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DELIVERING HEALTH SERVICES UNDER FISCAL STRESS

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CURRENCY EQUIVALENTS

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US\$1.00= 1,231 (2010); 1,261 (2011); 1,443 (2012); 1,578 (2013); 1,557 (2014); 1,614 (2015); 1,686 (2016)

ABBREVIATIONS AND ACRONYMS

AAP	Annual Action Plan
AfDB	African Development Bank
AIDS	Acquired Immune Deficiency Syndrome
AMISOM	African Union Mission in Somalia
ANC	Ante-Natal Care
ARV	Anti-Retroviral
BDS	<i>Bureau du District Sanitaire</i> (District Health Office)
BOP	Balance of Payments
BPS	<i>Bureau de la Province Sanitaire</i> (Provincial Health Office)
BRB	<i>Banque de la République du Burundi</i> (Burundi Central Bank)
CAM	<i>Carte d'Assurance Maladie</i> (Health Insurance Card)
CAMEBU	<i>Centrale d'Achats des Médicaments Essentiels et des Consommables Médicaux du Burundi</i> (Central Agency for Drug Purchases)
CBO	Community-Based Organization
CDS	<i>Centre de Santé</i> (Health Center)
CF	<i>Contropartie Financière</i> (Financial Counterpart)
CFCIB	Federal Chamber of Commerce and Industry
CHW	Community Health Worker
CNLS	<i>Comité National de lutte contre le Sida</i> (National Committee National Committee of Fight Against Aids)
COMESA	Common Market for Eastern and Southern Africa
CPA	Complementary Package of Activities
CPSD	<i>Cadre de Coordination des Partenaires pour la Santé et le Développement</i> (Health Development Partners Coordination Group)
CSO	Civil Society Organizations
CVD	Cardiovascular Disease
DHO	District Health Office (<i>Bureau du District Sanitaire</i>)
DHS	Demographic and Health Survey
DRH	Directorate of Human Resources
DTP3	Three doses of Diphtheria, Tetanus and Pertussis Vaccines

ECVMB	<i>Enquête sur les Conditions de Vie des Menages au Burundi</i> (Survey on Household Living Conditions in Burundi)
FAO	Food and Agriculture Organization
FDI	Foreign Direct Investment
FHC	Free Health Care
FONIC	<i>Fonds National d'Investissement Communal</i> (National Investment Funds for Communes)
FY	Fiscal Year
GAM	Global Acute Malnutrition
GASC	<i>Groupements d'Agents de Santé Communautaire</i> (Groups of Community Health Workers)
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GHI	Global Hunger Index
GSM	Global Severe Malnutrition
HC	Health Center (<i>Centre de Sante</i>)
HIPC	Heavily-Indebted Poor Countries
HIV/AIDS	Human Immunodeficiency Virus
HR	Human Resources
ICT	Information and Communications Technologies
IFMIS	Integrated Financial Management Information System
IMF	International Monetary Fund
ISTEEBU	<i>Institut de Statistiques et d'Etudes Economiques du Burundi</i> (Burundi Institute of Statistics and Economic Studies)
ITAS	Integrated Tax Administration System
KfW	<i>Kreditanstalt Für Wiederaufbau</i> (German Development Bank)
MC	<i>Mutuelles de Santé Communautaire</i> (Community Health Mutual)
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MDR-TB	Multi-Drug-Resistant Tuberculosis
MFP	<i>Mutuelle de la Fonction Publique</i> (Public Service Mutual Insurance Company)
MFPTE	<i>Ministère de la Fonction Publique, du Travail et de l'Emploi</i> (Ministry of Public Service, Labor and Employment)
MPA	Minimum Package of Activities
MSLPS	<i>Ministère de la Sante Publique et de la Lutte contre le SIDA</i> (Ministry of Public Health and Fight Against AIDS)
MSN	<i>Ministere de la Solidarité Nationale, des Droits de la Personne Humaine et du Genre</i> (Ministry of National Solidarity)
MTEF	Medium-Term Expenditure Framework
MUSCABU	<i>Mutuelles de Santé des Caféculteurs du Burundi</i> (Mutual Health Insurance for the Coffee Producers)
NCDs	Non-Communicable Diseases

NDS	National Decentralization Strategy
NGO	Nongovernmental organization
NHA	National Health Accounts
NPL	Non-performing Loan
O&M	Operations and Maintenance
OBR	<i>Office Burundais des Recettes</i> (Burundian Revenue Office)
ODA	Official Development Assistance
OOP	Out of Pocket
PBF	Performance-Based Financing
PCDC	<i>Plan Communal du Développement Communautaire</i> (Commune Development Plan)
PEFA	Public Expenditure and Financial Accountability
PEMFAR	Public Expenditure Management and Financial Accountability Review
PER	Public Expenditure Review
PFM	Public Finance Management
PHI	Private Health Insurance
PHO	Provincial Health Office (<i>Bureau de la Province Sanitaire</i>)
PIM	Public Investment Management
PMS	Minimum Package of Health Services
PNDS	<i>Plan National de Développement Sanitaire</i> (National Plan for Health Development)
PRSP	Poverty Reduction Strategy Paper
SDG	Sustainable Development Goal
SIGEFI	<i>Système Intégré de la Gestion de Finances Publiques</i> (Integrated Government Finance Management System)
SNIS	<i>Système National d'Information Sanitaire</i> (National Health Information System)
SOEs	State-Owned Enterprises
SSA	Sub-Saharan African
SUN	Scaling-Up Nutrition
TB	Tuberculosis
TBA	Traditional Birth Attendants
UCODE	<i>Union pour la Coopération et le Développement</i> (Union for Cooperation and Development)
UHC	Universal Healthcare
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization

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Executive Summary

Introduction

This Public Expenditure Review (PER) assesses the macroeconomic, fiscal and health service delivery impacts of the 2015 crisis in Burundi. The PER has a special focus on trends over the period from 2010 to the present, using the most up-to-date data wherever available. It is based on a combination of quantitative fiscal and service delivery data, and qualitative information collected in interviews with Government officials, NGOs, development partners, and private sector actors. The team also undertook field visits to frontline units (including District Pharmacies, District Hospitals, and Health Centres) to capture an assessment of the health system from the perspective of those delivering public health services.

The first part provides an overview of macroeconomic and fiscal developments, and especially growth performance, both before and after the 2015 political crisis. In this context, it examines, the composition of spending, revenue mobilization, and the issue of rising fiscal deficits. It considers the macroeconomic and poverty outlook — including the impact of exogenous variables on growth.

The second part provides an overview of health outcomes and health sector performance. It addresses health sector financing, specifically issues related to health appropriations trends, and the composition of the budget. Issues of equity are also addressed, with a particular focus on health service utilization, access, financing and health insurance schemes, as well as the incidence of diseases — and how they have affected different income groups. Public financial management concerns are also viewed from the point of view of the efficiency and effectiveness of health expenditures, specifically with regard to budget preparation, procurement, execution and fund flows.

Finally, conclusions and recommendations are offered for: improving the efficiency of the health spending; strengthening the programming of development assistance; improving medicine procurement and logistics management; and reducing inequities in the health sector in Burundi; in light of the weak short and medium-term prospects for economic growth and revenues as well as uncertainty about a rapid resumption of external aid:

Macro-Fiscal Developments

The political crisis of 2015 halted eleven years of positive economic growth since the signing of the Arusha Peace and Reconciliation Agreement in 2000. Real GDP declined by 0.6 percent in 2016, although this contraction was less drastic than in 2015 when the GDP growth rate stood at 3.9 percent. Even if the impact of the 2015 crisis can be contained, economic growth is expected to remain weak in 2017 — with attendant adverse effects on per capita income and poverty. The economy is functioning far below its estimated potential growth rate of 3-5 percent.

Shortages in foreign exchange reserves have limited much-needed imports for economic activities, hampering trade and investment. The Government has introduced rationing measures, limiting access to official reserves to three essential import goods (fuel products, fertilizers, and pharmaceuticals). Shortages in foreign exchange reserves led to reduced pharmaceutical imports during 2016. The value of total imports declined by 9.6 percent in 2016, including a decreased import value for pharmaceuticals of 12.4 percent. Imports are falling short of levels required to satisfy domestic demand.

Donor support has been very important, if highly unpredictable, furthermore, since the crisis, there has been a dramatic decrease in donor finance. Donor support has served as an important fiscal buffer. However, the disbursement of external aid has been unpredictable and volatile, mainly due to its link to the implementation of complex, but critical, public finance management (PFM) reforms. It has also fluctuated during times of political instability and conflict.

Efforts to increase domestic revenue, led by the Burundi Revenue Authority (OBR), have become even more important; however, tax efforts have not been enough to offset the effect of falling donor aid. The introduction of the OBR has helped to create additional fiscal space to partially compensate for (declining) budget support that accounted for 3.7 percent of GDP in 2010-2014 (annual average). Importantly, it also contributed to reduced fiscal deficits. Total current revenues grew by 120 percent from 2007-2009 to 2010-2014, that is, from 11.9 percent of GDP to 13.7 percent before the crisis. However, the tax revenue-to-GDP ratio declined to about 11.4 percent in 2015, down from 12 percent in 2014.

Insufficient domestic revenues have led to heavy reliance on the BRB's financing to execute the two recent budget laws and to an increased domestic. Other than the increasing recourse to / reliance on T-bills and advances from the Central Bank, the Government has recently begun to draw heavily on debt from the non-banking system.

Since 2005, the Government's active social policies resulted in increased allocations of domestic public resources to the social sectors. In particular, the combined budgets of the education and health sectors grew on average of 2.5 percent per year (or 1.6 percent a year in terms of executed spending) over 2010-2014. The wage bill and transfers and subsidies accounted for an increasing share of the budget in the period 2010-2014, growing by about 9 percent and 2 percent, respectively. This was primarily driven by the introduction of universal access to primary education and health care for pregnant women and children under the age of five.

Health Outcomes

Despite the progress during the last two decades, health sector outcomes are mixed in Burundi. Over the past two decades, Burundi has experienced improvements in certain health indicators, notably the under-five-child and maternal mortality rates, immunization coverage rates, and other key indicators. Maternal, infant and child mortality rates however lag below regional averages. Although the fertility rate marginally decreased from 6.9 children per woman in 1987 to 6.4 in 2010 (2010 Demographic and Health Survey [DHS]), it also remains one of the highest in the region.

Burundi has one of the highest prevalence rates of underweight children in Africa, with more than half of children under the age of five suffering from stunting. Indeed, stunting has remained unchanged for children under the age of five over the last two decades, oscillating between 56 percent (1987), 63 percent (2000), 58 percent (2005) and 58 percent (2010).

Service delivery data suggest that maternal and child health services were severely affected by the crisis, but recovered in 2016. Pre - and post-natal consultations by pregnant women at district hospitals declined substantially by 60 and 92 percent between 2014 and 2015 respectively. Likewise, the use of contraceptive methods and the demand for vaccines by pregnant women also declined. Demand for maternal and reproductive services increased again in 2016.

Health Financing

In terms of domestic resource allocations, the health sector is the second top priority of the authorities. On an average annual basis, it received 9.6 percent of the total domestically-funded budget. The health sector implemented 9.9 percent of total executed expenditures in 2010-2014, second only to the education sector's allocations of 27.8 percent.

Donor aid is the main source of health sector, making a fragile country like Burundi particularly vulnerable to the fluctuation and unpredictability of aid flows in insecure situations. 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. Analyses indicate a significant decline in donor assistance in 2015 and 2016 due to the crisis.

The health budget is dominated by wages and salaries, as well as transfers and subsidies. Representing 78.1 percent of budget allocations, and 81.6 percent of total health expenditures 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 performance-based financing (PBF) program — (amounting to more than 50 percent of the transfers, or 24 percent of total public health expenditures in 2014). 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 somewhat in 2015 and 2016 as a result of the crisis. Budget execution by type of expenditure shows a fairly stable pattern over the years 2010–2014, but declined in the last two years. Salaries (which averaged 106 percent execution) and transfers and subsidies (100 percent) were the best-performing types of expenditure. Indeed, they were even 'protected' from cuts which affected other parts of the budget during 2015 and 2016.

Of greater concern with regard to the execution of the health sector budget are the lower execution rates for goods and services (85 percent over 2010–2014) and investment (85 percent). Not only are appropriations already very low in absolute terms for these spending items, but the limited resources allocated are not being fully executed in the sector — likely undermining service delivery and the maintenance of health infrastructure. The execution rate for these expenditure categories is broadly in line with aggregate budget execution for the period (86 percent), suggesting that while non-discretionary health expenditures are protected during cash management, the same protection is not afforded to these items. There is simply not enough cash available to meet budgeted expenditures due to overly optimistic revenue forecasts. Consequently, this ultimately impacts on resource availability for the health sector.

Classification issues make it very challenging to isolate spending on preventive and curative services. However, the current distribution of resources appears to favor curative services, and preventive services are largely underfunded. Likewise, the national health programs have received little attention from the Government.

Equity concerns

The utilization pattern of health services is characterized by significant disparities. Inequities in utilization remain and have been aggravated by the 2015 crisis. Financial barriers continue to negatively influence the utilization of health care services, in particular by low- income and rural households.

Utilization of health services has improved as a result of the FHC-PBF program, coupled with improved access, particularly at the primary-level care facilities. However, inequities in utilization remain and have been aggravated by the 2015 crisis.

Financial barriers remain, disproportionately impacting poor households, and have most likely increased the cost of seeking care in the context of the recent crisis due to increases in prices (drugs, transport).

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; most out-of-pocket expenses across all income groups are consumed by fees for consultations.

Poor households are more likely to encounter catastrophic health expenditures and increased susceptibility to childhood diseases. In this respect, the burden of childhood diseases falls disproportionately on poor households. Although the prevalence of childhood diseases declined at the national level from 2009-2012, it has remained high among children of poor households. It will most likely further increase their vulnerability to developing diseases in the context of the recent malaria epidemic and the 2015 crisis. Households on the brink of poverty may be vulnerable to becoming impoverished.

The resources allocated to the district hospitals are regressive, and there appears to be a positive relationship between more consultations and poverty rates at the province level. The distribution of government transfers to the district hospitals is unequally allocated—with a bias toward the richer provinces.

Public Financial Management

PFM reforms introduced prior to the crisis have not persisted. The sustainability of the many public financial management (PFM) policies and practices adopted in the last ten years is an issue of concern. In particular, planning and budgeting in the health sector remains an exercise lacking in coherence and credibility.

The system for the procurement and distribution of medicines is simply not working as intended – and is fundamentally broken. 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 fulfill demand for medicines from district pharmacies, with an average fulfilment rate of 24 percent in 2016. 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. 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.

The financing of health services is not as efficient and effective as it could be due to the multiple health system levels (Central, Intermediary/Province, and Peripheral/District) and financing

sources. The three main layers of administration and associated administrative institutions for a country of Burundi's size and population density, are relatively costly and inefficient.

Further, the health delivery system is not aligned with the broader administrative structure of the country, undermining potential levers to ensure a more equitable distribution of services. Since 2005, Burundi has embarked on a governmental decentralization process. In May 2015, the Government approved a law on communal competences, assigning health responsibilities to the communes. Since then, however, the role of communes has remained limited, and health services are carried out by the deconcentrated branches of the Health Ministry through the Provinces and Districts — which are not aligned with the boundaries of the Communes. The result was health infrastructure shortfalls in fiscal years 2015 and 2016.

Effective management of the payroll is important in ensuring that health services are delivered in a cost-efficient and sustainable manner. Almost half of the Ministry's health workers are under a local contract, representing largely non-skilled support staff. Public servants account for 40 percent, followed by contract staff (11 percent). The different employment regimes enable the Ministry to address its staff needs in the context of budget constraints and caps on the recruitment of civil servants. However, they have also led to resource inefficiencies, as most health facilities have recruited unskilled staff (largely due to employment opportunities created for family members or friends) — thereby taking away resources for other, more meaningful activities.

Performance-Based Finance funding has substantially improved resource allocation in favor of front-line service delivery and subnational health administration. By ensuring resources reach frontline service delivery centers, notably health centers, and providing flexibility to facilities on how the funding is spent, PBF has had a significant positive impact on service delivery. However, challenges remain with the design of the PBF system, which are important to understand because of their central importance to health service delivery. One key challenge relates to fiscal sustainability. Second, the incentives created by the monitoring and performance framework appear to be having some unintended consequences. For example, the extent to which Burundi's medicine supply chain is fundamentally not working — and hence not delivering much needed medicines to meet citizen demand — is systematically understated by PBF.

Prospects for Reform

The most notable progress in public health service delivery in recent years has been made at the facility level, with the provision of financial resources and incentives through PBF. This is important not only because of the resulting public health gains, but because of the lessons it offers for sector managers seeking to build upon those gains in order to more comprehensively strengthen the health system.

Fiscal sustainability remains a huge challenge in the sector, with heavy reliance on external finance (albeit diminished since the crisis); there is also a lack of dialogue between the Ministry of Public Health and Fight Against AIDS (MSPLS), the Ministry of Finance and development partners. This in turn relates to the choice of aid instruments deployed in the sector. 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. Health sector aid is therefore highly fragmented, delivered in a manner that inherently undermines MSPLS' efforts to undertake strategic planning and resource allocation. It also mitigates against any dialogue regarding fiscal sustainability of the equity of overall sectoral resource allocation. Therefore, aid to the health sector is 'less than the sum of its parts' — missing opportunities for a more coherent, sustainable, and equitable approach that can benefit all Burundians.

Health outcomes are not solely affected by health spending, but the available evidence suggests that structural under-funding and inequitable resource distribution are exacerbating poor health outcomes. In the current context, increases in health expenditures could come from a reprioritization of the health budget, coupled with significant efficiency gains. Improvements in distributional equity can also be achieved by a revised approach to spatial allocation of resources. This should be done together with the expansion and deepening of health financing reforms and improving governance in the health sector.

Addressing these constraints would require a range of reforms in the short, medium and long term. Table below summarizes the key recommendations of the report.

Policy Options for Consideration

Policy Area	Issues	Options for Considerations	Sequencing
Macro-Fiscal	Economic Growth	<ul style="list-style-type: none"> ✓ Give priority to the agriculture sector with focus on smart climate and cold chain investments ✓ Design and implementation of a set of business-friendly policies in areas with comparative advantages (for example, construction material, labor-intense industries) ✓ Use of the rail-lake transportation unlock growth potential and increase access to FDI 	Medium-to-long term
Macro-Fiscal	Fiscal Management	<ul style="list-style-type: none"> ✓ Develop an action plan to rationalize tax exemptions and broaden tax base ✓ Creation of an independent fiscal entity/council ✓ Regular publication of budget execution for transparency purposes ✓ Evaluate size of arrears and establish a plan to reduce accumulation of arrears 	Short-to-medium term
Macro-Fiscal	Debt Management	<ul style="list-style-type: none"> ✓ Define a debt management strategy; capacity development for debt sustainability assessments 	Short-to-medium term
Macro-Fiscal	Exchange rate Management	<ul style="list-style-type: none"> ✓ Transparency in the allocation of scarce foreign exchange ✓ Promote dialogue to highlight the exchange rate policy in effect ✓ Evaluate the effectiveness of policies on foreign exchange control ✓ Improve the current fiscal-monetary policy inconsistency with the exchange rate policy 	Medium-to-long term
Health	Efficiency of the Health Sector	<ul style="list-style-type: none"> ✓ Increase domestic allocations to national programs (in particular to the reproductive health program) ✓ Include coverage of non-communicable diseases treatment and explore cost-effective interventions (for example, early detection) ✓ Prioritize budget allocation to investments and O&M ✓ Re-adoption of PFM process and procedures ✓ Streamline the health organizational structure and ensure alignment with country's territorial organization ✓ Develop phase-out plans for the PBF intervention and reinforce PBF system monitoring 	Medium-to-long term

Health	Development Assistance for Health	<ul style="list-style-type: none"> ✓ Improve monitoring of off-budget donor support ✓ Improve donor coordination revitalizing the <i>Cadre de Concertation des Partenaires pour la Sante</i> and putting in place a pooled aid system such as a basket fund 	Short-to-medium term
Health	Management of Health Workforce	<ul style="list-style-type: none"> ✓ Recruit skilled health workers to ensure primary health facilities meet national staffing norms ✓ Address the issue of unskilled staff' s hiring by health facilities ✓ Implement an incentive scheme for hard-to-reach rural areas 	Short-to-medium term
Health	Medicines Procurement and Logistics Management	<ul style="list-style-type: none"> ✓ Adopt more sophisticated quantification methods (for example, morbidity) ✓ Adopt expedited procurement process that is up to standard such as pre-approval of vendors, contract frameworks with suppliers ✓ Put in place an adequate transport system to deliver medical products 	Short-to-medium term
Health	Inequity in health	<ul style="list-style-type: none"> ✓ Improve the <i>Carte d'Assurance Maladie (CAM)</i> insurance scheme through: a. reducing overlapping mandates and target group between CAM and other insurance schemes, b. improving CAM performance through timely reimbursement to facilities, c. increasing CAM coverage, d. increasing CAM premium to enhance fiscal sustainability ✓ Revise allocation formula of health transfers to facilities and address delays in transfers releases 	Medium-term

CHAPTER 1: MACROECONOMIC AND FISCAL DEVELOPMENTS

A. Assessing Burundi's Growth Performance

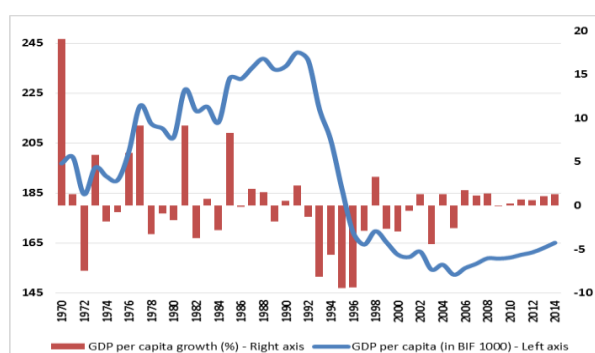
Before the 2015 crisis Burundi experienced good economic performance; notwithstanding, economic growth did not either decrease poverty rates or follow the typical boom pattern of a post-conflict country

Before the political crisis erupted in 2015, the economy of Burundi was performing relatively well. Improved macroeconomic management, and countrywide peace and security resulted in positive real gross domestic product (GDP) growth, averaging 4.2 percent in the period 2004-2014. During this period, the Government's sustained commitment to reforms, mainly in the policy areas of Public Finance Management (PFM) reform and the investment climate, helped to stabilize the country's economy. These efforts resulted in a slight growth rebound achieved amidst a challenging and fragile environment (World Bank 2008, 2010, 2013)¹. These eleven years of uninterrupted economic growth followed the devastating civil war period experienced by the country in 1994-2003, which saw GDP growth averaging -1.3 percent annually.

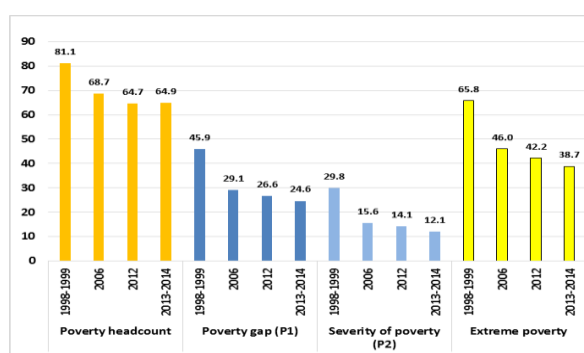
Despite good economic performance, progress toward poverty reduction has been limited. In nominal terms, GDP per capita stood at USD 286 in 2014 against USD 259.4 in 2013. With increasing population growth, Burundi's real growth economic performance in 2004-2014 translated into only a small increase in the average per capita real GDP (0.6 percent), insufficient to make a substantial dent in poverty reduction (see Figure 1). The poverty headcount rate, based on the national poverty line, declined slightly to 64.9 percent in 2014 from 68.7 percent in 2006. Based on the international poverty line of US\$ 1.90 per capita per day², Burundi's poverty rate stood at 72.9 percent in 2014 (See Figure 1A and 1B). The World Bank (2016)³ estimated that Burundi's international poverty rate in 2014 was 8 percentage points higher than its national poverty rate, and 30 percentage points higher than the average poverty rate in low-income countries (47.2 percent) and Sub-Saharan Africa (42.7 percent).

Figure 1: Insufficient Economic Growth vis-à-vis Increasing Population Rates

A/ Weak per capita Real GDP Recovery since 2005



B/ Weak Poverty Reduction Outcome since 2006



Sources: Burundi Poverty Assessment 2016, and "Enquête prioritaire" 1998-1999.

¹ See 2008 Public Expenditure Management and Financial Accountability Review (PEMFAR), 2013 Public Expenditure Review (PER), and 2010 PER.

² This is expressed in terms of the 2011 purchasing power parity exchange rate.

³ World Bank, "Republic of Burundi: Burundi Poverty Assessment", Africa Region, June 2016.

In contrast to comparator countries, Burundi did not experience a typical post-conflict growth boom over 2005-2014, despite substantial external aid inflows. Following the successful implementation of a series of reforms identified under the Heavily-Indebted Poor Countries (HIPC) debt forgiveness program in 2009, Burundi benefited from an unprecedented boom in external aid. However, unlike in other post-conflict settings (see Table 2), Burundi did not experience the type of post-conflict momentum evidenced by high real-GDP growth following the end of its protracted political strife in 2000. Several reasons account for this lack of post-conflict momentum. First, the normal resumption of economic activities in rural areas was delayed due to remaining sporadic armed fights in some western areas of the country. Second, the return of the normal the fragility conditions intensified by the protracted conflict in Burundi persisted after the conflict. These included a delayed return of nation-wide security, a delayed resumption of economic activities in rural areas, the slow return of Burundian refugees, the management of foreign refugees in Burundi, and the delayed final cease fire with the last, high-profile rebel group (FLN PALIPE-HUTU). Second, the execution of public external and domestic investments was weak, and the implementation of critical investment climate reforms was delayed. Third, the disbursement of external aid was unpredictable and volatile, mainly due to its link to the implementation of complex, but critical, public finance management (PFM) reforms. Finally, Burundi’s existing conditions also explain its lack of post-conflict momentum. These include the country’s limited natural resource endowment, high population growth, and an underperforming rural sector.

Table 1: Burundi’s Growth Performance in relation to Comparator Countries (in %)

	Before last war / turmoil period	Last war / turmoil period ^(*)	After last war / turmoil period
Burundi	1970-1992	1993-2003	2004-2014
	4.2	-1.8	4.2
Democratic Republic of Congo	1970-1989	1990-2003	2004-2014
	1.0	-3.9	6.6
Cambodia	1970-1978	1979-1991	1992-2014
	-	-	7.7
Liberia	1970-1988	1989-2003	2004-2014
	0.6	-0.7	6.3
Sierra Leone	1970-1990	1991-2001	2002-2014
	2.0	-2.7	9.3
Rwanda	1970-1989	1990-1994	1995-2014
	4.2	-11.5	9.7
	1970-1992	1993-2003	2004-2014
<i>Sub-Saharan Africa (LDC)</i>	2.6	3.1	5.7
<i>LICs</i>	1.4	3.0	5.6

Source: World Development Indicators 2017.

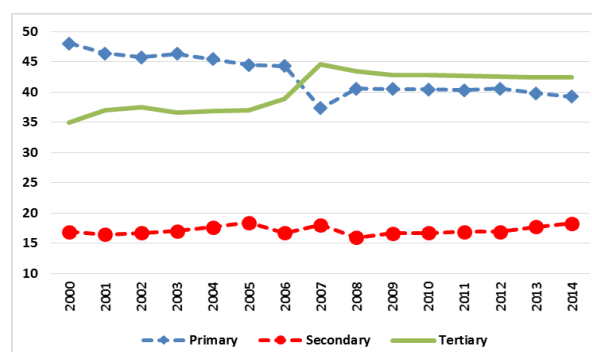
Notes: LDC = Least Developed Countries. ^(*) “Last war / turmoil period” tries to capture the period through which a given country experienced civil wars and / or difficult political regime destabilization. The attempt is made based on “Wikipedia” website information. For Burundi, this period is estimated to go from 1993 (beginning of the last civil war when President Melchior Ndadaye was assassinated) to 2003 (year where the CNDD-FDD became a politic party). For the Democratic Republic of Congo, this period is estimated to go from 1990 (beginning of the weakening of President Mobutu’s regime) to 2003 (year where the second war of DRC ended officially). For Cambodia, the period is estimated to go from 1979 (start of the Cambodian-Vietnamese war) to 1991 (year of the Paris Peace Accords). For Liberia, this period is estimated to go from 1989 (start of the first civil war) to 2003 (last year of the second civil war). For Sierra Leone, this period is estimated to go from 1991 (start of the civil war) to 2001 (President Kabbah declaration of the end of the war happened in January 18, 2002). For Rwanda, this period is estimated to go from 1990 (start of the 2-phase civil war) to 1994 (end of the second phase of the civil war). For Sub-Saharan Africa and LICs, the period used is that of Burundi for simplicity purposes.

During the period 2005-2014, modest growth was largely driven by the expansion of services followed by growth in the industrial sector. Burundi's tertiary sector accounted for 42 percent of GDP during this period, closely followed by agriculture (41 percent) and industry (17.2 percent) (see Figure 2A). The growth in services can be explained by the growth impetus that followed the successful implementation of investment climate reforms over the 2007-2014 period. Among services, education, health, information and communications technologies (ICT), transport, and tourism grew by over 10 percent every year. This was above the tertiary sector's average growth over this period. It was initially fueled by public investment and the attraction of increased foreign direct investment (FDI) inflows after 2010. The policies of free access to social services (health and education) for vulnerable households introduced in 2005-2006 also helps to explain the services boom. The expansion of industrial activities, to a large extent, captures the sustained growth in energy, extractives, and manufacturing (particularly agro-processing and textiles).

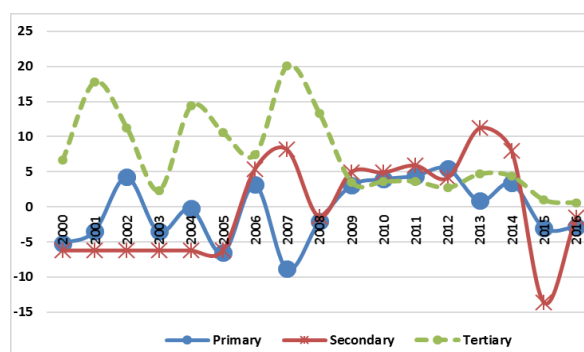
Finally, the contribution of the agricultural sector to GDP has declined over time, as this sector has grown at a slower rate than the overall economy. An underperforming agricultural sector delayed an economic catch-up anticipated following the Arusha Agreements. As such, it contributed to volatile economic growth. In the post-conflict era, the agricultural sector was the dominant (supply-side) driver of economic growth from 2000-2006. The share of the primary sector to GDP averaged 45.8 percent compared to 17 percent for the secondary sector and 37 percent for the services sector (Figure 2B). During this period, the economic growth performance remained highly volatile due to widely-fluctuating agricultural production (both for staple foods and export crops). The sector was also adversely affected by weather conditions, which caused drought and floods. Moreover, production and international price shocks also affected coffee and tea, Burundi's main export crops.

Figure 2: Slow Transformation of the Economy

A/ Sector share of GDP (in %)



B/ Sector growth (in %)



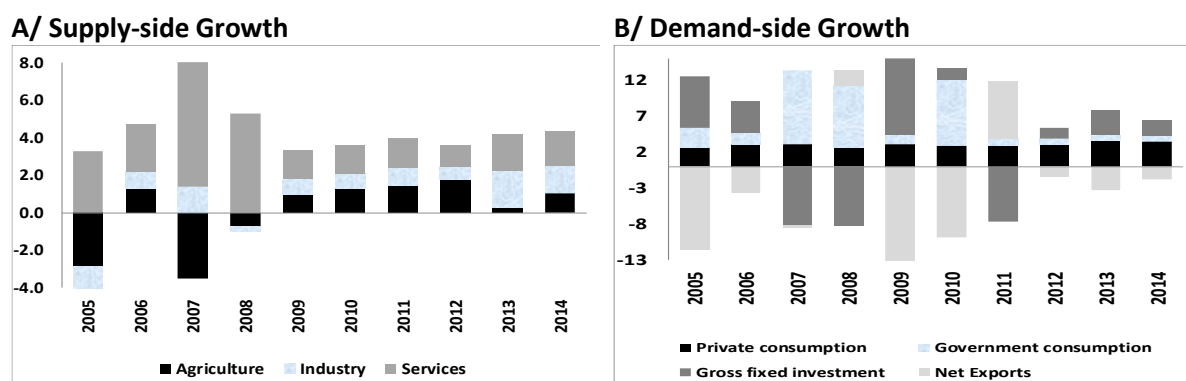
Source: World Bank staff using Burundi's National Accounts.

Note: GDP= gross domestic product.

Since 2000, consumption (public and private) has been the largest contributor to growth, followed by total investment (see Figure 3). Government consumption, starting from 2007, was partly driven by the demobilization program, a key stabilization initiative. The second contributor to demand-side growth was private consumption, followed by investment. The contribution of the external sector to GDP growth has been more limited. Net exports have been a drag on growth, primarily because of a narrow export base (partly because of the country's geographically landlocked position), as well as the need to import a large proportion of inputs (such as, construction materials, fuel products, food industry factors, etc.) that are not available in the country. The rise of official development assistance (ODA) to Burundi, starting from 2006, was accompanied by an increase in imports, thereby affecting positively the country's trade balance. In addition, a low domestic savings rate (2-3 percent of GDP)

resulted in a high dependence on foreign savings, which are typically associated with increased imports.

Figure 3: Sources of Growth in Burundi, 2005-2014 (%)



Source: World Bank staff using Burundi's National Accounts.

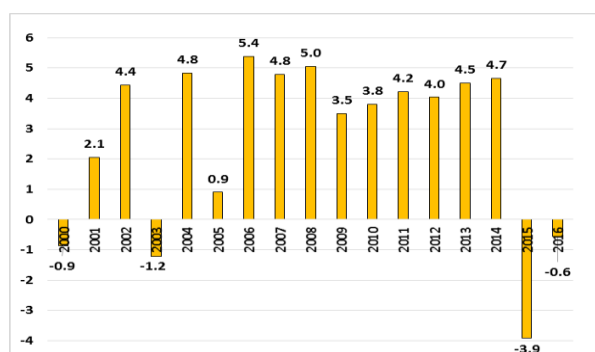
Since 2015 the economic activities have been slowing down, especially because of the continued dire shortages in foreign reserves

The political crisis of 2015 halted the eleven years of positive growth since the signing of the Arusha Agreements. Real GDP declined by 3.9 percent in 2015, driven by a sharp drop in the urban formal and semi-formal economy that has been so dependent on the aid industry (Figure 4A). Commercial and industrial activities were stopped in the capital Bujumbura for several weeks in April-June 2015 due to riots, significantly disrupting productivity. The weak domestic demand resulting from negative reactions of both businesses and donors was compounded by the tense political situation and acute insecurity during the second half of 2015. This held the economy on a low equilibrium. The secondary sector contracted by about 13.6 percent in 2015, including value-added contracting in manufacturing industries, utilities (including energy), construction and mining (4D). The primary sector contracted by 3 percent as well, mostly due to the combined effects of climatic shocks and forced migrations (4B), with food production dropping by 4.3 percent especially in the north and south. Despite a noticeable growth decline in the tourism sector (4.6 percent)⁴ and trade (6.9 percent), the tertiary sector seemed to show some resilience — mostly due to such sub-sectors as commercial banking and telecommunications (4C). Central Government activities also weighed in, with an increase in security expenditures that drained almost all available domestic public finances and foreign exchange reserves.

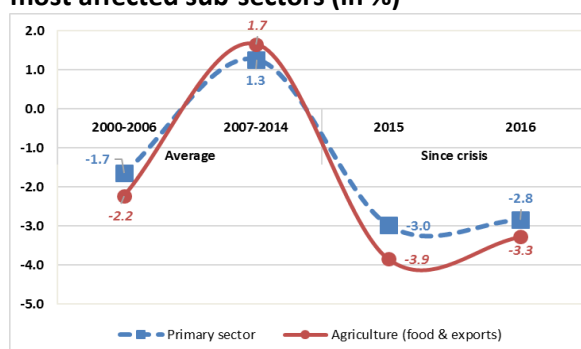
⁴ Several hotels and restaurants severely cut employment to reduce costs. Most of them have faced huge difficulties in repaying their debt owed to commercial banks.

