elaboration of the third PNDS 2019-2023.

● A priority area for WHO in Burundi is to continue strengthening intra-sectoral dialogue, so that the conversations launched in 2016 can be consolidated in the development of the next PNDS. The key activity will be analysing current coordination frameworks, and existing stakeholders, in particular taking into consideration that the Health and Development Partner Framework (*Cadre de Concertation des Partenaires pour la Santé et le Développement* - CPSD) could be improved. Lack of coordination is partly related to the lack of leadership and vision on the part of the MSPLS. Weakened and fragmented by post-conflict complexities and depleted of

[31] The management of the period following the events of 2015 was not conducive to the continuation of dialogue between the Government and the DPs within the partnership framework defined, even though bilateral dialogue was maintained.

resources, the MSPLS did not receive from the donors and from its constituents the necessary trust in order to lead all stakeholders on the path of health sector rehabilitation[32].

● As the lead agency for the water, sanitation and hygiene (WASH), education, nutrition and child protection clusters and co-lead of the health sector, UNICEF is adopting a holistic, multi-sectoral approach to address the needs of affected and at-risk populations across its humanitarian strategy. The emergency response is complemented by a social protection component to reduce the impacts of shocks on other sectors. By including youth in behaviour change and mobilization actions as key engagement actors and vectors of change in their communities, UNICEF is supporting young people to develop key skills and become active participants in the response.

● Despite numerous high-profile commitments, mostly the Paris Declaration, and the establishment of many co-ordination mechanisms, aid coordination remains essentially a tool of international politics. The whole architecture of aid needs to be transformed in Burundi. Future research should focus on the MSPLS capacity to coordinate aid towards an effective health system reconstruction.

● There is also an urgent need for better coordination in the sector to increase the efficiency of external assistance. In particular, by financing a strategy for the entire country and not for specific provinces, donors can ensure a better distribution of resources for the sector. Similarly, by financing the sector in a more predictable manner and for longer periods, donors can help the sector achieve better outcomes. The Government and partners are working towards a sector wide approach (SWAP) to support the health sector. This process is based on the premise that all DPs will support a single and comprehensive health strategy, will agree to a common plan of action, and will work together towards harmonizing procedures. All these activities will lessen some of the inefficiencies and inequities in the distribution of donor support to the sector.

[32] This suggests that coordination should be understood as a process that needs to take place not only across donors and other country-level recipients, but also within the MSPLS. DPs partners put their accountability towards their funders first, instead of putting it towards the MSPLS and Burundi's citizens.

(v) Human Resources Challenges[33]:

● The chronic underfunding of the health system, coupled with a significant health workforce deficit, had resulted in Burundi in a significant deterioration in the quality of care.

● The shortage of qualified medical personnel is today one of the main bottlenecks in the delivery of health services. Qualified health care personnel are scarce, but they are also unevenly distributed favouring Bujumbura and leaving poorer areas underserved. About 80% of doctors and 50% of nurses are concentrated in Bujumbura which is the region with the lowest poverty level and where only 10% of the population lives. Many qualified medical personnel has left the rural areas or the country, initially for security reasons, and in recent years due to an inadequate remuneration system for these personnel.

● Poor health workforce policy and planning, shortage and inequitable distribution of health workers, inadequate HRH education and training capacity should be pointed out. Investing in health workforce education, training, accreditation, recruitment, information systems as well as governance, management, and regulation is now a strategic challenge for Burundi.

● Priorities include recruiting skilled health workers to ensure primary health facilities meet national staffing norms, addressing the issue of unskilled staff's hiring by health facilities and implementing an incentive scheme for hard-to-reach rural areas.

● Besides, the Government and its DPs should prioritize the recruitment and re-skilling of health personnel in health districts, in particular of health professionals in health centres and at community level. To this end, resources should be allocated in an equitable manner and according to clear criteria at all levels.

[33] The health workforce is the cornerstone of every health system and critical to the provision of quality health services, improving population health, ensuring universal health coverage and the achievement of the Sustainable Development Goals. The Global Strategy on human resources for health (HRH) Workforce 2030 emphasizes that health systems can only function well when they have sufficient well-trained, competent, responsive, motivated, productive and equitably distributed health staff.

(vi) Health Information Challenges:

● MEASURE Evaluation, a program funded by USAID, has been working in recent years with the MSPLS to strengthen Burundi's monitoring and evaluation system through integration of multiple data collection systems for routine data, HIV/AIDS data, malaria data, and community-based data[34]. Much of this work requires strengthening the health information system (HIS). MEASURE Evaluation has in particular supported the piloting and deploying of the District Health Information Software[35], with modules for HIV/AIDS, malaria, and community-based information system data, to streamline data collection and management along with tools to enable routine data quality reviews.

