

Approved



**Burundi**

**Operational Plan Report**

**FY 2013**

Note: Italicized sections of narrative text indicate that the content was not submitted in the Lite COP year, but was derived from the previous Full COP year. This includes data in Technical Area Narratives, and Mechanism Overview and Budget Code narratives from continued mechanisms.



## Operating Unit Overview

### OU Executive Summary

#### I. Country context

Burundi is a low-income developing country with a population of 10.5 million (July 2012 CIA World Fact book), an annual population growth of 2.4 percent, and more than 300 inhabitants per km<sup>2</sup>. This makes Burundi the country with the second highest population density in sub-Saharan Africa. Burundi remains one of the poorest countries in the world with a per capita gross national income (GNI) of \$170, and it is considered one of the world's 40 "Heavily Indebted Poor Countries". Additionally, it is worth noting that a civil war, which lasted 13 years from 1993, killed more than 300,000 people, severely weakened the health and social welfare systems and negatively affected donor support and private sector investment in Burundi.

#### Epidemiology

The 2010 Demographic and Health Survey (DHS) demonstrated that the HIV prevalence rate among adults aged between 15-49 years was 1.4 percent. The data suggested that women are almost twice as likely to be infected as men with a ratio of 1.7/1. Although Burundi may be considered a low-prevalence generalized epidemic, there are specific key populations which demonstrate significantly higher prevalence rates. For example, a 2011 bio-behavioral survey showed that the HIV prevalence in female sex workers (FSWs) is approximately 20 percent, with rural areas being adversely affected. Amongst men having sex with men (MSM) the rate was 2.4 percent and 3 percent within the male prisoner population. In order to better understand modes of transmission and the dynamic of the HIV epidemic in Burundi, PEPFAR will finalize two surveys in FY13: 1) mapping key population size estimations and 2) modes of HIV transmission amongst select key populations specifically FSWs and MSM. Furthermore, the DHS revealed that the level of stigma and discrimination against people living with HIV (PLWHA) remains high with only 44 percent of women and 62 percent of men declaring tolerance towards an HIV positive person.

#### USG's Vision

In FY 2013, the PEPFAR program, with the strong support of the Ambassador and the GOB, will begin to strategically plan the scale up of HIV/AIDS interventions in Burundi to become model. With a population of approximately 10.5 million people, an estimated HIV prevalence rate of 1.4 percent, and with PEPFAR's current geographic coverage at 50 percent (eight of seventeen provinces), it is epidemiologically and financially feasible to reach national coverage to combat the AIDS epidemic in



Burundi. Currently, the government (through the Global Fund for AIDS, TB and Malaria) is reaching 27,098 of the estimated 46,712 adults in need of ART (using the WHO staging of 350 T-cells) and reaching 2,742 of the estimated 6,532 women requiring PMTCT services in Burundi, which includes 934 women supported through PEPFAR funding. Although PEPFAR does not currently cover ART for adults, it does provide PMTCT services in four provinces, reaching these 934 additional women. This leaves an estimated gap in ART services for 19,614 adults (or 42 percent), with an estimated need for PMTCT services for 3,790 women (or 58 percent), this year. However, by mid-FY 2013 the program will be scaled up in four additional provinces where PEPFAR will exclusively support PMTCT (not comprehensive HIV/AIDS services), which will increase the coverage for PMTCT substantially, but still leaves a gap for the other HIV services. Overall the country still has an unmet need of just over 50% for ART services for adults, pregnant women and children. PEPFAR could comprehensively meet the need and close the gaps currently identified in Burundi for prevention, care, support and ART provision in partnership with the Global Fund treatment program. However, without additional resources over the next two to five years, there will be significant opportunity costs for the country's fight against AIDS. At current funding and intervention levels, prevalence will continue to rise and the costs for universal coverage of a comprehensive package will only increase. We have an opportunity to effectively target the drivers of the epidemic, and are internally preparing to implement an expanded program that could make a substantial, cost-effective impact in this country.

The results of this strategic vision, if funded accordingly, will not only impact the effects of the epidemic in Burundi by promoting targeted prevention services, biomedical interventions and comprehensive testing and treatment, but it will impact the region through decreased transmission and improved quality of life of the population. The team, with the support of the Ambassador, is committed to the staffing and program plans laid out in COP 13 with a focus on building a strong base to develop the program effectively in the coming years. The expanded PEPFAR team will be able to support the GOB leadership and our partners to achieve national coverage and to become a model in the region.

#### USG's role in the National Response

In an effort to improve the national response to HIV, Burundi joined several international initiatives including the Commitment Declaration on HIV/AIDS, prevention acceleration, the 3X5 initiative, and universal access to prevention, treatment, care and support. Since 2002, Burundi has developed three national HIV strategic plans (NSPs) with the objective of defining clear priorities to coordinate the interventions of various donors. The most recent NSP 2012-2016 was prepared with the technical assistance from PEPFAR and sets realistic targets for prevention, treatment, care and support in light of the current financial environment. All USG HIV/AIDS assistance is aligned with the national strategic plans and regular consultations with the Government of Burundi (GOB) are frequently held. Currently, the USG is a voting member of the Country Coordinating Mechanism (CCM) and is the coordinator of the



technical committee in charge of the development of proposals for the Global Fund. A key strategy for the development of Burundi's COP 13 was to discuss priorities with the appropriate GOB counterparts as well as other key stakeholders, including civil society, and other donors—most notably the Global Fund Principal Recipients. Beginning in FY 2013 USAID will collaborate with the GOB and other donors to address livelihoods issues for vulnerable communities, PLWHAs and OVCs.

#### Other Contextual Factors

The civil conflict ended with the Arusha Peace Accord in 2000, and Burundi completed its second set of democratic elections in 2010. However, the country continues its struggle to recover from the effects of massive displacement, social disruption, and ethnic and gender-based violence (GBV), as well as the 2010 post-election political crisis. Furthermore, the country is plagued by many health problems and human rights issues which, in combination with the HIV/AIDS epidemic, undermine the well-being and productivity of the Burundi population. Burundi is making significant strides to emerge from conflict and to foster sustainable development. Economic growth and government services are recovering gradually, but unlike neighboring countries, Burundi's HIV/AIDS epidemic remains underfunded by the international donor community. In addition, with over half of the population affected by chronic under nutrition (58 percent) and 68 percent living in poverty, long term economic prospects for PLWHAs are less than optimal.