Figure 4: Economic Performance Indicators

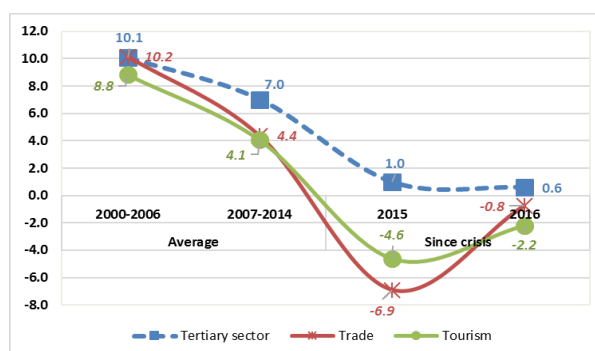
A/ Recent trends in economic growth (in %)



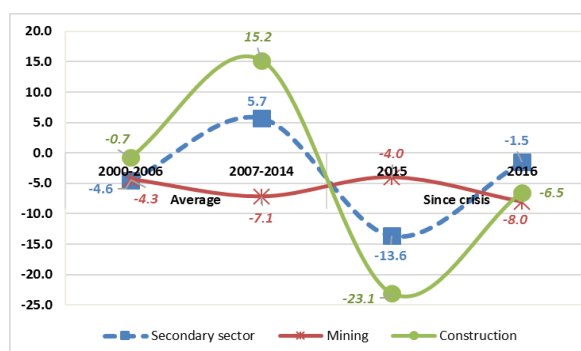
B/ Primary sector growth rates, with focus on most affected sub-sectors (in %)



C/ Tertiary sector growth rates, with focus on most affected sub-sectors (in %)



D/ Secondary sector growth rates, with focus on most affected sub-sectors (in %)



Source: World Bank staff estimates using the Government's national accounts.

The political instability that began in 2015 has continued to weigh on economic activity. Real GDP declined by 0.6 percent in 2016⁵, although this contraction was less drastic than in 2015 when the GDP growth rate stood at 3.9 percent. The decline was due to unfavorable weather conditions, which dampened agricultural production and energy supplies. These developments led to an underperforming industrial sector (including agro-processing for consumption and construction), which contracted by 1.5 percent in 2016. Early estimates for the first quarter of 2017 indicate continued sluggishness in agricultural production. In particular, the sugar sector, a critical supplier of agro-industries for consumption goods, has struggled to meet domestic demand. A moderate growth in services (mainly ICT and banking) was not enough to offset underperformance in other sectors.

Only the tertiary sector achieved a positive growth rate in 2016, but remained below pre-crisis levels. This sector is buoyed mostly by the performance of banking, insurance, transport, and telecommunications. However, trade and tourism continued to record negative growth, mainly due to heightened shortages of foreign currencies and the reputational damage the tourism industry has suffered since the crisis erupted in May 2015⁶. Partly due to the difficulties still experienced by construction (despite an improved situation compared to 2015) and weak private consumption,

⁵ The Government forecasted a growth rate of 1 percent. This was unlikely given the continued struggling performance in food production, as well as the continuing difficulties in the energy, construction and tourism sub-sectors.

⁶ Specific to tourism, the uncertain security environment impeded / delayed, for example, a promising (public-private partnership) investment seeking to scale-up exploitation of the "Source du Nil" or the launch of a new "Drums' Festival".

growth in the secondary sector improved. However, it remains negative (at -1.5 percent as of the end of 2016, as against -13.6 percent at the end of 2015).

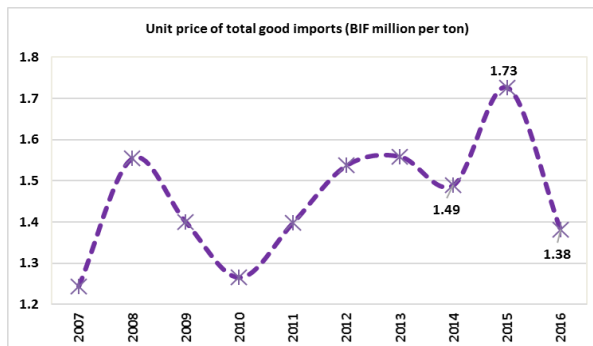
Declines in the exports of goods and services and investment were the main drivers of the economy's contraction in 2015. Growing at an annual average of 7.4 percent in 2010-2014, the export value of goods and services declined by 9.9 percent in 2015. This decline was driven essentially by declining coffee export volumes of 9.9 percent (against an annual increase of 3.5 percent in 2010-2014). In addition, coffee export unit prices decreased by 21.4 percent (against an annual increase of 13.9 percent in 2010-2014). This added to the stress on the country's foreign exchange reserves. At the same time, gross fixed investment declined by about 42 percent due primarily to: (i) interruptions of businesses relying on external aid; (ii) declining security in the main urban cities; and (iii) acute shortages in foreign exchange reserves. Gross fixed investment was just recovering from a 29.7 percent drop in 2011, and rebounded somewhat with a 12.4 percent increase (annual average) in 2012-2014. The freeze in both budget and program support resulted in a weak execution performance of public investment in 2015. Externally-funded investment expenditures experienced a sharp decline in the execution rate (55 percent), against a yearly average of 84.2 percent in 2010-2014. Although at a lower magnitude, domestically-funded investment expenditures declined as well from 82.2 percent in 2015 compared to 89.3 percent in 2010-2014.

With a slightly positive growth rate, private consumption may have stabilized in 2015. The import volume of food increased by 0.3 percent, and was procured at a lower import unit value. Both the stabilization of food import quantities and mechanisms of resilience developed by donors in rural areas helped to foster food production. Indeed, it grew on average at a rate of 3.5 percent in 2010-2014. In this context, it served as a buffer by providing some protection to rural people against the decline in food production in 2015. As food contributes to 50-60 percent of household consumption in Burundi, these developments resulted in a slight increase in private consumption by 0.6 percent in 2015. In fact, the import volume of non-durable goods (food, pharmaceuticals, and others) increased by 1.8 percent, with pharmaceuticals being procured at slightly greater unit import prices (3.6 percent increase in their import value). In 2016, more emergency spending from donors and the Government resulted in food import volumes increasing by 5.5 percent (at higher unit import prices for private importers). However, pharmaceutical import volumes decreased by 5.9 percent (at lower unit import prices for the Central Agency for Drug Purchases- CAMEBU). As a result, private consumption has started to bounce back, reaching a growth rate of 1.2 percent.

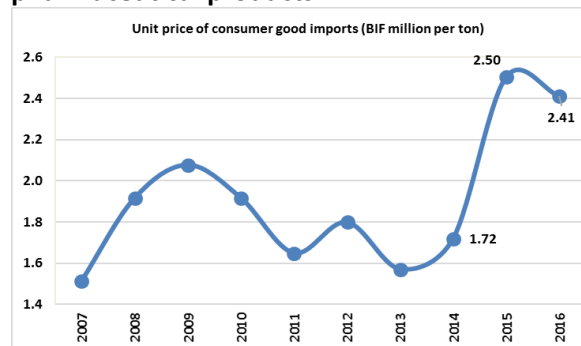
Shortages in foreign exchange reserves have limited much-needed imports for economic activities, hampering trade and investment. The value of total imports increased by only 13.1 percent in 2015 — compared to an average annual increase of 20.6 percent from 2010-2014. It then declined by 9.6 percent in 2016, mainly driven by decreased import values for capital goods (42.3 percent), pharmaceuticals (12.4 percent), and — to a lesser extent — fuel products (5 percent). This decline in performance is directly linked to the substantial decline in official reserves that occurred in 2015 (57 percent) and 2016 (30.1 percent). This contrasts with the earlier stabilization in official reserves in 2010-2014 (with an annual average growth of -0.2 percent), and coincided with the higher total import value growth rates. However, the analysis of the volume of imports shows a decline of 2.4 percent in 2015. Compared to an annual average increase of 18.9 percent in 2010-2014, this is a small decline. It reflects an economy adjusting to the soaring import unit prices (Figure 5A and 5B) caused by the acute foreign currency shortages following the external aid freeze (since 2015), as well as the effect of the rationing measures limiting access to official reserves to just three essential import goods. This adjustment seems to have come mostly in the form of import volume cuts in durable consumer goods (57.7 percent) and fertilizers (18.3 percent) (Figure 5C). Although the volume of imports rose in 2016, there was a decline in the respective import volume of pharmaceuticals (5.9 percent) and capital goods (4.2 percent).

Figure 5: Unit Import Prices of Imported Goods in Burundi (in Burundian Franc [BIF] million per ton)

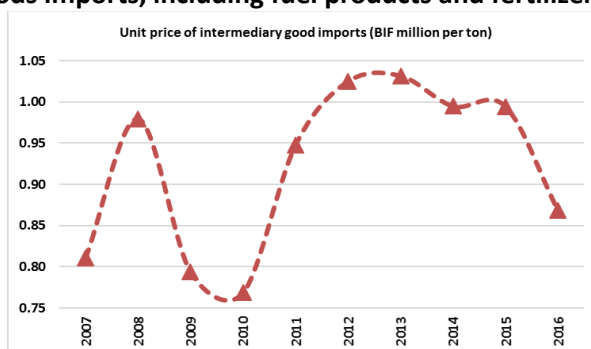
A/ For total goods imports



B/ For consumer goods imports, including pharmaceutical products



C/ For intermediary goods imports, including fuel products and fertilizers

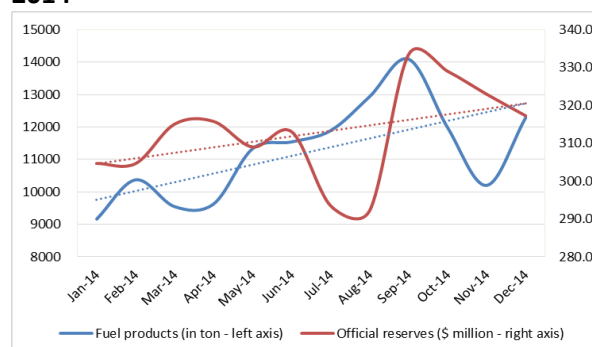


Source: World Bank staff estimates based on Burundi Central Bank databases.

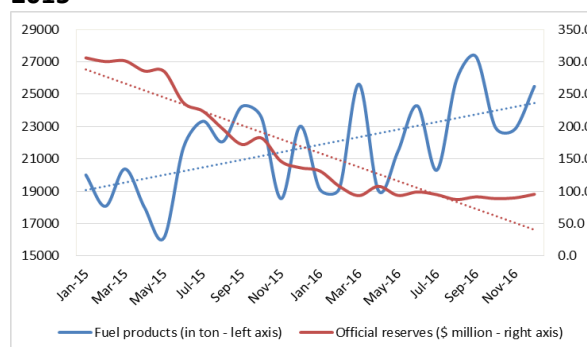
The rationing of foreign exchange resulted in reduced pharmaceutical imports in 2015. In terms of imported volumes, pharmaceutical products may face bigger challenges, especially for those pharmaceutical products not procured by the CAMEBU. The monthly import volume of pharmaceutical products has declined since January 2015, following the unprecedented declining trend in official exchange reserves (Figures 6B1 and B2). The lack of a similar decline for the import volumes of fuel products (Figures 6A1 and 6A2) and fertilizers (Figures 6C1 and 6C2) suggests that these products may have been given higher priority in the allocation of foreign exchange by the Central Bank. In this regard, scarce official foreign reserves have amplified the volatility of monthly imports for all three essential import goods. Interestingly, when official exchange reserves stood at an adequate level and were less volatile prior to 2015, import volumes for these goods were also rising.

Figure 6: Availability of official reserves and monthly import volumes of essential imports

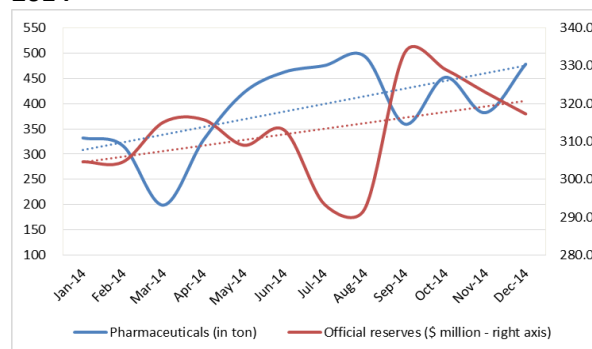
A1/ Increasing imports for fuel products in 2014



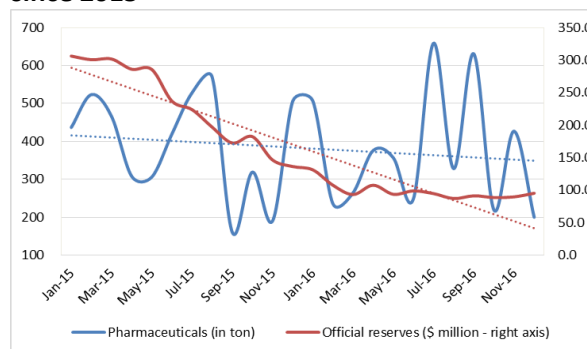
A2/ Increasing imports for fuel products since 2015



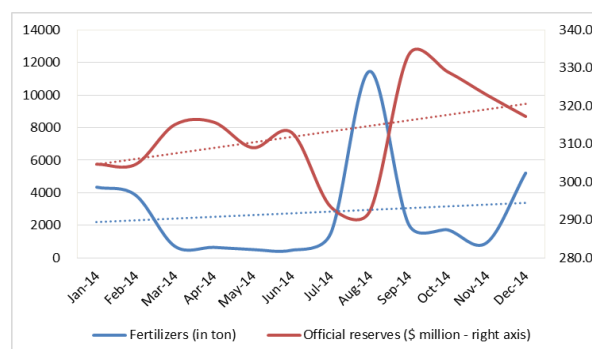
B1/ Increasing imports for pharmaceuticals in 2014



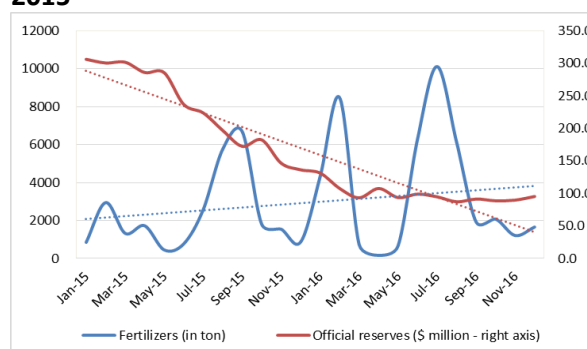
B2/ Declining imports for pharmaceuticals since 2015



C1/ Increasing imports for fertilizers in 2014



C2/ Increasing imports for fertilizers since 2015



Source: World Bank Group staff estimates using the Burundi Central Bank database.

The trend in the unit import price of pharmaceuticals suggests possible losses of quality in the imports of such goods after 2015. Increasing by an average of 2.0 percent a year in 2012-2014, the unit import price increased again in 2015 by 1.3 percent. It then declined in 2016 by 6.9 percent. This decline is said to be directly linked to the tendency of pharmaceutical importers to purchase products of lower quality standards. According to several accounts, including from targeted interviews with civil society organizations (CSOs), medical practitioners, drugstores, the ongoing exchange rate crisis has affected the quality of health care in the country because some medications and basic equipment cannot be easily purchased. A second objective of this report, then, is to take a closer look at public service delivery in the health sector.

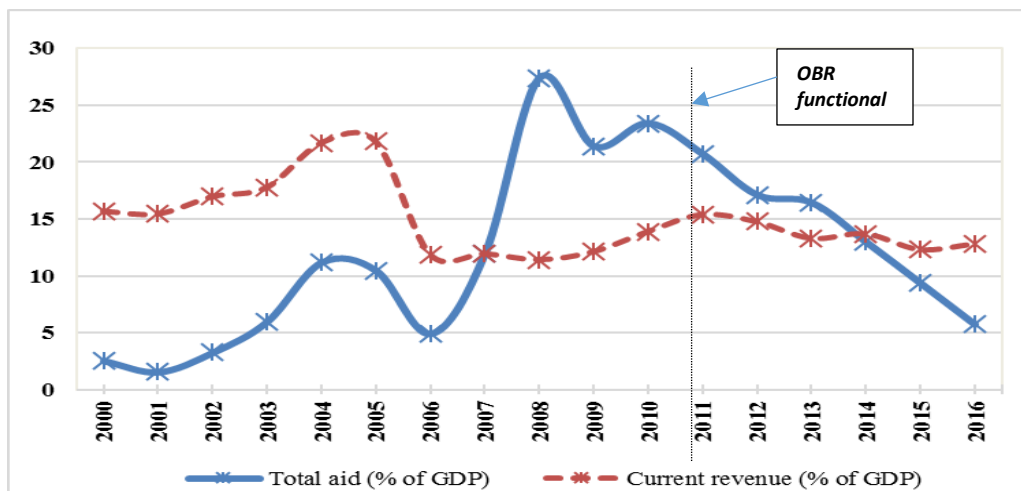
B. Assessing Burundi's Fiscal Performance

Increase donor resources and public financial management reforms contributed to a largely prudent fiscal management

Maintaining a broadly prudent fiscal policy has remained central to Burundi's economic growth program. Following the political transition that launched the reform process⁷, the fiscal deficit declined to 3.4 percent of GDP in 2007-2014 — down from 5.0 percent in 2004-2006, 11.5 percent in 2003, and 24.7 percent in 2000. This performance resulted from the Government's efforts to mobilize public resources, while applying more fiscal discipline to control the wage bill (both for the civil service and armed forces), as well as purchases of goods and services. In the period 2010-2014 when direct budget support steadily declined, better management of both the wage bill (averaging 8 percent of GDP over the period compared to 8.4 percent in 2009) and purchases of goods and services (averaging 3 percent of GDP compared to 4.9 percent in 2009) resulted in the overall fiscal deficit averaging 3.1 percent of GDP. This was down from 5.3 percent in 2009. In response to declining direct budget support, the Government modernized legal and regulatory frameworks to improve budget preparation and execution while also establishing the Burundi Revenue Authority (OBR).

Increased donor resources, despite their unpredictability, helped to provide an important fiscal buffer. External aid averaged 18.9 percent of GDP in 2007-2014, up from 5.7 percent in 2000-2006) (Figure 7). Despite their volatility, aid flows played a key buffer role in periods of acute turbulence, preserving both macroeconomic stability and the living standards of poor households. In particular, the economy experienced several major external shocks over the period of 2007-2011, including: successive international food and fuel price shocks; the Global Financial Crisis and attendant economic slowdown; and the debt crisis affecting its main development partners.

Figure 7: Volatile External Aid (declining following OBR's full operationalization in 2010)



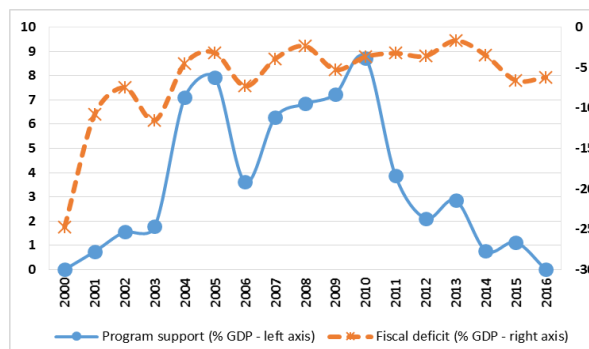
Source: World Bank staff using Central Government budget data.

Note: GDP= gross domestic product; OBR=Burundi Revenue Authority.

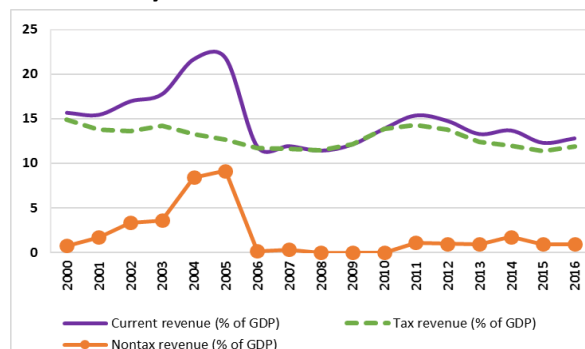
⁷ A series of World Bank budget support operations reinforced the modernization of Burundi's public finance management (PFM). These included: the 2000 Emergency Economic Recovery Credit (EERC); the 2002 Economic Rehabilitation Credit (ERC); and the series of development policy grants (DPGs) that started with the 2006 Economic Reform Support Grant (ERSG 1) followed by the ERSG 2-8 that covered the 2008-4 period. These reforms aimed at improving budget planning and execution procedures, increasing the share of priority economic and social development sectors in both voted budgets and executed expenditures, and introducing a computerized financial management information system (SIGEFI).

Figure 8: Critical Role of Budget Support

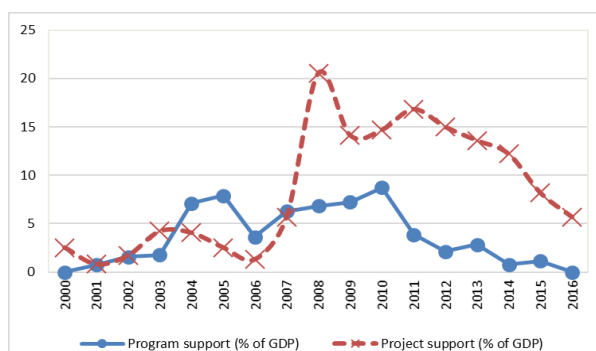
A/ Budget / program support helped ease the fiscal deficit during difficult times.



B/ But the arrival of OBR did not allow for enough revenue buffers to eliminate budget vulnerability.



C/ Project and budget support declines afterward, amid time of reduced domestic revenues.



Source: World Bank staff using Central Government budget data.

Note: GDP= gross domestic product.

Despite its volatility, external budget support also helped to maintain the momentum for public financial management reforms that proved to be successful in addressing budget execution bottlenecks (Figure 8). Aggregate budget execution rates improved significantly, partly as a result of these reforms⁸. Prior to the launch of the Poverty Reduction Strategy Paper (PRSP) in September 2006, the execution rates of total expenditures averaged 79.2 percent (2004-2006)⁹. This relatively low performance was driven essentially by very low execution rates in capital expenditures in the same period, which averaged only 58.3 percent of voted credits / appropriations. Executed at a rate averaging 56.5 percent of voted budgets, capital expenditures funded by external grants fared poorly in comparison to capital expenditures funded by domestic resources (66.5 percent average execution rate). In contrast, current expenditures performed rather satisfactorily in 2004-2006, displaying

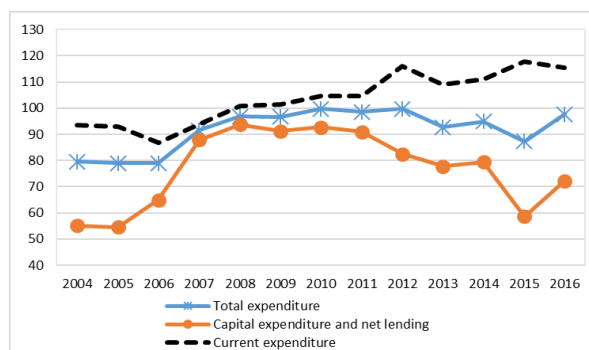
⁸ Reform efforts could be summarized as follows: (i) In September 2006, the State Inspector General (*Inspection Générale de l'Etat*) was created; (ii) operationalization of the Interim Computerized Financial Management Information System (SIGEFI) in 2006, which could produce quarterly budget execution reports up until 2014-2015 while also managing human resource data as of 2010; (iii) the Supreme Audit Court (*Cour des Comptes*) was strengthened; (iv) a new budget framework law was adopted in 2008 establishing the foundation for streamlined budgetary procedures and *ex-ante* controls; (v) the Medium-term budget planning was introduced to improve prioritization and quality in expenditures (but with mixed results); (vi) the decree on budget execution, accounting and control was adopted in October 2011. This decree planned to eliminate redundant Central Bank (BRB) controls and to transfer the budget authority to the line ministries; and (vii) the budget preparation process was progressively improved, resulting in a Public Expenditure and Financial Accountability (PEFA) Assessment score of "A" in 2014 and 2011, up from a "C" in 2008 (indicator PI-XX).

⁹ Available data series and documentation (Audit Court reports, draft budget execution reports, and voted budgets) have enabled an estimation of consistent expenditure execution rates only for the period 2004-2016.

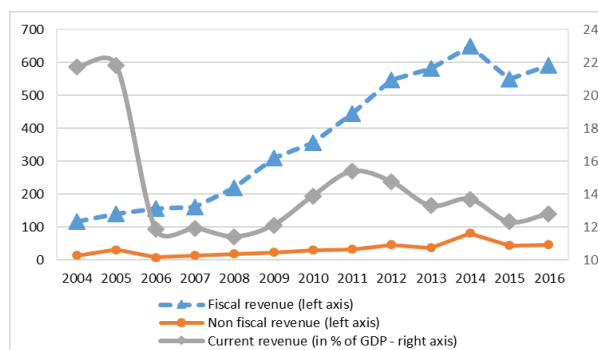
execution rate levels averaging 91.0 percent on an annual basis. With the implementation of the PRSP program further facilitated by increased donor aid, the execution of capital expenditures significantly improved in 2007-2014, the result of which was reflected in larger total expenditures' execution rates — even after the 2015 crisis. Particularly following the introduction of the SIGEFI in 2006-2007, total budget execution rates were close to 100 percent, averaging 98.3 percent of allocated appropriations in 2008-2012. Interestingly, capital expenditures were executed at better rates, averaging an annual rate of 90.2 percent. This was due to improved execution rates for externally-funded capital expenditures (91.7 percent execution rate), contrasting with a 85.2 percent average execution rate for domestically-funded capital expenditures (Figures 9A and 9B).

Figure 9: Budget Performance Indicators (since 2007)

A/ Execution rate of expenditures (in % of voted credits) on a rise since 2007



B/ Domestic revenue collection in nominal terms (BIF billion) rising importantly with OBR operationalized



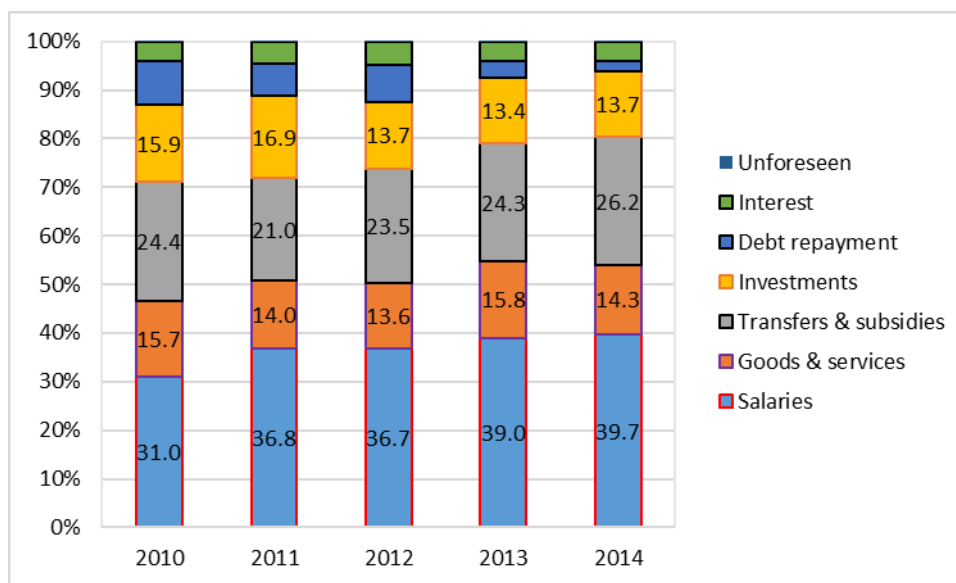
Sources: Data and reports from the Ministry of Finance and Supreme Audit Court.

Since 2005 the Government has increased domestic allocations to social sector and health spending has been the second top priority.

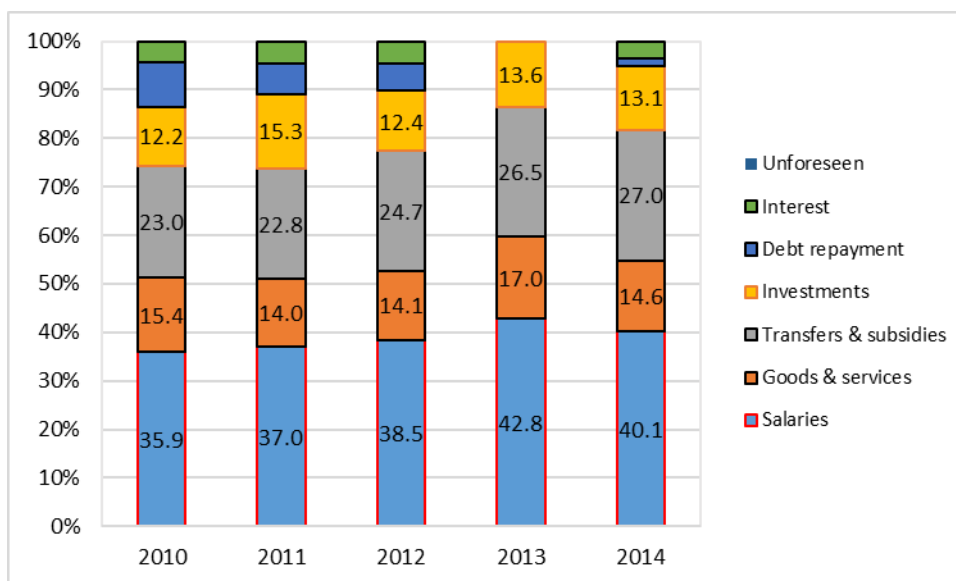
The wage bill and transfers and subsidies accounted for an increasing share of the budget in the period 2010-2014, growing by about 9 percent and 2 percent, respectively (Figure 10A). This was primarily driven by the introduction of universal access to primary education and health care for pregnant women and children under the age of five. A combination of tighter controls on spending for goods and services and a prudent borrowing policy helped create the fiscal space required to finance the growth in non-discretionary expenditures. The budget share for goods and services dropped by 1.4 percentage points, and that of the debt service (interest plus principal repayments) fell by 7 percentage points between 2010 and 2014. Executed expenditures, as depicted in Figure 10B, support this.

Figure 10: Structure of Total Domestically-funded Expenditures (by economic classification)

A/ Voted credits / appropriations (as a % of total voted credits)



B/ Executed spending (in % of total executed expenditures)

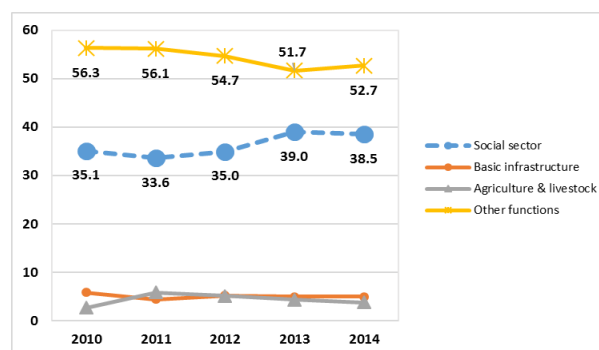


Source: World Bank Staff estimates using the Government's databases.

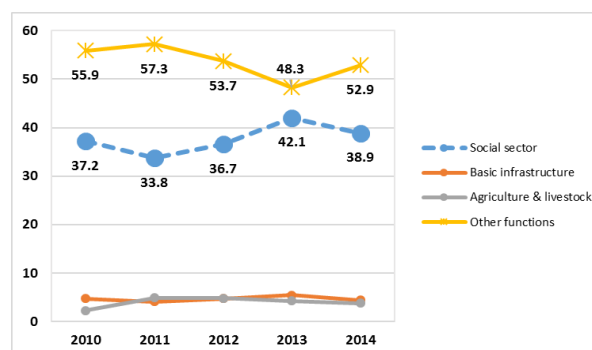
Since 2005, the Government's active social policies resulted in increased allocations of domestic public resources to the social sectors. In particular, the combined budgets of the education and health sectors grew on average of 2.5 percent per year (or 1.6 percent a year in terms of executed spending) over 2010-2014. The prioritization of health expenditures began in 2005, with subsequent annual average growth rates of 7.0 percent of budgeted amounts, and 6.1 percent growth in executed spending. At least part of the fiscal space used to cover the growing social sector expenditures in 2010-2014 was created at the expense of other public functions (Figure 11). In 2015, the year for which only approved budget data are available so far, the allocation to the social sector grew by 4.8 percent.

Figure 11: Share of Sectors in Total Expenditure Budget (by functional classification) (in %)

A/ Percentage share of total voted credits



B/ Percentage share of total executed spending



Source: World Bank Staff estimates using the Government's databases.

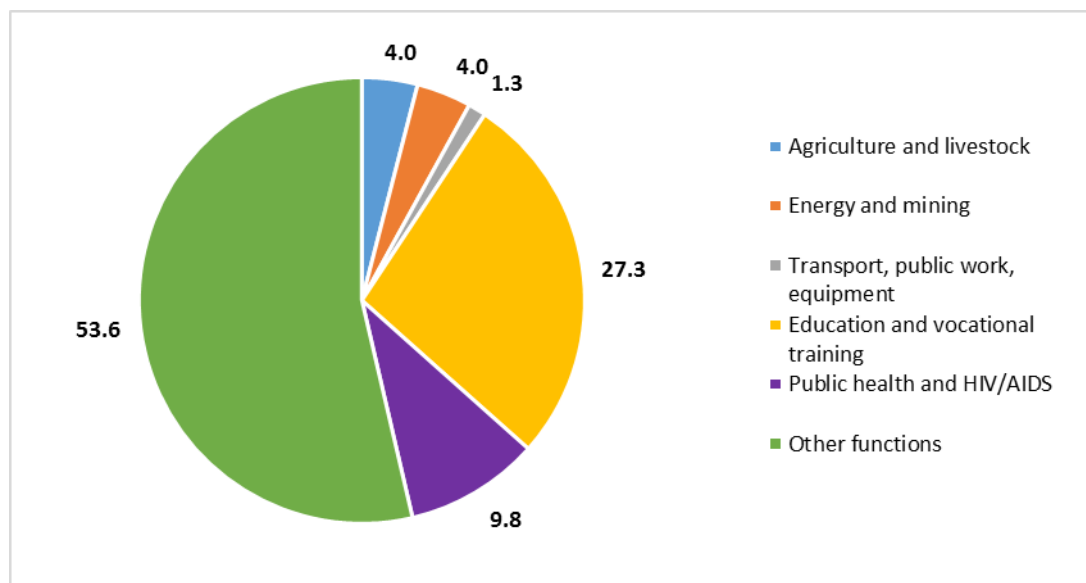
To implement its health program, the Government stabilized the allocation of domestic resources to health, relying increasingly on external aid for complementary interventions. In terms of domestic resource allocations, the health sector is the second top priority. On average, it received 9.6 percent of the total domestically-funded budget annually, and implemented 9.9 percent of total executed expenditures in 2010-2014. This was second only to the education sector's respective allocations of 26.7 percent and 27.8 percent (Table 3). During this period, the health sector was the top beneficiary sector of external aid allocated to development projects, receiving about 18 percent. The 2015 budget allocation for health was consistent with recent allocations, reaching 9.8 percent of total voted credits (Figure 12). The stabilization of domestic public resources allocated to Burundi's health sector can be attributed to at least two Government policy measures implemented since 2009: (i) significantly increasing the proportion of public expenditures allocated to priority economic and social sectors, with close monitoring and reporting; (ii) preparing a Medium-Term Expenditure Framework (MTEF) in the health sector that reflects priority expenditures to be obligatory protected in the event of budget cuts.

Table 2: Structure of Total Domestically-funded Expenditures (by functional classification) (as a % share of the total budget)

	2010		2011		2012		2013		2014		Average	
	Voted credits	Executed credits	Voted credits	Executed credits	Voted credits	Executed credits	Voted credits	Executed credits	Voted credits	Executed credits	Voted credits	Executed credits
Agriculture and livestock	2.7	2.3	5.8	4.9	5.1	4.8	4.4	4.2	3.8	3.8	4.4	4.0
Energy and mining	2.6	2.2	2.2	2.1	3.2	2.6	3.3	3.5	2.8	2.8	2.8	2.7
Transport, public work, equipment	3.3	2.4	2.2	2.0	2.0	2.1	1.7	1.9	2.2	1.6	2.3	2.0
Education and vocational training	25.3	27.5	23.8	23.8	26.2	27.6	29.2	31.3	28.7	28.9	26.7	27.8
Public health and HIV/AIDS	9.8	9.7	9.8	10.0	8.8	9.0	9.8	10.7	9.7	10.0	9.6	9.9
Other functions	56.3	55.9	56.1	57.3	54.7	53.7	51.7	48.3	52.7	52.9	54.3	53.6
Total	100	100	100	100	100	100	100	100	100	100	100	100

Source: World Bank Staff estimates using the Government's databases.

