IMPROVING HEALTH SYSTEM EFFICIENCY

BURUNDI

Performance based financing of priority health services

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Health Systems
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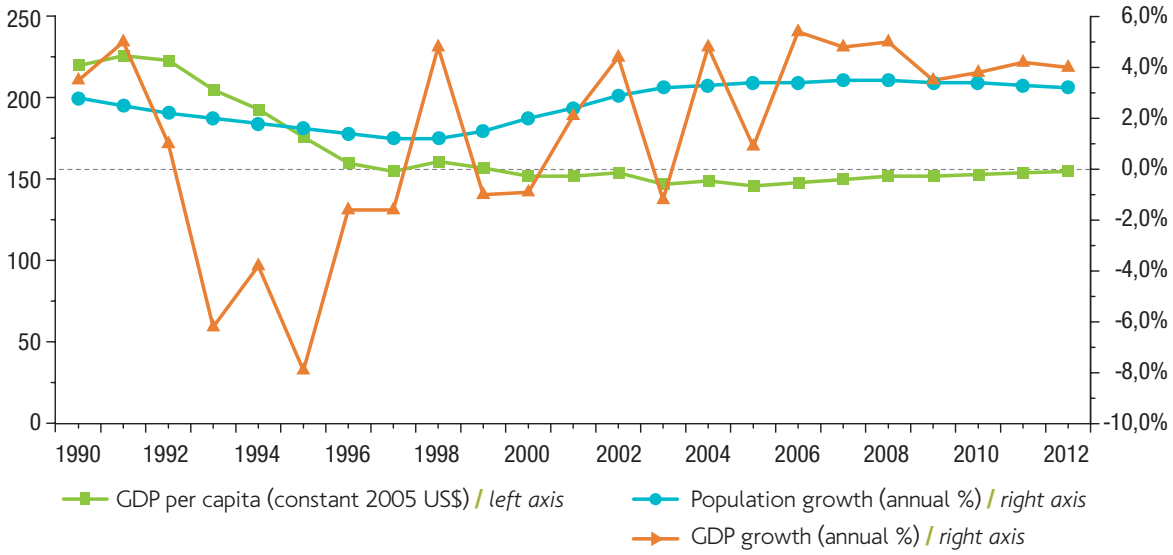
1 HISTORICAL, SOCIAL, AND ECONOMIC CONTEXT

During Burundi's civil war from 1993 to 2000, much of the country's physical, social, and human capital was devastated. A peace agreement signed in Arusha in 2000 opened the way for free democratic elections in 2005. Economic growth started to recover by 2004, but the per capita gross domestic product (GDP) has not yet recovered prewar levels.

Figure 1. Population growth and GDP



Source: World Development Indicators (WDI) 2013 (http://data.worldbank.org/country/burundi).

In the past decade, the country has made progress in its transition from a post-conflict to a developing economy, establishing a relatively stable macroeconomic environment, rebuilding institutions, and consolidating peace and security. The first Poverty Reduction Strategy Paper (PRSP) (from 2006 to 2011) introduced first-generation structural reforms. The second PRSP (from 2011 to 2015) builds on prior achievements and supports economic, social, and political reforms to stimulate inclusive and sustainable economic growth while consolidating peace and social stability *(1)*.

