The Case for Investing in Child Health

Investment in Africa’s children is especially important at a time of rapid population growth: the continent’s population is expected to double from 1.2 billion to 2.4 billion between 2015 and 2050. In Burundi, this is especially true. Fertility rates are exceptionally high (6.1 children per woman, UNFPA 2014) and the country’s population is expected to increase from 10.5 million today to 23.1 million in 2040. More than 50% of Burundi’s population are children under 18. These children are particularly exposed to widespread poverty and vulnerability. Today 6 out of 10 Burundians are poor (64.6%, ECVMB 2014).

Evidence suggests that investing in children does not only have a positive impact on children themselves, but also has profitable long-term effects on the development of the country. The Copenhagen Consensus, an expert panel of economists, identified Early Childhood Development (ECD) programs as one of the most cost-effective investments, yielding high economic future benefits (e.g. in form of higher salaries). At the same time, each UD spent to reduce levels of malnutrition is expected to result in a 30 USD pay-off (Hoddinott et al. 2012) and cognitive losses associated with not breastfeeding amount to 302 billion USD annually at global level (Lancet 2016).

A country’s budget is a demonstration of a Government’s commitment to translate children’s rights into reality. Burundi’s commitment to children’s development and the realization of their rights is reflected in the country’s Poverty Reduction Strategy Paper (CSLP II) and other sectoral policies. Most notably, the introduction of free health care for children under five and pregnant women demonstrates political will to invest in children and thus the whole nation.

The Burundian health sector, which involves the provision, distribution, and use of health services and related products, has experienced encouraging improvement after the end of the last civil conflict in 2005, in particularly for children and women. The introduction of the free health care policy coupled with the performance-based financing (PBF) system as well as the Government’s policy of decentralisation, including the establishment of health districts bringing healthcare closer to homes, resulted in decreased infant, child and maternal mortality.

The PBF system in particular prompted an increase of consultations of children under five (1.68 per child per year in 2009 to 2.2 in 2012) and improved the quality of provided services.

IN SHORT:

- **High aid-dependency of the Burundian health sector**: To continue provision of essential health services to the most vulnerable children and women, external support is necessary. Alarmingly, available external resources decreased significantly from 2015 to 2016: by 87%.

- **Decreased national resources**: Despite increasing needs in a context of rising vulnerability, 4.2% less national resources were allocated to the Ministry of Health in 2016.

- **Commitment to protect PBF fund**: the commitment to allocate 1.4% of the overall budget to the Performance-based financing system is maintained, but in the current context, this means the PBF has approximately 2.5 million USD less than the year before.

- **High rates of child mortality**: though child health has improved over the past years, neonatal, under-five and maternal mortality rates remain high. One in ten children never see their fifth birthday.

- **High rates of hunger and malnutrition**: Burundi is the hungriest country in the world and rates of chronic malnutrition of children under five are amongst the highest in the world (58%, DHS 2010).
(2) Trends in health care allocations

Health-related funding is primarily channelled through the Ministry of Public Health and the Fight against HIV/Aids (MoH). In 2016, 99.3 billion Burundian Francs (approximately 63.1 million USD1) were allocated to the Ministry of Health according to the Financial Law 2016, issued in December 2015. Nominal allocations to the MoH have increased steadily from 2008 to 2015; however, if partly high levels of inflation are taken into consideration, the rise over time is less remarkable.

Decrease in allocated resources by 54%. The on-set of the 2015 political crisis is visible in the 2016 ‘austerity budget’. While 216 billion BIF (137.2 million USD) were allocated to the MoH in 2015, allocations decreased in 2016 by 54% (see figure 1). Furthermore, Burundi has not yet reached the level of allocation 15% of public expenditures to health to which it committed at the 2001 Abuja Health summit for African leaders, with a share of only 7.7% in 2016. The share of declared resources to the MoH as part of the total credited budget decreased from 13.7% in 2015 to 7.7% in 2016 (see figure 2).

Commitment to the PBF continues, with a fixed rate of 1.4% of the total budget reserved for the PBF, which goes hand in hand with the free health care policy for children under 5 and pregnant women.

(3) Sources of health sector financing

Burundi is one of the poorest countries in the world and a majority of children lives in poverty. In the domain of health - despite encouraging improvements over the past years particularly with regards to decreasing infant mortality, mainly resulting from successful vaccination campaigning – Burundi still performs poorly on many health indicators in comparison to other countries.

Many of the Millennium Development Goals were not met in 2015: food insecurity and particularly chronic malnutrition amongst children under 5 as well as maternal and neonatal mortality rates are still high, and many children die as a result of insufficient or poor-quality treatment. Most child deaths are largely avoidable through cost-effective interventions. The current crisis has put additional pressure on an already fragile population and increased humanitarian needs in a country still trying to overcome its many structural challenges.

Historically high aid-dependency of health sector. As illustrated in figure 3, over past years, the country has had difficulties to ensure provision of quality basic social services crucial for children’s development and well-being without external support. While in 2015, 60.1% of allocated resources to the Ministry of Public Health consisted of foreign aid, contributions of donor Governments only represent 17% of health allocations in 2016, according to the financial laws of the Government of Burundi (see figures 4a & 4b). However, it is uncertain, whether these documents capture all foreign support, since (particularly in 2016) many donors may have chosen different financing modalities not reflected in the financial laws to ensure their continued support to Burundi’s population.