Figure 12: Structure of Total Voted Domestically-funded Expenditures (by functional classification) (as a % of total voted credits) in 2015



Source: World Bank Staff estimates using the Government's databases.

Since 2010 OBR made considerable efforts to increase tax revenues; but these efforts vanished with the crisis creating considerable fiscal distress.

Burundi's high dependence on inherently unpredictable aid flows remains a great source of fiscal fragility, requiring more domestic revenue mobilization. Persistent delays and unpredictability in external aid flows to Burundi have represented a huge challenge to fiscal management and service delivery.¹⁰ Irrespective of the 2015 crisis, this risk is unlikely to attenuate soon, given the weight of external aid in the Burundi budget¹¹. Although following a declining trend since 2010, external aid was still financing half of the budget up until the recent crisis. It represented 13.0 percent of GDP in 2014, down from 23.4 percent in 2010. The 2014 budget support, initially expected to stand at 2.6 percent of GDP, barely reached 0.8 percent, down from 2.1 percent in 2012 and 3.9 percent in 2011. This sharp drop mostly reflected donor concerns about the deteriorating political situation and democracy concerns following the 2010 elections.

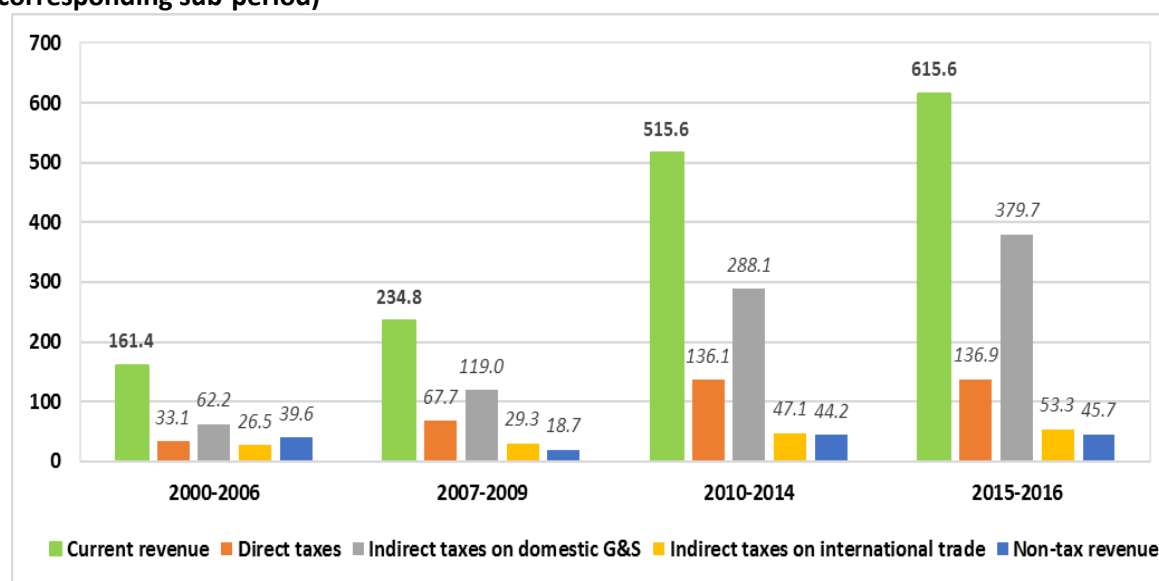
In a context of declining external aid, the efforts of the OBR to improve domestic revenue mobilization are extremely important. With the OBR formally beginning operations in July 2010, total current revenues collected (on an annual average basis) increased from Burundian Franc (BIF) 234.8 billion (US\$ 196.5 million equivalent) in 2007-2009 to BIF 515.6 billion (US\$ 351.1 million equivalent) in 2010-2014 (Figure). This represented an impressive growth rate of 119.6 percent (78.7 percent if expressed in US\$). In terms of the share of GDP, total current revenues improved from 11.8 percent of GDP in 2007-2009 to 14.2 percent in 2010-2014 — even reaching 15.4 percent in 2011, its highest level since the implementation of the first PRSP in 2007 (Figure 13). The introduction of the OBR helped create additional fiscal space to partially compensate for declining budget support that accounted for 3.7 percent of GDP in 2010-2014 (annual average). Importantly, it also contributed to reduced fiscal deficits. However, the fiscal situation remains highly insecure, due to both a high

¹⁰ As noted in previous public expenditure reviews (PERs) (World Bank 2008, 2010, 2013) and a recent study on the impact of budget support (European Union 2015), unpredictable aid is a major challenge.

¹¹ In 2012, donors pledged US\$2.5 billion in additional aid to support the country's second PRSP – more than double the originally anticipated amount of US\$1 billion.

dependence on volatile external aid and a low tax revenue base, constraining further domestic revenue mobilization.

Figure 13: Structure of Government’s Current Revenues (since 2000) (in BIF billion, average in the corresponding sub-period)



Source: World Bank staff estimates based on OBR reports and database.

Note: G&S= Good and Services. Current revenue is obtained by summing up direct taxes, the two categories of indirect taxes, and nontax revenues.

The 2015 crisis undermined the gains made by Burundi in broadening the tax revenue base, creating substantial fiscal stress. Current expenditures increased rapidly as the Government sought to ensure security. To finance this, the authorities relied heavily on BRB financing, as the tax revenue base and aid inflows had severely eroded. The tax revenue-to-GDP ratio declined to about 11.4 percent in 2015, down from 12 percent in 2014. Donors also reduced aid from 13 percent of GDP in 2014 to 9.4 percent in 2015¹². On the expenditure side, although spending on goods and services and investment were reduced, the new spending for security needs limited the Government’s ability to make expenditure cuts. Therefore, the Government resorted to increased domestic borrowing from both the BRB and commercial banks to address the shortfall. Overall, the fiscal deficit is estimated at 6.6 percent of GDP in 2015, up from 3.1 percent in 2010-2014. Financing comes for a variety of sources, including: from the Central Bank’s advance (4.5 percent of GDP); the issuance of treasury bills (1.4 percent of GDP); the non-banking sector (for example, insurance companies, national habitat promotion fund) (0.6 percent of GDP); and external borrowing (0.1).

In 2016, the Government continued to implement measures to partially offset the loss of on-budget donor finance, with a focus on domestic resource mobilization. Amid the suspension of budget support and reduction of project grants, the performance in collecting tax and non-tax revenues improved (figure 14). In nominal terms, total collected revenues increased by 7.6 from 2015 to 2016. In real terms, this increase reached only 2.0 percent (Figure). Relying on stricter policy measures (Box 1), the Government expects to achieve increasingly larger targets in domestic revenue mobilization. However, without at least a doubling of economic growth performance, improved domestic revenue mobilization might not be enough to return public finances to a sustainable pathway. Indeed, external budget support represented 3.7 percent of GDP annually in 2010-2014. Other grants — including the African Union Mission in Somalia (AMISOM) and the Common Market for Eastern and Southern Africa

¹² Project grants declined from 8.1 percent of nominal GDP in 2014 to 7.7 percent in 2015.

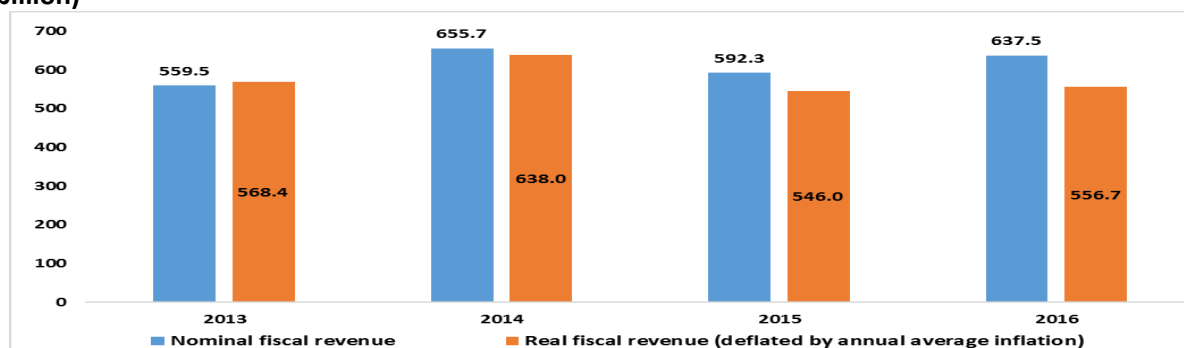
(COMESA) — contributed to 4.8 percent of GDP¹³. On the expenditure front, the pace of committed appropriations at the end of October 2016 suggests that executed expenditures could reach about BIF 1,231.8 billion (US\$ 730 million equivalent) (almost 25.0 percent of GDP), leading in turn to a fiscal deficit of 6.2 percent¹⁴ of GDP in 2016 (down from 6.6 percent in 2015). The wage bill represents about 7.3 percent of GDP (compared to 6.9 percent in 2015). It will increase by 9.5 percent in nominal terms compared to an increase of 6.0 percent in 2015. Meanwhile, interest payments on domestic debt will rise by about 69.4 percent primarily due to increased domestic public debt since the 2015 crisis.

Box 1: OBR’s Strategy to Increase Collected Revenues (from 2016 onward)

OBR’s strategy to increase collected revenues includes the following:

- Recruitment of the personnel needed to achieve assigned performance goals;
- More trained staff and assigned Specific, Measurable, Attainable, Relevant and Timely (SMART) objectives (with bonuses rewarding performance);
- Reinforcement of the localization of tax payers to enhance payments (both regular taxes and the recovery of arrears in lump sum taxes);
- Implementation of a more reliable tax account (“compte courant fiscal”) (that appears to have improved significantly the assessment of the tax contributions / payments owed by tax payers to OBR);
- Heightened efforts (including more allotted staff) to reach out to micro and small tax payers (tax base), while also implementing stricter / tighter instructions for tax arrears’ recovery;
- Creation of an oversight committee to examine more closely the granting of tax exemptions;
- Computerization of domestic revenue collection with the Integrated Tax Administration System (ITAS) software;
- Sensitization campaigns to significantly foster tax compliance and reduce tax evasion.

Figure 14: Domestic Revenue Mobilization Increasing (but still below the pre-crisis level) (in BIF billion)



Source: World Bank staff estimates based on OBR reports and database.

Insufficient domestic revenues have led to heavy reliance on the BRB’s financing to execute the two recent budget laws, thereby contributing to financing large fiscal deficits. The use of treasury bills (T-bills) — net subscriptions by commercial banks and non-financial institutions — also contributed to the (fiscal) financial gap in the equivalent of BIF147.8 billion (US\$ 91.4 million) in 2015 (3.3 percent of GDP), and BIF 206.9 billion (US\$ 122.5 million) in 2016 (4.4 percent of GDP), respectively. By contrast, the use of T-bills averaged BIF 57.8 billion (US\$ 36.1 million) in 2013-2014 (1.4 percent of GDP).

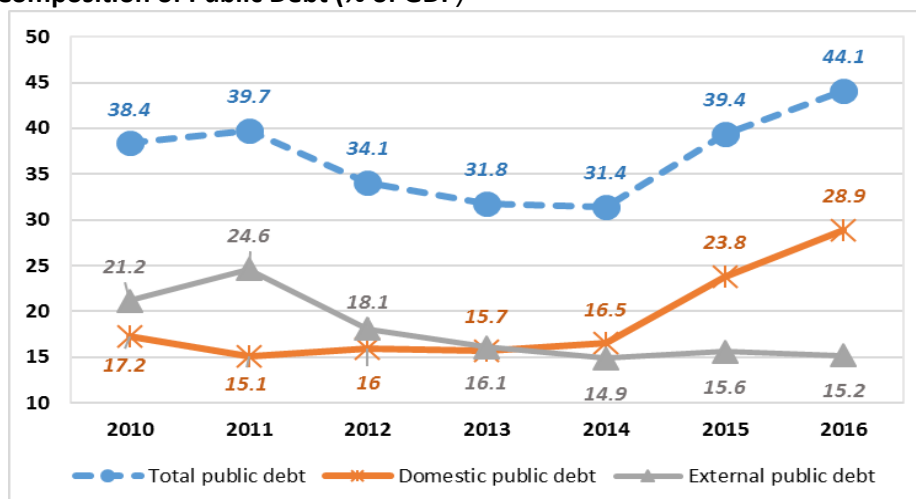
¹³ AMISOM funds provided the Government with financial resources equivalent to US\$ 68.6 million in 2014 and US\$ 59.4 million in 2015. A plausible suspension of AMISOM funds could lead to foregone revenues for the Government averaging, about US\$ 40-50 million, in future budget years.

¹⁴ It should be noted that payment arrears owed to both the private sector (BIF100 billion [US\$ 60 million] estimated by the Chamber of Commerce) and public enterprises (BIF32 billion [US\$ 19 million] owed to the Water and Electricity Company) are growing.

However, net claims on the Central Government increased by BIF 223.1 billion (US\$ 132.1 million) from 2015 to 2016, down from an increase of BIF 302.6 billion (US\$ 187.1 million) from 2014 to 2015. Consequently, there have been growing concerns about dramatic deviations in public debt (Figure 15). According to the Central Bank, the public debt ratio reached 44.1 percent of GDP in 2016, up from 39.4 percent in 2015.

The weight of domestic public debt has dramatically increased since 2015. Other than the increasing recourse to / reliance on T-bills and advances from the Central Bank, the Government has recently begun to draw heavily on debt from the non-banking system. In 2015, the Central Bank estimated that domestic public debt from the non-banking system amounted to BIF 49.9 billion (US\$ 30.9 million), down from BIF 49.2 billion (US\$ 31.7 million) in 2014 — and (a yearly average of) BIF16.8 billion (US\$ 11.1 million) in 2011-2013. Increasing by BIF 22.6 billion in 2016, the stock of domestic public debt owed to the non-banking sector should have reached BIF 71.8 billion (US\$ 42.5 million) at the end of 2016. Discussions with the Federal Chamber of Commerce and Industry (CFCIB) suggested that this debt should be close to BIF 150-180 billion (US\$ 80-110 million), if payment arrears owed to private (non -financial) business are taken into account. With regard to public enterprises, payment arrears of BIF 32 billion (US\$ 19 million) are presumably owed to the National Company for Water and Electricity.

Figure 15: Composition of Public Debt (% of GDP)



Sources: Central Bank reports and the Government’s national accounts.

Unsustainable fiscal deficits have threatened the capacity of the domestic financial sector to support economic growth. Commercial banks decreased credit to the private sector by -1.3 percent in 2016, following a previous credit contraction of -4.0 percent in 2015. This suggests an increasing liquidity constraint, mostly due to heightened exposure to the Government’s fiscal fragility. Treasury bills increased by 95.2 percent from 2015 to 2016¹⁵, comprising 23.9 percent of the current banking asset portfolio. By literally pushing the banks’ asset portfolio toward credit to the Government, a possible credit squeeze effect might compound the current difficult business environment. This context contributes to delaying a potential growth rebound. However, the quality of commercial banks’ asset portfolio has also worsened again. Non-performing loans (NPLs) reached 24.0 percent of this portfolio in 2016, up from 18.7 percent in 2015 and 11.1 percent in 2014. To date, the subsectors most affected by deteriorating loans are: tourism (37.3 percent of accorded loans to the subsector were unpaid); agriculture (30.2 percent); trade (21.0 percent); construction (17.6 percent); and industry (15.2 percent).

¹⁵ Subscriptions of T-bills increased by 72 percent between December 2014 and December 2015.

C. Macroeconomic and Poverty Outlook

The prospects of economic growth in the short-medium term are low due to climate shocks and external vulnerabilities

Without a rapid resumption of external aid, the prospects for economic growth and social development in Burundi will remain highly uncertain. Even if the impact of the 2015 crisis can be contained, economic growth is expected to remain weak in 2017 — with attendant effects on per capita income and poverty. Private investments will likely continue to be constrained by the unfavourable investment climate, for example, rationed access to credit, a worsening of foreign exchange shortages for imported inputs, a high risk of hyperinflation in the coming months, forced migrations, a lengthy returnee process, and so on). The economy is functioning far below its estimated potential growth rate of 3-5 percent. In the absence of external resources (donor aid and FDI) and given the chronically low export base, the country has lost its ability to stimulate domestic demand while also maintaining the current exchange rate policy — without further worsening the macroeconomic imbalances.

In the medium term, economic growth is projected to improve modestly to 1.5 percent in 2017 and 2-2.6 percent in 2018-19 — although this is still below its pre-crisis levels. Real GDP per capita growth will remain negative under this modest improvement in the growth outlook. Consequently, the poverty rate based on the international poverty line (defined as US\$1.90/day) is projected to rise to 83.5 percent by 2019, representing close to 10 million Burundians. Infrastructure development (for example, rehabilitation of the Jiji Mulembwe, Mpanda, Kabu 16, and Ruzibazi hydroelectric dams) is a priority, and is expected to drive growth over the medium term. However, implementation will require overcoming financing constraints. Agricultural growth is projected to improve slowly to 2.5 percent by 2019. This is significantly below the sector's performance prior to the 2015 crisis, since unfavourable weather will continue to affect the sector. In this regard, recent climate smart investments (for instance, the construction of hydro-agricultural dams), supported by the government and donors (World Bank and the African Development Bank [AfDB]), will take time to materialize. Industry is projected to grow at only about 2 percent in 2018-2019, as the Government slowly addresses the energy supply constraints. Security concerns and the effects of the recent foreign exchange dynamics are expected to continue to affect the services sector, especially tourism and banking.

Inflation is expected to continue rising further, reflecting the depreciation path of both the official and the parallel market exchange rates. The pace of inflation increases will be more pronounced the larger the parallel exchange rate premium — and the further the delays in addressing the foreign exchange shortages and fiscal pressures. Additionally, the current policy of monetizing the fiscal deficit — if perpetuated whether directly or through Central Bank lending to commercial banks for onward lending to the Government — should lead to an acceleration in the already rising inflation rate. It could also lead to a crash in the Burundi Franc if the current exchange rate policy is maintained. Moreover, the occurrence of weather-related shocks will put additional pressure on prices through food and energy price inflation.

The Government's commitment to macroeconomic and fiscal prudence is evidenced by a gradual decline in its fiscal deficit over the medium term. The fiscal deficit is projected to decline to 5.1 percent of GDP in 2017, with expenditure consolidation in light of limited official development assistance. A further decline in the deficit is expected in 2018-2019 because of continued consolidation and gradual improvements in revenue mobilization.

In current context, the country's external position is expected to deteriorate. The balance of payments (BOP) will continue to face structural vulnerabilities exacerbated by restrictions in the foreign exchange market in Burundi, as well as negative effects on remittances and FDI. Construction-related imports over the next two years (2017-2019) are expected to outpace modest export growth, and put upward pressure on the current account imbalance. The timely payment of Burundi's contribution to peacekeeping operations by the European Union is expected to help relieve future pressures on the foreign exchange market. A further reduction in capital transfers will put the country's external borrowing requirements at above 13 percent of GDP. With decreased financial inflows resulting from reduced FDI and trade credits, the flight to safety of foreign exchange deposits, and the BOP pressures will be heightened. Any overall balance of about 3.3 percent of GDP will erode all of the country's reserves. Alternatively, it will be financed exceptionally through the creation of external arrears or defaults. With a conservative assumption of financial inflows at 4.8 percent of GDP in 2016 similar to the level in 2015, the overall deficit can only be not less than 8 percent of GDP.

There are risks and challenges, both internal and external, to the projected moderate medium-term macroeconomic outlook. These include continued political problems, foreign exchange shortages and restrictions, exogenous climate shocks, slow progress on domestic revenue mobilization, and potential spending pressures as foreign aid remains below pre-crisis levels. Limited progress toward a resolution of an apparent political impasse in the country would continue to delay much needed foreign currencies from donors, as well as an anticipated rebound in economic activity. Distortions in the foreign exchange market, if persistent, are likely to affect real sector activities, as well as the banking sector, with implications on the fiscal side. Weather-related shocks will remain an important challenge to Burundi's economy, including the continuing need to meet food security needs to the rural population. Climate-smart investments should be prioritized to help mitigate food production shocks. Given a modest growth outlook, the Burundi Revenue Authority may not be able to sustain its recent outstanding performance over the medium term. Its superior performance was attributable to the rise in the payment of tax arrears, which have now declined. The increasing vulnerability of households due to drought and the influx of refugees will constitute an important source of spending pressures, even as foreign aid continues to be limited (Table 4).

Table 3: Macro-Poverty Outlook Indicators (annual percent change, unless otherwise indicated otherwise)

	2014	2015 e	2016f	2017f	2018f	2019f
Real GDP growth, at constant market prices	4.7	-3.9	-0.6	1.5	2.0	2.6
Private Consumption	4.6	1.2	2.0	4.5	6.1	7.2
Government Consumption	2.0	-3.0	-1.9	6.8	6.7	6.7
Gross Fixed Capital Investment	10.5	-41.7	1.0	4.1	5.5	7.0
Exports, Goods and Services	5.4	-9.9	-1.0	3.0	4.0	6.0
Imports, Goods and Services	5.0	-14.1	4.0	13.0	14.5	15.0
Real GDP growth, at constant factor prices	4.7	-2.5	-1.2	0.3	0.7	1.3
Agriculture	3.3	-3.0	-2.8	0.4	1.3	2.1
Industry	8.0	-13.6	-1.5	0.5	0.7	1.3
Services	4.4	2.8	0.1	0.2	0.3	0.7
Inflation (Consumer Price Index)	4.4	5.5	5.6	9.0	7.0	7.0
Current Account Balance (% of GDP)	-6.8	-7.3	-8.6	-10.6	-11.1	-11.4
Fiscal Balance (% of GDP)	-3.4	-6.6	-6.2	-5.1	-4.6	-3.3
Debt (% of GDP)	30.5	32.3	36.3	39.2	29.1	22.1
Primary Balance (% of GDP)	-2.7	-4.4	-4.3	-3.8	-3.3	-2.6
Poverty rate (\$1.9/day PPP terms)^{a,b,c}	73.1	76.8	78.9	79.9	80.6	81.1
Poverty rate (\$3.1/day PPP terms)^{a,b,c}	89.0	91.1	92.2	92.8	93.2	93.4

Sources: World Bank, Macroeconomics and Fiscal Management Global Practice, and Poverty Global Practice.

Note: e = estimate; f = forecast; GDP= gross domestic product; PPP= purchasing power parity. (a) Calculations based on 2002, 2008, and 2013, *Enquête nationale sur les conditions de vie des ménages* (ECVMB). (b) Projection using point-to-point elasticity at the regional level with pass-through = 1 based on GDP per capita in constant local currency units (LCU). (c) Actual data: 2013. Nowcast: 2014 - 2016. Forecasts are from 2017 to 2019.

CHAPTER 2: IMPACT OF THE 2015 CRISIS ON HEALTH SERVICE DELIVERY

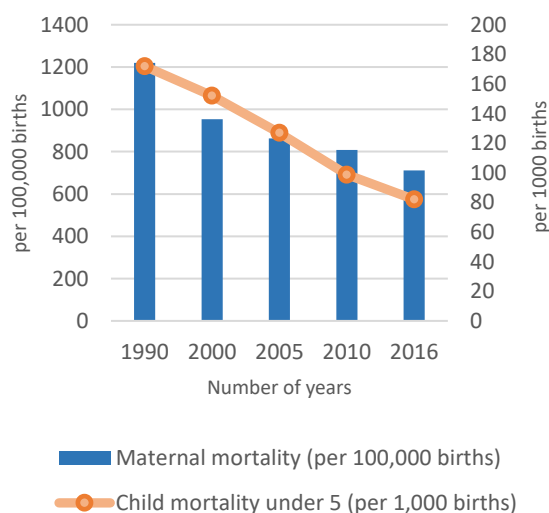
A. Overview of Health Sector Outcomes

This chapter reviews progress pertaining to the most important health outcome indicators, providing an analysis of the impact of the crisis in general, and of maternal and child health outcomes in particular.

Despite some improvements in health outcomes in recent years, Burundi's health levels remain low and the situation for some indicators has become alarming...

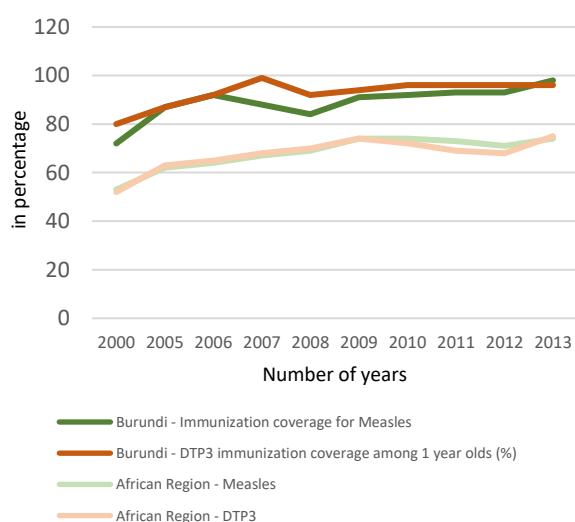
Over the past two decades, Burundi has experienced improvements in certain health indicators, notably the under-five-child and maternal mortality rates, immunization coverage rates, and other key indicators.¹⁶ Burundi made some important progress regarding child mortality, reducing the rate by more than half, from 176 percent in 1990 to 82 percent in 2016. Between 1990 and 2016, maternal mortality also declined – by 42 percent, that is, from 1,220 to 712 deaths per 100,000 births. (See figure 16). The country also succeeded in dramatically raising immunization coverage for six major childhood diseases (including diphtheria, pertussis, tetanus, polio, measles, and tuberculosis), with more than 94 percent of children (aged 0-11 months) receiving complete vaccination in 2015 (See figure 17). The rate of assisted deliveries increased substantially, reaching 82 percent in 2012 – up from 34 percent in 2005 and 65 percent in 2009. The contraceptive prevalence rate for women reached 38 percent in 2015, in contrast to 18 percent in 2010, suggesting that Burundi is also making some important advances in tackling the country's high fertility rates. The prevalence of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) also declined from 3 percent of adults aged 15 to 49 in 2007 to 1.4 percent in 2010. However, the prevalence of major diseases such as malaria and tuberculosis has not decreased. Life expectancy showed a marginal improvement, reaching 57 years in 2014, an increase from 51 years in 1990 and 49 years in 2008.

Figure 16: Maternal and Child Mortality, 1990–2016



Sources: World Health Organization (WHO) (2015, 2016), World Bank, (data.worldbank.org),

Figure 17: Immunization Coverage for Measles and DTP3, 2000–2013



Source: Atlas of African Health Statistics (2016).

Note: DTP3= three doses of diphtheria, tetanus and pertussis vaccines.

¹⁶ This Public Expenditure Review (PER) uses the World Health Statistics and the Atlas of African Health Statistics (2013) for international comparison purposes. The trends are confirmed by the 2010 Demographic and Health Survey (DHS), which also indicate a decline in mortality rates for children under five (from 176 in 2005 to 96 in 2010 for every 1,000 live births), and for mothers (from 615 in 2005 to 500 in 2010 per 100,000 live births).

A comparison with several countries in the region shows a mixed picture, with Burundi lagging behind in some key indicators, but above in others, specifically with regard to regional and World Health Organization (WHO) Africa averages (see figures 18, 19 and 20). Despite increases in the availability and utilization of maternal and child health services, Burundi's maternal mortality remains one of the highest in the region (three times higher than in Rwanda) and in Africa (ranked 39th of 46 countries) according to the WHO. Child and infant mortality rates are above both the Sub-Saharan African (SSA) average (83 per 1,000 live births) and the WHO Africa average (81 per 1,000 live births) due in large part to the prevalence of malaria, diarrhea, pneumonia, and HIV/AIDS (figure 21). Although the fertility rate marginally decreased from 6.9 children per woman in 1987 to 6.4 in 2010 (2010 Demographic and Health Survey [DHS]), it also remains one of the highest in the region. This poses a threat to per capita economic growth in what is already one of the most densely populated countries on the continent. Nonetheless, improvements in births attended by skilled health personnel in recent years (reaching 60 percent in 2015) have positioned the country above the WHO Africa average (accounting for 64 percent in the same year). Compared with neighboring countries, Burundi has the lowest rate of new HIV infections among adults aged 15-49 years. This can be attributed to the high concentration of HIV cases in Bujumbura, allowing for relatively focused provision of resources and HIV services (such as counseling, availability and accessibility of condoms, HIV testing, and early anti-retroviral treatment).

Burundi has one of the highest prevalence rates of underweight children in Africa, with more than half of children under the age of five suffering from stunting. It is therefore far removed from the Sustainable Development Goal (SDG) target of 29 percent (see figure 22). Stunting has remained unchanged for children under the age of five over the last two decades, oscillating between 56 percent (1987), 63 percent (2000), 58 percent (2005) and 58 percent (2010). Even more alarming, there are wide geographical disparities, with stunting being more prevalent in rural areas — in particular in the northern region (where more than 60 percent of children are underweight- figure 23). During the seasonal hunger period (around the months of October and April), only 1 out of 5 children (aged 6-23 months) receives a diverse diet, only around one-third are fed with WHO-recommended frequency, and only one-third consume adequately iron-enriched food. This situation is of serious concern given that malnutrition increases susceptibility to diseases and infections, which in turn translates into higher morbidity and mortality, especially among children. It also has an economic cost through cognitive delays in children, compromised learning performance, losses in work productivity, and increased health costs. According to the United Nations Children's Fund (UNICEF), chronic malnutrition in Burundi costs an estimated US\$ 102 million per year.¹⁷ The underlying causes are related to insufficient coverage of health and nutrition services, food insecurity, deficient maternal and child care practices, problems with water and sanitation and personal hygiene.

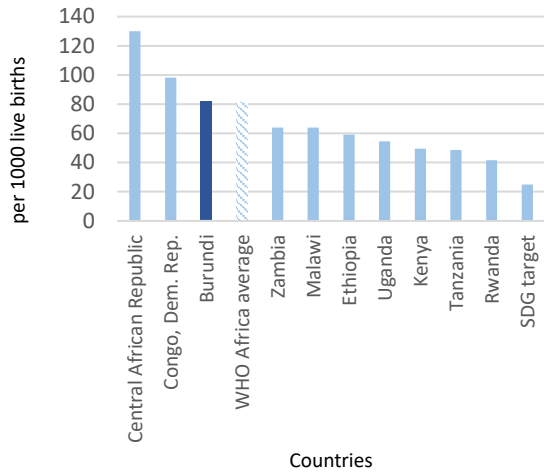
Burundi is the most food insecure country in East Africa, with one of the highest Global Hunger Index (GHI) scores worldwide. In 2014, Burundi's GHI was greater than 30, representing one of the highest scores worldwide and therefore a 'high level of hunger'.¹⁸ The main factor driving food insecurity is the country's legacy of war, along with challenging agro-ecological conditions and economic hardship.¹⁹

¹⁷ UNICEF, 2013. Annual Report for Burundi 2013

¹⁸ The GHI score could not be calculated for Burundi for 2015 and 2016 due to the lack of data on undernourishment.

¹⁹ Welthungerhilfe, IFPRI, 2016 Global Hunger Index, Getting to Zero Hunger, 2016

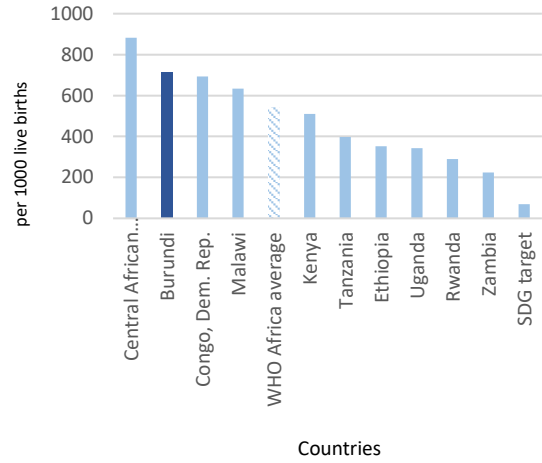
Figure 18: Regional Comparison of Under-Five Mortality Ratio (per 1000 live births)



Source: WHO (2016).

Note: SDG= Sustainable Development Goal.

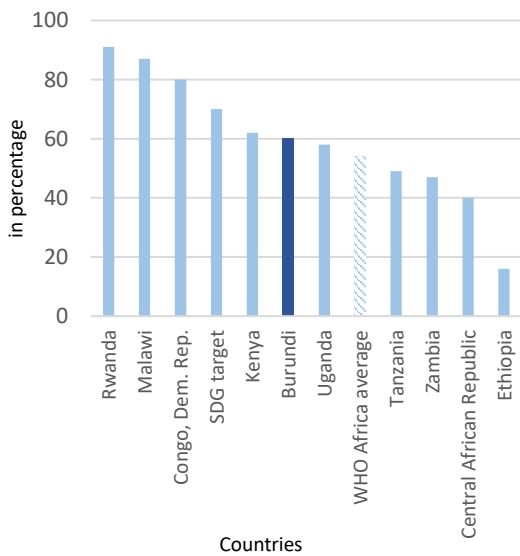
Figure 19: Regional Comparison of Maternal Mortality Ratio (per 100,000 live births)



Source: WHO (2016).

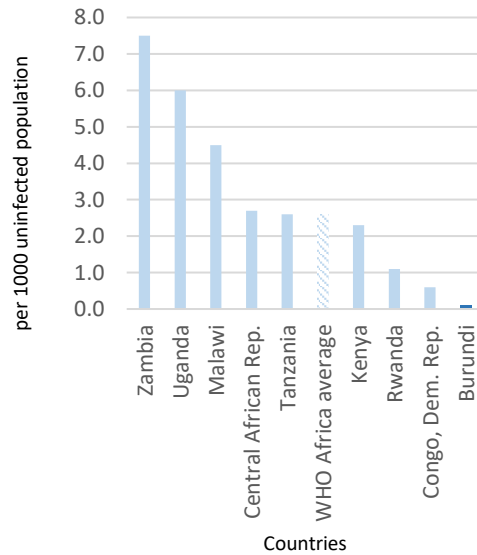
Note: SDG= Sustainable Development Goal.

Figure 20: Regional Comparison of Births Attended by Skilled Health Personnel (%) 2006–2014



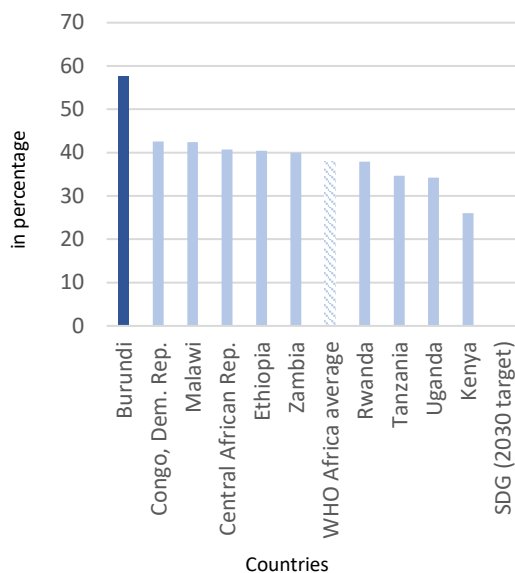
Source: WHO (2016).

Figure 21: New HIV Infections among Adults 15-49 years of age (per 1000 uninfected population), 2014



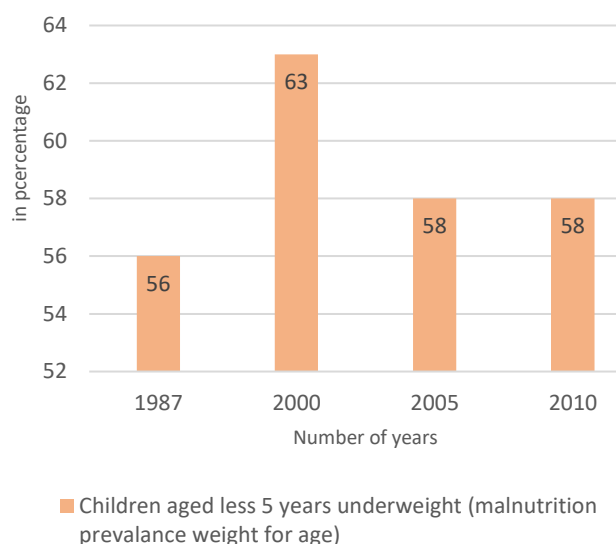
Source: WHO (2016).

