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#MEDCARE REVOLUTION CAMPAIGN: HEALTHCARE SERVICES OF QUALITY FOR ALL

ANALYSIS OF FINANCING OF HEALTH SERVICES AND SUPPLY OF MEDICINES IN BURUNDI

RESOLUTION CONNECT, THINK TANK

HEALT, WEALTH AND WELL BEING

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MEDCARE REVOLUTION PROJECT

ANALYSIS OF HEALTH SYSTEM FINANCING AND MEDICINE SUPPLY IN BURUNDI

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Contents

PREFACE

The Constitution of Burundi stipulates, in article 55, that: “Everyone has the right to access health care”[1]. The WHO, for its part, defines health as “a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity”.

With the notion of "complete well-being", good health is a dynamic, transversal issue where the health system is only one link in a long chain of which medicine (curative or preventive) is a necessary component and not sufficient. To obtain a better individual or collective state of health, financial, technical and human resources are required, such as the resources implemented for the proper functioning of hospitals and the supply of sufficient and good quality medicines.

However, in the land of drums, the financing of health care raises many technical, but also political, questions. This is a vast field of knowledge, conducive to research, but also to more ideological controversies. Underfunding [2](in relation to health needs) remains a significant challenge. The dependence of health services on public investment and foreign aid remains a major handicap; as a result, the disparity between supply and demand for health services remains extremely significant, thus making health costs more expensive; a permanent and widespread shortage of medical products in almost all public hospitals in the country.

While underfunding weighs on the health system, the attraction of private capital allows the government to facilitate the availability and access to health services through the importation of sufficient medicines, equipment and new medical technologies. This amounts to curbing the exodus of patients who struggle to find treatment and medicines in Burundi. Hence protecting families from extravagant health care costs.
How does the health system work in Burundi? What about the medicine market in Burundi? What are the advantages of the private sector and economic growth in the health services revolution?

[1]Constitution of Burundi promulgated on June 7, 2018, page 49
[2]Study on health financing in Burundi; world Bank, December 2018

i. Goals

The main objective of this workis to contribute to the promotion of good governance in the health sector and access to quality health care by emphasizing the role of the free market and the private sector in the revolution of Burundian health services .

The specific objectives are:

- Present the current drug supply, distribution and management system in Burundi,
- Diagnose the main flaws in Burundi's health financing system and the role of the free market
- Formulate concrete proposals to facilitate access to medicines and health services

This review will propose an effective management plan for drug supply structures of guaranteed quality for the populations served. This plan is subdivided into three stages. The first is to analyze the functioning and financing of the Burundian health system, the second is to try to see at the level of a health district which in the healthcare pyramid is responsible for supplying medicines to the peripheral level how should be pass the procurement process. Thirdly, at the level of wholesale pharmacies, we will evaluate their contribution and the difficulties encountered.