Gender inequity and GBV heighten HIV risk across age and socio-economic groups. According to UNICEF's Situation Analysis of Children and Women in Burundi (2009), 19 percent of children, as victims of rape and incest, had their sexual debut before age 10; 35 percent at ages 10-14, and 35 percent at ages 15-19. In 21 percent of cases, the partner was a parent or a family friend, and only 19 percent of those surveyed used condoms during their first sexual intercourse. One in five (19 percent) said that sexual violence had occurred in their school. Project data and other analysis suggest that additional factors contributing to high-risk behavior include alcohol abuse and poverty.

#### II. PEPFAR Focus in FY 2013

In 2012, Burundi received increased attention from the Office of the Global AIDS Coordinator (OGAC) regarding the strategic future and planning of its USG HIV/AIDS programs. For example, in September 2012, Burundi received a visit from the Deputy Principals (DPs) who requested that the team submit a plan to increase the PEPFAR package of current services in the four new prevention of mother-to-child transmission (PMTCT) Acceleration provinces. This included proposing additional staff to manage the increased resources and activities. The team promptly submitted the request and took the initiative to propose and cost out the further expansion of services to additional provinces of the country. The DP visit was followed up with another visit by Ambassador Goosby, where expectations were reinforced that scaling up HIV/AIDS activities in Burundi was a strong possibility. These messages were strongly



conveyed to both the in country team and the GOB. However, the official COP 13 letter received on November 27th, 2012 did not reflect an increase in budget nor did it reflect an indication of scaling up services. The letter detailed the following OGAC priorities for the Burundi program:

1. Prevention: Continue to use new data to focus on programs targeting key populations, such as FSWs and their clients, MSM, truck drivers, and mobile populations, and make adjustments to reach more key populations with prevention messages and services.
2. Treatment: Support the use of lifelong treatment generated by the PMTCT platform and improve linkages where possible with the Global Fund and GOB to provide ARVs and other treatment services to the majority of the eligible population.
3. Strengthening the National Response: Demonstrate continued and improved coordination with the GOB and the Global Fund for a development of a more cohesive response. The team was asked to consider a dedicated Global Fund Liaison for Burundi.
4. Pipeline: Monitor the pipeline and quarterly expenditures, while maintaining the 10 percent OVC earmark.
5. Targets: Meet the targets that were stated in the letter, specifically for PMTCT and Human Resources for Health.

The PEPFAR Burundi team will not be able to enact any significant programmatic expansion from the COP 12 due to budget limitations. However in response to the Deputy Principles recommendations, an initial increase in staff will assist in the management of FY13 programs and beyond. The team, with the support of the Ambassador, has a vision for expansion that will bring on three new team members to ensure high quality roll-out, technical leadership and effective monitoring of the expanding PEPFAR program. These positions will ensure the program in Burundi can strategically plan for, and effectively respond to further scale up in the coming years. Therefore, the four priority focus areas in COP FY 13 are as follows and in line with OGAC priorities:

1. Strengthening prevention programs targeting key populations. As highlighted in COP 2012, the PEPFAR program in Burundi will continue to focus on reinforcing the combination of structural, biomedical, and behavioral interventions targeting FSWs, MSM, mobile populations, truck drivers and other important key populations. In addition, Burundi will take advantage of the results of the study on mapping and size estimation of MSM and FSWs that will be implemented this year to better program prevention activities to reduce new infections and increase access to care and treatment for those who need services. Results of the survey are expected in May 2013.
2. Continuing to work toward the elimination of mother to child transmission of HIV (e-MTCT). The GOB chose PMTCT as a key intervention in the reduction of new pediatric infections. The GOB, represented by the Second Vice-President and the U.S Ambassador to Burundi, launched the Global Plan



towards the Elimination of New HIV Infections in Children and Keeping their Mothers Alive. To accelerate the attainment of the goal, the Minister of Health established a PMTCT task force in charge accelerating progress and results. The USG PMTCT Acceleration funding to Burundi will be critical for increasing PMTCT coverage and access to quality services.

3. Support for Integrated Services. Treatment is an essential component of an effective HIV/AIDS program. PEPFAR, who is not authorized to implement ART outside of PMTCT, will continue to partner with the Global Fund treatment program in the PEPFAR focus provinces. This will be accomplished through targeted technical assistance to the various levels of the health system; from training and supervision of the health providers to the provision of home-based care and support services. More importantly, PEPFAR will work closely with the GOB and the Global Fund to ensure that lifelong treatment needs generated from the PMTCT platform is assured over time.

4. Strengthening the national response. Building a more sustainable response to fighting HIV in Burundi was a fundamental priority from the beginning. Recognizing that the USG does not currently have a Partnership Framework with the GOB, the PEPFAR program is exploring additional strategic engagement with the GOB, including mutual accountability and promoting the scale up of HIV/AIDS interventions in Burundi as a model. In addition, more effective approaches to improve coordination with the Global Fund will be explored and applied. In that line, the PEPFAR team in Burundi is seeking technical assistance from Washington that will assist in defining benchmarks. It is worth noting that the USG is currently a voting member at the CCM and is the coordinator of the technical committee of the CCM in charge of the development of proposals.