Figure 22: Regional Comparison of Stunting in Children under 5 Years of Age (%), 2005–2015



Source: WHO (2016).

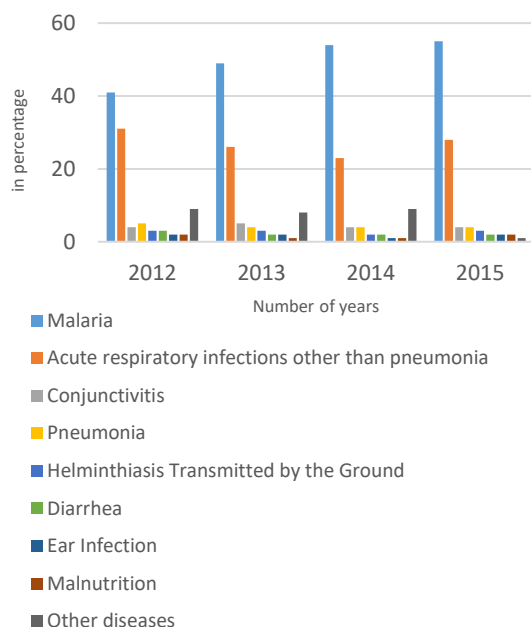
Figure 23: Percentage of Children Aged Less than 5 Years who are Underweight (malnutrition prevalence weight for age)



Source: DHS (2010), Institut de statistiques et d'études économiques du Burundi (ESTEEBU) (2012).

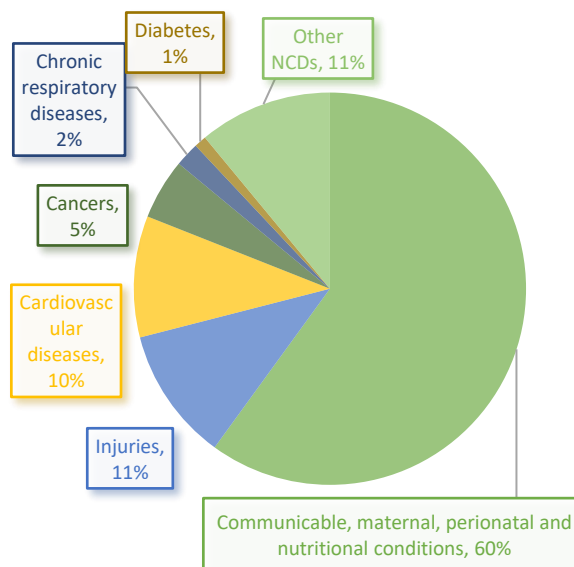
High levels of mortality related to communicable and non-communicable diseases also represent a significant public health challenge. In Burundi, communicable diseases — especially malaria, diarrhea, and respiratory tract infections — are the main causes of mortality and morbidity, especially among children under the age of five (figure 24). In addition to the communicable diseases, chronic and non-communicable diseases (NCDs), such as cardiovascular diseases and cancer, are becoming increasingly prevalent. In this context, the WHO estimated that non-communicable diseases accounted for 28 percent of deaths in Burundi in 2014 (figure 25). Therefore, the double burden of communicable and non-communicable diseases (which will increase the spectrum of services that the health sector will have to provide, thereby driving up costs), coupled with the high population growth rate are likely to put additional fiscal pressure on the country's health budget.

Figure 24: Causes of Mortality for Children under 5 (%), 2012–2015



Source: Authors' calculations; MSPLS, Annual Health Statistics (2015)

Figure 25: Mortality by Disease in Burundi (%), 2014¹



Source: WHO (2014).

Note: NCD= Non-communicable disease.

The political crisis of 2015 further compounded the delivery of health services.

Service delivery data suggest that maternal and child health services were severely affected by the crisis, but recovered in 2016. As shown in table 5, pre- and post-natal consultations by pregnant women at District Hospitals declined substantially by 60 and 92 percent between 2014 and 2015 respectively. Likewise, the use of contraceptive methods and the demand for vaccines by pregnant women also declined. The drop in the demand for reproductive health services in 2015 has been largely attributed to the spreading of incorrect rumors following the elections, including fears of increased health costs. However, with the exception of a continuous decline in the ‘first time’ demand for modern contraceptive methods, demand for maternal and reproductive services increased again in 2016. Regarding the provision of health services for children, fewer consultations have been recorded in hospitals for children above and below the age of five, in particular in Bujumbura and Bururi. This suggests that parents have been more hesitant to take their children to the hospital during the country’s unrest and insecure situation, except in cases of older children needing to be hospitalized.

Table 4: Evolution of Selected Performance-Based Financing (PBF) Indicators at Health Centers and District and National Hospitals, 2014–2016

	2014	2015	2016	2014–15 (%)	2015–16 (%)
Health Centers					
Pregnant women, curative consultations	596,289	718,324	792,926	20	10
Minor surgeries	75,272	83,073	97,736	10	18
Voluntary HIV/AIDS test	1,132,377	1,214,853	1,408,131	7	16
New persons placed on ART to combat HIV/AIDS	1,125	1,413	3,684	26	161
Curative consultation for children over the age of five	6,463,067	6,835,267	8,695,178	6	27
Curative consultation for children under the age of five	7,309,738	7,300,758	8,641,857	0	18
Days of hospitalization for children under the age of five	146,738	152,353	194,249	4	27
District and National Hospitals					
Number of new persons placed on ART	204	204	216	0	6
Cesarean delivery	22,516	25,103	26,837	11	7
Obstructed delivery	23,463	25,878	30,859	10	19
Days of hospitalization for children over the age of five	1,015,238	1,150,914		13	
Days of hospitalization for children under the age of five	683,614	677,525	1,471,264	-1	117
Consultations by a doctor for persons over five years of age	428,138	386,259	461,984	-10	20
Consultations by a doctor for children under five years of age	380,462	300,544	362,315	-21	21
Consultations by a doctor for pregnant women	87,312	79,416	91,933	-9	16
Standard prenatal consultations*	1,239,487	498,447		-60	
Postnatal consultations*	281,273	22,220		-92	
Pregnant women fully vaccinated*	367,087	314,514		-14	
Women using implants or intrauterine devices	3,691	2,539	4,099	-31	61
Acceptors/users of modern contraceptives	17,927	15,938	3,237	-11	-80

Source: PBF database.

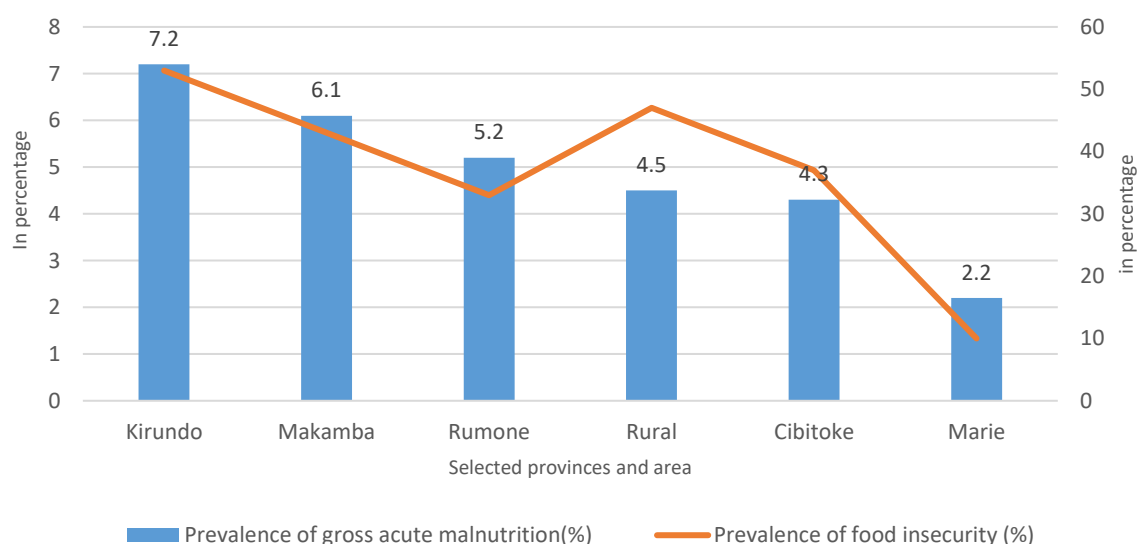
Note: ART=anti-retroviral treatment. *This indicator is not available for 2016. The respective services are no longer paid for in hospitals as they can be conducted in the health centers.

Demand for some health care services fell during the first six months of 2015, but recovered by the end of that year. Demand for health services, in particular those services related to HIV/AIDS, dropped substantially in May 2015. This decline coincided with the demonstrations and associated violence, notably in Bujumbura. Demand increased again in the following months, with continued improvements in 2016. Other indicators dropped during the first quarter of 2016, such as consultations and hospitalization for children under the age of five in health centers. Indicators then increased again from July onwards after the electoral period and with fewer demonstrations taking place.

By contrast, several health service indicators have seen continuous improvements since 2014, reflecting the fact that the impact of the crisis was localized to Bujumbura and urban areas. In comparison to 2014, more pregnant women participated in consultations at health centers, more minor surgeries were conducted, and more children older than the age of five were hospitalized in health centers in 2015. In hospitals, caesarean and obstructed deliveries, the hospitalization of children over 5 years of age, and the number of new persons placed on ART also increased substantially in 2015 as compared to 2014. On the whole, the delivery of health services at health centers was less affected by the crisis than at hospitals, since the majority of hospitals are located in urban areas.

The recent crisis has further exacerbated the existing food security and malnutrition challenges caused by the disruption of food supplies. Political instability and insecurity in Burundi since mid-2015, coupled with natural disasters, have resulted in falling agricultural production and economic contraction. This in turn has resulted in a fragile food security situation among vulnerable households. The World Food Programme (WFP) conducted a survey, the Emergency Food Security Assessment (EFSA), in all 18 provinces in April 2016. It reported that nearly 4.6 million people were food insecure (42 percent), of which 590,000 (about 11 percent) were found to be severely food insecure. The increase in food insecurity hit 15 of the 18 provinces in Burundi particularly hard, with dramatic spikes in Kirundo (33 percent), Makamba (25 percent), Cankuzo (24 percent), and Rutana and Bujumbura rural (23 percent each).²⁰ Moreover, food imports accounting for around 30 percent of food availability prior to 2015 have been hampered by insecurity and lack of foreign currency. This has led to a further widening of the country's national agriculture trade deficit and has further degraded food security.²¹

Figure 26: Prevalence of Gross Acute Malnutrition and Food Insecurity Index in 6 Provinces, June–August 2016



Source: EFSA (April 2016)

Repeated migration linked to political tensions, a low availability of food, and high food prices has compounded the malnutrition problem. The ongoing political tension disrupted crop production, as many farmers had to abandon their land due to insecurity. This led to the migration of over 300,000 people (of whom around 55 percent are children) to neighboring countries by September 2016.²² The most affected areas included the outskirts of Bujumbura (the epicenter of the crisis), and the provinces of Central, East-North and East where casual work opportunities were significantly reduced due to the crisis. With a decrease in food production and attendant increases in food costs, households may reduce the amount of food consumed or have to supplement their diets with market-purchased, less nutritious foods. Two rounds of mass screenings of children under the age of 5 were carried out in several food insecure provinces (including Bujumbura Mairie, Bujumbura Rural, Cibitoke, Karusi, Kirundo, Makamba, Rumonge, and Rutana) in June and October 2016. The results revealed an increase

²⁰ World Bank, Poverty Assessment (2015).

²¹ Food and Agriculture Organization (FAO), WFP, *Monitoring Food Security in Countries with Conflict Situations: A joint FAO/WFP update for the United Nations Security Council*, 2016.

²² Burundi, Humanitarian Situation Report, UNICEF, September 2016.

in the global acute malnutrition (GAM) and global severe malnutrition (GSM) rates in the Kirundo province (from 7.2 to 8.9 percent and 1.8 to 2.2 percent respectively) (figure 26). These declines were associated with low rainfall adversely affecting the agricultural season.²³

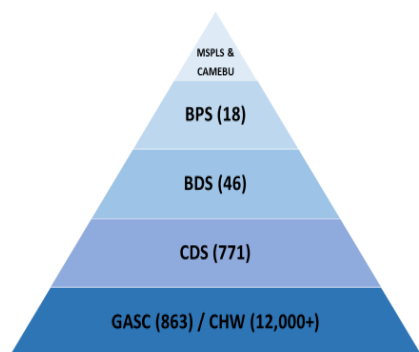
B. Health System Performance

This section provides a brief overview of the health sector’s organization. It also analyzes the performance of the health sector, and identifies bottlenecks in the delivery of quality health care interventions.

Half of Burundi’s provision of health care is managed by the government, although private health care provision is growing. Traditional medicine is widely used in rural areas. Community health is viewed as promising — but still operates on a small scale.

Burundi’s public health system is organized across three levels: Central, Provincial and District — although the roles and responsibilities of the health districts have not yet been formalized (figure 27). The central administration is responsible for providing overall strategic direction and policy formulation. It is also responsible for implementing, monitoring and evaluating the vertical programs. At the provincial level, there are 18 Provincial Health Offices (PHOs) – one for each province to coordinate the implementation of the national health policy and provide technical assistance to the health districts. In addition, there are 46 health districts that provide health services through the district hospitals and health centers. The health districts were established in 2009 following a restructuring of the health system. However, eight years later, the regulatory framework governing the districts and the autonomy of the health centers has not yet been defined.

Figure 27: Burundi Health System Organizational Chart



Source: Authors’ depiction.

Note: BDS= Bureau de District Sanitaire (District Health Office); BPS=Bureau de Province Sanitaire (Provincial Health Office); CAMEBU= La Centrale d’Achats des Médicaments Essentiels et des Consommable Médicaux du Burundi; CDS= Centre de Sante (Health Center); CHW= Community Health Workers; GASC= Groupements d’Agents de Santé Communautaire (Associations of Community Health Workers); MSPLS= Ministère de la Sante Publique et de la Lutte contre le SIDA (Ministry of Public Health and Fight Against AIDS).

There are 1,090 officially recognized medical facilities, of which about half are public facilities. According to the Ministry of Health Ministry of Public Health and Fight Against AIDS (Ministere de la Sante Publique et de la Lutte contre le SIDA - MSPLS)’ annual statistics, Burundi has 73 hospitals

²³ République du Burundi, PRONIANUT Rapport de dépistages de masse de la malnutrition aiguë dans six provinces prioritaires, Décembre 2016. The suggested WHO emergency response threshold for the GSM is 2 percent.

(including 42 district and 4 national hospitals) and 1,017 health centers.²⁴ (See figure 28). Even though the public sector provides the bulk of health services (62 percent of hospitals and 56 percent of the health centers are managed by the government), the private sector represents a very important share of service delivery. This is the case in particular in urban centers and especially in Bujumbura (see figure 29).²⁵ Despite the lack of quantitative data about its activities, the private sector has grown considerably in recent years. Indeed, it plays an increasing role in the health system, providing very specialized services such as neurology, ophthalmology, and dialysis. However, it suffers from inadequate quality control and supervision. Confessional health facilities are completely integrated into the public health system, and are included in the National Health Policy. The private sector, though, is not. The patient’s choice of provider is largely influenced by financial and physical accessibility, but also by the perception that confessional health facilities provide better health-care, although there is no data available to confirm this.

Figure 28: Number of Medical Facilities by Type and by Sector, 2015

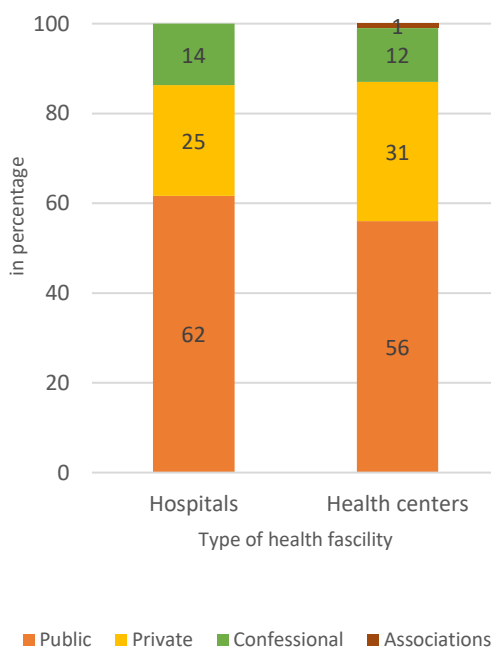
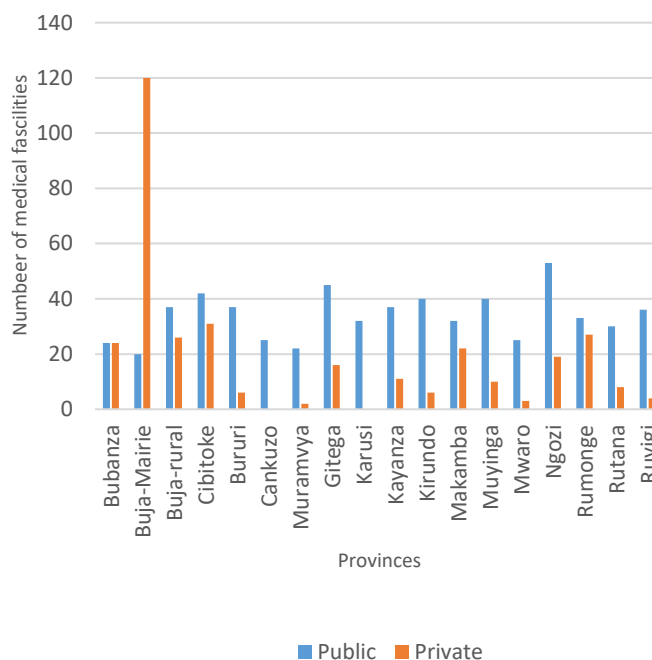


Figure 29: Distribution of Medical Facilities by Type and by Province Sanitaire, 2015



Source: MSPLS 2015 Annual Statistics.

Source: MSPLS 2015 Annual Statistics.

Note: The provinces of Bujumbura Marie, Gitega, Ngozi and Rumonge are considered urban areas.

Traditional medicine is widely used in Burundi, but is managed outside of the public health system.

Sick people are as likely to consult traditional practitioners as their modern health care providers, depending on the nature of their problem. The traditional medical practitioners are organized in an association (*Association des tradipraticiens du Burundi*). To improve the quality of home deliveries, the Ministry of Health, through the Performance Based Financing (PBF) has incentivized Traditional Birth Attendants (TBAs) to encourage pregnant women to seek health center services.

Public health centers are typically the first point of contact in the system, followed by district and national hospitals.

However, shortcomings in the health referral system have undermined the

²⁴ There are 45 public hospitals, 18 private for-profit hospitals, and 10 confessional hospitals. Among the health centers, 566 are public, 312 private for-profit, 127 are confessional and 12 are associations. (MSPLS, 2015 Annual Statistics, 2015).

²⁵ MSPLS, Human Resource Profile, 2016.

efficient use of the different levels of health service providers. Different packages of services are provided at each level of the health system, with basic health centers geared to provide primary care.²⁶ An assessment of children (aged 0-59 months) with acute respiratory infections showed that 43 percent of the parents sought treatment for their child at a public health facility in the first instance, 4 percent at a public hospital, and 2 percent with a private doctor. However, there is evidence that patients have bypassed lower level services, leading to the overcrowding of higher level facilities. For instance, although the national referral hospitals provide the highest level of services and should in theory function almost solely as referral centers from district hospitals, in reality, there is an overlap of the activities of the district and national referral hospitals. This results in national referral hospitals often assuming the responsibilities of district hospitals. The challenges with the referral system can be mainly attributed to: (i) the poor coordination and linkages within and between health facilities; (ii) non-compliance with referrals; and (iii) weak referral monitoring systems.

Community-based organizations (CBOs) and civil society organizations (CSOs) also participate through preventive and promotional interventions. However, collaboration with health centers and the Health District offices is not formalized. Since the official launch of the Community Health Strategy in 2012, the Government has put in place a volunteer-based system of Community Health Workers (CHWs) for all provincial health offices, as well as for the newly established GCHWs (Groupings/Cooperatives of Community Health Workers) placed at the public health centers. About 8,512 volunteer CHWs were trained in 13 of the 18 Health Provinces. Despite good results achieved in family planning and increased ante-natal and post-natal consultations, the community health approach is hampered by several weaknesses. These include: (i) weak assimilation of CHWs into the health system; (ii) insufficient supervision; (iii) insufficient harmonization of CHW training and training tools; and (iv) lack of a community information system.²⁷ At present, the Government is undertaking performance-based financing on a pilot basis at the community level in the provinces of Gitega, Makamba and Mwaro.

The gradual introduction of innovative and far-reaching health policy reforms over the past decade have contributed to improvements in several health indicators.

Building on the Health Policy (2005–2015) and several sector plans, Burundi’s health sector policy framework has been further strengthened with the introduction of a range of innovative policy reforms. In 2006, the Government adopted the national policy of *Free Health Care* (FHC) for pregnant women and children under the age of five. It also introduced *Performance Based Financing* (PBF) in the health sector. The latter was scaled up nationwide in 2010, with Burundi becoming the second country in Sub-Saharan Africa (after Rwanda) to implement this approach. In order to reduce transaction costs and streamline payments to health facilities, the PBF was merged with the FHC in a new consolidated program. This merger resulted in a dramatic improvement in the quality of health care provision (see Box 2). In 2012, the Government reformed the National Health Insurance Card scheme (*Carte d’Assurance Maladie* [CAM]), first introduced in 1984. The Government also deconcentrated the provision of health services by establishing health districts. Most recently (prior to the crisis), the Government launched the Scaling-Up Nutrition (SUN) movement, and issued a decree for the National Burundi Multi-sectoral Platform for Food Security and Nutrition to tackle issues of malnutrition.

²⁶ The health centers offer essential medical services, such as: promotional services; preventive activities in areas such as premarital consultations, postpartum care for mothers and children, family planning counseling and services, and epidemiologic surveillance activities; curative activities; inpatient (maximum 72 hours) and outpatient services; and laboratory testing. Health centers are only staffed with nurses. District hospitals provide mainly curative care, including management of referred cases, management of difficult labor, medical and surgical emergencies, minor and major surgical interventions, inpatient care, laboratory testing, and medical imaging.

²⁷ World Bank, Project Appraisal Document – Republic of Burundi for a Health System Support Project, February 2016.

Box 2: Burundi's Experience in Using Performance Based Financing (PBF) to Implement the Government's Free Health Care (FHC) Policy over the Past Six Years

Implementation: Until 2010, the implementation of the FHC scheme was constrained by a number of difficulties, such as overly-detailed invoices provided by health facilities, double-billing or long delays in paying the health facilities, thereby resulting in high transaction costs. With the merging of both programs, health facilities are paid based on their performance in delivering basic health care services to pregnant women and under-five children. This has resulted in lower transaction costs, simpler invoicing, and a fairly strong verification of the accuracy of reported levels of services.

Results: Since its introduction, the FHC-PBF program has contributed to achieving significant results as follows: (i) improving the use of health services, which increased from 0.4 to 1.6 new contacts / inhabitant per year from 2005 to 2014; (ii) strengthening the quality of care by transferring funds to front-line service providers; (iii) reducing inequalities by improving health services, especially for maternal and child health, as well as reducing household out-of-pocket spending, (iv) improving the management and autonomy of health facilities (for example, through decentralization of decision-making and enhancing financial management autonomy); (v) motivating health personnel through the payment of performance bonuses; and (vi) strengthening collaboration between health centers and stakeholders at the community level. It is estimated that about a quarter of the country's population will have benefited by the program by 2017.

In addition, the pooling of donor aid under one instrument has also led to positive changes, including: (i) improved coordination among the development partners; (ii) the use of harmonized donor procedures; (iii) predictable and rapid disbursements, with low transaction costs because there is no procurement for PBF payments; and (iv) direct and transparent payments to the health facilities.

Going forward: In the context of its new health policy (2016–2025), the government seeks to continue and improve the FHC-PBF program by introducing funding of community health programs through the PBF. To improve the quality of care by health facilities, the Government also seeks to increase payments based on quality indicators, and less on quantity indicators. Another priority will also involve the implementation of an enhanced cost containment policy to avert a spike in invoices and bonuses that led to program deficits of US\$ 8 million experienced in 2013.

Source: World Bank, Project Appraisal Document – Republic of Burundi for a Health System Support Project, February 2016.

The Government's recently developed second National Health Policy (2016–2025) seeks to achieve universal health coverage (UHC) while also tackling key bottlenecks in the health care system to improve health outcomes. In line with the health-related SDG targets, the recently finalized National Health Policy focuses on rolling out universal health coverage by expanding access to health care and overcoming inequalities in the system. To achieve this, the Government seeks to address the low-quality care that is adversely affected by: (i) the insufficient provision of health care (for example, nutrition); (ii) the shortages in qualified health care staff; (iii) the lack or insufficient availability of medical equipment, drugs and inputs for hospital and public health programs; (iii) the inadequate referral system; (iv) poor coordination and supervision of community health workers; and (v) the inconsistency of health data, including the insufficient use of data collection tools (see subsequent sections).

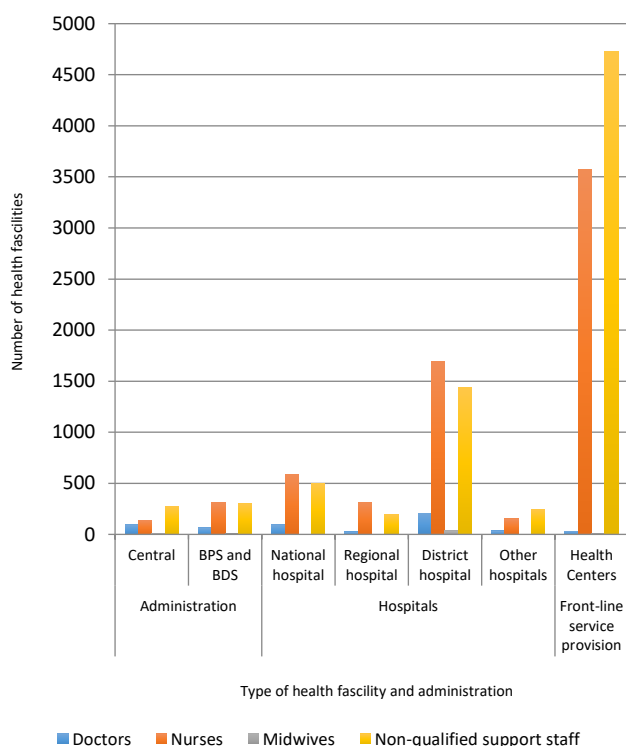
A fundamental problem underlying the low quality in the delivery of health care services in Burundi is the shortage in qualified human resources, including uneven geographical distribution and insufficient training.

Burundi, like many developing countries, has a serious shortage of qualified health workers.²⁸ In 2016, of a total of 18,570 health care personnel, 3 percent were doctors, 37 percent nurses, and 0.4 percent midwives. However, almost 40 percent were unskilled support staff. Burundi is still far from

²⁸ Data on the health workers employed by the private sector is not available.

the World Health Organization-recommended norms for doctors, nurses and/or midwives. For instance, the country has on average of 1 doctor per 17,765 population, whereas the WHO recommends 1 doctor per 10,000 population.²⁹ The situation is even more alarming for midwives, with one midwife for 171,102 women of reproductive age. Again, this is far below the WHO recommended rate of one midwife for every 300 women of reproductive age. Notwithstanding the opening of a midwifery school in 2010, the first midwife promotions have been absorbed by the administrative system. However, only a few midwives continue practicing at the level of front-line services.

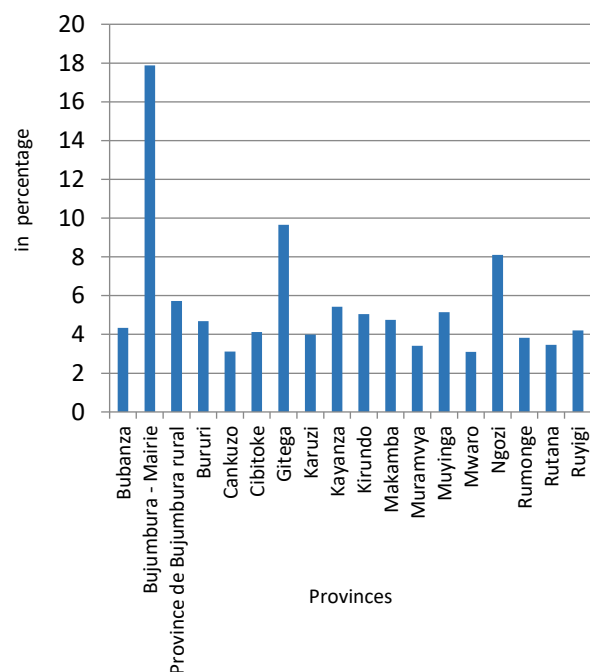
Figure 30: Distribution of Health Workers by Health System Level, 2016



Source: MSPLS, Human Resource Profile, 2016.

Note: BDS= Bureau du District Sanitaire; BPS= Bureau de la Province Sanitaire.

Figure 31: Distribution of Health Staff by Province, 2016



Source: MSPLS, Human Resource Profile, 2016.

Note: The province of Bujumbura Mairie is considered urban, and selected health districts in Gitega, Ngozi and Rumonge are considered semi-urban.

The shortage of health workers is worsened by geographical imbalances. About 70 percent of doctors serve 90 percent of the population living in rural areas, and the remaining 30 percent serve the population in urban and semi-urban centers (figure 30). Almost all specialist doctors work in urban areas. There is a particularly high concentration of health workers in the capital city, with almost 18 percent of all health workers and more 36 percent of all doctors located in Bujumbura. By contrast, the distribution of health workers is on average 5.6 percent across all provinces (figure 31). Efforts to redistribute medical staff more equitably according to the Ministry's norms have been hampered by the lack of incentives for medical staff to move to remote areas, as well as the absence of accountability and sanction mechanisms governing the distribution of medical staff.

²⁹ MSPLS, Human Resource Profile, 2016

Some policy measures have been introduced in an attempt to address the staffing imbalances, but have shown little impact to date. As part of a newly negotiated benefits package between the Ministry of Health and the Ministry of Civil Service in 2010, the Ministry of Health was authorized to provide a distance allowance for medical staff working in remote areas. However, the financial incentives have not proved adequate to move and retain health workers in underserved areas.³⁰ A similar allowance provided under the PBF's equity bonus aims to also address the long distances to the District offices. In 2014, the Ministry conducted a study assessing the decentralization of its human resource management, but the implementation of its recommendations has been on hold since 2015.³¹ Facing severe budget constraints and the freezing of recruitments in 2016, the Ministry decided to enforce the transfers of some medical staff both from the central level to the provinces and within the provinces to tackle the inequitable deployment. This move met with limited success, as individuals from Bujumbura were able to move back to their previous posts.

Even though Burundi has managed to produce more health workers in recent years, their performance is adversely affected by the low quality of training they receive. There are three medical universities, of which one is public (University of Burundi) and two are privately-owned (the University of Ngozi and the University Hope). In addition, there are 25 para-medical schools (including 19 private schools). Although information about the number of graduates is not available, it is widely acknowledged that the number of medical graduates from the medical universities has increased in recent years. This has resulted in shifting the primary constraint from a shortage of newly-trained physicians to their insufficient absorption by the health system due to hiring constraints by the public sector. Nevertheless, despite the higher number of graduates, the quality of student training has declined according to sector surveys. Health facilities and health managers have complained about graduates' level of qualifications.³² This is particularly a problem for the private medical schools, which have lower entry criteria for students, provide less training in residency and had, until recently, larger class sizes (on average 70 students per class). Following recent requests by the MSPLS, the private schools have lowered their class size to 40 students in accordance with the Ministry's norms. It is also noteworthy that there is no formal training program for nutritionists, even though malnutrition is a severe endemic problem in Burundi.

Salaries remain low, adversely affecting health worker motivation and performance. In addition to their base salary, all health workers benefit from "premiums"³³ and allowances. Despite efforts to improve the remuneration package of public-sector health workers in 2010, salaries have remained low.³⁴ The monthly salary of a newly qualified doctor amounts to US\$250 per month (basic salary, allowances and bonuses), whereas a doctor with 20 years of experience earns around US\$420 per month. In the absence of a national regulatory policy, some public-sector physicians supplement their income by providing healthcare services in the private sector. The insufficient remuneration package also contributes to the 'brain drain' of specialist doctors (currently about 150 specialist Burundian

³⁰ Following negotiations between the Government and the trade unions (SIMEBU, SYMEGEB, SYNAPA and SNTS) regarding the salaries of health workers that were considered insufficient for all categories (doctors, nurses, and so on), a joint agreement was signed on April 7, 2009 for a package of benefits and allowances to health workers. The attribution of additional benefits and allowances for the health sector includes: (i) new bonuses (function, scarcity, incentive, return, fidelity and fixation bonuses); and (ii) allowances (professional stabilization, representation, displacement, equipment, risk, housing, remoteness, clinical, custody, research, overtime, special on-call and cash). (*Ordonnance Ministérielle No 630/570/540 du 16/02/2010 portant montant et critères d'octroi des primes et indemnités spécifiques aux personnels de la santé publique.*)

³¹ MSPLS, *Elaboration d'une stratégie et d'un plan opérationnel de gestion décentralisé des ressources humaines pour le MSPLS*, 2014.

³² Facility Surveys, 2010 and 2013.

³³ Premiums provided under PBF, for instance.

³⁴ The attribution of additional benefits and allowances for the health sector include: (i) new bonuses (function, scarcity, incentive, return, fidelity and fixation bonuses); and (ii) allowances (professional stabilization, representation, displacement, equipment, risk, housing, remoteness, clinical, custody, research, overtime, special on-call and cash).

doctors work outside the country), which further undermines health care delivery. Although the provision of PBF-funded premiums for health workers at deconcentrated levels of the system has substantially contributed to improved staff performance and satisfaction, problems of motivation of health workers in some remote areas remain. These problems are attributable to difficult working conditions (such as lack of necessary medical equipment), inadequate housing, and a lack of adequate schools.³⁵

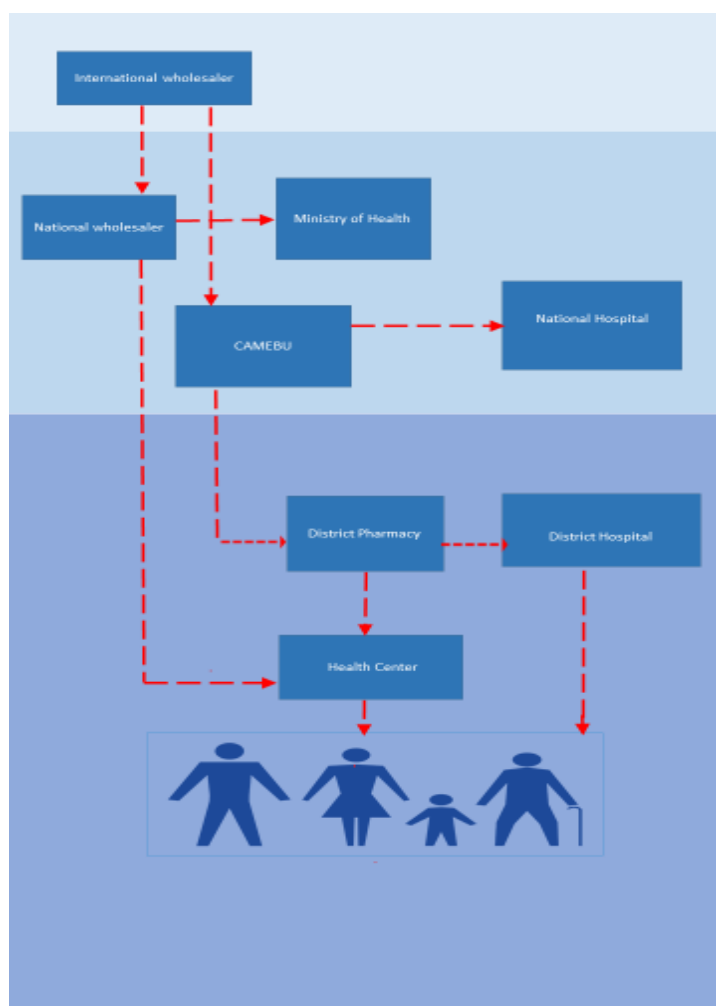
Burundi also suffers from an inappropriate skill-mix, undermining efforts to manage the health system in a more efficient and effective manner. According to the recent 2016 health survey, all 564 public-sector health facilities operate below the Ministry's technical norms. There is a lack of essential human resources (nurses, physicians, and specialists). Conversely, the health system has a surplus of 3,578 workers at the level of non-skilled support staff in health centers, district hospitals and regional hospitals. More than 80 percent of this surplus is found in health centers. A key constraint is the absence of a human resources information system to track the skill-set of service providers. For now, the ministry has developed a five-year staffing plan to consider the staffing needs of the various structures. The Ministry's aim is to reduce the various imbalances in the distribution of human resources, although it remains unclear whether it has the fiscal space and implementation capacity to put the plan into practice.