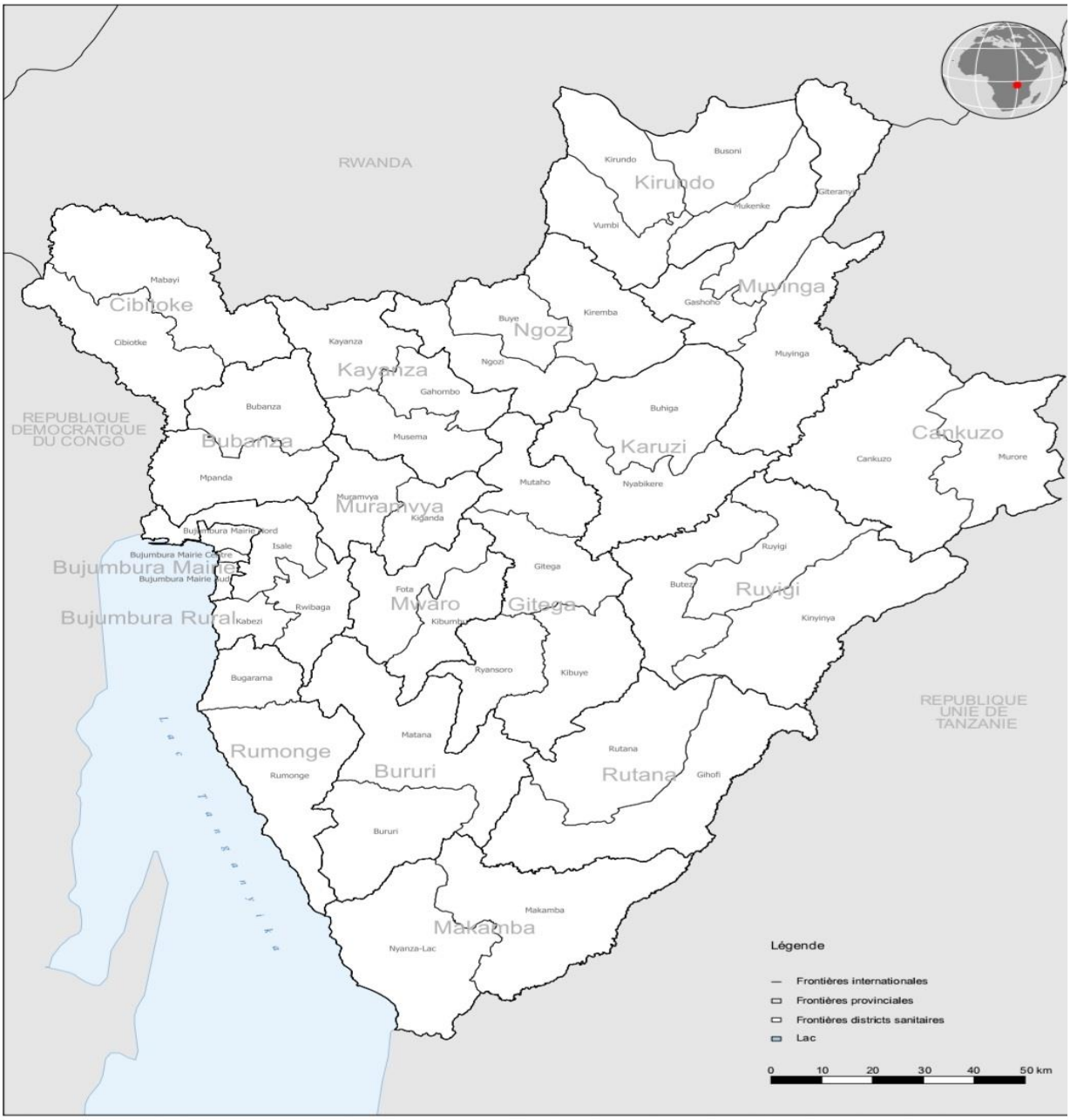
ii. Methodology.

In order to collect as much data as possible, we carried out a documentary research process (sometimes successfully) with institutions responsible for drug management:

- Consultation of legislative and regulatory texts,
- Consultation of activity reports, audits, etc.
- Hearings and interviews (physical or electronic) of authorized personnel: Pharmacists, wholesalers, doctors, nurses, patients, CDS managers and hospitals.

Chapter 1. ORGANIZATION AND FINANCING OF THE HEALTH SYSTEM.

1.1. Presentation of the health system of Burundi



Burundi's health system is organized in pyramidal form and is based on 3 levels[3]: the central level, the intermediate level and the peripheral level. However, the private sector is not well integrated into the national health system.

[3]WHO; Analytical summary of the health profile of Burundi, 2021

The central level includes various responsible services includes:

- The Minister's Office and a Permanent Secretariat,
- The General Inspectorate of Public Health,
- The General Directorates:
    - The General Directorate of Resources,
    - The General Directorate of Planning,
    - the General Directorate of Public Health which covers health programs,
    - Institutions under supervision including CAMEBU and autonomous hospitals.

At the central level, there are specific services intervening directly in the field of medicine: the IGSP, the DPML, the CAMEBU and the autonomous hospitals. The central level is mainly responsible for formulating sectoral policy, strategic planning, coordination, mobilization and allocation of resources as well as monitoring and evaluation. This level ensures the regulation and standardization function.

The intermediate level is made up of 18 provincial health offices (BPS). They correspond to the decentralized central level. The BPS are responsible for coordinating all health activities in the province and supporting health districts. This level corresponds to the second administrative level which is legally recognized.

The peripheral level is made up of 45 health districts covering 43 hospitals and 735 health centers spread across the country's 129 municipalities. A Health District covers 2 to 3 municipalities and corresponds to the third administrative level in the health sector, which differs from the territorial administrative level which is the municipality. This level integrates community participation which is applied through the management of health centers by the establishment of health and CDS management committees as well as community relays which ensure the interface between the health center and the community.
The health map of Burundi indicates that the country has 685 functional health centers, of which 63% are in the public sector. The country has 48 functional hospitals, including 43 district hospitals and 5 national hospitals.

The private non-profit sector is essentially made up of health centers (33% of the total) belonging to religious denominations. Eight district hospitals among the 39 which are functional at the national level belong to denominations. This sector fully participates in the implementation of the PMA and the PCA in accordance with the National Health Policy and is integrated into the public health system by approval.

The lucrative private medical and pharmaceutical sector is mainly present in urban centers and more particularly in the city of Bujumbura. This sector plays a gradually increasing role in the health system despite the absence of quantified data on their activities. In terms of healthcare structures, the lucrative private sector includes clinics located in the city of Bujumbura and health centers and pharmacies scattered throughout the territory. This sector also suffers from insufficient quality control and supervision.