● Developing an enabling environment is critical for planning, implementing, and maintaining a health information system (HIS)[36]. This may involve legislation[37], partnerships, policies, standards, financing, capacity and infrastructure[38]. Human resources for HIS, e.g., all of the people who interact with the HIS and drive its development and maintenance[39], information generation, e.g., the operationalization of the HIS[40], and HIS performance, e.g., measurement of HIS performance[41] are the others key components.

[34] MEASURE Evaluation has developed a model for strengthening health information systems (HIS) in low-and-middle income countries (LMICs).

[35] The District Health Information Software version 2 (DHIS2) platform.

[36] An HIS is generally defined to encompass all health data sources, including health facility and community data collected as part of routine health information systems (RHIS) or health management information systems (HMIS), electronic health records for patient care, population-based data, human resources information, financial information, supply chain information and surveillance information, e.g., every type of information that can be used for decision making in the health sector.

[37] For example legislation that outlines specific activities under HIS, e.g., maintaining data privacy, security, and confidentiality, establishing national statistics offices and conducting civil registration.

[38] A HIS model was developed in collaboration with experts around the globe, using the Health Metrics Network (HMN) Framework as a foundation, to address four key objectives: promote HIS as an essential function of a health system, define HIS strengthening, measure HIS performance, and monitor and evaluate HIS interventions.

[39] The human element may include individuals who engage with the HIS as part of the HIS workforce, a data user, or a health system beneficiary.

[40] Encompasses the entire process of collecting, cleaning, processing, managing, and analysing health and health-related data from a variety of sources, as well as the creation and distribution of health information products.

[41] HIS performance is defined using the dimensions of data quality, e.g., accuracy, reliability, precision, completeness, timeliness, integrity, and confidentiality and the continuous or systematic and institutionalized use of information for decision making. Effective data use requires the use of data from multiple sources, and it occurs at every level of the health system, formally and informally,

● Burundi has not succeeded yet in creating a government-led research infrastructure with strong national health information systems[42]. As a result, private structures have driven health research without creating national and local capacities.

● Likewise, PBF should capitalize on the existing health management information system already in place in Burundi, instead of encouraging the different levels of the health system to implement parallel systems for the purpose of gathering data specific to PBF. This represents a lost opportunity to ensure that PBF contributes to improving the MSPLS health information system.

3. WHAT IS NEEDED?

(i) Strengthening policy frameworks by:

● Adopting conducive policies and strategic plans:

- In December 2018, Burundi adopted its third National Health Development Plan (PNDS III), covering the period 2019 - 2023. This constitutes an implementation document for Burundi's National Development Plan (PND) 2018 - 2027, adopted in June 2018. The PNDS III is also harmonized with the National Health Policy 2016 - 2025 as well as the international declarations and acts that Burundi has ratified, in particular the Sustainable Development Goals (SDGs) and the Astana Declaration on Primary Health Care.
- The key areas of the national health plan are related to institutional frameworks, e.g., decentralization through the establishment of health districts, since 2009, universal access to health care (approximately 50% of the population) through the free health-care policy for children under 5 and pregnant women, from 2006, and the introduction of the health insurance card for the informal sector. Last but not least is the scaling up of the results-based financing (RBF) approach in 2010. RBF has resulted in increased use of health services, better quality of treatment, strengthening of the health system

planned and ad hoc. There are four categories of data use in any HIS: to improve data quality, generate health statistics, develop information products, and make data-informed decisions.

[42] Three categories of data sources can be distinguished : institution-based data sources, which include individual records, service records, human resources information, logistics management information systems, and health facility censuses and surveys; population-based surveys and the civil registration and vital statistics system; and mixed-data sources, such as the public health surveillance information system and national health accounts.

through private-public collaboration and community engagement, and greater numbers of health workers in peripheral zones.

- **Elaborating costing frameworks:**

- Costs analyses are still lacking in Burundi. So far, only cost-effectiveness analyses have been carried out for specific targets or programmes. For example, the incremental cost effectiveness of an integrated care package[43] for people living with HIV/AIDS was calculated in a not-for-profit primary health care centre in Bujumbura run by Society of Women against AIDS-Burundi (SWAA-Burundi), an African non-governmental organisation (NGO)[44].