### III. Progress and Future

PEPFAR Burundi and the GOB do not currently have a Partnership Framework in place. However, the USG-supported HIV/AIDS program is designed to provide the GOB with critically needed support to sustain and strengthen HIV/AIDS prevention and control while emphasizing national and local capacity building and key policy and structural reforms needed for a sustainable national response. The USG continues to capitalize on the GOB's high level of ownership and commitment to fighting HIV/AIDS to build an effective, mutually accountable partnership aimed at a country-led response with the vision to support Burundi to be a leader in HIV/AIDS programming and coverage. This paradigm aligns with Global Health Initiative (GHI) and PEPFAR II core principles, which place an emphasis on effective, efficient, and country-led platforms for the sustainable delivery of essential services and public health programs. Specifically, the continuing strategy in COP 13 enables the USG to support the GOB in implementing the Burundi HIV/AIDS NSP, National Health Development Plan, and Poverty Reduction Strategy by:

1. Improving access to high-quality HIV/AIDS prevention and care services;
2. Decentralizing HIV/AIDS services especially PMTCT services;



3. Building the capacity of CSOs to provide direct HIV/AIDS services;
4. Improving the performance of the national health system.

During his visit to Burundi in October 2012, Ambassador Goosby highlighted the importance of enhancing country ownership of the HIV response. The Burundian national authorities are in agreement with this principle and are leading the development of key strategic policies and documents. Additionally, the GOB is consistently advocating for resource mobilization, while also coordinating and overseeing the implementation of HIV/AIDS activities. Given its low-income status, Burundi is still far from being able to allocate sufficient internal resources to cover gaps in HIV services. In calculating the 2013 national health budget, 49 percent is expected to come from the international community. The 2009-2010 estimations of HIV resource flows and expenses report shows that the most important source of funding for AIDS in Burundi consists of external resources, which represents 95 percent of the total funding.

The Ministry of Public Health and Fight against AIDS (MOHA) has advocated for increased HIV/AIDS funding budget line item of \$10 million from the national budget in addition to \$3 million already budgeted. When the World Bank ended their five year project with the National AIDS Council 2011, the staff salaries were picked up by the GOB. To express its commitment to the elimination of new HIV infections in children and keeping mothers alive, the MOHA designated a PMTCT task force in charge of accelerating the elimination of pediatric infections. At the request of the GOB, the USG is currently funding an organizational management specialist group to restructure and build the capacity and human resources of the department of HIV/AIDS at the MOHA to better manage and coordinate their division. Additionally, it is worth mentioning that PEPFAR is supporting capacity building for six local organizations involved in HIV/AIDS in order to help graduate them as prime partners in the near future.

In 2013, Burundi will continue to face multiple challenges. Health infrastructure is weak and there remains the need to build local capacity to address the needs of the population in the area of PMTCT and overall clinical and community based services, including ART. Training and health systems strengthening will be essential to facilitate key activities for the success of a scale up plan in FY 2014. The country context will require new and innovative models to address subjects such as increased male involvement in ANC, integration of the role of community health workers, and the identification and targeted service delivery to key populations within the general population, especially FSWs. Despite the challenges, the benefits to the Burundian population could be enormous. The PEPFAR Burundi team hopes that the fundamental principles, vision, and progress that will occur in FY 2013 will lead to an appropriate scale up of resources in FY 2014.

#### IV. Program Overview

The overarching goal of the PEPFAR program in Burundi is to strengthen the capacity of the Burundian



government, civil society, and the private sector to plan, deliver, monitor, and evaluate high-quality, sustainable HIV/AIDS prevention, care, and treatment services. Given massive unmet needs (as described in the USG Vision)) and limited funding, PEPFAR assistance will focus on programming that mixes linked service delivery in priority areas, technical assistance for national and local capacity building, and preparation for longer-term policy and structural interventions.

#### Four Major Program Areas

1. Strengthening combination prevention programs for key populations and the general population: Based on increasing consensus that there is not one single set of behaviors or services that can effectively influence a long-term population wide reduction in HIV incidence, the USG's response to HIV prevention in the key and general populations will continue and improve upon a combination prevention framework. The PEPFAR team believes this is the appropriate mix of behavior, biomedical, and structural interventions per the needs, culture, context and epidemiological profile of each targeted audience. Behavioral interventions will aim to motivate behavior change within individuals, families, communities, and entire populations. These will address the reduction of sexual transmission and substance abuse. Biomedical interventions will intend to decrease infectiousness or prevent infection through early identification and treatment adherence, as well as PEP. Interventions include services and advocacy for male circumcision, condoms, STI treatment, PMTCT, Positive Prevention services, RH/FP integration, and the prevention of medical transmission. Structural interventions will change the context in which people live to reduce vulnerability or risk to HIV. Structural issues in Burundi include but are not limited to poverty, gender, GBV, cultural and traditional practices and stigma and discrimination.

According to the results of the key populations bio-behavioral surveillance survey conducted in 2011, poverty is one of the main reasons women resort to commercial sex work. Some FSWs consume alcohol and use drugs, and many FSWs are disempowered in their ability to make decisions regarding their sexual relationships. The majority of FSWs stated they were victims of verbal abuse (58.5 percent), 25.4 percent were arrested by the police, 17 percent experienced physical violence, and 15.4 percent were rejected by their parents. According to the same survey, FSWs engage in other economic activities in addition to sex work (small businesses, trade, agriculture, and livestock). They have an average of 26 years of age and most are educated (primary school level: 51,1 percent, secondary school level: 23,1 percent). Additionally, the survey also revealed the following characteristics of MSM in Burundi: they are not accepted by society or their families; they are mostly young men who are often students; they also have sex with women who are unaware of their MSM status; and most MSM do not have solid knowledge of modes of HIV transmission and prevention methods. In addition, condom use and HIV testing rates are low among this key population.

Burundi will scale up prevention interventions targeting FSWs and MSM through the current and



expanded PEPFAR programs, which will include the following activities:

- Community-based outreach activities through peer educators, discussion/support groups providing targeted information, education and communication (IEC) materials in order to increase their knowledge on HIV/AIDS, awareness on using condoms and uptake of voluntary testing and counseling (HTC) services and STI treatment;
- Condoms and condom-compatible lubricants will be readily available at hotspots identified in urban centers through trained peer educators;
- FSWs and MSM benefiting from community-based outreach will be referred to health facilities for HIV counseling and testing;
- An active referral and follow-up system to health care and antiretroviral treatment will be defined and implemented in order to increase access to treatment and care for FSWs and MSM (pre-ART, ART, TB/HIV screening and treatment). This will be done through training of outreach workers, building MSMs' trust in local HIV prevention and care programs, and facilitating linkages and referrals to friendly HIV prevention and care programs;
- Family planning services will be offered to FSWs of childbearing age (family planning products purchased by UNFPA);
- Advocacy activities aiming to set up an enabling environment (non discriminatory and responsive) for access to prevention, treatment, and care for FSWs and MSM will be conducted and will be focused on health care providers, police corps, justice officers, and community leaders. This will be achieved through advocacy trainings and campaigns aiming to raise awareness of the issue of access to HIV/AIDS services and reducing stigma and discrimination;
- Managerial and programmatic capacity for the civil society organizations will be reinforced to allow for better management of the activities targeting FSWs and MSM.