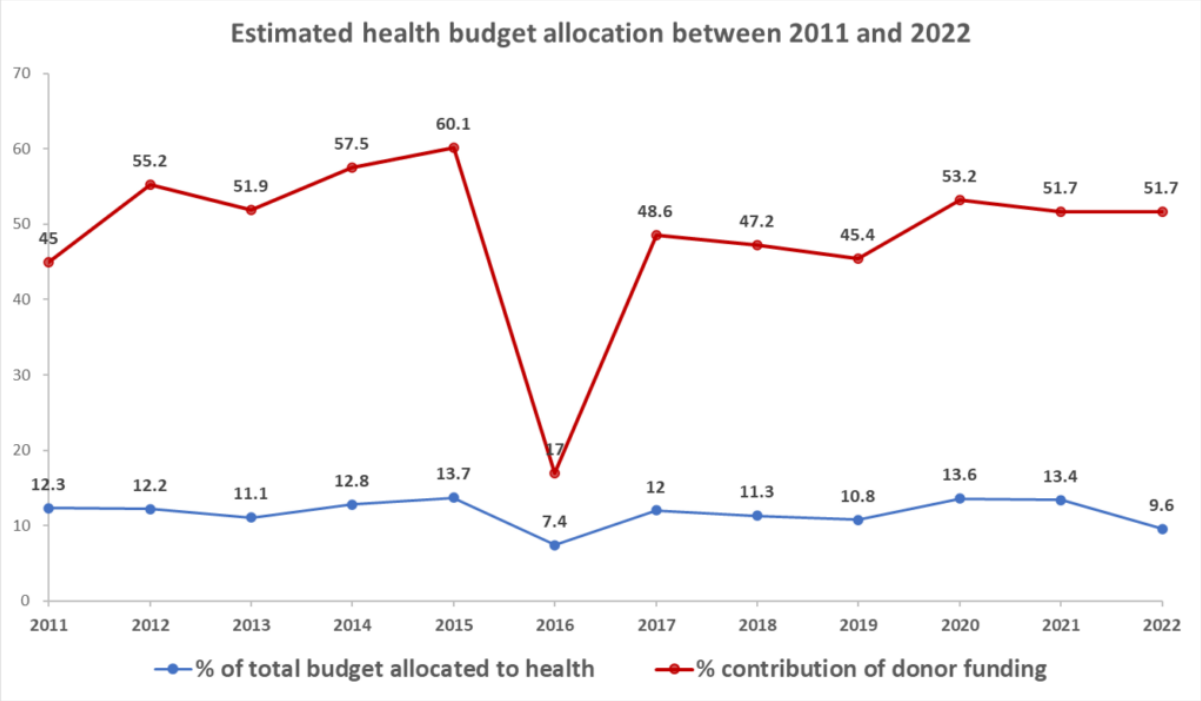
1.2. Financing of Burundian health services

The recommendation[4]of the WHO Macroeconomic Commission is to set aside USD 34 per year per capita for health care. In Burundi, the National Health Accounts for the year show that the national health expenditure is 17.4 USD per capita per year, or half of the WHO recommendation.

In the budget[5]of the State 2022/2023, the amount allocated to health is 228.7 billion Burundian francs (BIF), or 112.4 million US dollars; i.e. 9% of the

[4] MSPLT; Manual of procedures for the implementation of performance-based financing in Burundi; 2011
[5]Law No. 1/22 of June 30, 2022 establishing the general budget of the Republic of Burundi for the 2022/2023 financial year

national budget while the Abuja conventions and Burundi ratified stipulates that at least 15% of the Budget[6]must be invested in the health sector. Note that this budget is invested particularly in the remuneration of health officials and in the operation of hospitals and public health facilities.



The contribution of households was estimated at 40% of total health expenditure; this represents direct payments to providers and contributions to public and private insurance. The intervention of bilateral and multilateral cooperation, NGOs and initiatives also represented 40%, so that the State only intervenes in a congruent proportion of around 10%.

In terms of public health, and in the absence of third-party payers, the 40% contribution from households seems too high and unbearable given the low purchasing power of the population.
Some reforms[7]have been implemented to make the health system more accessible, in particular:

[6]A ; information note: 10 years after the "Abuja commitment" to allocate 15% of national budgets to health, Addis Ababa 2011

[7] Good governance in the reform of the financing of the health system in Burundi ,pages 229 to 240

- Decentralization through the establishment of health districts. These became the operational level of the MSPLS. A Health District (DS) is a geographical entity in which between 150,000 and 200,000 inhabitants live. In theory, a DS must have a District Hospital and ensure the supervision of 10 to 15 CDS; so much so that a health CDS offers care for 10,000 to 15,000 inhabitants.
- Performance-based financing (PBF). This results-based financing model was rolled out nationally in 2010 and coupled with free care for children under 5 and women giving birth (in force since 2006).
- The sectoral approach through the establishment of a national coordination framework; the partnership framework for health and development (CPSD) which brings together the MSPLS (state of Burundi) and all the Technical and Financial Partners (PTF).