- **Promoting equity in health system financing[45]:**

- Burundi attempted to address equity through the abolition of user fees for all under-five care and delivery-related expenses for all pregnant women[46]. This intervention led to increased utilization of services but also led to challenges for health providers in delivering the services because adequate financing mechanisms were not in place to compensate the costs. In addition, the distribution of Government transfers to the district hospitals is unequally allocated with a bias toward the richer provinces[47].
- If access to health services has improved as a result of the FHC-PBF program, particularly at the primary-level care facilities, financial barriers continue to negatively influence the utilization of health care services, in particular by low income and rural households. Financial barriers remain, disproportionally impacting poor households, and have most likely increased

[43] Medical care including antiretroviral therapy (ART) and other services such as psychological and social support.

[44] Results pointed out that the package of care provided by SWAA-Burundi is a very cost-effective intervention in comparison with other interventions against HIV/AIDS that include ART. It is however, less cost effective than other types of interventions against HIV/AIDS, such as preventive activities.

[45] It is generally accepted that the burden of health financing should be distributed according to an individual's ability to pay, that is, the burden should increase as household income increases.

[46] Removing user fees for some vulnerable groups was necessary to help reduce inequities and improve population health. Introduction of exemptions needs today to be carefully planned and implemented to avoid long-lasting, disrupting effects on the health system.

[47] A large share of the budget goes to high level hospitals and in particular to one hospital in the capital city. In a country where the majority of the population lives in rural areas and where the main causes of illness and deaths can be prevented or treated at lower levels of care, this is not the most equitable and efficient use of very limited resources.

the cost of seeking care in the context of the recent crisis due to increases in prices[48].

- Health spending is progressive with the upper quintiles spending more than the bottom quintile, particularly for hospital care, and to a lesser extent for health center care [49] . Poor households are more likely to encounter catastrophic health expenditures. In addition, the burden of childhood diseases falls disproportionately on poor households.
- Inequality in the distribution of donor funds is also a major issue in the health sector. The majority of donors and NGOs work in a limited number of provinces and as a result funding for the sector has been distributed very unequally across provinces. Donors and NGOs usually finance very different programs and thus foreign aid has also been unequally distributed across strategic objectives.

(ii) Strengthening legal and regulatory frameworks by:

- **Adopting robust legislations and implementing/regulatory measures:**

- Despite substantial recent efforts and the adoption of Law n°1/012 of May 12th, 2020, Instituting Social Protection in Burundi, Law n°1/07 of March 12th, 2020, modifying Law n°1/012 of May 30th, 2018, Defining Health Care and Services in Burundi, and Law n°1/11 of 08 May 8th, 2020, Instituting National Pharmaceuticals Regulation in Burundi, the legal and regulatory framework for health financing is still weak in Burundi. From a significant point of view, the National Health Plan 2016-2025 does not cast light on legislative or legal and regulatory aspects. It only mentions that the Government ensures the promulgation of laws and policies favourable to the health of the population and repeals or fails to promulgate legal provisions likely to hinder the implementation of health interventions and particularly those affecting the most vulnerable groups, in particular pregnant women and children under five, people living with HIV, people living with a disability, the elderly, the various minority social categories such as orphans.
- The Government has nonetheless identified the following priorities in its PNDS III: Development of all needed implementing texts for the National Pharmaceuticals Regulation Law of Burundi, in particular regarding approval,

[48] Mainly drugs and transport.

[49] Most out-of-pocket expenses across all income groups are consumed by fees for consultations.

inspection, pharmacovigilance, quality assurance, and price regulation; adoption of legislative and regulatory texts for the main reforms to be carried out, e.g., the decentralization of the health sector, health financing, human resources for health, and medicines; adoption of the law and implementing decrees on the status and functioning of CAMEBU; adoption of legislative and regulatory texts for the hospital reform; adoption of legislative or regulatory texts relating to the status and operation of Health Centres (CDS), Health Accounts (Comptes de la Santé - COSA), and health schools; establishment of a sectoral mechanism to fight against corruption and economic embezzlement in the spirit of "zero tolerance"; and establishment of a contentious service within the MSPLS.

(iii) Strengthening institutional frameworks by:

- Creating supportive environments:

- Institutional arrangements of health systems and the incentives they set are increasingly recognized as critical to promote or hinder performance in the health sector[50]. New Institutional Economics (NIE) literature has pointed out that the performance of an economy or of an organization (e.g. the public health system in LMICs) is the result of underlying institutional arrangements. Health systems can be seen as institutional arrangements whose main purpose is to co-ordinate economic agents involved in the production of health outcomes. The issue of health system performance in Burundi can then be formulated as the search for the institutional arrangements which provide the greatest well-being given an amount of resources available.
- The introduction of PBF in Burundi had a generally positive impact on the health system. The reforms to establish PBF implied major institutional changes, and still require considerable technical and financial support from DPs[51]. The institutional separation of health-systems functions into regulator, purchaser, and provider of health care is supposed to make the health system more efficient and effective. However, in practice, the separation is incomplete, with the MSPLS remaining the main provider and the main

[50] It could be useful to develop a tool to analyse complex health system interventions, looking beyond the evaluation of the final effects to focus on the processes through which institutional (re)arrangements affected those results.