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1 1 USD = 1 574.5 FBu, 1 March 2016, UN Operational Rate of Exchange
87% decrease in allocated external resources to the Ministry of Health in 2016. The detailed analysis of the financial laws highlights the importance of foreign resources to ensure the provision of health services to Burundi’s children and women. While the 2015 document lists 12 donors, in 2016 only three external sources of financing are reported in the financial law. Thus, on basis of the document, external support to the Ministry of Health decreased by 87%, with the World Bank and the United Nations as the most important multilateral partners in 2015 and important bilateral contributions coming from the United States, the Netherlands, Belgium and Germany. In 2016, only the World Bank, Belgium and UNICEF are listed in the financial law (see figure 5a & 5b). However, regular exchange of the technical and financial partners and with the Government reveals that not all external support is reflected and listed in the financial law. Most notably, the vaccine alliance GAVI and the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria are both actively scoping for alternative ways of continuing their support to Burundi’s children and their families.

Although the financial law may lack complete accuracy, it is an important indicator on how suspension and/or withdrawal of donor resources will impact the Government’s ability to ensure access to essential health care services. Particularly, the PBF system which ensures free health care for pregnant women and children under 5, is heavily externally supported and depends on a few donors – in 2014, 48% of contributions come from donor-side (figure 6).

Crisis threatens functioning of health sector. Since 2015, the national health system has undergone more and more under pressure, posing a real risk to health care access for the most vulnerable people. According to the ECVMB household survey 2013-14, only 2.3% of household expenses are used for health care. Although health services are meant to be free for pregnant women and children under 5, it was noted that many households needed to pay for drugs out-of-pocket, making it impossible for some families to get necessary treatment due to widespread lack of disposable income. In the same context, ensuring a steady supply of essential drugs to meet demands in all of Burundi’s 900 health centres has been identified as a key challenge, with stock outs being noted in some rural health centres. In recognition of this challenge, the Ministry of Health officially requested support.

National resources for health decrease by 4.2%. 82.4 billion BIF (52.3 million USD) were allocated to the Ministry of Health in 2016, representing a 4.2% decrease in national resources compared to 2015. National resources include taxes, tariffs, and duties, and it is unclear at this stage whether the Burundian Tax Authority will be in a position to mobilize the planned level of internal revenues. Within the Ministry of Health, certain programmes were subject to cuts in national funding (i.e. purchase of contraceptives and purchase of vaccines). National resource allocations to these programs decreased by 40% from 2015 to 2016.

Furthermore, 10% less national resources were allocated to the PBF system in 2016 compared to the previous year and 5% less to the program responsible for the national health insurance scheme (Carte d’Assurance Maladie). Allocations of national resources to the Ministry of Health remain much lower than those allocated to the Ministry of National Defence (see figure 7).
(4) Health care spending

Only a very small part of spent resources (5.6%) was used for "real" investments in the health sector. The majority of national funds was used to finance salaries (42%) and to cover for current costs (48.7%) to ensure the functioning of the sector, meaning only a small portion is being spent on improving quality of health services of the long term (see figure 8).

Latest data available on per capita health expenditures date back to 2012. According to the Ministry of Health, only 26 USD per person were spent in 2012, falling short on the WHO target of 34 USD (Health Financing report 2014). Although the Ministry of Health as well as other Government Ministries support the financing of the health sector to greatest extents, private households still often need to make direct financial contributions to receive services.

In 2012, 27.6% of total health expenditures are borne my private households. According to a 2012 Burundian health report (PMS 2012), average costs for health services mount up to approximately 1.9 USD per person per month. Only slightly more than a fifth of the Burundian population (22.3%) was covered by a health insurance (PMS 2012).

The current socio-political crisis has further weakened the health system in Burundi and increased families’ out-of-pocket expenditure, aggravating poverty levels of an already very vulnerable population. The National Drug Store (CAMEBU) has alerted difficulties in procuring urgently needed essential drugs due to lack of funding. For many women and children access to health care thus is no longer feasible, since they cannot afford to pay themselves for the necessary medication in private pharmacies. In this context of increasing vulnerability, without additional resources, there is a real risk of rolling back important gains achieved over past years in the area of healthcare.

Key Health Figures

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Key challenges for healthcare in Burundi:

There are 5 national hospitals in Burundi (all in the capital), 45 district hospitals and more than 900 functional community health centers, equipped to provide essential services, including vaccination. The main challenges of the sector in Burundi are:

1. Young populations and high fertility rates. Burundi’s persistent population growth makes it difficult to achieve progress in addressing its already very poor and vulnerable people’s many needs.
2. Child deaths caused by preventable diseases. Preventable and treatable diseases, such as malaria, respiratory infections, diarrhoea, tuberculosis and HIV/AIDS, are still main cause of morbidity and mortality in Burundi.
3. High levels of chronic malnutrition. High levels of chronic malnutrition amongst children under the age of five prevent children from making the most out of their potential.
4. Insufficient protection against HIV/AIDS. Only slightly more than a third of children born HIV-positive have access to antiretroviral (ARV) drugs (37.8%).
5. High maternal mortality. Maternal mortality remains unacceptably high with 740 maternal deaths per 100,000 live births, representing more than double of the average rate of its neighbours (UNFPA 2014).
6. 2015 crisis-related developments. Since the April 2015, Burundi has experienced cholera and malaria epidemics due to increased population displacement and faced difficulties to ensure availability of essential drugs.