In this arrangement, reimbursements of invoices should not exceed 50 days from the presentation of invoices by a health structure; deadline including all verifications, validation until payment of the amounts due, by the Ministry of Finance. The major problem is that the financing of the PBF depends very largely on external contributions in the form of projects; which implies problems with the sustainability of funding.

The cash flow difficulties that Burundi is experiencing, the premature end of certain projects due to the success of the PBF, no longer make it possible, at present, to honor this 50-day commitment; putting the operation of hospitals and health centers in great difficulty. If these difficulties persist, the entire health system will collapse in the short term.

Chapter 2. MANAGEMENT AND DISTRIBUTION OF MEDICINES

2.1. Generalities

By medication[8], we designate any substances or any mixture of these substances or products qualified as having curative or preventive properties and therefore useful for diagnosing, treating, preventing and mitigating diseases or other disturbances of the physical state or their clinical manifestations and to restore or modify organic functions in humans or animals.

Medication management has become a fairly broad field comprising a set of inputs, means and interventions which are mobilized specifically to make pharmaceutical products available and accessible so that all the health needs of patients are covered.

Medicines therefore occupy a very important place in several aspects of health care because they offer us a range of simple and effective answers. It is for this reason that the permanent availability of the latter in stock at any time in sufficient quantity, in an appropriate form, with assured quality, accompanied by adequate information and at an affordable price for all individuals and businesses communities should be the ultimate goal of any health care system.

With scarce and limited resources in many health systems around the world, WHO estimates that it is difficult for most of these health systems to meet the needs of their populations for medicines and that each of these health systems should necessarily do the best possible to ensure the availability of medicines at the level of healthcare structures and coverage of the needs of the population in medicines and medical devices, reasons why the WHO recommends that its member countries adopt the concept of essential medicines which it qualifies as an integral part of national health policies.

Access to essential medicines is also one of the eight components of primary health care that constitute the basis of every health system. These essential medicines are qualified by the WHO as medicines capable of meeting priority health needs and that they are accessible to the entire population due to their affordable price and therefore in sufficient quantity and of impeccable quality. It is with this in mind that most countries have established a list of essential

[8]WHO; pharmaceutical products and medicines

medicines taking into account common illnesses in their territories and the socio-demographic context of their country.

In Africa, with the prevalence[9]diseases are still very high, medicine is at the center of the functioning of health services. Household health expenditure on medicines is up to 50% and between 20 to 30% of the total operating costs of public and private health establishments are dedicated to the supply of medicines.

The management of medicines is such a vast area requiring the establishment of a national pharmaceutical policy by all governments through the technical services of their ministry of health and to make it one of the pillars of management of these products in order to provide the population with quality medicines, effective, safe and accessible geographically and financially because until today the management of pharmaceutical products remains a major challenge especially in many health systems of countries still in the development path and certain points low levels remain observable such as stock shortages in health care structures, supplies of generic medicines lower than those of specialties, the cost of care which remains high despite exemptions on medicines; inability to obtain supplies from international firms and the use of local wholesalers, thus increasing the price of these products with direct repercussions on the health of customers; the ceiling imposed by public procurement procedures which remains low, and which exposes itself to the (illegal) fragmentation of markets, and therefore to stock shortages as well as product storage premises at the intermediate and peripheral level which are often in poor conditions conditions exposing pharmaceutical products to deterioration.

[9]WHO; Health sector planning and statistics unit

2.2. Supply of medicines

In Burundi[10], drug supply is a vast area within curative and preventive care, involving several stakeholders. Several establishments or institutions import medicines.

In the public sector:

- CAMEBU
- The Civil Service Mutual
- Health programs (PEV, PNILT, etc.)
- The CNLS (PRIDE Project, Global Malaria Fund Project) o National reference hospitals

In the lucrative private sector:

- Wholesale pharmacies
- Retail pharmacies
- Private polyclinics

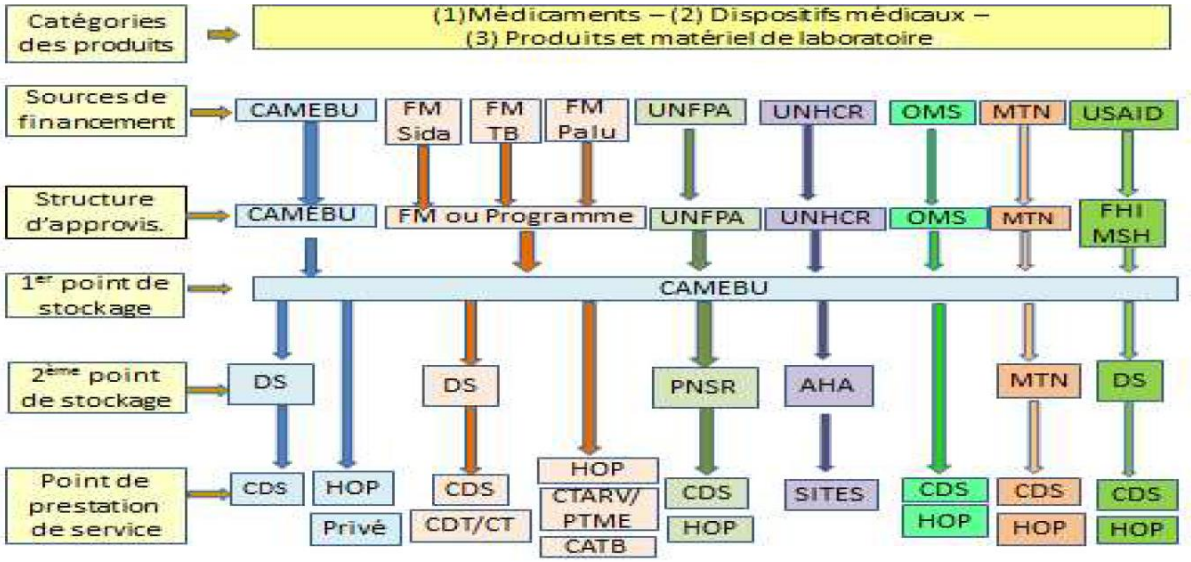
In the private non-profit sector:

- National and international NGOs,
- Charitable organizations (donations),
- Faith-based structures approved by the Government of Burundi.

Moreover, several ministries are not involved in the field of pharmaceutical products. There is no coordination between them; whether in the acquisition of products or their distribution. Thus, it seems obvious that the subject is vast and deserves much more time than the period allocated to the consultant. This work will therefore mainly focus on the MSPLS which is in charge, in a sovereign manner, of the health of the population.

[10]Observatory of government action: Medicine supply system in Burundi, 2014

2.3. The medicine supply chain in Burundi.



In Burundi, the national supply of pharmaceutical products is ensured mainly by a single body managed by the state called "the Central Purchasing of Essential Medicines of Burundi (CAMEBU)" which plays the role of purchasing directly from companies and international institutions, also serving as storage and control of all medicinal substances entering Burundi. The District Health Offices, in turn, must obtain supplies from CAMEBU through the district pharmacy unless there is a shortage. The pharmacies of district hospitals as well as those of health centers in turn obtain their supplies from the health districts. This body allows the State to control the market for public sector pharmaceutical products.

Good, effective inventory management ensures that products are constantly in stock to meet user needs. Medicines are more likely to be available if you regularly order the required quantities. To achieve this, the estimation of needs must be based on the quantities of products used or their previous consumption.

At the health district level, before each order, the form developed by the Burundian Medicines and Food Regulatory Agency (ABREMA) respecting the list of essential medicines serves as a basis for developing order forms. The quantity to order for each product is calculated taking into account the Average Monthly Distribution (Average Monthly Consumption). Here we are talking about distribution because district offices do not provide care but play the role of controlling the peripheral level in the pyramid of health systems in developing countries.

The monthly consumption of a product is the number of trips made to a healthcare establishment per month for each molecule. Consumption varies depending on the month. Therefore, the average monthly consumption (CMM)[11] will be the basis for estimating the quantity that will be consumed during a month if health conditions remain the same.

CMM= X 30

To place the order, districts such as Health Units use the following formula:

Quantity to order = (CMM X2) - SR (Remaining Stock)

When the order form is completed (form pre-established by ABREMA), the district pharmacy manager goes to CAMEBU to stock up on medicines and consumables. The CAMEBU director checks whether the list meets the standards and agrees to serve the customer. The problem with this supply system with a single national agency like CAMEBU is that disruptions are most often observed, reflecting the inability of the latter to satisfy all the needs of public healthcare structures.[12]. But the advantage is that we can control the types of products to be brought into the national territory while respecting the list of essential medicines established by the Ministry of Health. Also this policy makes it possible to follow the same pattern for all public structures and the monitoring and evaluation of the progress made becomes easy. If there are shortages at CAMEBU, the district pharmacist will obtain supplies from private wholesale pharmacies which present at least 5 pro-forma invoices to the District in closed envelopes. With pro-forma invoices, it is with the aim of respecting public procurement policy and fighting against fraud and non-compliance with the purchase of essential medicines from these wholesale pharmacies.