The performance of the supply and distribution chain of drugs and other health care inputs remains unsatisfactory, resulting in a major impediment to value-for-money in health care services.

The organization of the public drug supply chain in Burundi is illustrated in figure 32. Burundi's medical supply chain has three tiers: (i) a central drug purchasing unit, *La Centrale d'Achats des Médicaments Essentiels et des Consommable Médicaux du Burundi (CAMEBU)*; which sells to district pharmacies and national hospitals(ii) district pharmacies that sell to health facilities (district hospitals and health centers); and (iii) health facilities selling to patients.

³⁵ Facility Surveys, 2010 and 2013.

Figure 32: Drug Supply Chain



Source: Authors' schematic.

Note: CAMEBU= *La Centrale d'Achats des Médicaments Essentiels et des Consommables Médicaux du Burundi*.

Inadequate supply from CAMEBU leads district pharmacies to rely heavily on the private sector to procure medicines, medical equipment and consumables. However, these are subject to strict limits³⁶. Due to low order fulfilment rates by CAMEBU, district pharmacies place a significant number of orders with the private sector, accounting for about 40 percent of the quantity ordered³⁷. Although this dual supplier system exists, stock outages are frequent and the prices of medicines are quite high (see section F below). According to PBF annual reports, 55 percent, 35 percent and 33 percent of health facilities experienced at least one stock outage of one or more tracer drugs, respectively in 2013, 2014 and 2015.

Quantification of essential medicines is conducted annually utilizing data on CAMEBU's sales to clients; warehousing and inventory management is improving. With the support of donor aid, CAMEBU's storage capacity tripled from 10,000 square meters (m²) in 2009 to 30,000 m² in 2013. However, the forecasting of essential medicines remains an issue, affecting CAMEBU funding levels and product availability.

³⁶ Five Million Burundian Francs (BIF) (US\$ 2,900) monthly.

³⁷ Burundi National Supply Chain Assessment Results, August 2014.

The transportation of medicines is organized on an ad hoc basis. CAMEBU reportedly has a small number of trucks available for the distribution of medicines that district pharmacies can rent. However, based on the team’s field visits, CAMEBU fleet rentals are hampered by the following constraints: (i) trucks need to be booked well in advance due to the limited number; (ii) renting CAMEBU trucks is more expensive than private transport vehicles; and (iii) rental payments are done through purchase order, which is a more complex and laborious process than the cash system used by the private transporters. The facilities (including health centers and district hospitals) collect the products from the district pharmacies using available transportation ranging from bicycles to pick-up trucks.

Waste management infrastructure and processes are not systematically in place across the health supply chain. For instance, according to the team’s field visit findings, district pharmacies identify and separate unusable products and burn the products on pre-identified sites at irregular times. This results in high volumes of unusable products being stored at each level. The situation merits further research to better understand the extent of the problem.

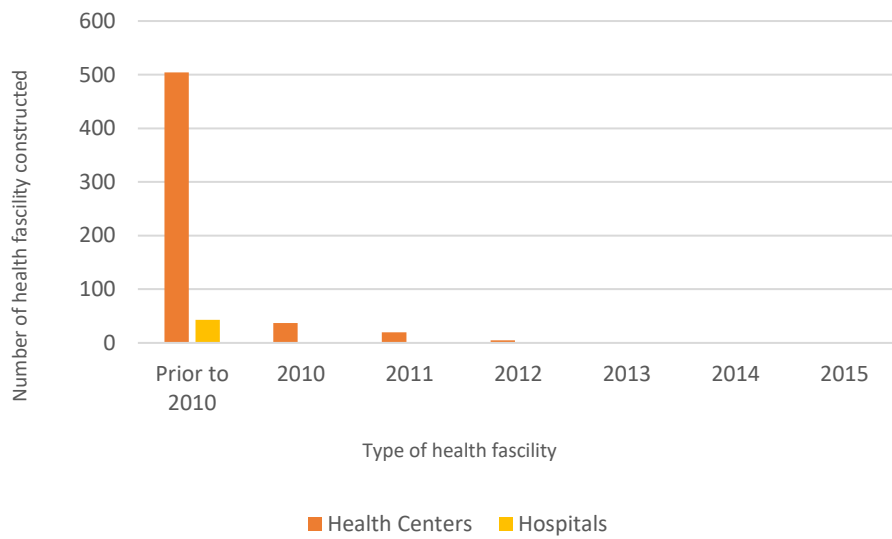
Vaccines and other related inputs are supplied by donors. Of the 45 health districts, 36 have a positive refrigerator and a negative freezer for vaccine storage, and of the 897 health centers, 646 have cold-chain equipment³⁸. The weaknesses of the supply chain management system for vaccines include: (i) gaps in vaccine storage capacity at all levels, as well as transport capacity, especially for health centers; (ii) out-of-stock vaccines, particularly in health centers with new staff having low capacity to estimate needs; (iii) a lack of access to a continuous source of electrical energy, including 65 percent of health centers administering vaccines; therefore, they use generators — but experience frequent difficulties in supplying the oil; and (iv) low maintenance and cold-chain maintenance capacity.

The development of the physical health infrastructure is critical for achieving UHC; however, this remains a challenge in the context of fiscal constraints and other government priorities.

The construction in health facilities is lagging, with the bulk of the construction having been done prior to 2011 (figure 33). Between 2010 and 2015, the number of public health centers increased from 504 to 566, whereas the number of public hospitals stood at 45 in 2015 (up from only 43 in 2010). This results in 1 health center per 16,405 population, and 1 hospital per 206,336 population. Therefore, the country’s infrastructure density is below WHO norms, which recommend 1 hospital center/10,000 population and 1 hospital for every 150,000 population. Conversely, the number of hospital beds is estimated at 7,412 (accounting for 1 hospital bed per 1,253 inhabitants). In this context, Burundi’s inpatient services are above the African average of 1 hospital bed per 29,411 population. To support the country’s “2025 Vision” of universal access to health services, the Ministry estimates an annual construction of 10 health centers per year. This has been outlined in the recently finalized plan to extend health coverage. However, in recent years the government has not undertaken any construction of new health centers, thereby increasing the shortfall in front-line service providers. This has also adversely affected access to health services. The insufficiency in physical infrastructure is further compounded by its poor geographical distribution, as shown by the Ministry’s recently prepared health map (*carte sanitaire*).

38 Inventory of the cold chain, July 2014, and the analysis made during the development of the solar transition plan.

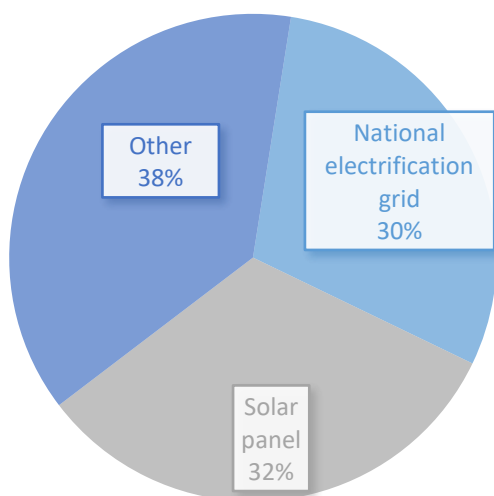
Figure 33: Construction of Health Centers and Hospitals between 2005-2015



Sources: MSLSP, Politique National de Sante, 2016-2025; Data from the Directorate of Infrastructure.

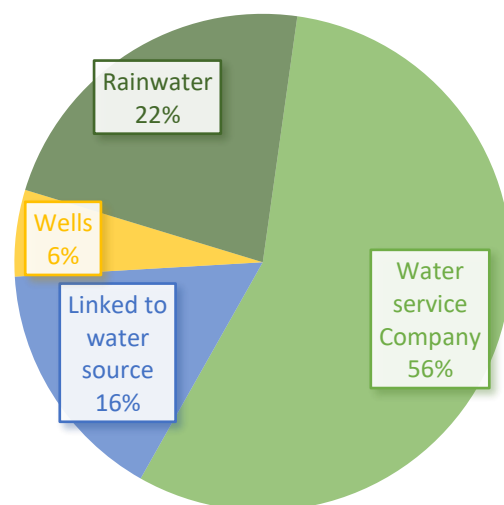
Public health facilities also face operations and maintenance (O&M) challenges. Although almost all health facilities have access to some source of energy and water, unreliable electricity (figure 34) and water supplies (figure 35) have taken their toll on the performance of some health centers. For instance, apart from hospitals located near provincial capitals that have access to the national electricity grid, access to electricity remains a major challenge for most rural health facilities. About one-third of health centers have to use solar panels, but with limited power to keep lights on and medical equipment running. Another 40 percent have access to an even less reliable energy source, such as a generator. Only half of the health facilities are connected to the public water supply network, and one-fifth have to harvest rainwater or use water from a nearby stream (16 percent).

Figure 34: Health Facilities Access to Electricity



Source: MSPLS.

Figure 35: Health Facilities Access to Water



Source: MSPLS.

The inadequate O&M budget is also a problem for the effective maintenance of medical equipment in the health sector. Medium-term projections of the recurrent cost requirements of existing and planned health investments have not been made. This, in turn, leads to inadequate provisions for recurrent expenditures in subsequent budgets and further undermines the sustainability of sector investments. This situation is even further aggravated in the case of donor-funded investments that are not always well linked with government priorities— and that are also disconnected from the government’s recurrent budget. To address this issue, a maintenance plan for medical equipment and infrastructure is currently being prepared by the Ministry, but has not yet been finalized.

Unreliable data sources hamper proper health sector planning and monitoring of health outcomes.

A National Health Information System (*SNIS - Système National d’Information Sanitaire*) was introduced in Burundi in 2008, and is operational at the different health sector levels. The smallest data collection unit is the health center. Each month, health centers and district hospitals send activity reports to the district offices that consolidate and enter them in the online data base, the DHIS2 (District Health Information Software 2). In 2010 with the adoption of the PBF nationwide, the reporting and data entering became quite cumbersome. Since then, the system collects data on 107 indicators³⁹. While system design and activities to strengthen the system have contributed to positive progress, in general, the system is not sufficiently responsive or effective. The system is constrained by the following factors: (i) inadequate governance structures; (ii) ineffective implementation of policy and procedures for data collection and reporting; (iii) insufficient number of health workers to handle the workload, as well as a lack of technical capacity, especially at the health center level; and (iv) lack of infrastructure, including electricity and internet capacity which threatens the use of web base DHIS 2. Indeed, the quality of data within the system is largely dependent on the quality of data received, aggregated, and submitted at the district office level. As a result, information products (for example, the *cartographie sanitaire*) are produced and disseminated, but deficiencies in quality, timeliness, and widespread availability hamper their use and relevance.

³⁹ Indicators are related to health infrastructure, human resources, curative activities, children and women’s preventive health activities, promotional activities, community participation, as well as financial management data.

C. Financing of the Health Sector

This chapter examines health-system expenditures with special attention to the use of health resources for service delivery, within the limits imposed by data availability. To this end, it examines the financing sources, trends in health appropriations, and the composition of the budget. Given that the bulk of public health resources are managed by the MSPLS, the chapter focuses on the appropriations and actual spending of the MSPLS.⁴⁰

Data limitations make it difficult to establish a complete picture of health expenditures because the bulk of the health expenditures are externally funded and managed outside of the government's budget. There are also challenges in acquiring an up-to-date picture of on-budget expenditures. Expenditure data for the years 2015 and 2016 was provided by the MSPLS, but has not yet been consolidated by the Ministry of Finance. The most recent National Health Accounts (NHA) exercise dates from 2013, and covers the years 2010, 2012 and 2013.⁴¹

Donor aid is the main source of health sector financing, making a fragile country like Burundi particularly vulnerable to the fluctuation and unpredictability of aid flows in insecure situations.

Donor aid has been the largest source of finance for the health system up until 2014: the sector's funding composition was significantly affected by the crisis in 2015 (figure 36). According to the NHA (2013), donor assistance accounted for 62 percent of total health sector funding; household contributions for 19 percent; government domestic resources for 13 percent; and the government's insurance scheme (*Mutuelle de la Fonction Publique*) for 5 percent. It seemed reasonable to assume that this funding composition did not substantially alter in 2014. However, a rapid assessment of donor aid included in the 2015 and 2016 budget laws indicates that a sharp drop occurred — by 87 percent — in planned external assistance. The impact of the crisis on donor aid channelled outside the budget is not known, but most likely also declined dramatically.

The high levels of donor assistance showed the sector's vulnerability to the often unpredictable nature of aid, which was exacerbated by the country's experience with conflict and violence. Burundi has one of the highest ratios of external to domestic finance in the health sector (around 50 percent in 2014) as compared to other countries (see figure 37). This high level of aid dependence is not unique to the health sector. Indeed, other sectors such as agriculture, energy and transportation are also heavily aid dependent. Even more concerning for the predictability and sustainability of health sector funding is the large portion of the Ministry's recurrent expenditures (55 percent) financed through external resources. Furthermore, countries that have experienced periods of fragility, violence, or conflict are, in general, more likely to experience higher volatility in their aid flows.⁴² The recent political crisis showed the country's vulnerability to episodes of "stop-go" aid, as evidenced by

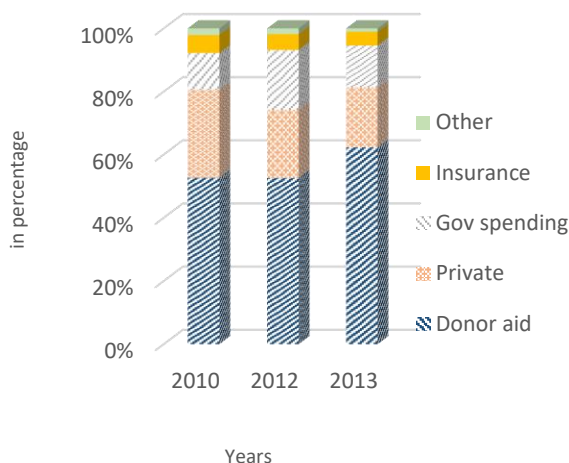
⁴⁰ Other Ministries are also involved in the health sector, but fund only a few programs. These include: The Ministry of National Solidarity, Human Rights and Gender (funding the care for the indigent), the Ministry of Higher Education and Scientific Research (financing the equipment and maintenance of the Hospital Center at the University of Kamenge), the Ministry of National Defense and Veterans Affairs and the Ministry of Public Security (financing the health-related care of army and police personnel).

⁴¹ Health expenditure analysis uses several sources for this financing assessment, including: (i) the appropriations (comprising donor aid) and expenditures (excluding donor aid) of the MSPLS; (ii) the National Health Accounts (including public and private financing); and (iii) field visit data collected at several Health Centers and District Hospitals in three provinces (Bujumbura Marie, Karuzi and Muramvya).

⁴² The World Bank's 2011 *World Development Report: Conflict, Security and Development* examined aid volatility for countries that have experienced violence over the last 20 years. The report noted that it is not an uncommon phenomenon for aid to fluctuate during and after a conflict. This includes Burundi, where total aid dropped by 20 or 30 percent in one year — and then increased by up to 50 percent the following year. (Humanitarian aid and debt relief were excluded from the statistics, which would further increase the volatility).

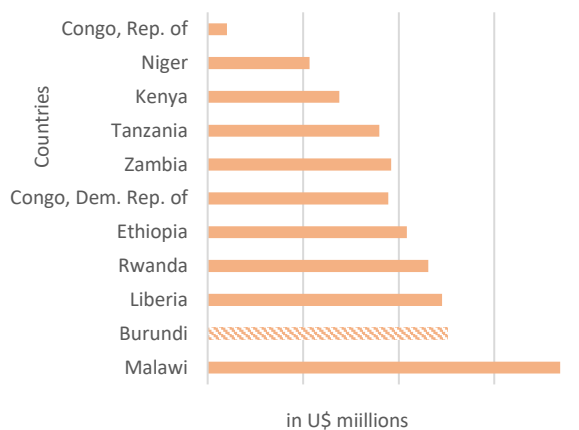
the drop in total external aid in 2015.

Figure 36: Sources of Funds for Burundi's Public Health Sector (%) (2010, 2012-2013)



Sources: MSPLS, NHA 2013.

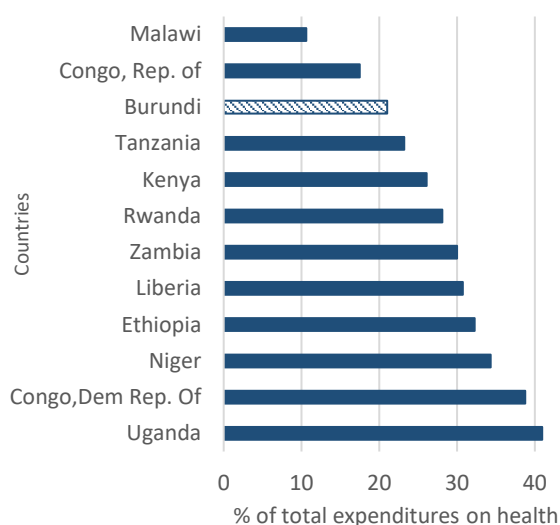
Figure 37: Comparison of Burundi with Other African Countries: External Resources as a Share of Total Health Expenditures (in US\$ millions), 2014



Source: World Development Indicators, 2014.

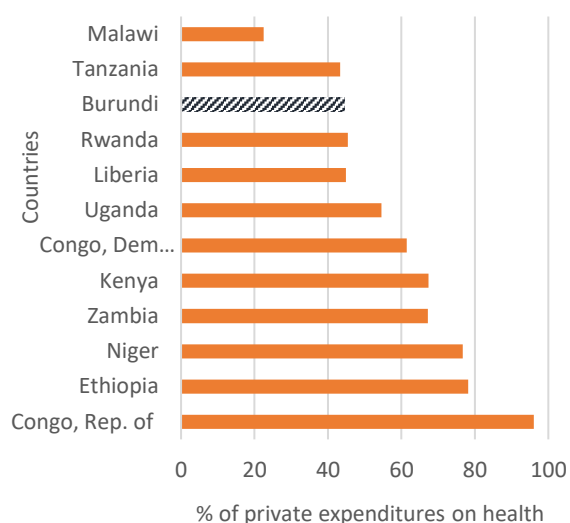
Private health expenditures — that is, out-of-pocket (OOP) spending by households — is relatively low in comparison to other regional peer countries; however, it is likely to have risen since the crisis. Between 2010 and 2013, household OOP spending declined both in relative and in real terms. This decline coincided with the abolition of user fees under the FHC program and the scaling-up of the Medical Assistance Program (CAM). In 2013, household contributions amounted to US\$ 5 (BIF 8,000) per capita, compared to US\$ 8 (BIF 9,000) in 2010 (see figures 38 and 39). Household OOP compares favourably with regional peer countries. However, the recent exchange rate shock seems likely to lead to increased health costs and reduced access to services. In this context, an updated NHA exercise will be required to confirm this. Private pre-payment mechanisms (*Mutuelle de la Fonction Publique*, and others) cover only civil servants, and do not comprise an important part of private health financing.

Figure 38: Out-of-Pocket Health Expenditures (as % of total expenditure on health)



Source: World Development Indicators, 2014.

Figure 39: Out-of-Pocket Health Expenditures (as % of private expenditure on health)



Source: World Development Indicators, 2014.

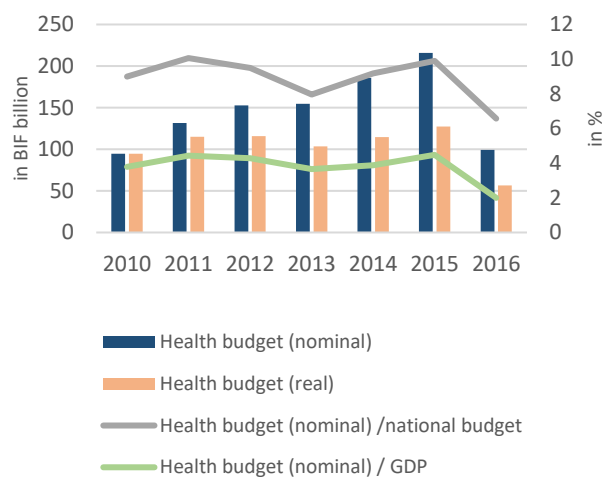
Examining past trends related to the MSPLS’s health appropriations, the domestically-funded resources seem to have been focused more on other priority sectors (such as agriculture, energy etc.), whereas the externally-funded resources were the main driver for total health budget increases; yet, the overall resource levels remain low.⁴³

The total budget allocations (both domestic and external) for the health sector more than doubled in nominal terms during the years 2010-2015. In real terms, the total budget allocations for the health sector increased by 7 percent between 2010 and 2015 (see figure 40). By 2015, the health sector accounted for 10 percent of the national budget, and 4 percent of gross domestic product (GDP). This upward trend is wholly attributable to a doubling in external resources in real terms over this time period.⁴⁴ Allocations of domestic resources to the health sector increased by 30 percent in nominal terms, that is, from BIF 66.1 billion (US\$ 53.6 million) in 2010 to BIF 86.1 billion (US\$ 53.3 million) in 2015. However, in real terms this amounted to a 22 percent decrease as a result of double digit inflation. Furthermore, domestic budgetary allocations to other sectors such as agriculture, energy and transportation did increase in real terms over the same period (figure 43). This suggests that the Government prioritized other sectors in domestic resource allocation, possibly due to the large increase in external assistance to the health sector (figure 42).

⁴³ Health appropriations are defined as the appropriations included in the MSPLS budget (domestically-funded appropriations) and donor aid (externally-funded appropriations); the latter are listed in the Annex of the budget laws for the health sector. The amount of respective disbursed donor aid is not available as this has not been captured in a systematic manner, neither by the Ministry of Finance nor by the MSPLS.

⁴⁴ Note that nominal increases in aid rose by more than 4 four times, that is, from US\$ 23.1 million (BIF 28.5 billion) in 2010 to US\$ 89.5 million (BIF 129.9 billion) in 2015. However, they are substantially lower when taking into account the double digit increases in price levels in past years (US\$ 47.5 million in 2015).

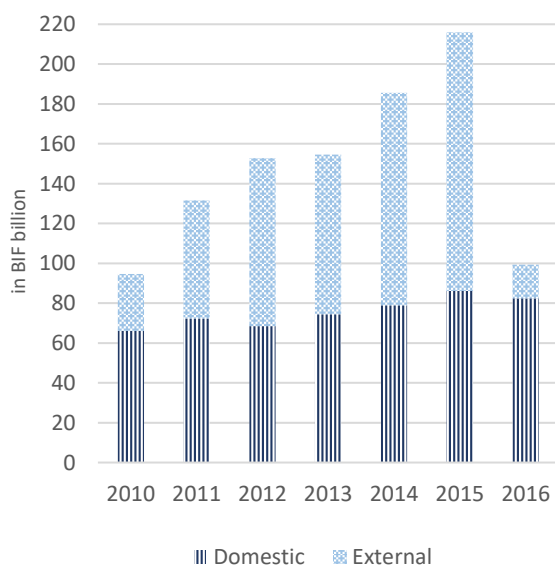
Figure 40: Burundi's Public Health Appropriations (domestic and external), 2010-2016



Source: MSPLS.

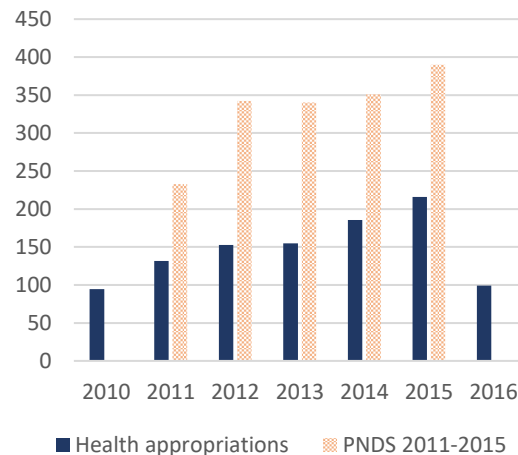
Note: GDP= gross domestic product.

Figure 42: Health Appropriations by Financing Source, 2010-2016 (BIF billion)



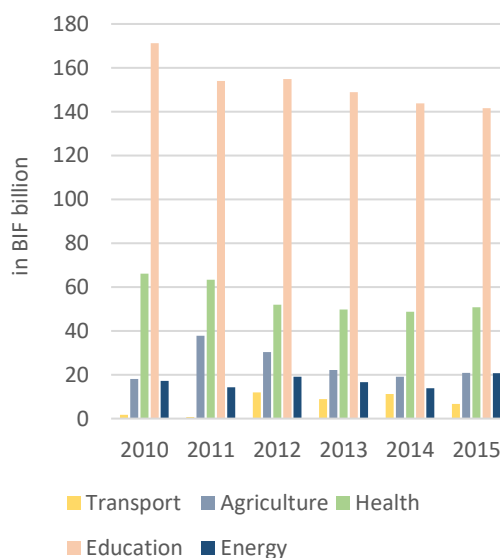
Source: MSPLS.

Figure 41: Government Health Allocations Compared to Funding Needed by the National Plan for Health Development (PNDS), 2010-2016, (BIF billion)



Source: MSPLS.

Figure 43: Appropriations by Selected Sectors, 2010-2015 (BIF billion)



Source: MSPLS.

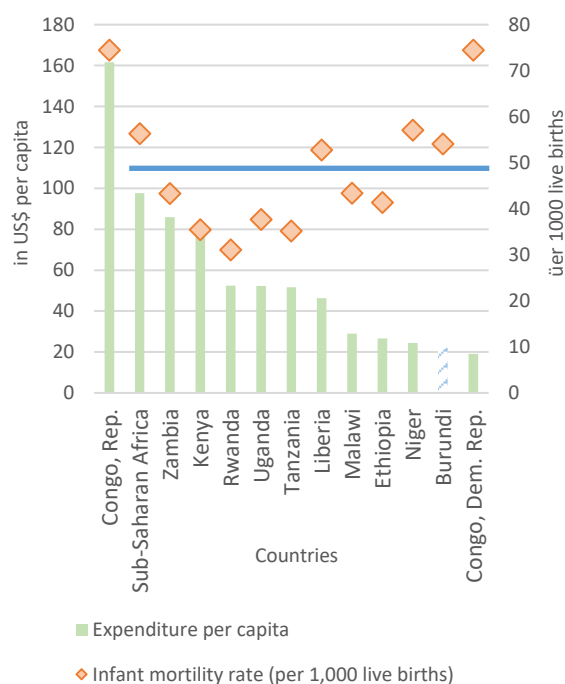
The increases in total health allocations over the years 2010-2015 were entirely lost following the crisis. In 2016, total health appropriations dropped sharply, falling by more than half in real terms — bringing the sector's resource envelope back to its 2010 level. This largely resulted from a decline in external assistance following the suspension of some donor-funded programs or delays in the renewal of others in the health sector (for example, donor aid related to performance-based financing [PBF]). Domestic resources also declined, but by a far smaller amount. These resources fell by 9 percent, that is, from BIF 86 billion (US\$ 53 million) to BIF 82 billion (US\$ 49 million). Health resources also fell as a

share of the overall budget in 2016, declining to 7 percent as a share of the budget, or 1.4 percent of GDP.

Despite the upward trend until 2015, health appropriations remained short of what was required to finance key interventions (notably, those related to nutrition, malaria and non-communicable diseases) envisaged in the PNDS (2011-2015). The low level of sustained funding is one of the factors that have undermined the achievement of the health Millennium Development Goals (MDGs). In addition to a more stable and predictable flow of resources, more resources are particularly needed to address the shortage in health staff, infrastructure development and insufficient preventive care that continue to place serious constraints on both the accessibility to and quality of care.

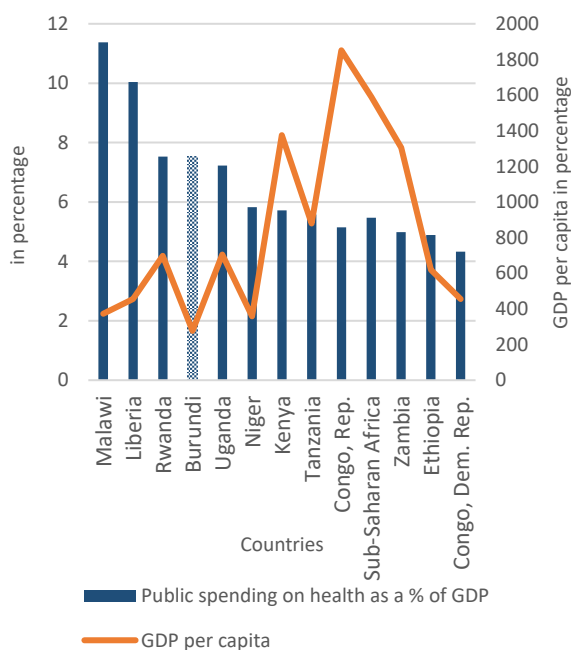
Total public health spending is also very low by the standards of Burundi’s regional peers. In 2014, Burundi’s total health expenditures were about US\$ 21.6 per capita or about 8.2 percent of GDP. In per capita terms, this is far below the SSA average (US\$ 97.7), as well as the recommended WHO norm of US\$34-US\$40, needed to provide essential health services.⁴⁵ Lower spending can result in the relatively lower performance of key health indicators, as evidenced by Burundi’s high infant mortality rate (see section A). At 8.2 percent of GDP, Burundi’s spending is well above the SSA average (of 5.5 percent) (see figures 44 and 45). However, this is due to the country’s very low level of GDP rather than relatively high health sector spending. Low spending levels are in turn reflected in poor health outcomes. In this regard, countries with a similarly low level of income (for example, Niger and Malawi) actually show better health outcomes than Burundi.

Figure 44: International Comparison of Health Expenditures (per capita, US\$), 2014



Source: World Development Indicators, 2015.

Figure 45: International Comparison of Health Expenditures (as % of GDP), 2014



Source: World Development Indicators, 2015.
Note: GDP= gross domestic product.

⁴⁵ Burundi’s per capita spending is even less in sync with norms if compared to the guidelines from the Taskforce on Innovative Financing for Health Systems (FHS), which recommends a per capita expenditure of US\$ 56 per year.

The Government's spending priorities show its commitment to Free Health Care, but there remain severe disparities in its efforts to adequately fund different health care functions.

The ratio of recurrent-to-investment expenditures heavily favors recurrent items (notably led by spending on wages and salaries, as well as transfers), thereby crowding out critical inputs for operations and maintenance and investment spending (figure 46). Recurrent expenditures constituted the largest spending item, increasing from a share of 83 percent of public health expenditures in 2010 to 96 percent in 2016. This trend suggests a severe lack of fiscal space for investment expenditures, which in turn is likely to undermine the development of the health infrastructure needed to serve the growing population. In addition, a closer look at the composition of health spending reveals a few issues affecting both the quality and coverage of the health system.

Wages and salaries have fallen in real terms over the last seven years. Although wages and salaries represent one of the main spending items, accounting for on average 43 percent of total public health expenditures, in real terms, they declined by 22 percent between 2010 and 2016.⁴⁶ At the same time, annual recruitments show a steady downward trend since 2011, specifically from 2,256 newly-recruited health workers in 2011 to 469 in 2014. The loss of 161 health workers (notably 101 doctors, 103 nurses and 13 midwives) due to the insecure situation in 2015 was, to some extent, compensated for by the recruitment of 169 new staff in 2016 (however, including only 25 new doctors). This increasing shortage of qualified medical staff erodes the delivery of health services and undermines the attainment of reaching UHC (figure 47).

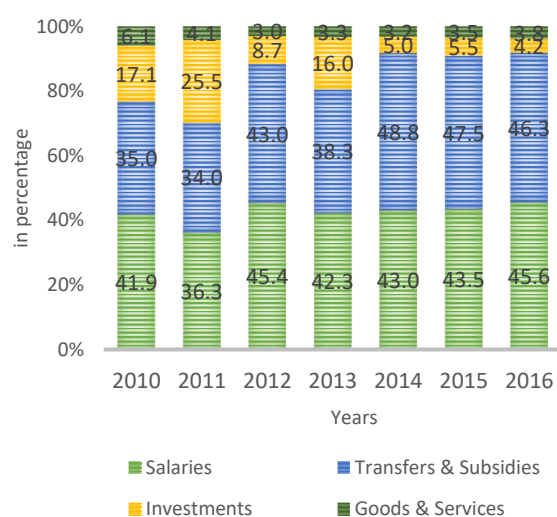
Spending on goods and services has declined by 55 percent between 2010 and 2016, accounting for less than 4 percent of total public health expenditures during this period. This low expenditure level is worrisome, given the importance of goods and services for both operations (in particular, medical supplies) and maintenance (for example, the maintenance of medical equipment and health infrastructure). Furthermore, it puts the sustainability of existing and future investment programs at risk, as the provision of funding is insufficient to cover existing running costs, let alone any system expansion. The underfunding of O&M also results in part from a reliance on external financing, which covers the cost for most complementary inputs, such as medical supplies, drugs, information campaigns, training, and supervision missions. Indeed, reliance on external funding for these health inputs is not only unsustainable, but also creates vulnerabilities for health care services as development assistance is vulnerable to the country's own internal shocks, such as the recent conflict.

Transfers and subsidies represent the only spending item that increased in real terms, indeed, increasing by 8 percent from 2010–2016 (figure 48). They also increased as a share of total public health expenditures, that is, from 35 percent to 46 percent between 2010 and 2016. The increase in transfers and subsidies has been heavily driven by the government's contribution to the PBF program — amounting to more than 50 percent of the transfers, or 24 percent of total public health expenditures in 2014. The high level of government PBF funding, accounting for almost half of the total PBF budget in 2015, reflects the country's strong commitment to financing the FHC. Even during the peak of the crisis, the Government continued to meet its counterpart commitments under the PBF. Transfers to the health insurance scheme, CAM, have also increased considerably since 2010, both in real terms and as a share of the budget. However, the upswing in total spending on transfers, in particular those related to the PBF program, coincided with a contraction in spending on other transfers (targeted at local front-line services and the national health programs).

⁴⁶ The wages and salaries of staff in the national universities and the reproductive health program are classified under the transfers and subsidies category. Also, local contract workers that are paid by the local health facilities are not included in the official payroll. Thus, the sector's salaries and wages category largely underestimates the true level of the wage bill.

Investment expenditures have fluctuated, but show a general downward trend in real terms and as a share of the public health expenditures (figure 49). They declined from 17 percent of total health expenditures in 2010 to 4 percent in 2014. Most of this decline is explained by a reduction in construction expenditures (for health centers). (The brief rise in spending in 2011 was for the construction of the Karusi hospital). The boost in counterpart spending and budgeting in 2014 and 2015 is attributable to the Government’s commitment to purchase contraceptives. While it is not possible to measure the amount of externally-funded investment expenditures in the sector due to a lack of data, a comparison of the Government’s investment appropriations with the planned donor aid (included in the budget annex) shows, on average, that 84 percent of the investment budget was financed by donor aid over the period 2010-2015. In this context, though, it should be noted that this fell to 69 percent in 2016 as a result of the crisis.⁴⁷ The Government’s low investment spending, together with low rates of O&M spending on maintaining existing infrastructure, raise concerns about the sector’s capacity to deliver health infrastructure commensurate with the needs of a growing population.

Figure 46: Composition of Public Health Financing by Category, 2010–2016



Source: MSPLS.

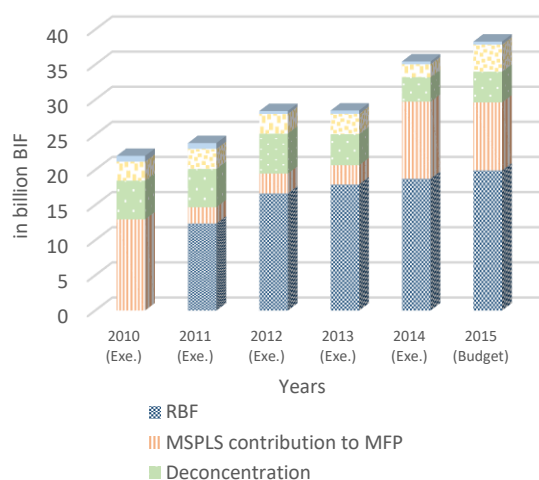
Figure 47: Number of Health Workers, 2010–2017



Source: MSPLS.