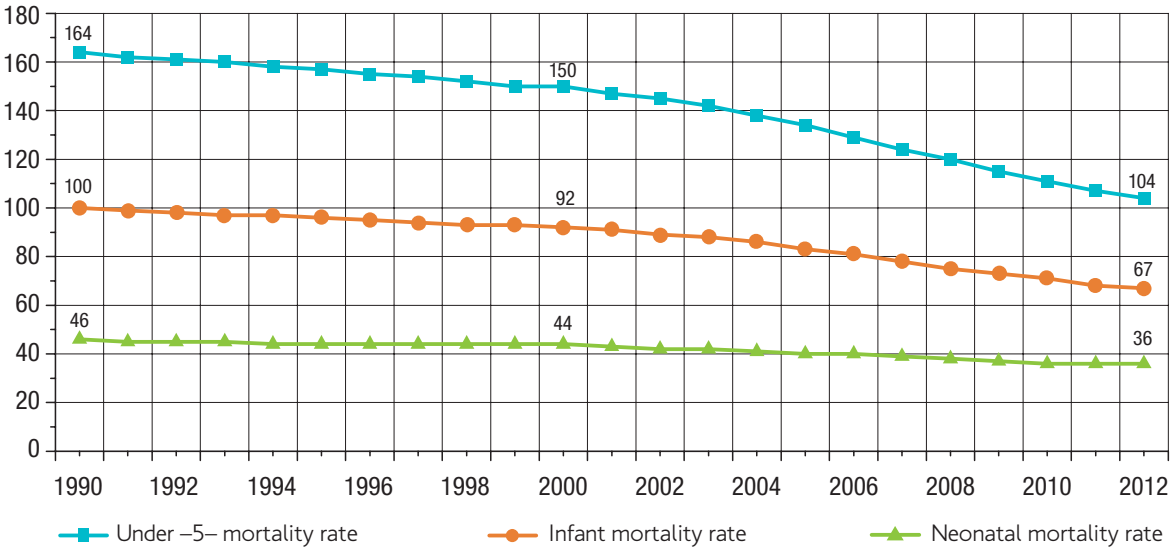
In January 2009, Burundi reached the Highly Indebted Poor Countries Initiative completion point and became eligible for US$ 833 million in debt relief, reducing the country's public debt by more than 90% in net present value terms. In spite of these positive trends, Burundi's Human Development Index value for 2012 (0.355) remains below the average of 0.466 for countries in the low human-development group and below the average of 0.475 for countries in sub-Saharan Africa *(2)*.

2 HEALTH SYSTEM CONTEXT

2.1 Health status

During the civil war, all sectors of life were affected and the health system was deeply disrupted. The rates of malnutrition[1] were high, and the incidence of infectious diseases was on the rise.[2] There have been improvements during the postwar period, but the millennium development targets for maternal and child health are still far out of reach *(3)*.

Figure 2. Trends in mortality rates[3]



Source: WDI 2013 (http://data.worldbank.org/country/burundi).

The epidemiological profile of Burundi continues to be dominated by communicable, maternal, neonatal, and nutritional causes of illness. In 2010, these factors were responsible for 76% of all years of life lost – which was only a small reduction from 82% in 2000 *(4)*. Health conditions related to HIV infection and tuberculosis increased, and nutritional causes declined. In 2010, however, almost 58% of all children in Burundi were found to be chronically malnourished, with approximately half of them suffering severe malnutrition *(1)*.

1 Among children ‹ 5 years, acute malnutrition ranging between 6% and 17% and severe acute malnutrition ranging between 1.1% and 4.1%.

2 Prevalence of HIV (% of population ages 15–49): from 3% in 1992 to 4% in 1998. Incidence of tuberculosis (per 100 000 people): from 294 in 1994 to 328 in 1998.

3 According to the Demographic and Health Survey (DHS) 2010, the ‹5MR is 96.

2.2 Health policy

Assessing the situation in 2004, the Government of Burundi undertook the development of a series of policies and reforms. The 2004 High-Level Forum on Health summarized the following challenges and bottlenecks in the health sector:

- insufficient and poorly trained staff, with 80% of medical officers and 50% of clinical officers and nurses based in the capital;
- poorly motivated staff with high turnover and attrition rates;
- poor quality of health services;
- lack of reliable health information;
- frequent stock-outs of essential medicines;
- excessive administrative centralization;
- lack of involvement of the community in the management of health services; and
- weak sector coordination.

The national health policy and the two national health strategic plans (NHSP) addressed these challenges through a range of reforms. Most of them followed a commonly observed approach of introducing reforms in the six building blocks of health systems as defined by the World Health Organization (WHO). The reform in Burundi, however, distinguished itself through emphasis upon performance and the introduction of a contracts model for health-service delivery. This new approach has also helped to unify some of the international aid, thereby promoting both alignment and harmonization of aid.

Table 1. Chronology of health-sector events

Year	Health sector	Other
2003	• First Global Fund grants for Malaria and HIV	
2004	• High level forum on health	
2005	• National health policy 2006-2015 • National health strategic plan 2005-2010 • Roadmap to accelerate the reduction of maternal and neonatal mortality • First Global Fund grant for tuberculosis	Free and democratic elections
2006	• Presidential Decree establishing free health care for pregnant women and children under 5 • National policy on contracting health service delivery	PRSP I 2006-2009
2006	• Start of first pilots on performance-based financing (PBF) in several provinces • Burundi joins IHP+	