At the District level, the commission responsible for analyzing and opening the envelopes meets and proceeds to open the envelopes. She fills out the price comparison table and the winner is the lowest bidder for each product. To this end, the commission draws up a report on the opening of the envelopes, specifying each time the winner by type of product.

[11]SIGL descriptive manual, May 2020
[12]Decentralized distribution of medicines in Burundi; FHI360

The Pharmacy manager, with the order form which was presented to CAMEBU, the pro forma invoices, the report of opening the envelopes and the comparative price table, deposited these documents with ABREMA for verification and authorization of order from wholesale pharmacies.

The products thus ordered are accompanied by the invoice, the delivery slip and the original order form. The district reception committee meets to acknowledge receipt and a report of receipt of pharmaceutical products is drawn up. Pharmaceutical products are stored in the district pharmacy and stock cards are updated.

This proposed circuit does not lack shortcomings, however if it were respected to the letter in underdeveloped countries, fewer defects in the management of pharmaceutical and consumable products are observed.

Good management of pharmaceutical products helps avoid building up overstocks or having shortages. Both consequences are evidence of the lack of performance of the system which does not meet the priority needs of the population (lack of relevance) and poor use of resources which are generally scarce and limited (lack of efficiency).

Regardless of the management model used, quality assurance procedures must always be put in place for the management of pharmaceutical products in healthcare structures.

Monitoring, supervision and evaluation of logistics management are essential procedures which make it possible to identify and take corrective measures for possible malfunctions in the logistics management system with the aim of guaranteeing regular supply to structures.

Supervision deals with important points of management such as the assessment of storage conditions, verification of the existence of different management tools as well as control of their completeness and promptness because it is thanks to these that we arrive to estimate needs without making any mistake. It is also necessary to ensure that the theoretical stocks correspond well with the physical stocks of the tracer products. In stocks, it is important to always arrange these products while respecting the principles of storage to get out what

is needed. This classification is based either on the dosage form or the route of administration, etc.

Supervision also ensures that the manager checks the calculation of CMMs and quantities to order as well as the calculation of logistics management indicators. It is necessary to identify the capacity building needs of the pharmacy manager.

In short, pharmaceutical product management must respect all stages by using the appropriate tools for each link in the chain and completing them properly. This would lead to the eradication of stock shortages observed in developing countries in healthcare structures, it would also avoid significant expiry dates in the event of overvaluation; we must always respect the list of essential medicines so that the cost of these products does not limit access to users but we must also limit the use of local wholesalers because this entails an additional cost which is passed on to the customer (the patient).

Chapter3. PRIVATE SECTOR AND ACCESS TO HEALTH SERVICES

3.1. The CAMEBU monopoly

In Burundi, the health sector is largely dominated by the public sector[13]. On the one hand, legal barriers and complex processes for investing in this sector limit the penetration of private capital. A large number of documents required and a sum imposed to open a health facility; as well as the slowness of procedures lead to monopolies; speculations; corruption and lobbying. This system weakens the health system and swallows up any attempt to move towards universal healthcare coverage.

On the other hand; the medicines market is dominated by CAMEBU; the only public institution responsible for importing pharmaceutical products. Notwithstanding; its dysfunctions have a snowball effect on the health structures of Burundi, whether associative or public. CAMEBU suffers from its status which does not grant it facilities in its supplies. Furthermore, CAMEBU establishes its orders based on sales and not on field needs due to lack of feedback. This sometimes results in exaggerated expiry dates and under or overvaluation of imports which deprive peripheral structures and therefore patients of cheaper products.

The ceiling of 5 million imposed by public procurement procedures is low compared to the frequency of shortages at CAMEBU and the needs expressed by the Health Districts; this ceiling therefore exposes itself to the (illegal) fragmentation of markets, and therefore to shortages. of continuous stocks. Concerning the medicines market, most of the players in this field suffer from limited supplies due to lack of currency, which undoubtedly pushes them to stock up on less expensive, low-quality products.

3.2. The role of the private sector

Given these difficulties of CAMEBU, this is where the role of the private sector comes into play because in the event of a stock shortage, public healthcare structures must obtain supplies from private wholesale pharmacies but following a somewhat long process which delays supplies and consequently

[13]Law no. 1/11 of May 8, 2020 regulating pharmacy and medicines for human use

shortages of weeks are observed, pushing insured patients to purchase medicines themselves from non-hospital pharmacies and thus increasing health expenses.

The private sector contributes to the revitalization of health services; availability of medicines at all times without fear of stock shortages by focusing on free competition and eliminating the CAMEBU monopoly. As the government does not have the necessary means to maintain stocks of pharmaceutical products or import certain health materials and services; the attraction of private capital (local or foreign) makes it possible to fill the gap in order to balance the system. In this case, the government intervenes in controlling the quality of products and services; as well as in the establishment of a climate favorable to investment in the health sector.