In addition, prevention activities targeting the general population will be implemented and will include evidence-based communication and small-group/individual interpersonal interventions. To facilitate and sustain behavior change, PEPFAR-supported activities will strengthen peer education. Peer educators will implement messages that promote behavior change, increase access to condoms, counseling and testing services, SGBV, and alcohol consumption. PEPFAR activities will also facilitate HIV prevention through positive behavior by working with the PLHIV association and by focusing interventions on the household unit. In addition, activities will include BCC targeting young girls and family communication, use of post-exposure prophylaxis kits by the health centers, and training to ensure that CHWs, teachers, and health workers are capable of screening for and addressing risks for GBV, including providing or referring GBV victims for PEP, care, and legal services. Finally, to support the voluntary medical male circumcision program, PEPFAR will continue working with the MOHA/NAC to support VMMC through PBF in 4 provinces and as a member of the national VMMC technical committee. PEPFAR activities will



be coordinated with the Global Fund project implemented by the National AIDS Council Secretariat, UNFPA, and other donors supporting HIV activities targeting FSWs and MSM in order to leverage greater resources.

In order to improve the health outcomes for the Burundi National Defense forces, a new implementation structure was created by the USG, which includes four regional coordinators assigned at every military region and located within the camp. This strategy allows the USG to reach more military personnel more efficiently and for the targets to be met. Among military personnel, the HIV prevalence rate according to DOD is 1.3 percent and in FY 2012 6,870 military personnel were reached with prevention messages and received condoms and 8,815 clients tested for HIV were military staff or members of military families. This strategy combined with the condom distribution strategy newly implemented among the military will contribute towards reducing the HIV prevalence among military populations and their families. Additionally, the Minister of Defense validated the first National HIV Strategic Plan 2012-2016 in December 2012. The four strategic axes are:

- Increasing prevention efforts to reduce HIV transmission;
- Improving the overall management and care of infected military and their dependents infected and affected by HIV/AIDS;
- Reducing the impact of HIV infection among the military population;
- Strengthening HIV/AIDS coordination, partnership and monitoring – evaluation.

## 2. Expanding PMTCT services and support:

The USG and GOB, along with other international and local partners, have made significant strides in PMTCT efforts. The USG is currently implementing PMTCT interventions in four provinces: Kayanza, Kirundo, Muyinga, and Karusi. Activities such as community sensitization for HTC, PMTCT trainings, prevention messaging integrated with family planning (FP), testing and counseling services offered during antenatal care (ANC), and ART for HIV-positive mothers and infants are serving to contribute to the reduction of new HIV infections among children and women of childbearing age. In addition, PEPFAR will begin to implement the PMTCT Acceleration Plan in the next few months, whose goal is to rapidly and effectively scale up PMTCT services in four additional provinces of Burundi: Gitega, Ngozi, Bujumbura (capital), and Bujumbura (rural). Using an integrated, community-based, family-centered approach, the USG will build on community-level synergies and provide quality access to critical services such as FP, ART, and psychosocial support for those who test seropositive. The mid-term goal will increase coverage of fully integrated PMTCT services such that 95-100 percent of all pregnant women presenting at ANC and labor and delivery services are tested for HIV and receive subsequent related services. The current coverage is 37 percent in non PEPFAR supported sites and 82 percent in PEPFAR sites. The program will also include early infant diagnosis (EID) as a component of early identification of HIV-positive



newborns.

FY 2013 will coincide with the scale-up of PMTCT activities in four additional provinces. This will be reached through three underlying approaches: improving quality, implementing a family-centered approach, and creating linkages between the community and facility based services. In order to address these, the USG will first conduct a situational analysis to evaluate ANC and PMTCT services in the provinces of Gitega, Ngozi, Bujumbura (capital), and Bujumbura (rural). This pre-evaluation will serve as a baseline assessment for current activities being conducted, service gaps, successes and challenges, and guidance for new interventions. Program interventions will include HTC, HIV information and sensitization, linkages to nutrition and malaria care, and ongoing HIV prevention for HIV-negative mothers will be effective in reducing new HIV infections. Interventions such as referrals and access to care and treatment, FP, ART and breastfeeding guidance will provide prevention of transmission from mother-to-child for HIV-positive pregnant women and provide care and treatment as necessary for their children and families.

In FY13 the USG will develop three pilot programs to support PMTCT efforts under the program objectives:

- To increase male involvement in PMTCT and ANC visits, where targeted HTC services can be provided;
- To involve Traditional Birth Attendants (TBAs) and other categories of Community Health Workers (CHW) into the PMTCT circuit to allow for more comprehensive, community-base care;
- To develop a system for identifying and providing targeted care to key populations in the PMTCT system, especially FSWs.

### 3. Supporting Integrated Service Delivery:

The PEPFAR program will continue to build on the successes achieved and lessons learned thus far in Burundi and globally to support GOB priorities in HIV/AIDS, malaria, FP and maternal, newborn and child health (MNCH). The USG will achieve this through investments and activities that seek to achieve three interrelated results: strengthened health management information systems; improved health seeking behavior and increased demand for health services; and improved quality of health services as articulated in the approved GHI Strategy. The USG in Burundi will make a concentrated effort to leverage its resources and harmonize its efforts to attain greater impact. This includes close coordination among USG health teams and other health partners to increase efficiencies. As a contribution to the integration approach, PEPFAR funding will contribute to the following activities:

HIV/AIDS prevention and treatment services, including:



- HIV testing and counseling (HTC) as the entry point to care, treatment, and support services. To make sure that HTC is in line with state-of-the-art practices, PEPFAR Burundi is negotiating with OGAC a technical assistance in this area;
- Family-focused PMTCT;
- STI and opportunistic infection (OI) screening and treatment;
- Clinical youth- and family-friendly comprehensive Positive Prevention services;
- PEP for post-rape victims;
- Expanded condom, basic care package for PLWHA, and home based care package distribution.

