



Taking Stock Report  
**Burundi**

March 2008

**THE INTERNATIONAL HEALTH PARTNERSHIP  
(IHP) IN BURUNDI**

**STOCK TAKING REPORT**

**Prepared for: THE INTER-REGIONAL COUNTRY HEALTH SECTOR TEAMS  
MEETING**

**LUSAKA, ZAMBIA**

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## **I. Current status of health development plans and strategies in Burundi within the framework of IHP+/HHA**

1. Burundi is in a post-conflict situation and has begun reconstruction and development. In March 2007, a framework for collaboration among health and development partners (CHDP) - the sector coordinating group - was set up by the Ministry of Public Health and AIDS Control (MSPLS) to facilitate coordination of technical, material and financial support for the implementation of the national health development plan (NHDP). The purpose of this new framework for coordination is to attain national health objectives and the health-related Millennium Development Goals (MDGs) as reflected in the PRSP and the Government's priority actions plan (PAP).

CHDP met on several occasions to prepare the Partners' Round Table in May 2007 and to progress towards harmonization of support for the health sector via a sector-wide approach (SWAP) to coordination of planning, implementation, monitoring and evaluation of health-sector interventions.

As part of the International Health Partnership (IHP+), Burundi has been a signatory to the agreement since 5 September 2007 as one of the first 7 countries.

From 23 to 31 October 2007, the Ministry of Public Health and AIDS Control (MSPLS) organized a joint mission with development partners from the health sector. This marked the starting point for a gradual evolution towards an authentic sector-wide approach to health in Burundi.

The Government of Burundi has begun the process of establishing a group of partners for development (GPD) which is chaired by the Second-Vice President of the Republic via the Permanent Secretariat of the National Assistance Committee (PS/NACC) and composed of sectoral policy-makers and technical and financial partners. Within the health sector, CHDP provides the technical and policy framework for GPD.

In conjunction with the national coordination agencies - the Partners' coordination Group (PCG), the Standing Secretariat of the National Assistance Committee (PS/NACC) and the Framework for Collaboration among Health and Development Partners (CHDP) - a permanent multi-sector technical entity involving the partners and technical ministries concerned (Health and Finance) will be set up to carry out specific missions connected with steering and monitoring-evaluation of health development in Burundi, by mutual agreement with the partners.

The shortcomings of coordination have been so apparent, that each operator has endeavoured to introduce its own system, with the risk of creating further problems for the Government. Two examples of the most deeply rooted mechanisms that exist in parallel to the coordination system are: (a) The Country Coordination Mechanism (CCM) which has been introduced with funding provided by the Global Fund and the International Agency Coordinating Committee (IACC), in connection with the funds provided by GAVI.

2. A long-term national health policy (2005-2015) and a National Health Development Plan (NHDP 2006-2010) have been drawn up. A paper on a medium-term plan of action for the implementation of NHDP (2007-2009), has also been adopted by the Government.

A common vision has developed which sees the Medium-Term Expenditure Framework (MTEF) and the National Health Accounts (NHA) as the tools needed to help implement the sector-wide approach. All the national health development programme strategies refer to the Poverty Reduction Strategy Paper 2006-2010 (PRSP) and the attainment of the MDGs. They include HIV/AIDS, malaria, tuberculosis, EPI, reproductive health and essential medicines.

Together with a common results framework, the national health accounts (NHA) and the Medium Term Expenditure Framework (MTEF) have proved essential aids for the introduction of the sector-wide approach. These tools have been developed by consensus at the level of CHDP.

At the present stage, progress towards attainment of the expected outcomes of NHDP is slow.

3. Four main reforms are under way in connection with the implementation of NHDP. They are
  - i) designation of the health-district level as the level to which the organization, funding and management of community- and family-based health services are to be decentralized;
  - ii) performance-based contracting to increase availability and quality of health services and motivation;
  - iii) integration of existing top-down programmes to achieve better results at lower cost thanks to synergy, coordination, and strengthening of the cross-cutting responsibility of MoH,
  - iv) reform of paramedical training. Other reforms are planned, in particular in the area of human resources for health, the funding system, the national health information system and the essential medicines supply and management system.

A recent study has made a start at analysing funding requirements and sources of funding with, and it will shortly be possible to estimate the funds available and funding shortfalls thanks to the development of MTEF.

4. The national strategy for domestic health-sector funding has yet to be determined. The share of the State budget to public health-sector operating expenditure is still very low (4% of total State expenditure in 2006 i.e. approximately US\$ 1 per capita in comparison with 5% in 1992). This budget is well below the WHO norms and the Abuja objectives to which Burundi has subscribed (15%). Capital expenditure too is very low: 6.7% in 2006, with an average of 3.1% in the last ten years.

In 2006, health care accounted for 5.6% of total household expenditure, i.e. approximately US\$ 8.6 per capita. Understandably, the burden of expenditure on health in the household budget, together with the levels of extreme poverty, mean that the financial barrier is the main barrier to primary health care.

At present domestic sources of funding are the State, households and insurance/mutual insurance funds, although the share of the latter is very marginal as it concerns only public sector employees. On account of the low level of insurance cover, and despite the Presidential measure relating to free care, direct out-of-pocket expenditure probably still represents a relatively large proportion of health funding.

At present, and under Government coordination, attention is being directed within the context of CHDP to the establishment of a medium-term expenditure framework on which to lay the foundations for a sector-wide approach based on realistic and sustainable funding scenarios.

Within MSPLS, the Directorate-General for Resources (DGR) is the central structure currently responsible for coordinating public resources for health, including management of State funds. The operation of DGR will be based on norms for the provision of established services and on quality and quantity requirements determined by the Directorate-General for Health (DGS).