⁴⁷ As noted, planned health care aid is captured in the annex of the annual budget law. However, the respective aid disbursement is not available.

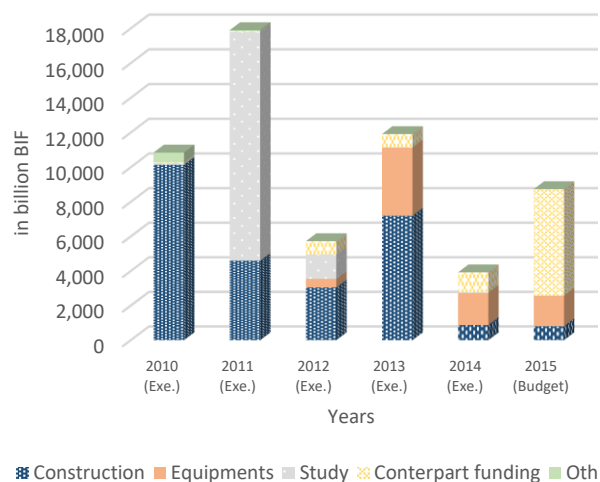
Figure 48: Composition of Transfers and Subsidies by Function



Source: MSPLS.

Note: PBF=performance-based financing. Exe.= execution

Figure 49: Composition of Investment Expenditures by Function



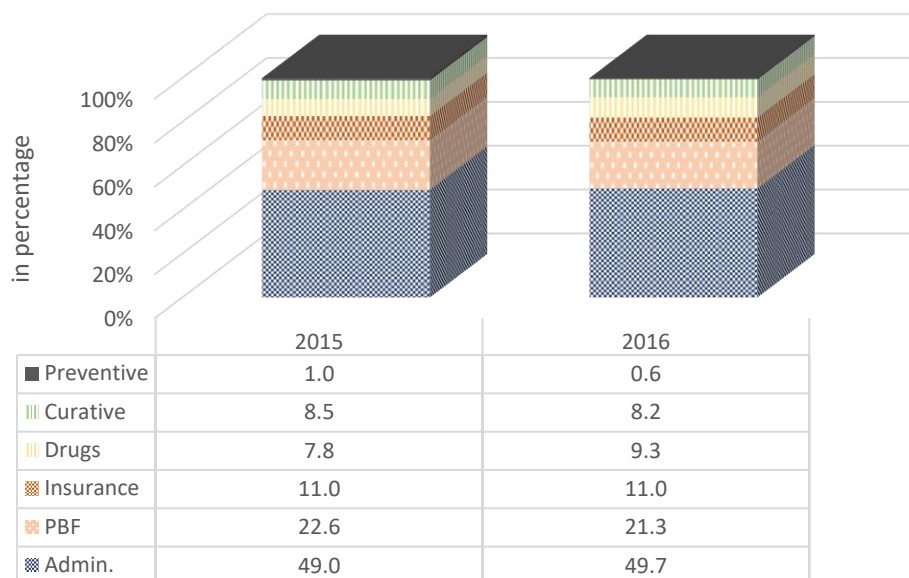
Source: MSPLS.

Classification issues make it very challenging to isolate spending on preventive and curative services. However, the current distribution of resources appears to favour curative services, and preventive services are largely underfunded. Likewise, the national health programs have received little attention from the Government.

The way the health budget is classified impedes a comprehensive understanding of how resources are allocated to different programmatic expenditure areas, such as curative and preventive services (figure 51).⁴⁸ A rough classification of the MSPLS’s health appropriations by a very broadly programmatic classification of health care services shows that budgetary allocations to curative services accounted for roughly 8 percent of public health appropriations (including hospital and ambulatory care, and some national programs including HIV, malaria and tuberculosis). In contrast, preventive health services, as identified in the MSPLS’s budget, represented on average less than 1 percent of the Ministry’s budget envelope in 2015 and 2016. These services comprise Ebola prevention, the national programs on reproductive health, vaccination, malnutrition, and health education. The level of preventive spending seems likely to be higher in practice since preventive activities in health facilities are also funded under the PBF. However, these cannot be identified under existing budget classifications. Even if it were possible to capture these ‘hidden’ preventive resources, Government spending on health prevention is very low, with most of these low-cost and high-impact activities financed by the development partners.

⁴⁸ Currently, all hospital-related resources are classified as ‘curative services’ — even though some of the services might support preventive health care. While it is not possible to distinguish the different services within the given budget classification, it is assumed that district hospitals largely provide curative care.

Figure 50: Health Appropriations by Type of Care (%)



Source: Authors using MSPLS data

Note: PBF= performance-based financing.

Although the Government has made efforts to devote more resources recently to some national health programs (such as the malaria and vaccines programs), these important programs remain underfunded. As shown in table 6, the national health programs accounted for less than 2 percent of the MSPLS budget between 2010 and 2014. The inadequacy of the funding levels for national programs is well illustrated by the case of malaria. In 2014, 40 percent of cases treated in health centers were linked to malaria. However, the budget of the national malaria program had declined to US\$29,000.⁴⁹ Budgetary allocations to all national programs increased to 7 percent of total health expenditures in 2015 and 2016. In particular, allocations for vaccines and malaria increased. The malaria program's funding was increased to tackle the recent outbreak of an epidemic. In this context, the rise in the purchase of vaccines reflects efforts to increase domestic financing for vaccines. To date, these have been largely externally funded. However, most other important programs continue to be confined to less than US\$ 100,000 a year, raising the question of what can realistically be expected to be achieved.

Table 5: MSPLS Budget Allocations to National Programs, 2010–2016 (US\$ '000)

	2010	2011	2012	2013	2014	2015	2016
Vaccination	505	461	726	809	1,742	2,046	1,288
<i>of which CF (Purchase of medication) in %</i>	NA	NA	98	98	99	99	99
AIDS	65	34	26	20	18	21	21
Health reproduction	268	361	768	668	554	791	705
<i>Of which CF (Purchase of contraceptives) in %</i>	NA	NA	79	42	27	58	35
Endemic-epidemic control	37	34	17	15	14	14	14
Malaria	37	34	32	33	29	6,036	8,109
<i>Of which CF (Purchase of medication) in %</i>	59	57	50	44	46	41	29
Chronic non-communicable diseases	91	110	116	90	84	79	69

⁴⁹ MSPLS, *Suivie du financement des PTF*, Burundi, 2014 Note. Only 3 percent of external funding supported malaria-related activities.

<i>Of which CF (onchocerciasis program) in %</i>	59	57	50	44	46	41	29
Nutrition	37	28	26	108	23	100	105
<i>Of which CF (Purchase of vitamin A) in %</i>	NA	NA	NA	76		76	76
Tuberculosis / Leprosy		28	25	38	21	22	23
Hygiene and Sanitation	25	22	13	14	13	12	12
Cross sectoral	21	17	8	9	8	8	8
TOTAL	1,085	1,128	1,757	1,805	2,506	9,129	10,354
Memo							
Share of CF/Total national programs	5	6	171	162	305	1,216	1,334
Share of programs/ Total health budget	1	1	2	2	2	7	7

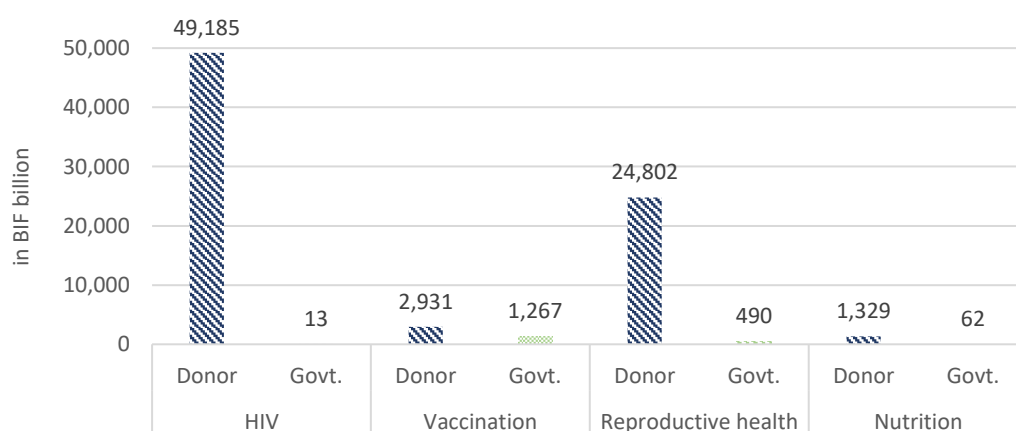
Source:

Note: CF= *Contrepartie Financiere*; NA= not available.

In a context of limited budget resources, a key challenge for policy-makers is to ensure that available resources are properly directed toward health interventions that will have the greatest impact on health outcomes. For example, HIV/AIDS spending is very high relative to other national programs — despite relatively low prevalence rates. This is not immediately obvious from data on spending through national programs alone. Funding is channelled through budget lines reserved for counterpart funding under MSPLS’s Cabinet rather than through the national program. Whereas the Cabinet receives US\$1.2 million per year, the national HIV program manages only US\$21,000. The HIV/AIDS counterpart funding is managed by a National Committee (CNLS) which administers interventions in parallel to the national program. However, there is a lack of clarity about the division of labor between the two. Overall, the bias in funding toward HIV/AIDS relative to other programs raises questions about the most efficient use of resources in the context of other health priorities, such as nutrition, reproductive health, and malaria.

Most activities of the national programs are funded through external resources, which has given rise to coordination challenges during planning and implementation (figure 51). Donor funding represents the main source of funding for four major national programs, including HIV/AIDS, vaccines, reproductive health and nutrition. The reproductive health program is managed differently from the other three. Specifically, it has been converted into an independent administrative entity, receiving salaries and non-current expenditures directly into its own separate account. While this funding arrangement was established to attract donor funding, the mechanism has worked only partially, with some donors directly financing the program while others (in particular, non-governmental organizations [NGOs]) continue to provide funding outside of the program’s budget.

Figure 51: Funding of Health Programs by Source, 2015 (in BIF billion)



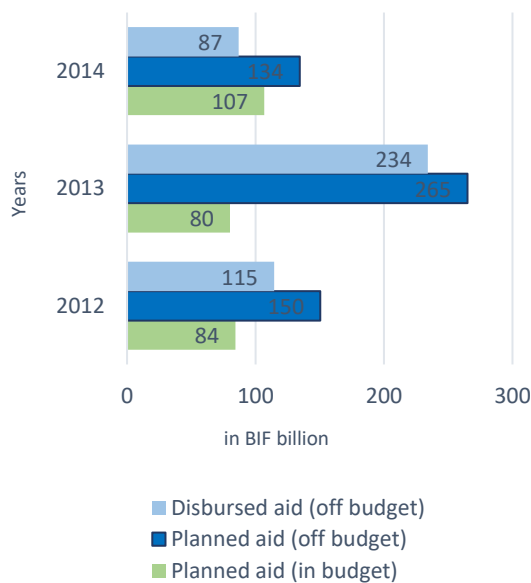
Selected health programs by source of funding

Source: World Development Indicators, 2014

Aid effectiveness has been undermined by a large share of off-budgetary aid, a plethora of aid instruments and a large number of donors and NGOs; efforts have been made to increase aid coordination and harmonization, but these were put on hold since the 2015 crisis.

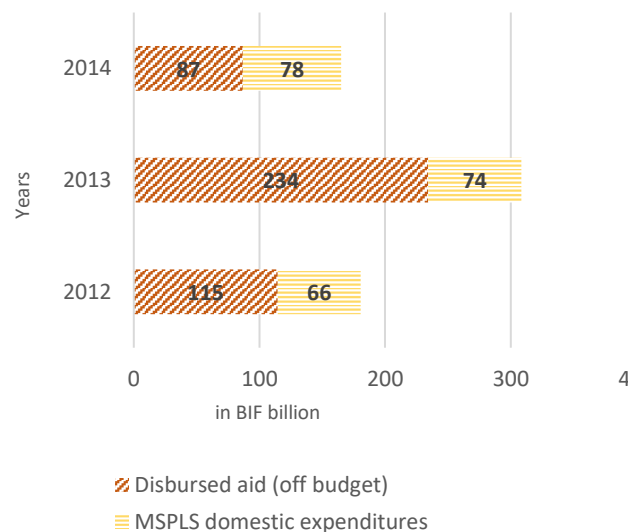
A sizable portion of aid is off-budget, adversely affecting aid predictability and monitoring. According to surveys conducted by the MSPLS, off-budget aid disbursements peaked in 2013, However, they more than halved again in 2014, declining from US\$ 148 million in 2013 to US\$ 56 million in 2014. As well as being inherently unpredictable, off-budget aid flows also raise transparency issues because such flows constitute an important source of sector finance, and are more difficult for MSPLS to effectively monitor. Estimates suggest that total off-budget aid is 2-3 times higher than the government’s domestically-financed expenditures. External funds have largely focused on HIV/AIDS, maternal health, and cross-sectoral activities related to communications, drugs, and medical equipment. Current projections indicate a significant decline in donor assistance in 2015 and 2016 due to the crisis (figure 52). This underscores the need for the Government to take measures, such as increasing sector budget allocations, improving budget/sector execution, and optimizing the structure of health spending (figure 53).

Figure 52: Planned and Disbursed Aid Flows, 2012-2014 (BIF billion)



Source: MSPLS.

Figure 53: External and Domestically-funded Expenditures, 2012-2014 (BIF billion)



Source: MSPLS.

Current earmarking of budget lines for counterpart funding limits the government’s discretionary fiscal space, while cuts in donor aid have made it more important to mobilize counterpart funding. In anticipation of donors’ phasing out of financing for high-impact health interventions (such as HIV/AIDS), the MSPLS began to earmark budget lines to prioritize co-financing. The MSPLS is working to ensure that over time, as donor financing decreases, government financing increases. This requires careful economic and fiscal analysis to ensure that the proposed earmarking of budget lines does not prematurely overburden the MSPLS’ limited resources in the short-term.

Aid management is cumbersome due to a proliferation of donor and NGO projects and programs, predominantly delivered off-budget — and with a lack of consolidated reporting. More than 20 donors and NGOs provide support to the health sector, although the bulk of donor aid is provided by

only a few donors. The various donor projects and programs in the sector put a substantial strain on the MSPLS' administrative capacity in terms of the procurement, disbursement, and monitoring requirements from multiple agencies. For instance, the MSPLS staff spend a considerable amount of time fielding numerous donor missions. Further, the short-term duration of many projects has led to continuous re-programming. Aid disbursement is often unreliable, and predictability is therefore a huge challenge. This is further impacted by factors such as inflation, exchange rate depreciation, and political and social instability – making it more difficult to conduct long-term strategic planning in the health sector, as well as provide for stable and predictable delivery of health services.

Efforts have been made in recent years to improve aid coordination, but these initiatives were put on hold following the 2015 crisis. In 2008, a high-level forum called the *'Cadre de Coordination des Partenaires pour la Santé et le Développement'* (CPSD) was established to improve the effectiveness and efficiency of aid. It also sought to align it with the Government's health policies and plans, and strengthen mutual accountability. The forum was chaired by the Minister of Health, and included the lead donors to the health sector. It was supported by a Secretariat in charge of day-to-day coordination and implementation. The CPSD comprised thematic groups (including Human Resources, Medicines, and Finance) to discuss sector plans and identify priority areas for new aid programming. In an effort to harmonize rules and reduce transaction costs, the Government together with several development partners, committed to putting into place a 'basket fund' that would support the strengthening of fiduciary oversight in the MSPLS and the use of country systems. However, the 2015 crisis had a detrimental impact on aid coordination, undermining donors' willingness to align behind the national Government and its ability to pursue a coherent agenda. The implementation of the basket fund has been put on hold.

D. Equity of Health Expenditures

This section seeks to examine equity issues of Burundi's health care system with a particular focus on how utilization, access, financing and health insurance schemes, as well as the incidence of diseases, have affected different income groups. In addition, it examines how these aspects have been affected by the recent political crisis.

To this end, the section provides first an assessment of the trend and prevalence of childhood diseases. It is followed by an assessment of the impact of the Free Health Program (FHC) on health service utilization, the use health facilities and financial barriers for households. The subsequent analysis focuses on: the financial aspects, such as the level and use of out-of-pocket (OOP) payments; the importance of catastrophic health expenditures and impoverishment; and the relationship between the distribution of public resources to the provinces, poverty and outcomes. The final part of this section examines the effectiveness of the different health insurance schemes in place.

The prevalence of childhood diseases declined at the national level between the years 2009 and 2012. However, it has remained high among children of poor households, and will most likely further increase in the context of the recent malaria epidemic and the 2015 crisis.

Although major childhood diseases continue to be more common in the poorest quintile, the recent malaria epidemic in 2016⁵⁰, coupled with a recent increase in malnutrition, has increased the risk of these children contracting malaria. According to the 2012 Survey regarding the Minimum Package of Health Services - PMS⁵¹, the incidence of major childhood diseases such as diarrhea, acute respiratory infections and fevers dropped between 2009 and 2012. Nonetheless, if examining the prevalence of these diseases by income, children from the poorest quintile are more affected by these diseases than children from the higher quintiles (see figure 54). In the case of malnutrition, chronic malnutrition affected 64 percent of the poorest children compared with 46 percent of children in the richest quintile in 2012.⁵² Likewise, poor children are also more likely to be underweight (36 percent) than rich children (22 percent). Malnutrition substantially increases their risk of death from infectious diseases, including malaria, given their lower levels of immunity.⁵³ The country's recent severe malaria epidemic suggests an increased risk of morbidity for children with severe malnutrition who are living in the affected malaria-endemic areas.⁵⁴ A recent assessment of the malaria epidemic in Burundi indicated a sharp increase in acute malnutrition (at least 1.5 times higher in 2016 than in 2015), which is another indication of the elevated risk for children in contracting malaria.⁵⁵

⁵⁰ The malaria epidemic has been officially declared by the Government of Burundi only in 2017.

⁵¹ A Survey undertaken by the Ministry of Public Health and Fight Against AIDS.

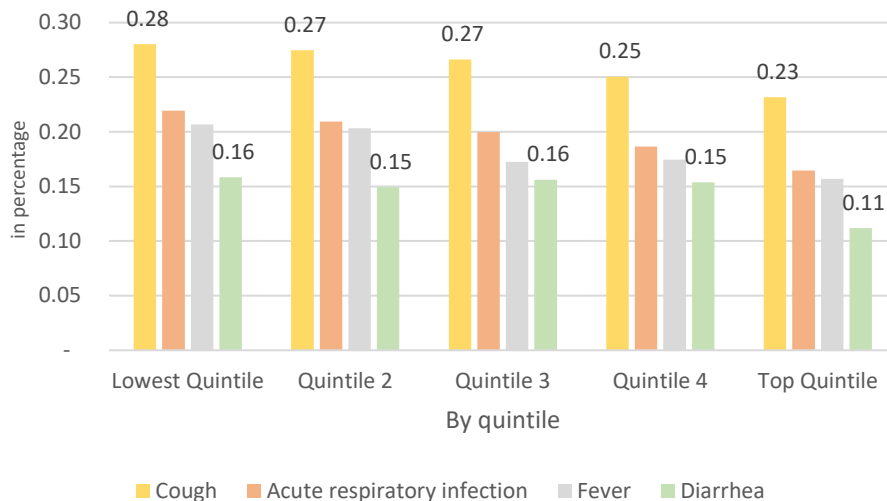
⁵² Minimum Package of Health Services (PMS), Ministry of Public Health and Fight Against AIDS, (2012).

⁵³ WHO, "Malaria and malnutrition. Best practices and lessons learnt from implementing malaria control in complex emergencies in Africa 2000-2004, 2005."

⁵⁴ Burundi is facing a major malaria outbreak, which was officially declared by the Ministry of Health in March 2017. According to the Ministry, the cumulative number of malaria cases reported during the first 10 weeks of 2017 is 1,960,620 — with 869 deaths (Ministry of Health, March 23, 2017). This is higher than the same period in 2016 (with 1,804,258 cases and 841 deaths). (UNICEF, Burundi Humanitarian Report, March 2017).

⁵⁵ MSPLS, UNICEF, *Rapport final de documentation des flambées épidémiques du paludisme au Burundi*, 2017.

Figure 54: Prevalence of Diarrhea, Cough and Acute Respiratory Infections by Quintile in 2012 (in percentage)



Source: World Bank, Health Equity Study (2014).

The recent crisis and subsequent impact on income may also have put the poorest and most vulnerable more at risk of contracting other diseases. Most of the disease burden of poor households finds its roots in the consequences of poverty, such as poor nutrition, indoor air pollution and lack of access to proper sanitation and health education.⁵⁶ A large proportion of these diseases are avoidable or treatable with existing medicine or prevention measures. As noted, the political instability and insecurity resulted in an economic contraction, a decline in agricultural activity and a loss in work opportunities. Poor households and other marginalized groups have been more prone to suffer from these adverse developments because they have less room to re-adjust and cushion their spending for essential medications and treatment of diseases.

The FHC-PBF program, coupled with improved access, have contributed to improved utilization of health services — in particular at the primary-level care facilities. However, inequities in utilization remain and have been aggravated by the 2015 crisis.

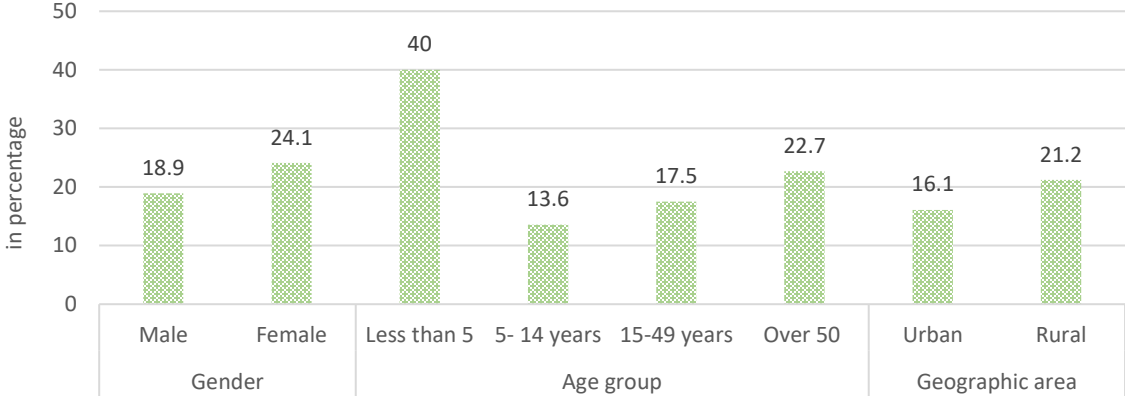
The combined FHC-PBF program contributed to increased utilization of health services, in particular of Maternal and Child Health (MCH) services, but disparities remain. As illustrated in figure x, medical consultation services were particularly in demand by women (24 percent) and children younger than 5 years old (40 percent) in 2014. It shows that the removal of health care costs for pregnant women and children has had a positive impact on the use of services. Also, 21 percent of rural households ask for medical consultations compared to 16 percent in urban settings. This is an indication of a decrease in inequalities because rural households are typically less well-off and have less access to basic health infrastructure and services.⁵⁷ Nonetheless, some evidence points to equity challenges in ensuring a basic set of services and reaching the poorest population. According to the 2015 World Bank Poverty

⁵⁶ WHO, “Diseases of poverty and the 10/90 gap”, 2004.

⁵⁷ World Bank, Poverty Assessment, 2015.

Assessment, 99 percent of mothers reported at least one prenatal consultation at a trained facility (with doctors, nurses, or midwives) over the period 2004-2011. However, only one-third of them visited such facilities four times during their pregnancies, as recommended. Pregnant women belonging to the poorest households are also more at risk because half of them had not been assisted by trained personal during childbirth in 2010. The 2015 crisis adversely affected consultations, in particular pre- and post-natal consultations of pregnant women (see figure 55), thereby highlighting the vulnerability of FHC to the fragile political setting in Burundi (see section A).

Figure 55: Medical Consultation Rate by Gender, Age Group and Geographic Area (in percentage)



Source: World Bank Poverty Assessment (2015).

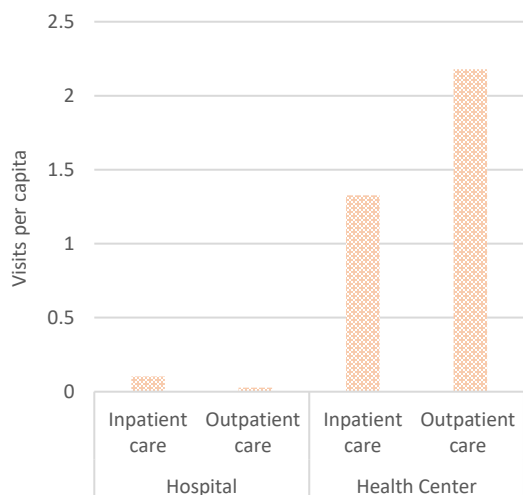
Better physical access has improved the utilization of primary-level care facilities; these are largely attended by the poor; consultations at hospitals are low compared to health facilities and tend to be visited more by those who are financially better off. Physical access has improved with more than 80 percent of the population now having access to a health facility within a radius of less than 5 kilometers to obtain free health care.^{58,59} Improving the accessibility of primary care makes it easier for beneficiaries to access FHC, thereby improving health coverage. Figure 56 shows that most outpatient service consultations take place in health centers as compared to hospitals (2.2 compared to 0.03 visits per capita) as well as for inpatient care (1.3 inpatient visit per capita in health centers compared to 0.1 in hospitals).⁶⁰ Primary health care facilities are mostly utilized by the poor (figure 57). In contrast, the utilization of public hospital services for inpatient and outpatient care is more concentrated among the financially better-off households. This may be attributed to several factors, such as residency in urban areas and affordability. However, it is also attributable to the poorly functioning referral system that has allowed patients to bypass primary care. As a result, they pay more in out-of-pocket costs for specialists and/or better quality care.

⁵⁸ The WHO recommends a distance of 5 kilometers or 30 minutes to a basic health center.

⁵⁹ Despite improved access to health facilities, the majority of Burundians feel that their health conditions remain ‘acceptable’, in particular, in urban areas and among the older people. However, only 33 percent reported having ‘good’ levels of health. (World Bank, Poverty Assessment, 2015).

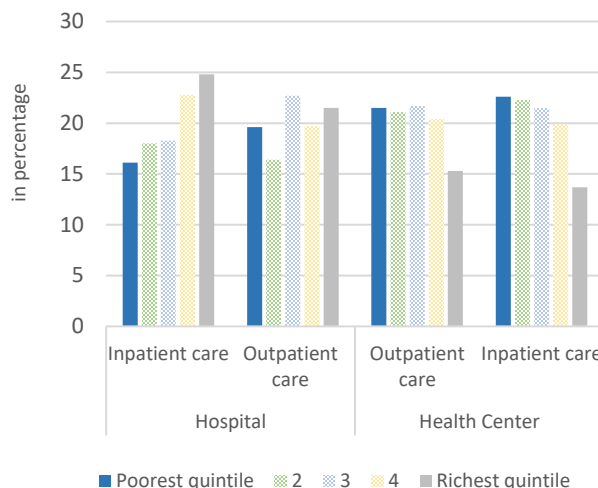
⁶⁰ World Bank, Equity Study, 2014.

Figure 56: Use of Health Services by Type of Health Facility (visits per capita)



Source: World Bank Equity Study 2014.

Figure 57: Use of Health Services by Type of Health Facility and by Quintile (in percentage)



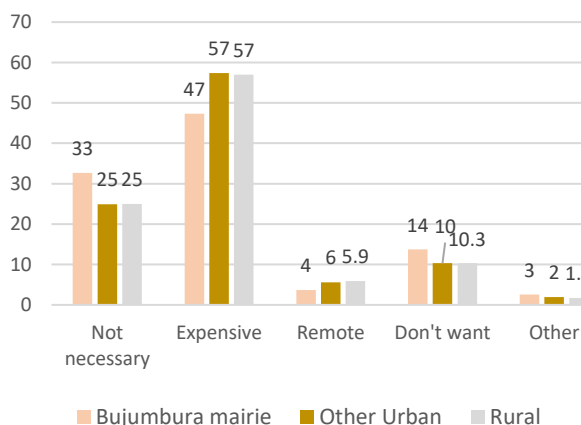
Source: World Bank Equity Study 2014.

Financial barriers remain, disproportionately impacting poor households, and have most likely increased the cost of seeking care in the context of the recent crisis due to increases in prices (drugs, transport,..)

Financial barriers continue to negatively influence the utilization of health care services, in particular by low-income households; such barriers most likely worsened access disparities during the recent crisis. Although the FHC covers about 23 percent of the population and the Medical Assistance Program (CAM) provides some support, there is still a share of the population that pays out of pocket for services and drugs.⁶¹ The 2013/2014 Household Survey (ECVMB) showed that, independent of residency and income, the cost of services remains the main reason for not utilizing the health system (see figures 58 and 59). In this context, 74 percent of the poor tend to seek *less* medical help when ill due to a lack of resources and an attendant loss of income as compared to 48 percent of the rich. Furthermore, the recent rise in the cost of drugs (section E) and a probable rise in transport costs due to fuel price increases have put a financial strain on low-income households seeking much-needed health care.

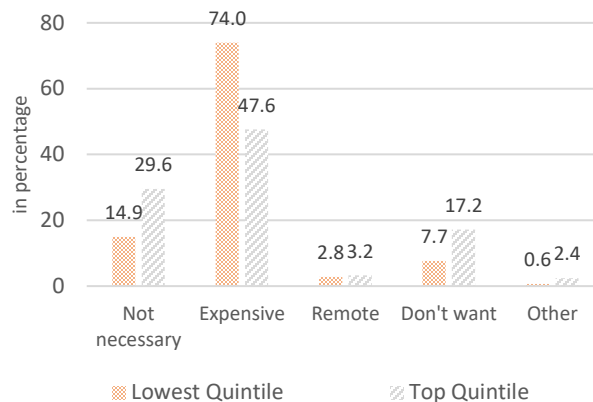
⁶¹ The FHC targets children under five and pregnant women, which represent 18 percent and 5 percent, respectively, of the population.

Figure 58: Key Reasons for Not Consulting Health Services (while the person was sick or injured by geographical area) (percentage)



Source: World Bank, Poverty assessment (2015).

Figure 59: Key Reasons for Not Consulting Health Services (while the person was sick or injured by quintile) (percentage)

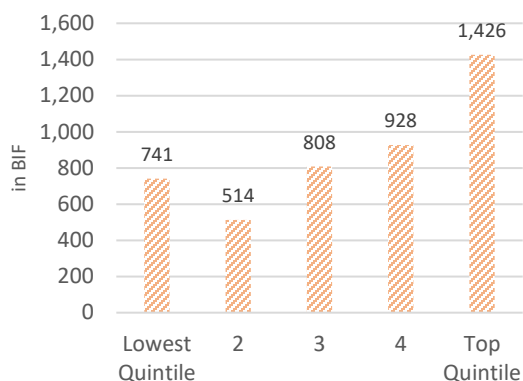


Source: World Bank, Health Equity study (2014).

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; most OOPs across all income groups are consumed by fees for consultations.

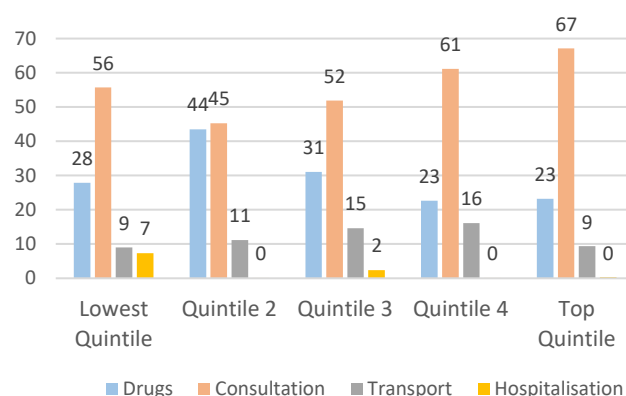
Poor households out-of-pocket spending is low and is largely spent on consultations — although the rise in prices from the recent economic recession might have caused households to incur higher OOPs. The poorest households spend, on average, US\$ 0.5 per month whereas the richest spend US\$ 0.9 per month (BIF 1,426) (figure 60). The bulk of the OOP for poor households is for consultation fees (56 percent), followed by drugs that comprise almost a third of OOP (see figure 61). However, transportation costs to a health facility are low, which can be attributed to the proximity of health centers. Taking a closer look at direct payments made for treatments by health facility, payments by households from the upper quintiles are higher than the lowest quintile regardless of the type of treatment and health facilities. For example, whereas the richest quintile contributes 32 percent to direct payments for inpatient care in hospitals, the poorest quintile contributes only 14.0 percent (see figure 62). The apparent progressivity in the system needs to be put in perspective, as poor households might seek less or no health care services due to their financial resource constraints.

Figure 60: Out-of-Pocket Spending by Quintile (in BIF)



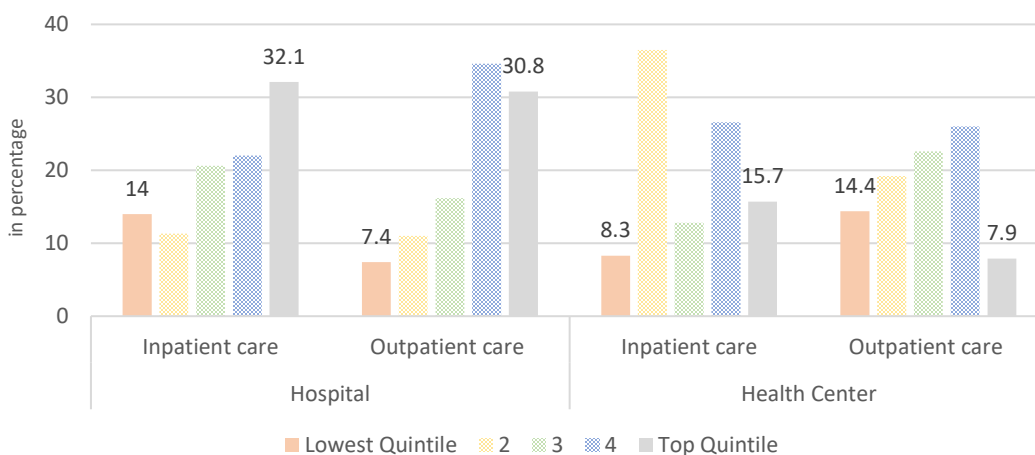
Source: World Bank Health Equity study (2014).

Figure 61: Out-of-Pocket Spending by Category and Quintile (in percentage)



Source: World Bank Health Equity study (2014)

Figure 62: Direct Payments for Outpatient and Inpatient Treatment by Health Facility (in percentage)



Source: World Bank Health Equity Study (2014).

Poor households are more likely to encounter catastrophic health expenditures, and households on the brink of poverty may be vulnerable to becoming impoverished.

In Burundi, poor households are more likely to experience catastrophic health care costs than the better off. Catastrophic health expenditures occur when they exceed some threshold of total health expenditures. The thresholds, according to which the shares of expenditure are deemed catastrophic, are between 5 percent and 40 percent. The incidence of catastrophic payments is higher among the poor.

About 15 percent of the poorest quintile spend 5 percent of their household expenditures on health compared to 1.8 percent of the richest households. A small share of poor households (1.2 percent) spends as much as 40 percent of their total expenditures on health. The higher exposure of the poor to catastrophic health expenditures points to inequities in health financing. It is a consequence of the insufficient targeting of the low-income households in the FHC scheme, as well as inadequate financial protections schemes in place.