The PEPFAR program will contribute to the implementation of cross-cutting aspects at the facility level, including:

- Leveraging the ANC platform for PMTCT, FP, malaria in pregnancy, and emergency obstetric and neonatal care;
- FP for women of reproductive age, MNCH, PMTCT, and malaria services integrated into child health services;
- Integrating HTC into in- and outpatient clinics and services;
- Counseling within the facility with integrated messages;
- Linkages with ART programs for a strengthened continuum of care model
- Pharmaceutical management at the health facility level;
- Expanding ITN distribution to community at large, as directed by GOB policy (PEPFAR will not be procuring bed nets);
- Integrating health services into other health and non-health resources and programs (e.g. income generation; water and sanitation; food and nutrition).

It will also contribute to community-based services for specific target audiences, including:

- Community-based Positive Prevention;
- Home-based care;
- Services and support for OVC;
- Community-based condom, ITN, ORS, point-of-use water treatment, and FP distribution (via partners);
- Referrals to complementary services (e.g. food; agriculture; nutrition; economic strengthening);
- Implementation support for behavioral interventions/social and behavior change communications (SBCC) to targeted audiences;
- Implementation of male involvement strategies.



#### 4. Strengthen National Health Systems:

Burundi has completed its Poverty Reduction Strategy Paper for the period 2012–2015, which places a strong emphasis on fulfilling the health needs of the population. To further elaborate the requirements for the sector and chart a course for achieving the Millennium Development Goals (MDGs), the GOB prepared its second National Health Development Plan for the period 2011–2015. The GOB's health goals defined in the NHDP are to: reduce maternal and neonatal mortality; reduce infant and child mortality; reduce mortality from communicable diseases; and strengthen the health system. The USG through PEPFAR programming and other USG health programs is already contributing to the aforementioned goals. In the specific area of health systems strengthening, the PEPFAR program will focus on the three themes below.

1. Strengthening of the laboratory system appears prominently in the National Health Development Plan for 2011-2015. The activities aimed at improving laboratory services related to HIV will benefit from the enabling environment. With the needed scale-up of PMTCT services, laboratory activities will also be scaled-up to support this effort. The minimum package of HIV laboratory services will include:

- Provincial/National Level: CD4 and EID + district level package,
- District Level: CD4, HIV rapid testing kits, liver function test/biochemistry, hematology, reagents, microscopy,
- Health Center Level: Rapid HIV testing.

To reinforce the laboratory system, the following activities will be implemented:

- Building on an initial supply chain management report resulting from a SCMS technical assessment visit, an assessment of the laboratory system will be conducted. The laboratory assessment will also draw from a review of the national laboratory system done through PMI to make sure that there are no duplications of effort. In addition, PEPFAR Burundi is negotiating a technical assistance in this particular area expected to take place not later than May 2013;
- Implementing standardized laboratory policies, quality assurance mechanisms, and trainings where necessary.
- Establishing a sample referral and result distribution process between the different facility levels. This will contribute to minimizing missed opportunities for pregnant women and infants.
- Supplying reference laboratories with equipment and reagents for biological follow-up including hematology and biochemistry for HIV+ pregnant women under ARVs.
- Reinforcement of the QA/QC for the laboratory and for other services. For that purpose, sufficient budget to support site visits and assessments to regularly review the quality of the laboratory and other health services provided throughout PEPFAR sites will be built into the program. Better QA/QC will help



gather better information for the performance based financing (PBF) scheme.

2. The weaknesses of the supply chain (SC) system are impeding the provision of quality services in Burundi. In this area, some assessments and audits have been conducted by the USG and development partners on the Burundian pharmaceutical management and supply chain system. To build on the past recommendations and findings for the supply chain system, the USG will support Burundi in addressing supply chain design, performance, and planning in order to support the provision of HIV services. With COP 2013 funds, the USG will pursue the implementation of the supply chain work plan developed and validated by various partners. Some of these activities include:

- In collaboration with USG implementing partners, ensure the procurement and secure and reliable delivery of USG PEPFAR-funded commodities;
- Support the strengthening of a coordination mechanism for SC within the MOHA, to maximize commodity forecasting and procurement, and monitor the implementation of an integrated SC involving the various stakeholders;
- Support the definition and establishment of a harmonized, standardized system for tracking commodities in the SC system;
- In collaboration with in-country partners, develop a framework for measuring performance of the SC in areas linked to supply chain support.

3. To maintain quality HIV services, the development of human resources for health will be critical. In that regard, specific support from PEPFAR will include:

- Initial and refresher training of health providers and community health workers: PEPFAR will use official modules already approved by the GOB and will work with the national cadre of trainers.
- Providing support for the development of new healthcare workers through the pre-service training approach. The PEPFAR team believes that empowering the pre-graduate nurses with HIV/AIDS knowledge will allow them to easily prescribe ARVs when they start working. PEPFAR is already exploring ways to work with the MOHA to include and operationalize the inclusion of an HIV/AIDS module for all of the pre-graduates of nursing schools. This approach will allow the Ministry to have more than 300 new health providers in two years that are ready to provide HIV/AIDS services.
- Providing assistance in the development of the required national documents.
- Supporting national entities, including the national technical committee for PMTCT.
- Assessing the health curriculum in order to develop a SOW for an evaluation of the current health provider training curriculum. The assessment will show which level of health providers are most needed and what effort is needed to train individuals in these areas. All of the trainings will meet the global standards.