Private capital has clearly demonstrated its strengths in the Burundian health sector. For example; among the 4 largest national hospitals located in Bujumbura, the largest city in the country; none have a scanner. However, the new private hospitals, two have at least one scanner and other modern imaging techniques and the hospital services are fast compared to the services of public healthcare structures following complex public protocols (In public hospitals the appointment with a doctor can take 3 hours or more to wait while in private facilities the wait is usually less than 30 min). The shortage of medicines is very marked in public hospitals.

In addition, congestion in the distribution chain of pharmaceutical services and products stifles the process. Hence the chronic shortages of medicines in the health districts. On the contrary; if private pharmacies could participate in central and peripheral supplies at the district and CDS level; they could combat stock shortages and CAMEBU as a public institution for importing and managing medicines could play the pivotal role in ensuring that the private sector respects the contract and that the level of satisfaction at the peripheral level is high.

3.3. Quality control

At the national level, upon receipt of products, quality controls are carried out in laboratories following sampling according to recognized international standards. The products are sent to the laboratories of INSP and the sub-region: MEDS (Kenya) and TFDA (Tanzania). Unfortunately, the results arrive late and do not allow quarantine except for macroscopically defective products. So the products which enter the territory are then very doubtful because the placing on the market of falsified pharmaceutical products today constitutes a major public health problem which, if nothing is done, will soon produce epidemic figures. This scourge has both a health and economic impact for the affected health systems because it promotes and creates resistance in certain infections to antibiotics, antiretrovirals, antimalarials, etc. These counterfeit medications can also cause very harmful side effects and even death.

It is difficult today to measure the extent with figures, especially in Africa. The WHO estimates that 10% of medicines circulating around the world are counterfeit. According to the same source, one in 10 drugs on the global market could be counterfeit. This figure can reach 7 out of 10 in some developing countries. For example, in 2009, Tanzania discovered that an antimalarial drug found in around 40 pharmacies did not contain enough active ingredient. In Burundi, cases were documented at Kamenge University Hospital in the 2000s (paracetamol instead of Quinine, hydrocortisone in alcoholic solution)…

This counterfeiting is favored by the absence of legislation or the lack of rigor in the application of legislation observed in Africa. Most products come to African soil from India and most countries do not have rigorous legislation to control the quality of these products. Which makes it easy for traffickers. The involvement of certain members of governments in the trafficking of these products also leaves counterfeiters unpunished. Counterfeiting medicines has therefore become a very popular activity for organized crime and with the flow of money circulating there, counterfeiters buy from anyone and continue to become stronger and stronger.

So the national policy of essential medicines which consists of the use of generics, copies of branded medicines, but retaining the same properties as the latter at an affordable cost, is particularly concerned because prescribers no

longer have confidence in these medicines continuing to be used prescribing expensive specialties to the population pushing the population to catastrophic expenses. These prescribers are afraid of certain counterfeit pharmaceutical products containing the correct active ingredient(s), without however having the correct doses. Which does not allow its therapeutic objective to be achieved. If it is underdosed, it will not do any harm but in case of overdose there is a risk of irreversible side effects. Finally, there are other pharmaceutical products containing impure active ingredients that are harmful to health and even potentially fatal.

In conclusion, on national soil, it is difficult to have access to quality pharmaceutical products but above all at an affordable price given the current socio-economic context.

Chapter4. THE MAIN CHALLENGES TO BE ADDRESSED

3.1. The challenges of supply chain bottlenecks.

3.1.1. Late payments to healthcare structures.

The functioning of healthcare structures is completely compromised by State arrears which have reached an unsustainable level.

The consequences are multiple:

- Staff salaries are becoming increasingly difficult to meet. Some hospitals and CDS accuse contracted agents of non-payment for several months.
- Reimbursements of staff credits, contributions to the INSS and the MFP are constantly deferred. Penalties will worsen the already precarious situation.
- Suppliers are no longer paid. In turn, they no longer grant credits (including CAMEBU); hence inevitable stock shortages,
- Drug stocks are decreasing or completely running out,
- Patients buy their own product; often in private pharmacies, therefore expensive,
- Perverse effects of PBF are observed in certain healthcare centers: the little product available is reserved for patients eligible for PBF to increase performance.

3.1.2. The challenges linked to CAMEBU.

From the study of the drug supply and distribution system, we draw conclusions on the availability of drugs and their impact on customers.

- The CAMEBU supply system sets out:
  - Stock shortages at CAMEBU itself and healthcare structures (in a cascade) through an undervaluation of quantities, significant expiry dates in the event of overvaluation, insufficient market coverage of generic medicines, the cost of care which remain high despite exemptions on medicines.
  - The use of local wholesalers results in an additional cost which is passed on to the customer (patient),

- ❖ The ceiling of 5 million imposed by public procurement procedures is low, and exposes itself to (illegal) fragmentation of markets, and therefore stock shortages.