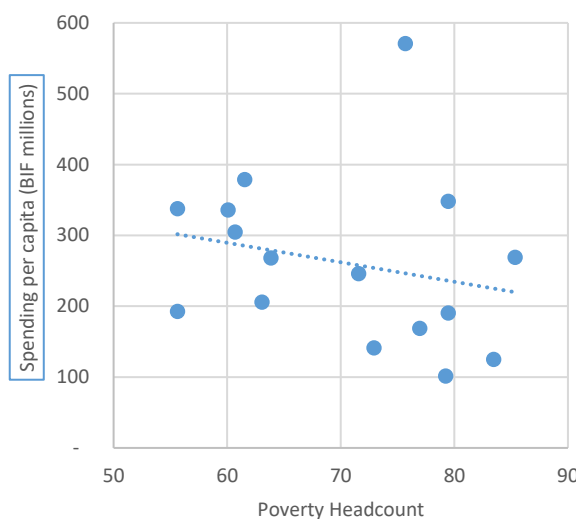
There is a risk of 'impoverishment' due to OOP payments. A household is impoverished due to high OOP health expenditures when its total spending falls below the poverty line after paying for the health care services. Thus, the difference in the poverty headcounts before and after OOP payments for healthcare reflects the poverty impact of OOP health payments. Applying this approach to the 2012 household data (Minimum Package of Health Services - PMS) and using the poverty line of US\$ 1.15 for urban households and \$ 0.7 for rural households, it has been estimated that an additional 1.3 percent of the population have become poor due to health expenditures.

The resources allocated to the district hospitals are regressive, and there appears to be a positive relationship between the consultation and poverty rates at the province level.

The distribution of transfers from the MSPLS to the District Hospitals is unequally allocated across provinces. MSPLS transfers to the district hospitals at the provincial level account for only a small share of the Ministry's spending (4 percent of total public health expenditures in 2014).⁶² The level of these funds is low, as it is shared between 44 district hospitals (amounting, on average, to US\$ 55 000 per district hospital per year). Examining the distribution of these resources by province against poverty, it shows a bias toward the richer regions (notably Bujumbura and Bururi). The five provinces with the lowest level of funding (the Provinces of Bujumbura, Karuzi, Kayanza, Kirundo, and Muyinga) have a poverty rate above the national average of 65 percent (figures 63 and 64). The results suggest that the distribution of public resources for service provision is not prioritized for the poorer provinces (see section E).

⁶² Note transfers also include a small funding to District and provincial offices but a breakdown of these transfers by provinces is not available. Health centers do not receive any transfers under MSPLS's budget but are largely funded through PBF resources (see also section E).

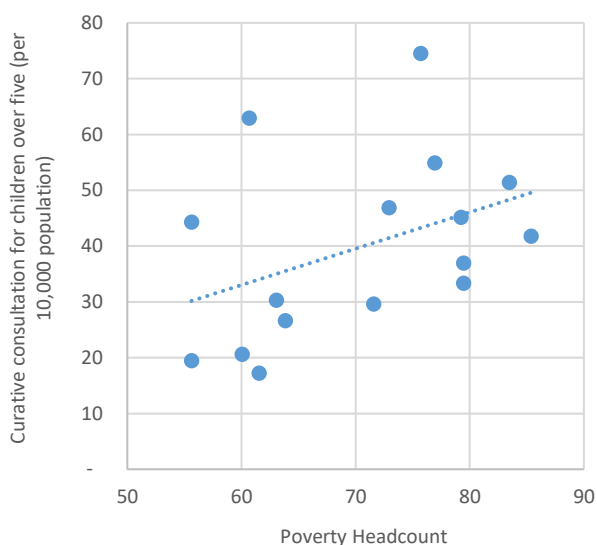
Figure 63: Comparing Spending of Transfers by Per Capita and Poverty



Source: MSPLS.

Note: The poverty rate for Rumonge is not available.

Figure 64: Comparing Spending of Transfers by Per Capita and Curative Consultation for Children over the Age of Five



Source: MSPLS.

Poverty can be positively associated with increased consultations. An assessment focusing on the relationship between poverty and a key service delivery indicator (the curative consultation for children over age five at health centers) showed that with some exceptions (Cibitoke and Province de Bujumbura), most provinces with high poverty rates (that is the Province de Bujumbura, Muyinga, and Ruyigi) have also high consultation rates.⁶³ These findings need to be interpreted in view of the low tariffs, which suggest a high consultation rate at health centers in provinces where a large share of the poor live. In provinces with a larger share of the population that is financially better off, consultations are made at district hospitals.

There are several health protection schemes in Burundi that, in part, seek to cover the poor and vulnerable populations. However, the schemes are fragmented and marked by inefficiencies, limited coverage, poor performance and a lack of funding.

Burundi has established a number of financial protection schemes, including health insurance for public employees, private insurance schemes, community insurance and the FHC scheme. Over the past two decades, the Government has put in place various insurance schemes to ensure financial protection and facilitate equitable financial and physical access to services. According to estimations, half of Burundi's population is covered by some type of insurance scheme.⁶⁴ While this is remarkable for a country that has

⁶³ The consultation rate for children over the age of 5 was chosen because it is not an indicator of the PBF program, and therefore not a beneficiary of the FHC program.

⁶⁴ MSPLS, Health Financing Study, 2014.

undergone several crises and economic contractions, these schemes suffer from a range of shortcomings, including overlapping target groups, the absence of regulations, unclear responsibilities, an outdated tariff system, and chronic underfunding. The 2014 Financing Study conducted a review of the health insurance scheme, the main findings of which are summarized as follows:

Free Health Care Scheme. The free health care policy coupled with the PBF has contributed to achieving MDGs 4 and 5 by funding free health care for children under the age of 5 and pregnant women. It reflects Government's strong commitment to reduce financial barriers and renders the health system more equitable. It has strengthened some core health functions, contributed to coverage, increased efficiency and accountability in particular at the level of front-line health services (see section A and E). The good performance has enabled the leveraging of resources from a range of development partners. In the meantime, the Government's important contribution to PBF funding is a critical first step to integrating the PBF into the public health system.

Despite these important results, the combined FHC scheme faces a number of challenges. As part of the FHC service package, the population is covered through a Minimum Package of Activities (MPA) offered by the health centers, as well as a Complementary Package of Activities (CPA) offered by hospitals. However, access to CPA health care at the hospitals is not conditioned by a reference from the health center. This contributes to an overuse of the hospital's services and an inefficient use of resources. The requirement of an identity document can constitute an obstacle for the most vulnerable beneficiaries who may not have any identification. The verification of eligibility for the FHC is left to the health care provider, which presents a potential conflict of interest. Similarly, no effective tracking and monitoring system is in place to limit FHC to patients not affiliated with other existing schemes, such as the MFP or other private medical insurance. Thus, there is a risk of an indirect subsidization of other schemes by the FHC or a double payment for the same benefits. Lastly, payments are in some cases irregular, late or the repayment may be only partial (see also section E). In the case of hospitals, the delayed repayments and the low tariffs for certain indicators (that is, for Caesarean section whose actual value is US\$ 100 is refunded at a rate of only US\$ 40) have led to substantial financial management constraints.

The Medical Assurance Scheme (CAM).⁶⁵ The CAM is a voluntary insurance scheme for the informal and rural sector, allowing families to enroll in the system. It requires a 20 percent copayment for services and a US\$ 2 (BIF 3000) annual fee to access health care services. The remaining 80 percent is provided by the Government (inscribed in MSPL's budget). CAM's membership accounted for more than a third of the population in 2013. It covers a package of basic services available at the public health centers, religious facilities and District Hospitals (excluding services provided under the FHC for pregnant women and children under the age of 5). If well implemented, it is considered the key instrument for introducing universal health coverage and reducing inequities in Burundi's health system.

However, the effective functioning of the CAM is undermined by a number of shortcomings: First and foremost, the CAM is underfunded. The level of the annual memberships (US\$ 2 / household and per year) and the Government's funding (on average US\$ 6 million or BIF 9.6 billion between 2014-2016) are insufficient to cover all financing needs (estimated at US\$ 11 million or BIF 16 billion in 2012).⁶⁶ Second,

⁶⁵ The CAM was introduced in 1984 to provide insurance for workers in the informal sector. However, it faced a number of shortcomings, such as the reallocation of CAM funds by communes to other spending areas, lack of interest in enrolling, a low level of contributions, and so on). In 2012, the Government reorganized the CAM and introduced a new regime. CAM's membership accounted for more than a third of the population in 2013. (MSPL, Financing of the Health Sector, 2014).

⁶⁶ More recent estimates are not available. Initial estimates from 2012 also show that a 100 percent coverage of the target group would require a budget of about US\$23 million or BIF 34 billion.

the insufficient funding has resulted in the creation of debt by the Government based on payments owed to health facilities, as well as substantial delays in reimbursing the health facilities — which in turn has adversely affected their financial management (see section D). Third, at times, CAM members receive only partial or no services at several health facilities because of a lack of confidence of health facilities. Consequently, they are refused services. Likewise, most religious health facilities charge for treatments provided by CAM.

Public Service Mutual Insurance Company (MFP). The MFP was created in 1980 to administer the public-sector insurance scheme for civil servants and their families. Placed under the Ministry of Public Service, Labor and Employment (MFPTE), the MFP is the largest health insurance scheme in the country, covering a range of services provided by public and religious health facilities, pharmacies and others.⁶⁷ Members pay a 20 percent copayment for consultations or hospitalizations, and 10-30 percent of the cost of drugs. The remaining part is covered by the MFP.⁶⁸ The Ministry of National Defense, the National Police, the MSPLS and the MFP itself cover all copayments for their staff. According to the National Health Account (2013), almost 8 percent of Burundi's population is covered by the MFP. The MFP is well established and stable, with adequate funding as evidenced by reasonable payment periods and mandatory membership.

However, members often avoid waiting for good care ('bon de soins'), and either pay out-of-pocket or obtain CAM membership for the payment of services. Reimbursements granted by the MFP are often below the 80 percent threshold (around 40-60 percent). Furthermore, the MFP reimburses on the basis of the 2001 tariffs, which are now obsolete and very low.⁶⁹ Fraud has occurred. However, fraud detection has been poorly pursued and sanctioned. A key problem is also the absence of a referral system. There is no obligation for the patient to go to a general practitioner or receive a referral before going to a specialist or hospital, as is the case with the CAM, for example. This contributes to an overcrowding of hospitals with patients that could be treated more cheaply. Furthermore, it inflates the cost for the MFP and the patient.

The indigent insurance. The indigent insurance was introduced together with the CAM in 1984. It targets indigent children enrolled in school and any person who is unable to generate income. The status of the indigent is issued by the Ministry of the Interior and the Ministry of Health. The insurance covers a care package (including for consultation, drugs, childbirth, and so on) for the health center and the district hospital. Health services under the insurance are free of charge with the bulk of the funding being provided by the central government (the Ministry of National Solidarity) and the rest by the municipalities. The proportion of the indigent population was estimated at 10 percent in 2012, although there is a lack of a clearly defined criteria. Nevertheless, the very small budget allocated to the insurance (US\$ 9 million (BIF 1.5 billion), included in the budget of the Ministry of Solidarity, shows that it does not constitute a political priority. This represents a budget of less than a dollar (BIF 1,555) per indigent, which is far from sufficient to cover the care needs of the beneficiaries who often suffer from chronic illnesses. Also, services are only provided to two hospitals per province and the national hospitals. This hampers access

⁶⁷ It provides health coverage to civil servants, civil service contractors, local and regional authorities, staff from the Ministry of National Defense and the Burundi National Police, students of the University of Burundi, Magistrates, staff of public companies and institutions, private education, and political institutions.

⁶⁸ The scheme is financed by a contribution based on the gross wage minus family and housing allowances. Since its revision in 1999, the contribution rate has been fixed at 10 percent (6 percent paid by the employer and 4 percent by the employee).

⁶⁹ For example, the price of a general consultation is US\$ 3 cents (BIF 50) at the health centers, US\$ 13 cents (BIF 200) at the public hospital, and US\$ 32 cents (BIF 500) at autonomous hospital, thereby putting a substantial strain on the health facilities' financial management. This is also a constraint for insured persons who seek general consultation in autonomous hospitals. For example, in the military hospital, the general consultation costs US\$ 1.2 (BIF 1800), whereas the MFP reimburses 80 percent of US\$ 32 cents (BIF 500), that is, US\$ 26 cents (BIF 400), and the insured patient has to pay US\$ 90 cents (BIF 1400).

of the poor who do not live in provincial capitals. Finally, there is a risk of discriminatory practices given the absence of clearly defined and objective criteria for indigents. This creates opportunity for nepotism, local patronage and bias in the selection process.

Community Health Mutual (Mutuelles Communautaire - MC). There are 35 community health mutual and 5 affiliated associations in Burundi. They cover outpatient services (consultations, laboratory, hospitalization and medicines) and, in exceptional cases, inpatient care. This care is provided by public, private and non-profit health facilities. Each mutual association sets its own conditions of coverage, and the amount of the user fees is generally 20 percent in public health facilities and 40-50 percent in private clinic. Like the CAM, these organizations target the rural and informal populations. They are estimated to cover between 1.5 and 2 percent of the Burundian population. The range of benefits covered by the MC schemes is more limited than in the case of the CAM.⁷⁰ In addition, co-payments are usually high (between 20 percent and 50 percent). There has been some evidence that health facilities, particularly hospitals, have favored the MC at the expense of the CAM. The indigent's scheme in providing medications are considered more reliable in reimbursing the health facilities.

Although the mutual community insurance has played a pioneering role because of their proximity dynamics, flexibility and community approach, they have faced numerous challenges. Their capacity to extend their coverage of the population is still limited, and restrictions on risk coverage (that is, high co-payment rates, guaranteed ceilings for reimbursement, and so on) can constitute a significant obstacle to attracting new members. If the CAM could become an integral part of universal health coverage in the future, the question then becomes which role the MC should play in the future insurance scheme. Lastly, the MC lacks resources and would need to be supported by Government subsidies or donor aid to ensure financial sustainability and good coverage for eligible beneficiaries.

Private insurance. Despite the provision of the 2000 Social Security Code (imposing health care costs on employers), and the passage of the law on maternity and sickness insurance for the formal sector, there is no functioning national health insurance system in place. Instead, a range of private insurances have been developed since 2010 that have filled an institutional vacuum left by the enactment of the Social Security Code. These provide different arrangements for employers to cover their worker's health care costs, ranging from institutionalized care in large companies (establishing an infirmary with nurses or at times a doctor), to providing a purchase order or vouchers, establishing a custom designed health insurance fund in companies or contracting with a private insurance company. Private insurers have demonstrated technical expertise in insurance management and are generally considered "good payers" by health service providers.

In practice, however, it is not clear if companies effectively comply with the law in the event of an employee's illness, given the Government's weak capacity to monitor and enforce it. There is also no central reporting or tracking system for the coverage of medical care by employers. In addition, the legal and regulatory framework remains unclear, such as the determination of the care package which is left to the employer. The level of coverage and the capacity for expansion of private, micro or professional insurances are low. These organizations often focus on narrow commercial niches, which are limited to employees of medium- to large-sized companies, or a few well organized self-employed associations.⁷¹

⁷⁰ For example, at the *Mutuelles de Santé des Caféculteurs du Burundi* MUSCABU, hospital expenses are capped at US\$ 51 (BIF 80 000) per year. At the *Union pour la Coopération et le Développement* (UCODE), private or denominational care is limited to US\$ 20 or BIF 30,000.

⁷¹ According to ISTEERU (2010), the formal sector population accounts for around 6 percent of the active population; however, estimates suggests only a small number of people are covered.

E. Budget and Human Resources Management: Selected Efficiency and Effectiveness Issues

As highlighted in the financing section, government health spending is less than it was before the country's crisis and needs to increase but priority should be given to spending existing resources more efficiently. This chapter discusses selected budget and human resource management issues identifying efficiency and effectiveness shortfalls.

This chapter starts with a stock take of overall PFM's reform process in Burundi, followed by a discussion on health budget preparation and execution. The health sector budget is skewed to salaries and wages and this section analysis the bottlenecks hampering a proper human resource management. Finally, the section describes the procurement of medicines and the decentralization of health financing which contribute heavily to inefficient spending and poor health care.

The sustainability of the many public financial management (PFM) policies and practices adopted in the last ten years is an issue of concern.

Since 2008, Burundi has made significant progress in modernizing the expenditure management system. However, following the 2015 crisis, the implementation of all PFM processes and procedures adopted by the government was suspended. It is not yet clear when it will be possible to reactivate the policy reform process of the last ten years.

Since 2010, the Government adopted and effectively used a central Medium-Term Expenditure Framework (MTEF) for strategic budgetary planning. The central MTEF was consistent with the macroeconomic framework that was used in the preparation of the budget. As the central MTEF process seemed to work, more attention was paid to sector MTEFs. Sector MTEFs were viewed as a tool to help sector ministries in agriculture, education and health translate the strategic priorities of their sectors into budget allocations. As a result of these initiatives, the composition of public expenditures has significantly improved toward priority sectors. Indeed, the share of priority economic and social sectors in budget allocations increased from 38.7 percent in 2008 to 43.7 percent in 2010, and then to 47.2 percent in 2014⁷².

Severely constrained by the scarcity of external funding in 2015, the government devoted its highest priority to addressing short-term public finance issues. The 2015 crisis and the suspension of budget support by major donors dramatically changed public finance management practices. The PRSP-II, which set the policies and priorities of the Government for 2012-2015, was extended to 2016. However, the development of the next PRSP has not progressed. Most of the initiatives aimed at empowering sector ministries were abandoned. The control over appropriations has not been effectively decentralized. Sector MTEFs are still prepared, but have virtually no influence on public spending. In 2015 and 2016, budget negotiations did not take place. Since 2015, quarterly public expenditure execution reports have not been published on the Ministry of Finance's website. Government accounts are no longer reviewed and audited by the Court of Accounts. The 2014 Budget Execution Law has been prepared by the Court and voted on by the Parliament in October 2016. The Government claims that the citizen budget initiative

⁷² Draft ICRR, Sixth, Seven, Eight Economic Reform Support Grant, World Bank, 2017.

continues, but it is based on budget laws that are no longer in the main public financial management document. Finally, the introduction of program budgeting has been delayed to 2019.

So far, the crisis has not significantly affected the progress made in terms of institutional development and national capacity building in public financial management. Three ministries (agriculture, education, and health) have planning units capable of preparing sector strategies and sector MTEFs. Their influence on decision-making processes remains limited, but they do have the technical expertise necessary to prepare well-conceived sector MTEFs.

Planning and budgeting in the health sector remains an exercise lacking in coherence and credibility.

The health delivery system is not aligned with the administrative structure of the country. Since 2005, Burundi has embarked on a governmental decentralization process. In May 2015, the Government approved a law on communal competences, assigning health responsibilities to the communes⁷³. Since then, however, the role of communes has remained limited, and health services are carried out by the deconcentrated branches of Ministry of Health. As a result, the National Investment Funds for Communes (FONIC - *Fonds National d'Investissement Communal*), which provides some support entailing an equal transfer by communes for capital expenditures, did not address the health infrastructure shortfall in fiscal years (FYs) 2015 and 2016⁷⁴.

Box 3: Decentralization in Burundi

Progress on decentralization in Burundi is mixed, and continuing uncertainty undermines effective planning, accountability and service delivery — including in the health sector.

At the end of the conflict, the Arusha Peace Agreement and the 2005 Constitution laid out the foundations for an ambitious decentralization program. As such, it became a national priority to promote social cohesion and deliver a “peace dividend” to the poor.

The promotion of a new legal framework confirmed the Government’s commitment to the reform process. In 2005, the Communal Law and Electoral Code further highlighted the commitment of the central government to open the way for more direct participation and accountability at the local level.

Burundi has a two-tiered territorial organization. There are 129 communes that are formally divided into the 13 communes of Bujumbura—the capital and the largest city in Burundi— and the 116 communes outside Bujumbura. The law recognizes communes as autonomous and decentralized entities managed by communal council members. It also recognizes the communes’ deliberative and decision-making powers. In so doing, it allows them to adopt economic and financial measures, including the preparation of the communal budget and the communal community development plan (*Plan Communal du Développement Communautaire*, PCDC).

In 2007, the government created the National Fund for Communal Investment (FONIC) to address the resource constraints of communes. The decree that established the FONIC stated that 15 percent of the national budget should be transferred to the institution (which one?) that channels funds to the communal level for capital spending purposes. Until recently, in part as a consequence of persistent funding gaps from the central government, these transfers have not been realized. As a result, communal budgets remain very limited, and investment resources were mainly channeled through donor-funded grants and projects.

In 2009, a National Decentralization Strategy (NDS) was approved, providing the basis for the institutional and regulatory framework guiding the decentralization reform process. However, since 2010, when a few amendments to the 2005 Communal Law were introduced, there has been little progress toward effective

⁷³ Burundi, Loi 1/16 du 25 Mai 2015 portants Modalities de Transfert de Competences de l’Etat aux Communes.

⁷⁴ Burundi, FONIC data, 2015 and 2016.

decentralization in Burundi. One exception is the Government's recent adoption of the Law on the Responsibilities of the Communes.

Source: Republic of Burundi, Fiscal Decentralization and Local Governance: Managing Trade-Offs to Promote Sustainable Reforms, World Bank, 2014.

Health planning and budgeting are not synchronized. The National Health Plan covering the period 2011-2015 (and extended to 2018) represents the planning document for the sector. The Ministry's Annual Plan for year (n+1) is formulated through a bottom-up approach. Each September year (n), each health center and district hospital prepares a draft Annual Action Plan (AAP). The health district then consolidates and transmits these to the Provincial Health Offices (PHOs). In each October, the PHOs aggregate the plans of the health districts. Then, in each December, the Ministry of Finance consolidates the planning inputs received from the PHOs, the national health hospitals, as well as all of the Ministry's Departments. Thus, the annual health sector plan cannot be considered in the national budget approved by the Parliament, which is generally done by the end of each December.

Health budget preparation is a centralized and input-based process. The subnational health facilities and health administrations prepare the budgets. Salaries and contributions are assessed for the next year, based on the institution's staff and salary regulations. Contributions are determined based on social and health insurance regulations. All expenditures to cover operations and maintenance, supplies, and so on are finally budgeted, and are based on the previous year's allocations. In preparing their budget proposals, decentralized health administrations and health facilities consult with development partners and non-profit organizations to assess their potential contributions. Since 2012, budget negotiations between the Ministry and the subnational health administrations have not taken place. In this context, negotiations were not so effective in discussing proposed activities and final allocations. Furthermore, budget revisions often hampered budget formulation efforts. The cash shortfall during the crisis also made the deconcentrated planning and budgeting unrealistic.

The crisis hit the health sector budget in 2015–2016, undermining already low levels of spending on goods and services —and especially investment.

When the budget execution is disaggregated by sector, it shows that health performed very strongly over the period 2010–2014, averaging 98 percent (figure 65). The only sector with a stronger average budget execution performance was education (99 percent). All other sectors performed worse. The superior budget execution performance of the health sector is likely driven, in part, by the relatively high share of wages and salaries, as well as transfers (which are predominantly spent on salaries in deconcentrated units). However, it also demonstrates a degree of sector protection in cash management by the Ministry of Finance. In this regard, budget allocations for health averaged 9.6 percent of total budgeted expenditures over the period — but 9.9 percent of actual outturns (figure 66).

Figure 65: Sector Budget Execution (%)

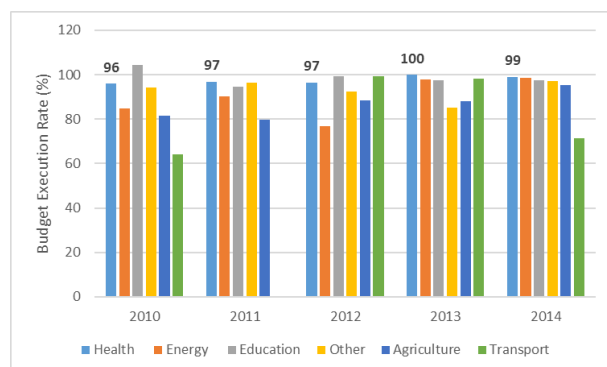
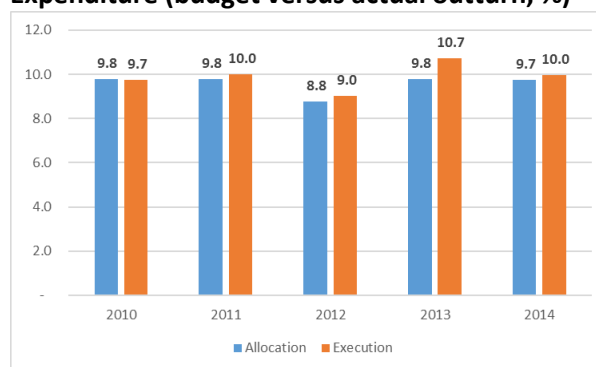


Figure 66: Health Spending as a Share of Total Expenditure (budget versus actual outturn, %)

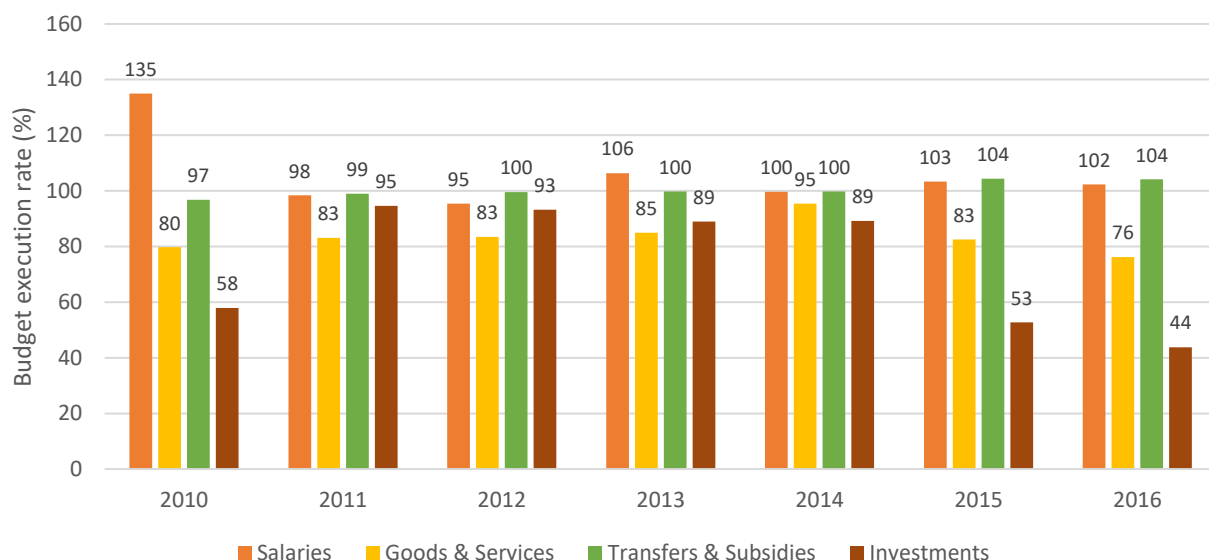


Sources: Budget Documents and Ministry of Finance data.

While overall budget execution performance in the health sector has been strong between 2010 and 2014 (figure 67), the lower execution rates for goods and services (85 percent) and investment (85 percent) are of great concern over the same period. Salaries (which averaged 106 percent execution) and transfers and subsidies (100 percent) were the best-performing types of expenditure. In contrast, for goods and services and investments, appropriations were not only very low in absolute terms for these spending items, but the limited resources allocated are not being fully executed in the sector, likely undermining service delivery and the maintenance of health infrastructure (see section C). The execution rate for these expenditure categories is broadly in line with aggregate budget execution for the period (86 percent), suggesting that while non-discretionary health expenditures are protected during cash management, the same protection is not afforded to these items. There is simply not enough cash available to meet budgeted expenditures due to overly optimistic revenue forecasts. Consequently, this ultimately impacts on resource availability for the health sector.

Even though some spending items were protected, the crisis has further negatively aggravated spending on goods and services and investment in 2015–16. Salaries were ‘protected’ during 2015 and 2016, reflecting the fact that wages are a non-discretionary expenditure, and that ‘transfers and subsidies’ to deconcentrated health offices and facilities are primarily used to also pay salaries. However, the 106 percent execution rate for salaries is also indicative of in-year recruitment of personnel, with delayed inclusion in the budget appropriation. The impact of the crisis is mainly seen in lower-than-budgeted spending on goods and services (79 percent over the crisis period of 2015-16 compared to 85 percent over 2010-14) and investment spending (48 percent compared to 85 percent, respectively, over the same period). This deterioration in execution performance is very concerning. For instance, it affects the central sector administration and undermines the regular responsibilities of the MSPLS, most notably with regard to supervision. It is noteworthy that execution of transfers and subsidies was actually higher in 2015-2016 (at 104 percent) than over the preceding five years (99 percent).

Figure 67: Budget Execution in the Health Sector by Expenditure Category, 2010–2014



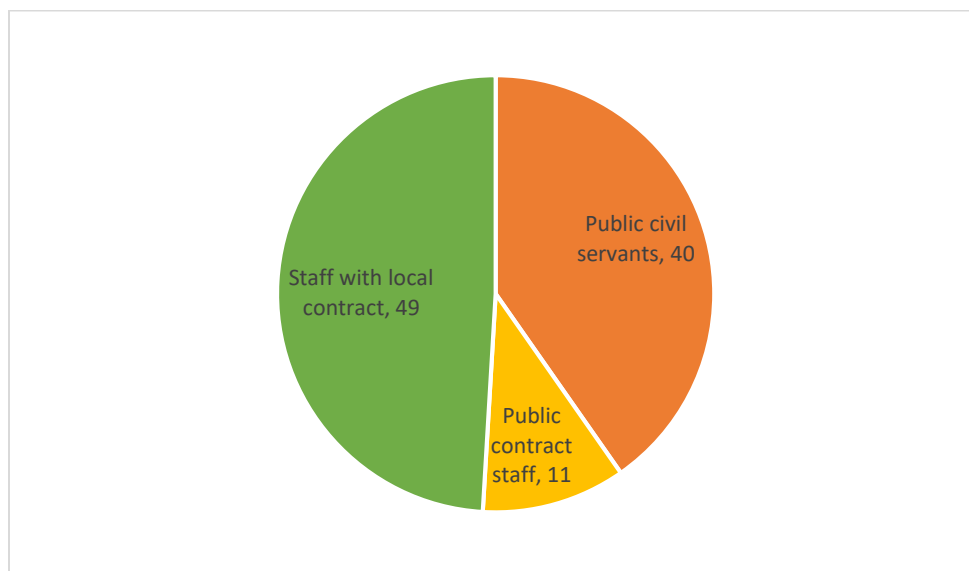
Sources: Budget Documents and Ministry of Finance data.

Effectiveness of Payroll controls in the health sector: what is working and what can be further improved

The MSPLS employs health workers in accordance with three employment regimes: i) public civil servants; (ii) public contract staff; and (iii) staff with a local contract hired directly by local health facilities (that is, hospitals or health centers). Almost half of the Ministry’s health workers are under a local contract, representing largely non-skilled support staff. Public servants account for 40 percent, followed by contract staff (11 percent). (See figure 68)⁷⁵ The different employment regimes have the advantage of enabling the Ministry to address its staff needs in the context of budget constraints and caps on the recruitment of civil servants. However, they have also led to resource inefficiencies, as most health facilities have recruited unskilled staff (largely due to employment opportunities created for family members or friends). This, in turn, takes away resources for other, more meaningful activities. Additionally, there is evidence that some local staff had worked without a contract, but received all medical coverage (equivalent to the MSPLS staff). This then generates high costs without having formalized the recruitment.

⁷⁵ Data on the medical staff in the private sector are not available.

Figure 68: MSPLS Health Workers by Employment Regime, 2016



Source: MSPLS, Directorate of Human Resources (DRH).

Recruitment processes, salaries, career management and benefits of public servants are centrally managed by the Ministry of Civil Servants (MFPTE). The MFPTE manages the payroll data base, although the military, police and parastatal organizations are administered separately. In the case of the health sector, however, all salaries of staff hired locally and paid by the local health facilities (hospitals and health centers) are separate from the MFPTE’s database — which renders the effective management of the Ministry’s medical staff difficult.

The Government has given priority to recruitment in the social sectors. Although all sector ministries develop recruitment plans based on this criterion at the time of budget preparation, only the ministries in charge of health, education, and (partly) the justice system were allowed to recruit in recent years. In 2016, the MSPLS was authorized to recruit 169 medical staff, including 25 doctors. However, this has not fully compensated for the departure of 101 doctors in the same year. For other ministries, recruitments were only approved for the replacement of staff.

Some procedures can be cumbersome. According to the latest (2014) Public Expenditure and Financial Accountability (PEFA) Assessment for Burundi, the procedures for recruiting or modifying statutes are long and involve different levels of control that are sometimes redundant.⁷⁶ At the MSPLS, while the recruitment process takes only 2-3 months, the newly recruited individuals can wait for up to 3 to 6 months before receiving their salary due to several verification procedures by the MFPTE. Nonetheless, changes in personnel status are carried out within 1-2 months. It is noteworthy that some staff are appointed by the presidential decrees, including General Directors, Department Directors, and all Medical Directors. Although this is a common procedure of the public civil service, it is not clear why Medical Directors are also subject to a presidential appointment.⁷⁷

⁷⁶ Salaries are defined by the Law No. 1/28 of August 23, 2006 regarding the general status of civil servants, and by the law No. 1/24 of October 2, 2009 laying out special provisions for the regulations governing civil servants applicable to health care workers.

⁷⁷ All district medical officers are nominated by Ministerial Order.

There is no integrated payroll system which links the staff database of the Directorate of Human resources (DRH) with the payroll system of the MFPT. As in other ministries, the DHR uses a simple Excel database to track all health staff. In order to obtain reliable and comprehensive health resource data from all health provinces, HRD organizes field trips to support Provincial Health Office (Bureau provincial de la santé) (BPS) / District Health Office (Bureau du district de santé) (BDS) managers in data collection. This database is managed manually and updated based on the information provided by the Provincial and District offices. The lack of a follow-up system to monitor staff mobility at all levels of the health system has been one of the major problems in human resources management. Efforts have been made recently to monitor staff mobility (including new recruits and departures) at the level of the health centers, with the Provincial District Office transmitting the collected information to the central administration on a tri-semester basis. Following the recent introduction of this human resource (HR) monitoring system, it is not yet clear if all health facilities have received the reporting instructions. In particular, budget constraints have hindered the systematic distribution of the reporting format to all health centers.

Moreover, although the payroll system of the DRH's staff database is not interconnected with the payroll system of the MFPT, the MFPT has started to share its salary and employment list. It has done this in Compact Disc (CD) form on a monthly basis with the DRH since 2016, which has enabled the DRH to update its staffing database accordingly. Plans are to continue the reconciliation of the staff and payroll exercise on a monthly basis.

A verification of the database was done recently by the DRH, but systematic control and tools for regular monitoring of staff mobility at all levels of the health system are still being developed. The DRH conducted a thorough verification of its staff records in 2016, identifying only a few ghost workers at the subnational level. It plans to put into place a systematic verification of the staff records from 2017 onward. Additionally, the DRH plans to integrate staff reporting tools into the Performance Based Financing (PBF) Monitoring and Evaluation System to collect staff information and to better track staff movements and departures. In this context, it should be noted that, since 2008, no external audit has been conducted to perform payroll checks and verify staff records across all sector ministries.⁷⁸

Procurement of medicines and supply chain management is poor, hampering the access to essential medicines.

All pharmaceuticals are centrally procured. Burundi has centralized the procurement of pharmaceutical products by creating a central medical store called the Central Agency for Drug Purchases (CAMEBU). The Ministry of Health procures mainly drugs for opportunistic infections. The remainder is procured through private wholesalers. Donors manage their own procurement. This is typically done for priority diseases such as HIV/AIDS, and malaria. Donors stock their supplies at CAMEBU, paying 1 percent of the supplies' value for storage and inventorying services. CAMEBU and the Ministry of Health are the only suppliers in Burundi authorized to import anti-retroviral (ARV) drugs. CAMEBU provides generic essential drugs and medical supplies to national hospitals and district pharmacies. District pharmacies in turn sell pharmaceutical products to district hospitals and health centers.