5. The bottlenecks and constraints responsible for the shortcomings of the health system may be discerned in the following:
  - The poor quality of infrastructure (most of which is antiquated);
  - The shortages of staff, who are also badly distributed;

- The concentration of health workers in the capital, Bujumbura and the low numbers in the hinterland;
- The managerial weaknesses of health facilities (because of insufficient competent management staff and their poor motivation);
- The weakness of the essential medicines and medical consumables supply system;

This situation is responsible for the sector's poor performance as regards the operation and provision of services in rural areas.

**We should also draw attention to:**

- the heavily centralized management of the health sector;
- the paucity of financial resources assigned to the sector and inefficient use of those available.
- the weakness of the epidemiological surveillance and health information systems, and
- poor hygiene and sanitation

In response to these challenges and in collaboration with its partners, Burundi has committed itself, within the framework of CHDP, to intensifying consultation, coordination and collaboration in respect of national priorities in the health sector, and in particular to:

- Scaling up of operational health districts;
- Motivating health professionals, by performance-based contracts and/or health services procurement to persuade them to work in rural health centres and health facilities;
- Organization of a single, properly managed supply system for essential medicines and health products;
- strengthening the cross-cutting responsibilities of MSPLS in the areas of medicines supply, NHIS, monitoring and evaluation, IEC, accounting, staff training and supervision and other areas.

6. The changes needed in order for the Government, development partners and civil society to put into practice the Paris Declaration on aid effectiveness involve:

a) The introduction of a robust and coherent sectoral strategy for health development in Burundi circumscribed by the underlying philosophy of international initiatives, and in particular:

1. The International Health Partnership (IHP);
2. The recommendations of the High-level Forum on the health related MDGs;
3. The work of the OECD Development Assistance Committee (DAC) to transform health into a flagship sector;
4. The « One UN » approach adopted by the United Nations High-level Panel on System-wide Coherence;
5. The recent commitments by G8 (2005-2007) in respect of health;
6. The Declaration of Commitment on HIV/AIDS by the United Nations General Assembly (2006);
7. The recommendations of the Global Task Team on improving AIDS Coordination among Multilateral Institutions and International Donors;
7. The development policies of the European Union and in particular those relating to « MDG Contrasts » and the ongoing work of the European Commission on aid harmonization, alignment and coordination among Member States;
8. The Poverty Reduction Strategy Paper (PRSP) adopted by the Government of Burundi.
9. The New Partnership for Africa's Development (NEPAD): health strategy;
10. The commitment made (in Abuja in 2001) by the Heads of State of the African Union to the objective of assigning 15% of the national budget to health.

- b) Putting into practice the commitment by the Government of Burundi and its partners, in collaboration with civil society, to take up the challenges facing Burundi's health system.

The Government and its partners will focus in particular on the indicators of the Paris Declaration contained in the partnership framework / MoU. It will in particular collaborate with PCG and PS/NACC to measure the progress made by these indicators in the sphere of health, and in particular in relation to ownership, alignment, harmonization, results-based management and mutual responsibility.

- c) One of our concerns is the changeover from the existing system of funding inputs to funding results. Some initiatives, such as performance-based contracting for health facilities and services procurement are now being introduced in Burundi.
7. The purpose of the technical support needed to prepare the pact / MoU and other sectoral instruments is:
- To update and finalize the medium-term health programme within the framework of MTEF (March -April 2008)
  - To strengthen the secretariat of CHDP and of the theme groups (April 2008-April 2010)
  - To draw up the national health accounts (March 2008-March 2009)
  - To draft the MTEF for Burundi (April 2008-September 2008)
  - To design and introduce the SWAP (March 2008- March 2009)
  - To provide any ad hoc support needed for the implementation of health reforms and during monitoring and/or evaluation missions (March 2008-March 2010).

## **II. Summary of the other discussions on development of the partnership framework / pact /MoU.**

Since September 2007, Burundi has been one of the seven pilot countries in which the International Health Partnership (IHP) is to be implemented. The inclusion of Burundi in the Partnership should make it possible to improve the way in which international agencies, donors, civil society and the beneficiary countries harmonize and coordinate their interventions to attain the health-related MDGs.

A partnership framework document /compact has been drawn up and finalized by both the Government and its technical and financial partners in the health sector. It is due to be signed shortly by the Minister of Health and AIDS Control, the Minister of Economics, Finance and Cooperation for Development, as well as by the development partners.

The value added by the development of this partnership framework is summarized by the following elements:

1. Greater efficacy of international assistance thanks to enhanced mutual coordination, resulting in less overlapping, better harmonization and more focused use of the (increased) resources assigned to the health sector to implement NHDP.

2. Health services provided to the population will be improved in terms of both quantity and quality thanks to:
- the improved ability of public entities to design, plan, implement and evaluate a coherent and effective strategy;
  - more numerous, better and more stable human resources for health together with consistent and transparent management of human resources;
  - greater and more predictable financial resources for health which are also efficiently, consistently and transparently managed;
  - increased, better quality and more readily available equipment, inputs and medicines and a lowering of the financial barriers to access by the poorest;
  - greater transparency and efficiency in the management of material resources for health.

The following documents are annexed to this report: National Health Policy 2005-2015, National Health Development Plan 2006-2010, ToR of the Framework for Collaboration among Health and Development Partners, Partnership Framework, Programme of Priority Action 2007-2010, Poverty Reduction Strategy Paper and National Strategic HIV/AIDS Control Plan 2007-2011.

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