For improved integration, capacity building will also address health providers working in critical areas such as MNCH, FP, nutrition, and tuberculosis (TB). As Burundi is already implementing performance-based financing (PBF) in the health sector, this approach will continue to be applied in providing PMTCT services. In addition, the project will contribute to supporting PBF in targeted geographic areas. Performance-based financing has been endorsed by the GOB since 2006 as an approach to structuring the flow of resources to pay for results. The MOHA has adopted PBF countrywide to strengthen the health system by improving quality care and retaining key personnel.

#### V. GHI, Program Integration, Central Initiatives, and other considerations

Burundi developed a GHI strategy 2011 as an overarching umbrella that encompasses USG health-related programs on HIV/AIDS, malaria, MNCH, FP, and nutrition. It links closely to other U.S. Presidential development initiatives including PEPFAR and the President's Malaria Initiative, where synergies with GHI are possible. To achieve its goals, PEPFAR Burundi reaches beyond the health sector to areas that link with health, such as safe water, sanitation, health financing and gender related aspects. For example, this principle is demonstrated in the a new Integrated Health Services project which is currently in the procurement phase, and which will contribute significantly to the achievement of Burundi's GHI strategy. Additionally, to complement continuation of the four key OGAC program areas, the PEPFAR team will coordinate closely with USAID/Burundi's new economic growth initiative. This will focus on three key areas:

- Strengthening referral linkages between PEPFAR services and economic growth activities,
- Mainstreaming high-risk/vulnerable communities, PLWHAs and OVC heads of household into the formal economy, and
- Improving health outcomes of PEPFAR program beneficiaries through improved food security.

The economic growth (EG) team will support PEPFAR by working in the same districts, to undertake an impact evaluation to understand the outcomes of the collaboration.

The Global Fund is a key player in the health sector and provides a significant share of funding to combat HIV/AIDS, TB, and malaria in Burundi. Through the implementation of the Round 8 HIV/AIDS grant (Phase II with more than \$80,000,000 over three years), the Global Fund provides:

- Prevention services among the general population and for specific at risk populations
- Provision of ARTs for treatment
- Improved diagnosis and treatment of sexually transmitted infections in health facilities
- Enhanced prevention of HIV through blood transfusions, providing better case management of



accidental exposure to blood, and to victims of sexual violence

- Expanded primary prevention of HIV infection in women of reproductive age
- Strengthened PMTCT services by integrating reproductive health services

The PEPFAR program will be working closely with the Global Fund to make sure that necessary synergies are established and efforts to avoid duplication are successful. The USG has been identified by the Ministry of Health and Fight against AIDS as a member of the GF committee in charge of selecting the sub recipients to implement the Round 8 phase II community component. This engagement of the USG field staff in such processes is a special opportunity to demonstrate its firm commitment to improving GF program performance. Additionally, the PEPFAR Burundi team works closely with the East Africa regional Global Fund Liaison based in Nairobi to provide support to GF activities in Burundi.

Currently, Burundi is not receiving additional funds through USG central initiatives.

Burundi is still at a crossroads. After nearly 13 years of civil war in which more than 300,000 people were killed and many more displaced, Burundi is struggling to consolidate its peace and stability. The government is focused on economic growth and achieving a better quality of life for its people. Health care, including HIV/AIDS, remains a top priority of the Burundian government. The PEPFAR Burundi team believes that this COP submission for FY13 will address not only HIV/AIDS activities but also underlying health and sustainability concerns as Burundi moves forward as a country.

### Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV	61,000	2011	AIDS Info, UNAIDS, 2013			
Adults 15-49 HIV Prevalence Rate	01	2011	AIDS Info, UNAIDS, 2013			
Children 0-14 living with HIV	19,000	2011	AIDS Info, UNAIDS, 2013			
Deaths due to HIV/AIDS	5,800	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among	1,900	2011	AIDS Info, UNAIDS, 2013			



adults						
Estimated new HIV infections among adults and children	3,000	2011	AIDS Info, UNAIDS, 2013			
Estimated number of pregnant women in the last 12 months	283,000	2010	UNICEF State of the World's Children 2012. Used "Annual number of births as a proxy for number of pregnant women.			
Estimated number of pregnant women living with HIV needing ART for PMTCT	5,200	2011	WHO			
Number of people living with HIV/AIDS	80,000	2011	AIDS Info, UNAIDS, 2013			
Orphans 0-17 due to HIV/AIDS	120,000	2011	AIDS Info, UNAIDS, 2013			
The estimated number of adults and children with advanced HIV infection (in need of ART)	49,345	2011	WHO			
Women 15+ living with HIV	38,000	2011	AIDS Info, UNAIDS, 2013			

### Partnership Framework (PF)/Strategy - Goals and Objectives

(No data provided.)

### Engagement with Global Fund, Multilateral Organizations, and Host Government



## Agencies

### How is the USG providing support for Global Fund grant proposal development?

The Global Fund grant proposal development is one of the responsibilities of the CCM. To better implement its mission, the CCM was restructured in 2010 to incorporate two technical committees: a monitoring and oversight committee and a proposal development committee. The USG was identified to serve on the proposal development committee. Since its election as a full voting member of the CCM in September 2012, the USG is also chairing the proposal development committee of the CCM. The PEPFAR M&E specialist will be the point of contact and lead for this activity as he has extensive experience in the design and development of public health and HIV/AIDS proposals. The USG's involvement and contribution to the grant proposal development, as well as to other CCM activities and decisions will ensure continued coordination and understanding. In addition, the coordinators of the committees are automatically members of the Executive Bureau of the CCM. This will serve as an entry point to increase close collaboration to avoid duplication with the Global Fund programs.

### Are any existing HIV grants approaching the end of their agreement (Phase 1, Phase 2, NSA, CoS, or RCC) in the coming 12 months?

No

Redacted

### To date, have you identified any areas of substantial duplication or disparity between PEPFAR and Global Fund financed programs? Have you been able to achieve other efficiencies by increasing coordination between stakeholders?