3.1.3. The risks of poor management at the intermediate and peripheral level.

This is the final destination of pharmaceutical products. There is a "cohabitation" of public, confessional and private CDS. There are also private medical practices. Surveillance and stock control by hierarchical levels are not ensured effectively.

Therefore, the risks of mismanagement exist materialized by the absence of supporting documents for purchases of private CDS during inspections of certain private structures. Furthermore, the peripheral and intermediate level is the place of consumption and therefore of the prescription of medicines.

Thus, certain bottlenecks can be identified:

- ➢ Product storage premises at the intermediate and peripheral level are often dilapidated, inappropriate and prone to premature deterioration of products.
- ➢ The sale of products to private structures due to the solvency of these centers exposes them to stock shortages in the private establishment,
- ➢ The temptation for corruption is high (between the private sector and the district),
- ➢ The problem of conflict of interest when a private healthcare structure belongs to staff of the public establishment,
- ➢ The problem of prescribers:

-There is no standardization of treatments;

- therefore risk of several products for a single pathology,
- the prescription of medication is not regulated, the prescription for others due:

The cohabitation of paid and free medicines (example of medicines against opportunistic infections), free care for MSPLS staff, the presence of beneficiaries of the Civil Service Mutual Fund

-Lack of continuing in-service training on pharmacology.

- The perverse effects of PBF:

- Patient substitution and product diversion,
- Reserve products for PBF indicators

Chapter5. RECOMMENDATIONS

- To the Government:

i. Create an environment favorable to the ejection of private capital into the health sector by liberalizing the medicines market and collaborating with the private sector in improving health services in Burundi.

ii. Design and implement a sustainable health financing system such as universal mutuality,

iii. Establish a National Regulatory Authority for the sector of Medicines and other related substances and provide it with sufficient resources,

iv. Establish an efficient and recognized quality control laboratory,

v. Change the status of CAMEBU and provide it with a responsive management system,

vi. Establish a multisectoral group to ensure the coherence of policies having an impact on health (health determinants, medicines policy, etc.).

- At CAMEBU:

i. Establish an effective system for quantifying the needs of health structures: an effective communication system must be put in place,

ii. Change the nature of the agreement between CAMEBU and vertical programs (malaria, tuberculosis, HIV/AIDS) for better feedback and planning.

- To peripheral healthcare structures:

i. Build or continue the construction of pharmacies to acceptable standards,

ii. Regulate or review the status of rural pharmacies and private CDS,

iii. Ensure effective supervision of districts, CDS with standardized tools and establish standards,

iv. Standardize drug prescriptions.

Chapter 6. CONCLUSION

Burundi's health system is flooded by countless challenges particularly linked to underfunding of health; the poor management of healthcare structures which are largely public and the monopoly of the medicines market by CAMEBU.Due to internal and external pressures such as public debt and insufficient revenue, global challenges such as climate change, the impact of the COVID-19 pandemic and the impact of the war in Ukraine on commodity prices, Burundi continues to suffer from a budget deficit which harms investment in health. Added to this are corruption and political uncertainties, which threaten the social stability of the country.

While the country of drums is among the five lowest economies globally with around 300 US dollars per capita; health services prove extremely difficult as every day about 123 Burundians fall into poverty after health care.

Public health insurance, such as the CAM and the MFP, does not provide expensive care (surgical care, certain specialized care is not covered by the MFP and the CAM) and operates mainly in public health structures. In addition, the delay in reimbursement by insurance companies means that some hospitals tend to be wary of mutual funds.

As a result, direct payments of health costs expose families to extravagant costs of health services; which makes household economies even more fragile. Today more than 60% of Burundians cannot cover all healthcare and only 20% have access to health insurance.

To change the situation; it is not superfluous to focus on the free market and its strengths. By including the private sector in the procurement of medical services and products; free competition could allow availability; innovation and decentralization of quality care and medicines. This liberalization would also make it possible to take maximum advantage of private capital, boost the performance of hospitals and insurance companies, unload public hospitals and import techniques, technologies and medical materials not available in Burundi. In this way, Burundi could cope with the exodus of patients and human resources to other countries in the sub-region or to the West.

However ; for this to be possible, public authorities must introduce measures; which encourage investors to invest in the health sector by fighting against monopoly; by reducing regulations; surcharges and by reviewing the complex processes linked to the registration of pharmacies and health facilities and avoiding lobbies and favoritism to ensure that competition is free. In this way ; Burundi could take a giant step towards modernizing its health system and towards universal health coverage

Chapter7. Appendices

7.1. References

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7.2. Some photos from the workshops on this research










NINETY THREE