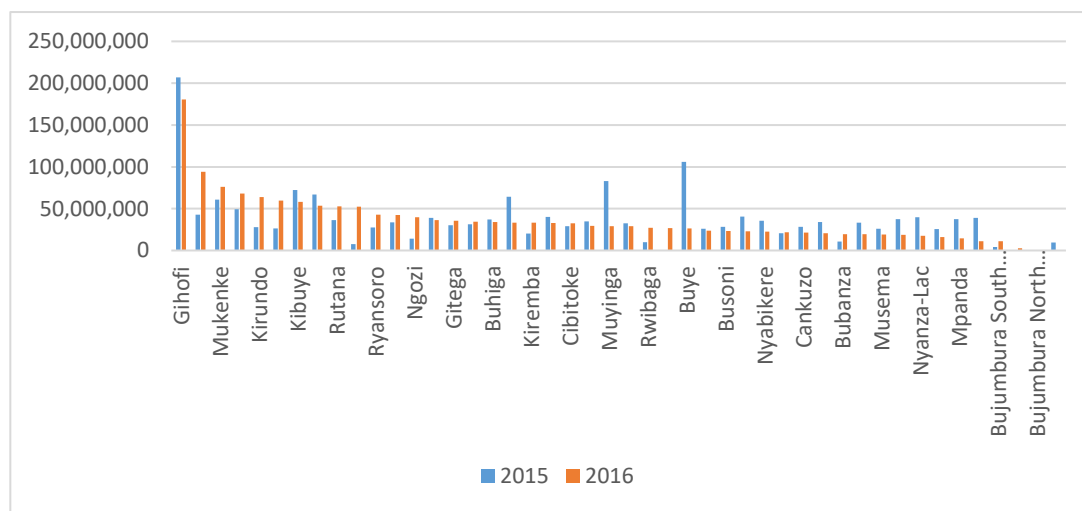
The procurement process is cumbersome — a well know constraint regarding CAMEBU. CAMEBU procures essential medicines and medical supplies through national and international open tendering processes. CAMEBU uses past sales to predict future needs, which is not as accurate as more sophisticated

⁷⁸ According to the PEFA, the last major systematic verification (census) was conducted in 2008.

quantification methods. The procurement of essential medicines follows the regulation of the Public Procurement Act, with all procurements placed under tenders. According to the most recent analysis⁷⁹, CAMEBU's procurement process takes 202 days from the quantification determination to placing the order with the selected vendor. Therefore, the urgent need of some medicines often leads to a relaxation of the procurement processes, thereby increasing the risk of corruption and abuse within the system. CAMEBU obtains competitive prices for medicines according to international reference prices⁸⁰. CAMEBU also applies a price surcharge of 15 percent to the drugs supplied to district pharmacies. District pharmacies take an additional 5 percent, and district hospitals and health centers a final 10 percent. However, even when compounding all of these price surcharges, the price paid by the patient remains at or below reference prices⁸¹. Based on the findings of the team's field visit, the price surcharge applied by the district pharmacies is used to cover the costs associated with the transport of drugs and medical commodities.

Foreign currency shortages, inflexible financing due to earmarking by vertical disease programs, and district pharmacies' insolvency resulted in an insufficient and unreliable supply of medicines during the crisis. In addition to problems related to the quantification method and procurement lengthiness, CAMEBU's supply capacity is severely hampered by a number of financial constraints. These were further exacerbated by the crisis. CAMEBU finances the purchase of the essential medicines through both budgetary resources and the sale of those drugs to district pharmacies and national hospitals. The sales allow CAMEBU to maintain a revolving fund, as well as a certain degree of autonomy. District pharmacies depend on district hospitals and health centers to pay for drugs. Health facilities depend on the predictability of such financial transfers as well as on reimbursements from medical insurances. As will be discussed, transfers and reimbursements were delayed during the crisis. This resulted in a debt by district pharmacies to the CAMEBU of BIF 1.7 billion in 2015⁸² and BIF 1.63 billion in 2016 (figure 69).

Figure 69: Debt of District Pharmacies (2015 and 2016) (BIF)



Source: CAMEBU.

⁷⁹ Burundi National Supply Chain Assessment Results, August 2014, President's Emergency Plan for AIDS Relief (PEPFAR).

⁸⁰ According to the 'Enquete Sur la Disponibilite et les Prix des Medicaments au Burundi, Janvier 2014' and 'Rapport sur l'Analyse du System Pharmaceutique au Burundi, Octobre 2015', CAMEBU's prices are competitive according to international standards.

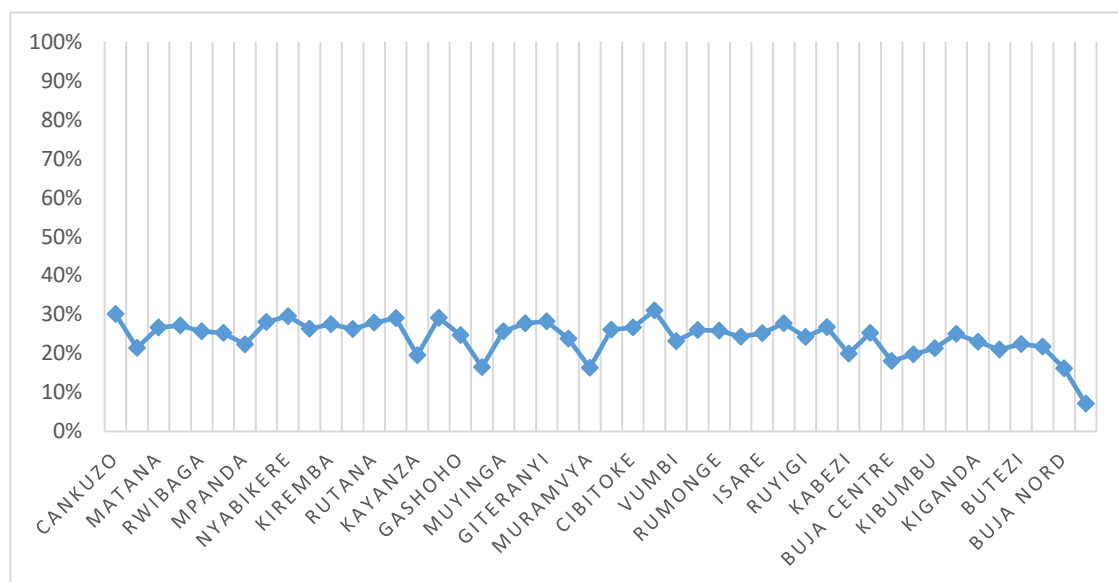
⁸¹ Enquete Sur la Disponibilite et les Prix des Medicaments au Burundi, Janvier 2014 and Rapport sur l'Analyse du System Pharmaceutique au Burundi, Octobre 2015.

⁸² Under normal circumstances, district pharmacies pay the previous purchase (n-1) to CAMEBU, before placing a new order (n).

CAMEBU's financial insolvency effected its procurement capacity in 2015 and 2016. Together with the shortage of foreign currency, it explains the reduced volume of imported medicines.

During the crisis, the financial constraints faced by CAMEBU coupled with the procurement difficulties led to the insufficient purchase of medicines and increased prices for households. The district pharmacies purchase their drugs from CAMEBU. However, when medicines are not available, district pharmacies can purchase from private wholesalers up to a limit of BIF 5 million per month⁸³. In 2016, due to the low order fill rate by CAMEBU (figure 70), district pharmacies placed a significant number of orders through private wholesalers, confirming CAMEBU stock outages of certain medicines.

Figure 70: District Pharmacy Average Order Fill Rate in 2016



Source: Department of Pharmacy, Medicines and Laboratories, Ministry of Health.

Wholesalers prices of medicines are higher than the CAMEBU ones. Therefore, CAMEBU inability to purchase sufficient medical supplies had a domino effect in the system, leading to increased prices of medicines for households

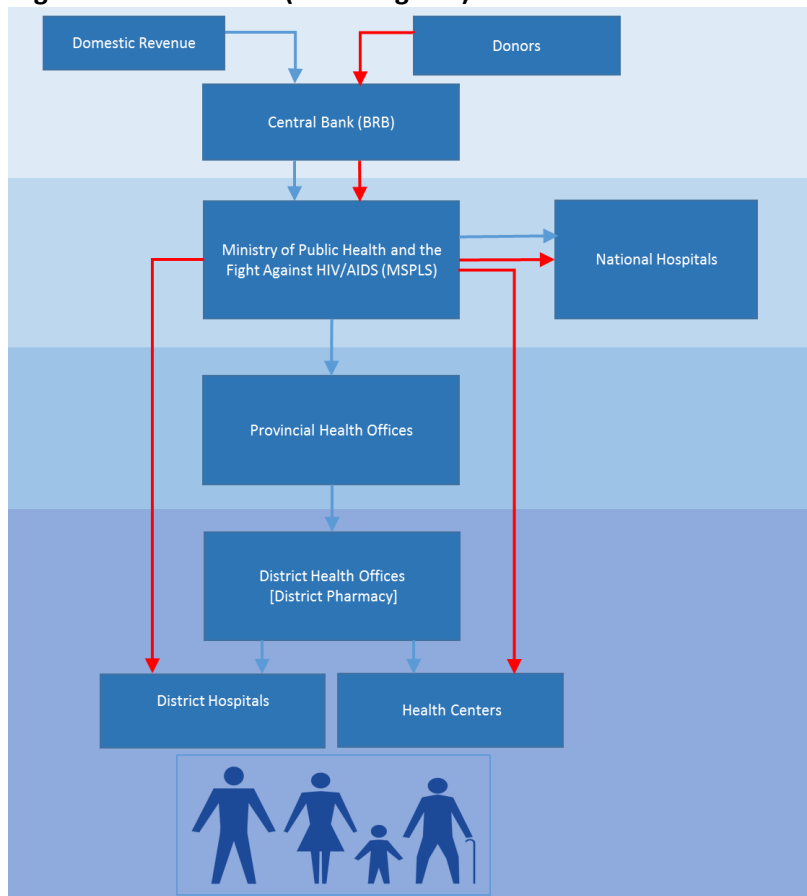
Transport systems at all levels of the medicine supply chain in Burundi is ad hoc. At each level of the supply chain (CAMEBU-district pharmacy- health facilities), orders are collected by the receiving entity. The receiving entity is responsible for securing the necessary means of transport and visiting the distributing facility for its products. The means of transports range from trucks to bicycles with increases vulnerability of products. Indeed, vehicles are not fitted with equipment to maintain the cold chain, so products that require cold chain are transported in cold boxes.

⁸³ Prior authorization from the Department of Pharmacy, Medicines and Laboratories, Ministry of Health. The Department provides only one authorization per month and per district pharmacy.

The financing of health services is fragmented due to multiple health system levels and financing sources. PBF funding has substantially improved resource allocation in favor of front-line service delivery and subnational health administration; however, sustainability is an issue

Although the health budget remains largely concentrated at the central level, health facilities, and district and provincial offices receive financing from the Ministry. Specifically, the Ministry provides: (i) resources to the district and provincial offices for their operational costs; (ii) ad hoc transfers to national and district hospitals to fund both recurrent costs and wages and salaries (salaries only to the national hospital); and (iii) funds to the health center, but through the PBF (national counterpart-*Contrepartie Financiere* [CF]). In the past, ad hoc transfers were estimated based on input-based costing. However, in recent years, funding has been based on historical allocations — without consideration of changes to staff and operational costs. Furthermore, health facilities have differences which are not equalized in the transfers (see figure 71).

Figure 71: Funds Flow (excluding PBF)

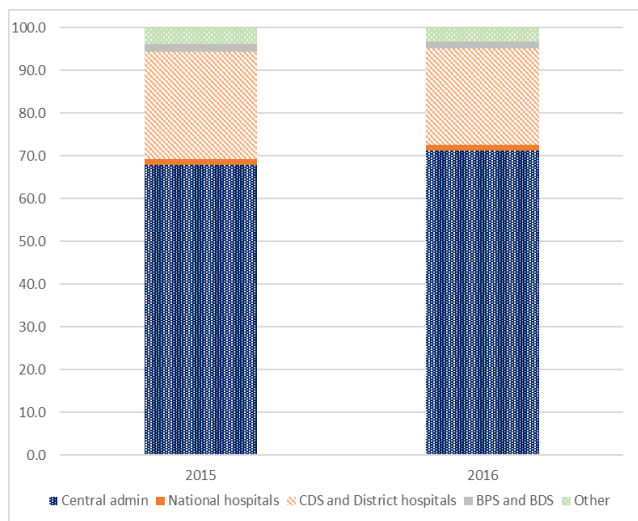


Source: Authors’s schematic.

The allocation of funds by level shows that, on average, about 69 percent 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 (representing mainly the Government’s PBF counterpart funding, as illustrated in figure 72). The overall decline in fund transfers in real terms between 2015 and 2016 was 8 percent. This disproportionately impacted more of the front-line services, which declined by 18 percent.

This can be attributed to a slightly stronger decline in the Government-financed PBF resources (by 13 percent) as compared to the remaining transfers (by 6 percent) (See figure 73).

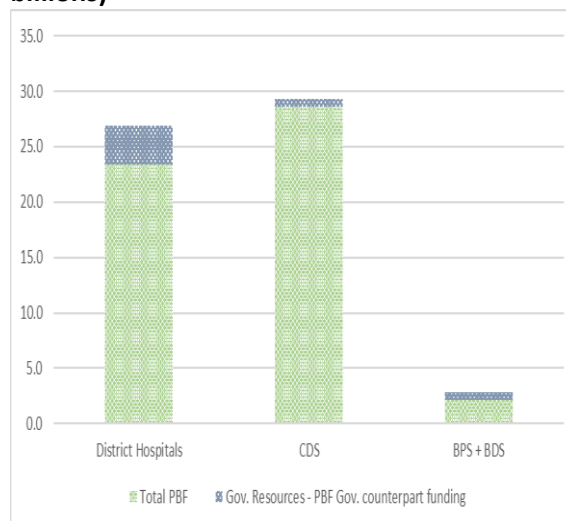
Figure 72: Government Domestic Funding by Level, 2015-2016



Source: MSPLS.

Note: BDS= District Health Office; BPS= Provincial Health Office; CDS= Centre de Sante.

Figure 73: Resource Allocation by Source at the Subnational Level, 2015-2016 (BIF billions)



Source: MSPLS.

Note: BDS= District Health Office; BPS= Provincial Health Office; CDS=Centre de Sante; PBF= Performance-Based Finance. Government should be abbreviated as Govt.

Burundi’s small country size and limited public resources for the health sector raise concerns about the number of health administrative layers. As noted, both the provincial and district health offices receive funding for staff and operational costs. As assessed during the team’s field visits, district and provincial offices have overlapping and redundant coordination and supervisory responsibilities for the provision of the health services at decentralized levels. Burundi is a small country with an overly structured health sector organization. As such, it misallocates the limited public resources for the health sector, thereby compromising the efficiency of service delivery.

Burundi has been one of the first African countries to implement PBF to improve the access to and quality of health service delivery⁸⁴. Figure x illustrates the PBF funding flow and the beneficiary entities. Based on the quality and quantity of services provided, the health facilities receive performance-related funding. The quality is assessed against a number of output indicators, including ante-natal care (ANC), vaccinations, family planning, and so on. Different levels of PBF payments are associated with these outputs indicators (for instance, 2,000 BIF, hospitalization ≤ 5). The payment level (*tariffe*) also comprises a number of factors, such as a Province’s poverty and remoteness (*bonus equite*). The health facilities report monthly about the quantity of incentivized services delivered and the reports are verified. In addition to the quantity-based payment, the health facilities receive a quality bonus according to the quality of the services provided (administrative procedures, staff behavior, and so on)⁸⁵. The performance-

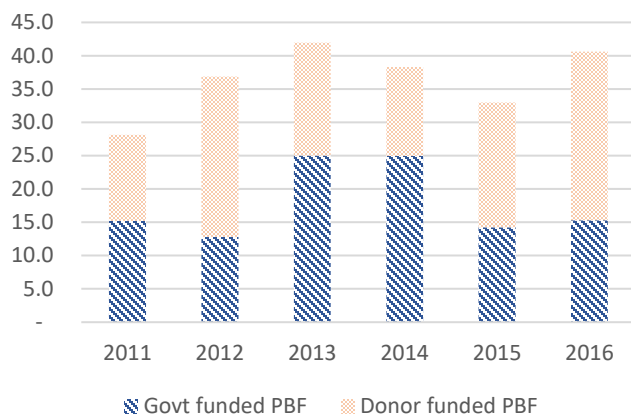
⁸⁴ The World Bank Health Results Innovation Trust Fund, 2013.

⁸⁵ According to the PBF manual, the quality evaluation is done every 3 months for technical quality aspects, for example, for procedures, and every six months for the quality perceived, for example, staff behavior.

based funding is used according to a set of financial management procedures for an eligible expenditure menu, including financial incentives to staff (*prime individuelle*)⁸⁶.

Although PBF has been critical in ensuring the funding of locally-based health care services and the promotion of good performance, the sustainability of this financing mechanism raises some concerns. PBF has led to considerable improvement in the financial autonomy and capacity at decentralized levels. However, half of the PBF is in the form of donor aid (figure 74).

Figure 74: Evolution of PBF Funds by Source, 2011-2016



Source: MSPLS.

Note: PBF= performance-based financing.

Some shortcomings with the PBF’s incentive scheme and its impact on the quality of health care have been properly addressed, while others remain. PBF has had some positive impacts, especially regarding the types of care which require behavioral change of the health workers (when the patient is already in the clinic). For instance, the anti-tetanus injection during an ANC visit clearly improved⁸⁷. However, over the period 2009-2011, only one-third of mothers visited facilities four times, as recommended⁸⁸. To address the difficulty of the PBF in increasing the utilization of services that depend on patient choice, some PBF performance indicators have been modified. For instance, the ANC visits now account for the progressive numbers of visits. Furthermore, the PBF will reintroduce performance-based pay initiatives in favor of the MSPLS’s central administration. This will be done to address the issue of low motivation, which has adversely affected the performance of the intermediate and peripheral levels that receive often insufficient support from the central administration. Apart from these improvements, according to the team’s field visits, some health facilities retain drugs and medical supplies to fulfill the medical stock performance criteria — positively impacting the quality of health care.

The 2015 crisis affected the PBF’s performance and health care results. As described in Section A, some performance health indicators (child and maternal indicators) decreased in 2015. Performance payments arrears to health facilities have been registered in the amount of BIF 8.9 and 10.1 million respectively in

⁸⁶ *Outil d’indice dans le cadre de la mise en œuvre du financement base sur la performance*, Burundi, 2014.

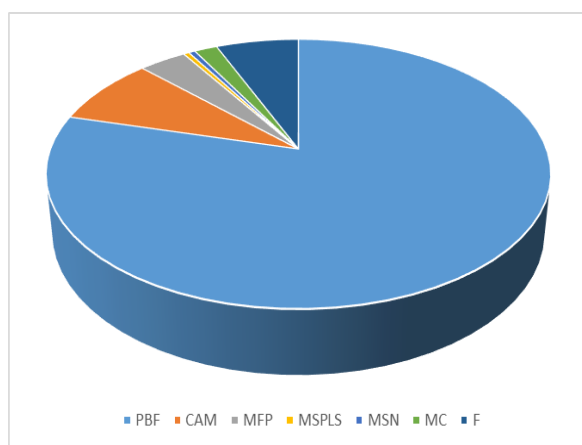
⁸⁷ “The effects of performance incentives on the utilization and quality of maternal and child care in Burundi”, Institute of Health Policy & Management, Erasmus University Rotterdam, The Netherlands, 2014.

⁸⁸ Burundi Poverty Assessment, World Bank, 2016.

2015 and 2016⁸⁹. This was triggered by a decrease in PBF’s donor contributions. In 2015, some PBF donor financing agreements came to an end and were not renewed (including the United States Agency for International Development - USAID). Some were either not concluded as planned (Germany [Reconstruction Credit Institute - KFW] in the amount of €20 million) or were delayed (€30 million from the European Union). In this regard, it should be noted that the PBF Government counterpart funding increased slightly in 2015 to compensate for the donor funding shortfall.

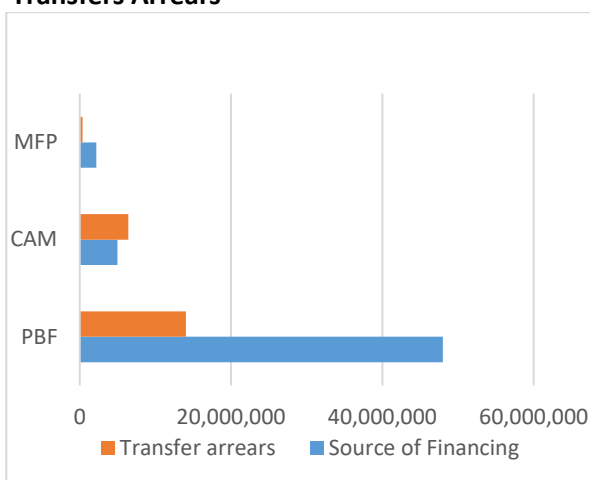
A lack of certainty and predictability regarding the transfer of funds (aggravated by the crisis) hampered the financial management and day-to-day functioning of health facilities. During the team’s field visits, a data sample about the financial revenues of the facilities was collected. The number of funding sources and the volume and importance of transfer delays are illustrated in Figures 75 and 76.

Figure 75: 2015 Muramvya Health Center Budget



Source: Muramvya Health Center.
Note: CAM= National Health Card Insurance Scheme; F= Military Insurance; MC= Community Health Insurance; MFP= National Public Health Service; MSN= Ministry of National Solidarity; MSPLS= Ministry of Public Health and for the Fight against AIDS.

Figure 76: 2015 Muramvya Health Center and Transfers Arrears



Source: Muramvya Health Center.
Note: CAM= National Health Card Insurance Scheme; MFP=National Public Health Service; PBF= Performance-Based Financing.

The 2015 Muramvya Health Center budget reveals that PBF constitutes the largest source of financing. It accounts for 79 percent of the total revenues, followed by the National Health Card Insurance Scheme (CAM) which contributes 8 percent. Health user fees and other insurance schemes constitute the remaining 13 percent. An analysis of the transfer delays by type of source shows that 29 percent of the PBF performance payments were not transferred to the facility in 2015. This created a cash shortfall and impacted the quality and quantity of service delivery. According to PBF’s internal analysis⁹⁰, the time lag of PBF transfers to health facilities is, on average, 50 days from the submission of the facility’s performance report to the actual disbursement. Again, this situation was exacerbated by the crisis in 2015 as shown in figure X.

⁸⁹ PBF data.

⁹⁰ Burundi PBF Procedure Manual, 2015.

Although health facilities charge fees for the services provided, such fees are quite low. A revision of the user fee structure is ongoing. Finally, off-budget donor aid constitutes an additional important source of health financing (including in-kind contributions). However, it is not possible to track the level and use of off-budget donor aid at the subnational level.

Financial reporting creates an administrative burden and entails additional costs to health facilities.

There is no clear reporting framework providing for the financial cost type, number and deadline. The reporting structure is also not clearly defined. Facilities send various reports to different entities, such as the PBF, vertical programs, the Ministry of Health, District Health Offices, and so on. On the basis of the team's field visit, it was observed that the health center of Nyabibuye is staffed with only three nurses — but produces 10 monthly reports. (Box 4).

Box 4: Health Center Financial Reporting

1. SIS Report
2. VIH – CNLS Report
3. CAM Report
4. Malaria Report
5. Mosquito net Report
6. Vaccination Report
7. PNSR Report
8. FHI-360 Report
9. Medicines and IST Report
10. SSRAJ Report

CHAPTER 3: CONCLUSIONS AND RECOMMENDATIONS

Despite steady progress, health outcomes and access to basic health services in Burundi remain below regional comparators in many respects— and are also subject to regional disparities. During the last two decades, many health indicators in Burundi improved, including increased immunization coverage rates and reduced under-age-five-children and maternal mortality rates. Yet, under-five-children and maternal mortality rates remain higher than in comparator countries in the Africa region. Burundi is the most food insecure country in East Africa, with the highest prevalence rates of underweight children in Africa. Indeed, more than half of children under the age of five suffer from stunting. The incidence of communicable diseases — especially malaria, diarrhea, and respiratory tract infections — is very high. The utilization pattern of curative health services by the adult population is characterized by significant income inequities, and is negatively affected by capacity to pay. However, the country has been able to ensure more equitable access to maternal and child health services through the FHC-PBF program.

In the short- and medium-term there is no scope for economic growth to generate significant additional fiscal space for health, particularly *without* external aid returning to pre-crisis levels. In the medium-term, economic growth is projected to improve modestly to 1.5 percent in 2017 and 2-2.6 percent in 2018-19 — although this is still below its pre-crisis levels. Real GDP per capita growth will remain negative under this modest improvement in the growth outlook. Government revenue is projected to increase over the medium-term, which will partially offset the decline in on-budget external aid. As such, significant increases in health expenditures from general revenues are unlikely, and the government's health spending as a share of GDP is likely to remain relatively flat.

Insufficient and inefficient public spending on the health sector, inequity in the provision of care and the shortage of qualified health workers are some of the major factors behind the mixed results in health outcomes. Although public health appropriations doubled between 2010-2015, they remain among the lowest in the region. They also dropped sharply following the suspension of some donor-funded programs or delays in the renewal of others in 2015 and 2016. The government has taken measures to offset this decline by slightly increasing the share of domestically-financed expenditures in primary health care through the PBF in 2015. Notwithstanding this, the current distribution of resources appears to favor curative services. In the meantime, national programs for preventive services are largely underfunded. Public spending on health is heavily skewed toward wages and salaries, while other expenditures (notably investment spending and goods and services) have declined as a share of the budget, with a more marked decline following the crisis. In addition, current resource allocations do not adequately consider health needs particularly at the deconcentrated level. However, resources are channeled to deconcentrated health offices and health facilities on an *ad hoc* basis, based on incremental roll over of line-item budgets determined before 2012 — thereby perpetuating inequalities. The undersupply of qualified medical staff — aggravated by geographical imbalances, low salaries and insufficient training — has adversely affected the delivery of services, particularly in front-line care providers outside of Bujumbura.

Heavy dependency on external aid has rendered the sector not only vulnerable to the fluctuation and unpredictable nature of aid flows, but the aid is also largely off-budget. Efforts to increase aid coordination and harmonization have been put on hold since the 2015 crisis.

The Government made substantial efforts to address inequities in the health system by introducing the free health care and improving physical access programs, yet inequities in the health system persist. Public spending is regressive and not well targeted, while financial barriers continue to adversely influence the utilization of health care services, particularly by poor households. Despite a

decline in OOPs prior to the crisis, the recent eruption in violence and insecurity are likely to have increased household OOP expenditures because of an increase in the cost of drugs and transport, thereby affecting disproportionately low-income households. The establishment of several insurance schemes to cover the poor has been undermined by inefficiencies, weak performance and a lack of funding.

In the context of tighter financing constraints, increases in health expenditures could mainly come from a reprioritization of the health budget, coupled with significant efficiency gains. Improvements in distributional equity can also be achieved by a revised approach to the spatial allocation of resources and the strengthening of the financial protection schemes. This should be done in concert with the expansion and deepening of health sector financing reforms and improving governance in the health sector.

This review offers suggestions to: (i) sustain progress toward health targets; (ii) meet current demographic trends; and (iii) address inefficiencies and inequities in light of the weak short- and medium-term prospects for economic growth and revenues — as well as uncertainty about a rapid restoration of external aid to pre-crisis levels.

Sustain the macro-fiscal framework

Promote Economic Growth. Burundi experienced sustained economic growth between 2005-2015. However, the country's growth and economic development deteriorated during the recent crisis. Moving away from a post-conflict context to a developing economy, it is essential to maintain macroeconomic stability through prudent monetary and fiscal policies involving spending constraints. Within the context of a restricted budget, the Government needs to create more fiscal space for efficient and effective priority spending to improve public service delivery (including education, energy, health, and roads). To promote productivity growth and diversification, priority should be given to the agricultural sector, with a focus on smart climate and cold chain investments. The design and implementation of a set of business-friendly policies in the areas in which Burundi may have a comparative advantage (food processing, construction materials and other labor-intensive industries) also provides an opportunity for the country to stimulate investments in the context of regional integration. Because of its geo-strategic location, the Government should also support the exploitation and use of the Rail-Lake transportation option of the central corridor to unlock growth potential through increased regional and international trade, as well as access to regional FDI.

Foster fiscal management. Burundi will need to undertake a number of key fiscal reforms if it is to improve its fiscal outlook. In light of the country's severe recent fiscal stress, priority should be given to the design and implementation of a cost-effective action plan aimed at rationalizing tax exemptions and enlarging the tax base. The creation of an independent fiscal entity or council would help foster greater transparency and accountability. This entity would conduct independent evaluations of fiscal-related issues to monitor compliance with national fiscal policy rules. Furthermore, fiscal transparency would be greatly enhanced by the regular publication on budget execution. Evaluating the size of arrears and establishing a plan to reduce the accumulation of arrears should not only limit the build-up of arrears, but also stimulate private sector activity.

Strengthen debt management performance. The recent increase in domestic public debt underscores the need for prudent fiscal policy. It also shows a limited scope for additional borrowing in case of another fiscal shock. The design and implementation of a sound debt management strategy for Burundi, a common tool applied in the East African Community, would assist the Government in fostering fiscal rules (that is, respecting ceilings on expenditure, debt, and so on). In addition, it would

be important to strengthen local capacity for the preparation of debt sustainability assessments, which would allow the country to better detect, prevent and resolve potential crises.

Strengthen exchange rate management. A shortage of foreign exchange has limited much-needed imports for economic activities, thereby hampering trade and investment. Key measures aimed at strengthening exchange rate management should focus on: (i) promoting transparency in the implementation of the foreign exchange restriction policy, in particular, the allocation of the scarce foreign exchange among operators in the priority sectors based on clear and transparent criteria; (ii) promoting a dialogue between monetary authorities, the private sector, and the public to highlight the exchange rate policy in effect; (iii) evaluating the effectiveness of policies by examining the impact of recent decisions on foreign exchange controls; and (iv) improving the current fiscal-monetary policy inconsistency with the exchange rate policy.

Improve the efficiency of the health sector

Prioritize expenditures in health to primary care and preventive health services, notably to the under-funded national programs. Increased domestic allocations to national programs would leverage the resources allocated to vertical programs, as well as provide an initial basis for the sustainable financing of these programs beyond the lifetime of vertical donor funding. The Government should conduct a study examining the fiscal space and options to address the phasing out of some programs (for instance, GAVI). Consequently, it should focus on the need to gradually substitute external funding for medication and other services supported by the vertical programs with financing from domestic resources.

Reinforce cost-effective interventions. The quality of care is key to improving health outcomes, efficiency, and user satisfaction. Effectively targeting resources to the areas of greatest need is critical to improving the quality and use of health services. To achieve this, Burundi needs to strengthen those health interventions that have the greatest possible benefits (for example, maternal and infant programs, nutrition, and so on) In particular, evidence suggests that there are high returns to investments in reproductive health programs, which could be supported by increased domestic resource allocations to better conduct supervision, training and support to key areas of the program that have been neglected in the past (for example, gynecological cancer, and sterilization issues).

Enhance the health care package to include coverage for non-communicable disease treatment. Given that chronic and non-communicable diseases (NCDs) are becoming increasingly prevalent, it is recommended to include them in the health care insurance package. As this requires additional resources, a focus should be put on exploring cost-effective interventions such as methods of early detection, and affordable medication for prevention and treatment of conditions such as heart attacks and diabetes. Moreover, these types of interventions can reap future savings in terms of reduced medical cost and improved quality of life.

Better align health spending with sector priorities. The health spending composition is skewed and wages and salaries represent the bulk of expenditures which are crowding out capital and recurrent expenditures (including funding for monitoring and supervision, as well as O&M). Given the country's demographic pressures, the government will need to mobilize resources to invest more in the construction of health centers in line with the health sector's extension plan to ensure adequate access and coverage in the medium term. Similarly, more resources to the maintenance budget, coupled with better costing of maintenance needs and additional technical staff to ensure maintenance of the health infrastructure, would be key to achieving value for money in the new facilities.

Modern public expenditure management processes and procedures adopted in the last ten years have to be reactivated to ensure efficient allocation and spending (including the basic disciplines of annual planning and budgeting in the ministries of finance and health). The institutional and technical capacity in public financial management still exists and it will be important to capitalize on it.

Decentralization provides a unique opportunity to address long-standing inefficiencies and inequities. To this end, streamlining the health sector organizational structure and improving its alignment with the country's territorial organization could result in efficiency savings. The provincial and district offices have overlapping roles of coordination and supervision. In a context of limited resources, a clearer definition of roles and responsibilities is certainly required. In this regard, the Government could even consider eliminating one of those tiers in order to reallocate the funds and personnel to focus on the provision of health services. Finally, a clear definition of the commune's role in the provision of health services and a coordination framework with the health deconcentrated health offices should be defined to ensure that communal resources, notably the *FONIC*, are used to address infrastructure shortfalls.

The Ministry of Health needs to develop phase-out plans for the PBF intervention that rely heavily on donor financing. Furthermore, it will be important to reinforce monitoring of the PBF system considering that some of the selected indicators show that it could be unintentionally harmful to qualitative service delivery. Finally, a rigorous evaluation of the system should be carried out to enable a comprehensive, transparent and objective assessment of the system.

Strengthen programming of development assistance for health

Establish a system to capture and monitor large resource inputs provided through off-budget donor support. Although this process is expected to be complicated, a potential starting point could be those inputs that can be monitored through the existing government systems, such as donor-funded drugs and medical supplies that are managed through CAMEBU. Furthermore, development partners could share expenditure information with the Ministry of Health through a resource tracking system administered at both the mid and end of the financial year. This process requires closer dialogue between the Ministries of Finance and Health.

Pursue available avenues for improved donor coordination and harmonization. The crisis has exacerbated the fragmentation of donor funding to the health sector. A joint effort involving both the Government and development partners is required to ensure that external support is better aligned to national priorities and delivers better value-for-money. Revitalizing *the Cadre de Coordination de Partenaires pour la santé*, including the Ministry of Finance to support effectiveness, as well as the health sector annual reviews are initiatives clearly worth pursuing. The ministries of finance and health should explore the willingness of donors to convert their assistance into a pooled-aid instrument, such as a basket fund – as was being discussed before the crisis. Such an instrument would provide more fungible financing to the sector and could be linked to strengthened planning and dialogue. At present, a majority of donors tie their aid flows to specific major communicable diseases, thereby undermining strategic prioritization and distorting the allocative efficiency of spending. A more linked aid instrument would also require the ministries of finance and health to produce credible, financeable programs that donors can fund.

Improve the management of the health workforce

Strengthen human resource management. The ability of a country to meet its health goals depends largely on the skills, motivation, and deployment of the health workers responsible for delivering services. Given the shortcomings of Burundi's human resources in the health sector, it will be critical

to: (i) recruit skilled health workers to ensure that primary health care facilities meet their nationally recommended staffing norms; (ii) address some of pervasive incentive challenges in the current system, such as the hiring of unskilled staff by health facilities; and (ii) implement an effective incentive scheme to attract and retain essential health workers; this could include the revision and strengthening of the current allowance scheme for hard-to-reach rural areas, the provision of a package of accommodations for health workers serving in remote and rural areas (housing, internet, vacation, and so on), and finally, the linking of a career progression to having worked in a remote rural facility.

Improve medicine procurement and logistics management

Improve the procurement and distribution of medical supplies in Burundi. More sophisticated quantification methods that take into account a variety of factors (for example morbidity) rather than solely past sales data could reduce CAMEBU stock-outages. To improve the efficiency of the procurement process, CAMEBU should implement an expedited procurement that is up to standard. For instance, pre-approval of vendors can reduce delays for individual purchases, thereby speeding up procurement processes. A framework agreement which would allow CAMEBU to purchase from a competitively selected vendor over an extended period of time could be also an option. The framework agreements could be particularly important in case of emergency and unplanned purchase of medicines due to epidemic outbreaks (for instance, the malaria epidemic in 2017). Finally, an adequate distribution system to deliver medical products to district pharmacies and health facilities with a routine delivery schedule should be put into place.

Reduce inequity in the health sector

Render the current insurance schemes more efficient and equitable with a particular focus on the CAM. Inequities in the utilization of services remain due to the persistence of financial barriers disproportionately affecting the poorer population. Promoting health insurance can offer financial risk protection for the population while also addressing inequities. To this end, the Government will need to introduce a number of corrective measures: (i) reduce overlapping mandates and target groups between the CAM and other insurance schemes (in particular with the indigent and community-health insurance schemes); (ii) improve CAM performance (for example, through timely reimbursements); (iii) increase its coverage and; (iv) improve its financial sustainability by providing adequate public resources and reviewing the insurance premium (which is too low).

Address the regressive resource allocation to health facilities. There is no correlation between the amount of resources allocated to the District hospitals and the poverty rate at the provincial level where the poorest, most remote, and least urbanized provinces receive the lowest per capita allocation from the Ministry of Health. Priority should be given to the development of an allocation formula, considering health facilities' costs and expenditure needs, remoteness, population size, population under the age of five, infant mortality, maternal mortality and the general disease burden. Finally, additional data analysis is needed to address the delays in fund releases and lower than initial allocation needs for health facilities.

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