No

## Public-Private Partnership(s)

Created	Partnership	Related Mechanism	Private-Sector Partner(s)	PEPFAR USD Planned Funds	Private-Sector USD Planned Funds	PPP Description
2011 APR	Public-Private Partnership		BICOR Insurance	0	0	



	between USAID/Burundi and BICOR: Prevention of HIV/AIDS Among Motorcycle Taxi Drivers		Co.			
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### Surveillance and Survey Activities

Surveillance or Survey	Name	Type of Activity	Target Population	Stage	Expected Due Date
Surveillance	Antenatal surveillance	Sentinel Surveillance (e.g. ANC Surveys)	Pregnant Women	Planning	01/01/2013
Survey	Bio-behavioral survey among uniformed service members (militaries, police)	Surveillance and Surveys in Military Populations	Uniformed Service Members	Planning	09/01/2014
Surveillance	Extension of sentinel surveillance sites from 8 to 20 by expanding the targets to TB patients, female sex workers and their clients	Sentinel Surveillance (e.g. ANC Surveys)	Female Commercial Sex Workers, Pregnant Women, Other	Planning	09/01/2014
Survey	Mapping and size estimate of Most-at-risk populations (FSW and MSM)	PLACE	Female Commercial Sex Workers, Men who have Sex with Men	Development	09/01/2013
Survey	MARPs population size estimates	Population size estimates	Female Commercial	Development	05/01/2013

Approved



			Sex Workers, Men who have Sex with Men		
Surveillance	Modes of Transmission (MOT) study	Other	Female Commercial Sex Workers, General Population, Men who have Sex with Men	Development	05/01/2013



## Budget Summary Reports

### Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source			Total
	GAP	GHP-State	GHP-USAID	
DOD		1,001,048		<b>1,001,048</b>
State/AF		100,000		<b>100,000</b>
USAID		14,258,952	3,500,000	<b>17,758,952</b>
<b>Total</b>	<b>0</b>	<b>15,360,000</b>	<b>3,500,000</b>	<b>18,860,000</b>

### Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency				Total
	DOD	State/AF	USAID	AllOther	
HBHC			944,735		<b>944,735</b>
HKID			702,312		<b>702,312</b>
HTXD			1,208,202		<b>1,208,202</b>
HTXS			521,289		<b>521,289</b>
HVAB	18,136	100,000	631,928		<b>750,064</b>
HVCT	336,273		835,202		<b>1,171,475</b>
HVMS	56,091		1,959,158		<b>2,015,249</b>
HVOP	290,548		3,437,944		<b>3,728,492</b>
HVSI			1,005,193		<b>1,005,193</b>
MTCT	300,000		2,606,618		<b>2,906,618</b>
OHSS			3,480,169		<b>3,480,169</b>
PDCS			5,362		<b>5,362</b>
PDTX			420,840		<b>420,840</b>
	<b>1,001,048</b>	<b>100,000</b>	<b>17,758,952</b>	<b>0</b>	<b>18,860,000</b>

Approved



## National Level Indicators

### National Level Indicators and Targets

Redacted

Approved



## Policy Tracking Table

(No data provided.)



## Technical Areas

### Technical Area Summary

#### Technical Area: Care

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	944,735	0
HKID	702,312	0
PDCS	5,362	
<b>Total Technical Area Planned Funding:</b>	<b>1,652,409</b>	<b>0</b>

#### Summary:

##### *Overall Programmatic Strategy*

Burundi is a low-income developing country that ranks 185 out of 187 in the Human Development Index (UNDP 2011 Human Development Report). With a population of 8.7 million, the country has the second-highest population density in sub-Saharan Africa. A 13-year ethnic crisis killed 300,000 people and severely weakened health and social-welfare systems and diminished donor support for Burundi. Burundi completed in 2010 its second set of democratic elections; however, the country continues its struggle to recover from the effects of massive displacement, social disruption, and ethnic and gender-based violence. Furthermore, the country is plagued by other health problems and human rights issues that are similar across borders and, in combination with AIDS, undermine the well-being and productivity of the Burundi population. Health indicators are still alarming:

- Child mortality rate is 96/1000 live births;
- Anemia in children under five years of age remains at 45%;
- Stunting rate in children under five is 58%, indicating that the nutritional status has worsened over the past five years; and
- Maternal mortality is 866 deaths per 100,000 live births.

Moreover, as documented by a recent assessment of the transport corridors, community members in Burundi and elsewhere cite alcohol abuse, violence against women and girls, and the lack of critical health services as major issues. Economic activity and government services are recovering gradually, but unlike in neighboring Rwanda, Burundi's HIV/AIDS epidemic has been largely neglected by international donors.

Burundi faces a low-prevalence generalized HIV/AIDS epidemic that continues to be a priority public health threat. National health information systems are weak and provide little reliable or recent data on HIV/AIDS. Recent studies include a national HIV survey conducted by the National AIDS Council (NAC) in 2007, and older studies by UNAIDS and the World Bank. The most recent Demographic and Health Survey (DHS) was conducted in 1987; data collection for a new DHS is complete and the information should be available in early 2012. The data available currently suggests that 110,000 people are estimated to be living with HIV (PLWHA), with 47,000 in need of ART. AIDS related deaths are estimated at 11,000 per year and TB incidence was estimated at 31,225. UNICEF estimates the number of orphans and vulnerable children (OVC) due to HIV/AIDS are approximately 240,000, out of a total of 800,000. Available data suggest that main drivers of the epidemic include heterosexual transmission through multiple concurrent partnerships (MCP), including transactional, intergenerational, and commercial sex; low condom use; high risk populations; and weak knowledge about HIV.