[51] The cost of this support is not reflected in the PBF operating and management costs reported annually by the PBF technical unit. Operation and maintenance of the system accounts for only about 10% of expenditures, hiding the real cost of the reforms.

financing agent. Besides, if the PBF system in Burundi mixes supply-side and demand-side financing mechanisms, the improvements in allocative efficiency created by the introduction of PBF are mitigated by the fact that a residual of the financial imbalance is transferred to the health facilities[52].

- **Advocating for new investments:**

- There is a serious lack of compliance with international best practices related to public investment management (PIM), especially with regard to strategic planning. Although in Burundi the core ministries have clear and separate mandates, in practice public investment program (PIP) planning is weak. The roles of different stakeholders are not well defined, and the budget process does not ensure that the best mix of demonstrably good projects is funded with the limited resources available. As a result, many projects in the health sector are not fully designed and have no credible staffing, procurement, or implementation plan.
- Public Expenditure Reviews (PERs) have identified health (together with education) as the sector that offers the best prospects for growth and poverty reduction. Major achievements include the adoption of a new functional budget classification and the establishment of a central Mid-Term Expenditure Review (MTEF) in the MSPLS.
- In 2016, only a very small part of spent resources (5.6%) was used for investments in the health sector. The majority of national funds was used to finance salaries (42%) and to cover for current costs (48.7%) to ensure the functioning of the sector. This means that only a small portion is spent on improving quality of health services in the long term. In the next future, increased public spending in health in Burundi are expected to lead to higher rates of utilization of existing health facilities, and slightly reduced maternal and child mortality rates.

- **Establishing close monitoring and accountability for results:**

- Strong emphasis is now placed on accountability to affected populations to facilitate the participation of communities in the humanitarian project cycle and in the establishment of feedback and complaint mechanisms.

[52] Most of the essential package of health services is free of charge to the patient, but the subsidies allocated to the health facilities for these services are not based on actual costs. This permits the central level to adjust the rates paid for each service or indicator in order to remain within the available budget.

- As more resources are flowing directly to the health facilities, there is still a need to increase community participation in their management to ensure transparency and accountability in the use of these funds. This could be achieved by revitalizing the Health Committees (COSA) and Management Committees (COGE) to help manage resources at the health facility level and ensure some degree of transparency.

● Aligning overall health system and health financing reforms:

- There is a lack of dialogue between the MSPLS, the Ministry of Finance and DPs. In recent years, the total cessation of direct budget support has been accompanied by the abandonment of plans to introduce a more coherent approach to health sector aid. As a consequence, health sector aid is still highly fragmented, and delivered in a manner that undermines MSPLS's efforts to undertake strategic planning and resource allocation.
- Priorities to align overall health system and health financing reforms include to improve monitoring of off-budget donor support, to improve donor coordination by revitalizing the *Cadre de Concertation des Partenaires pour la Santé* and to put in place a pooled aid system such as a dedicated fund.

● Transferring powers and resources to local authorities (decentralization)[53]:

- The Burundian health care system is using a mix of many decentralization types at different level but with a consistent use of de-concentration at national level. District Hospitals (DH's) and Health District Offices (HDO's) constitute the decentralized units but are neither administratively nor financially autonomous. Responsibilities of planning, budgeting, human

[53] Decentralization is a process by which political, administrative and fiscal authority, responsibilities and functions are transferred from the central government to the state/region governments. There are at least three aspects of decentralization: devolution, deconcentration and delegation. Devolution is the transfer of authority and responsibility from central government ministries to lower-level, autonomous units of government through statutory or constitutional provisions that allocate formal powers and functions. Deconcentration is the transfer of authority and responsibility from central government ministries in the country's capital city to field offices of those ministries at a variety of levels (region/state or local). Delegation is the transfer of authority and responsibility from central government ministries to organizations not directly under the control of those ministries, for example, non-governmental organizations, and/or autonomous region/state and township governments. In Myanmar, devolution should be sought rather than deconcentration or delegation.

resources recruitment are highly centralized[54]. Decision-making remains very centralized at national level, especially budget allocation. The central level exerts an active and direct control and even if in theory DH's can count on communal funds, these funds are insufficient for their operability.

- In May 2015, the Government approved a law on communal competences, assigning health responsibilities to the communes[55]. Since then, however, the role of communes has remained limited, and health services are carried out by the deconcentrated branches of the MSPLS through the Provinces and Districts. A mix of decentralization and recentralization strategies and the balance between those strategies can definitely improve the Burundian health care delivery in a next future.
- From a decentralization perspective, priority reforms in Burundi include reducing the size of the central government by redeploying resources from the center to the periphery, increasing local democracy and participation, improving efficiency and equity in service delivery at the local level and strengthening local communities[56]. An action plan has already been developed, focusing on several pillars such as strengthening the legal and

[54] Health budget preparation for example is still a centralized and input-based process. The financing of health services is fragmented due to multiple health system levels and financing sources. PBF funding has substantially improved resource allocation in favour of front-line service delivery and subnational health administration. Although the health budget remains largely concentrated at the central level, health facilities, and district and provincial offices receive financing from the Ministry. The allocation of funds by level shows that, on average, about more or less 60% of domestic health resources are retained at the central level, and about one-third of resources are transferred to the health facilities and deconcentrated offices.

[55] The introduction of the Government's policy of decentralisation, including the establishment of health districts bringing healthcare closer to homes, resulted in decreased infant, child and maternal mortality.

[56] In Burundi, the central level is responsible for the definition of health policy and the development of intervention strategies, planning and administration of the health sector, and the definition of quality standards, their monitoring and their evaluation. The central level is represented by the Office of the Minister, a General Heath Inspectorate, 2 General Directorates, specific institutions, 6 departments, 9 health programs and the related services. Due to the merger of the Ministry of Public Health and the Ministry of Fighting AIDS (MSPLS), a new organizational chart was put into effect in order to integrate the fight against AIDS into the sector. This reform provided for the creation of a Permanent Secretariat, a General Directorate of planning and of monitoring-evaluation and a National Integrated Program to fight HIV/AIDS. The intermediate/provincial level, in turn, assumes a role of technical supervision, follow-up and translation of directives, strategies, and policies in the form of instructions and data sheets to facilitate implementation at the level of Health Centres. The intermediate/provincial level is also intended to provide secondary health care through the Regional Hospital. Lastly, the peripheral/district level is responsible for the technical supervision for the implementation of the strategy of the primary health care (preventive, curative, promotional, supervision, training, supplies, etc.) through Health Districts and satellite health facilities.

institutional framework for decentralization, promoting local economic development, poverty reduction, and the provision of social services and enhancing fiscal decentralization.

- **Developing Public-Private Partnerships (PPP) and "contractual arrangements":**

- A robust national health system requires cooperation and strong dialogue between the public and private sectors, ensuring that all local actors play a role in increasing access to essential health services[57].
- The World Bank and the Government began a policy dialogue in 2000 on how to control the spread of the HIV/AIDS epidemic and reduce its impact. This dialogue resulted in the National HIV/AIDS Control Strategy (2002 - 06), which became the basis for the future Multi-sectoral HIV/AIDS projects. These projects used to financing performance-based service contracts and agreements with public and private health facilities at the local level to provide clinical care for HIV/AIDS patients. Actually, the Country Partnership and Country Assistance Strategies embedded PPPs in these projects.
- The World Bank is now supporting the Government to strengthen its institutional framework for PPPs. When advising governments on the various models for providing health services, it is now necessary to discuss the whole range of options, from the public and mixed options to the other possible types of PPPs, in the context of the Burundi's state of reform, overall maturity, and track record in using PPPs. To be better positioned to deliver such strategic advice, the Government is encouraged to better integrate its sector reform and policy work when developing PPPs. Access for the poor and affordability need not only to be systematically considered at the design stage, but also tracked to ensure that the poor actually benefit from PPPs. Lastly, the recently developed Bank Group - IMF Public Fiscal Risk Assessment Model (PFRAM) tool for assessing fiscal implications should be systematically applied to structuring PPPs that have substantial fiscal implications.

[57] In Burundi, only a few organizations have deep connections to the diverse set of private providers in the country: see for example the Association Nationale pour la Franchise Sociale (ANFS, National Association for Social Franchise), a network composed of independent private health clinics; and the Réseau des Confessions Religieuses pour la promotion de la Santé et le bien-être intégral de la famille (RCBIF), a community-based organization that works with faith-based health clinics throughout the country and across four religious denominations to provide a range of primary health services.