*The Government of Burundi (GOB) is fully engaged in the fight against HIV/AIDS, with a vision, as stated in the National HIV/AIDS Strategy (2011-2015), of "a country where the population at the household, workplace, commune, and provincial levels are made up of competent communities with enough skills to face HIV." The GOB established a treatment protocol for PLWHA in 2010 that includes regular follow-up, free treatment for OIs, and free cotrimoxazole for all HIV-positive patients. Decentralization of these services is ongoing, with training for providers to manage an integrated approach to HIV/AIDS and health care provision. The majority of HIV prevention outreach and community-based care and support services are provided by local civil-society organizations (CSOs) and faith-based organizations (FBOs), aligned with a strong national network of people living with HIV (RBP+). OVC programs are coordinated by the NAC. To improve access to the most vulnerable groups such as women and children and accelerate the achievements of the MDGs for Burundi, the GOB has put in place policies to support free services to pregnant women for deliveries in facilities, for children under five years of age, and to expand community-based service delivery and national health insurance schemes. The GOB will continue to strengthen the quality of health services through human resource management, capacity building, quality assurance and control, and the performance-based financing approach.*

*Through the GHI the USG is supporting the GOB's goals and objectives for the next five years. All HIV/AIDS and other health programs are aligned with new National Health Development Plan (NHDP II) for the period 2011-2015. The GOB's health goals are to: reduce maternal and neonatal mortality; reduce infant and child mortality; reduce mortality from communicable diseases; and, strengthen the health system and meet MDG goals 4, 5, and 6 respectively related to reducing child mortality, improving maternal health, and combating infectious diseases. The NHDP II is informed by the findings of the previous NHDP's evaluation, conducted in close partnership with the USG, development partners, and civil society.*

*The PEPFAR program in Burundi is in its infancy and has not drafted a partnership framework agreement or a partnership framework implementation plan, although the team hopes to be authorized to begin the process in 2012. In 2011 the PEPFAR program focused on four Northern provinces, as requested by the GOB. The USG supports 100% of health facilities in three provinces (Kirundo, Kayanza, and Muyinga) and 70% of facilities in the fourth province (Karusi). The Burundi model is to support full integration of HIV services, including PMTCT, into all primary health care facilities with support to strengthen links with and quality of ART services. Major accomplishments expected with 2012 COP funding is the USG expansion of PMTCT to 139 sites (74 current and 65 new sites) and building upon two existing programs; providing nutritional support to malnourished children; and a family planning initiative targeting returning refugees. Furthermore, Burundi was selected to scale up the PMTCT program and the PMTCT Acceleration Plan has been approved the Headquarters. Therefore, the USG will expand comprehensive PMTCT services to four additional provinces to increase coverage to 60% in the first year and will be working closely with GF to support Early Infant Diagnosis (EID) in the country. The comprehensive services package includes care and support and ART for the HIV + women and infants (please see the PMTCT plan for details).*

*Major goals for the PEPFAR Burundi program over the next two years are to support health systems to include an improved national supply chain system, specifically regarding the delivery of commodities. At present the Global Fund (GF) purchases all ARVs. The USG is funding the procurement of test kits and reagents, home-based care kits which include cotrimoxazole (CTX), OVC kits, and general health facility-based HIV supplies in the four provinces. The USG plans also to support the supply chain system by increasing technical assistance (TA) to the MOH. Specific TA will be provided to the central pharmacy (CAMEBU) to implement a comprehensive assessment of the national supply chain system. Capacity building will strengthen CAMEBU's forecasting and monitoring of essential HIV/AIDS commodities, including products procured by other donors, allowing the GOB to own the procurement process and remain accountable for commodities brought into the country. The second major goal for the PEPFAR program is to continue to support the performance-based financing system which is being used to improve access to and quality of services. PEPFAR will provide support to achieving improvements in the 7 HIV/AIDS indicators that have been defined at the national level. Additional objectives for the 2012 care and support PEPFAR program include:*

- *Strengthening the provision of integrated, high quality care and support, palliative care, for PLWHA,*



including but not limited to free access to ART, prevention of opportunistic infections, and psycho-social and economic support for the poorest PLWHA;

- Strengthening the provision of integrated, high quality care and support, including palliative care, for OVC at the community level for those infected and affected by HIV/AIDS;
- Scaling-up coverage of community and home based care (CHBC) and support programs to increase the numbers of PLWHA and OVCs reached with services;
- Expanding PLWHA and OVC access to the continuum of care and comprehensive HIV/AIDS services by building integrated networks of services and referrals;
- Supporting the implementation of the national guidelines and standards and a minimum set of quality services for CHBC and OVC programs at the district and community levels; and
- Strengthening adherence to life-saving medications such as ART, TB medications and CTX prophylaxis.

The USG will collaborate closely with the GF, which remains the only significant donor in HIV/AIDS. The collaboration is essential for the success of the scale-up of an integrated national HIV plan. The GF is a key player in the health sector, providing a significant share of funding to combat HIV/AIDS in Burundi. Through the implementation of the Round 8 HIV/AIDS grant (Phase I with \$36,789,591), the GF is providing:

- 1) Prevention services among the general population and for specific at risk populations;
- 2) Improved diagnosis and treatment of sexually transmitted infections in health facilities;
- 3) Enhanced prevention of HIV through blood transfusions, providing better case management of accidental exposure to blood, and to victims of sexual violence;
- 4) Expanded primary prevention of HIV infection in women of reproductive age; and
- 5) Strengthened PMTCT services by integrating reproductive health services.

The GF program also promotes male circumcision and increases the coverage and quality of therapeutic case management and monitoring of PLWHA at the national level. The negotiation of Round 8 Phase II will take into account ongoing PMTCT activities for improved coordination.

At the time the USG team in Burundi was drafting this COP, the information on the Global Fund commitment of additional funds for the Phase 2 (almost \$57,000,000 for three years) of the Burundi HIV/AIDS program was formally released. This represents a good opportunity for PEPFAR for leveraging and coordinating.

The USG currently does not procure ARVs. However, it will begin modest procurement of ARVs to support the expanded PMTCT program in 2012. The USG does procure diagnostic equipment, HIV rapid test kits, and laboratory reagents for clinical monitoring of PLWHA. As mentioned above, the USG will soon purchase a limited number of ARVs for PMTCT, post-exposure prophylaxis, CTX, drugs for treatment of sexually transmitted infections, and other products for PLWHA through one USG partner in Burundi for all USG implementing partners. For the moment, given the deficiencies of the national supply system, these products are procured and managed through a separate system. The President's Malaria Initiative (PMI) provides TA to the pharmaceutical management and supply chain system as it relates to commodities for the prevention and treatment of malaria. PEPFAR activities will continue to leverage the existing TA provided by PMI as well as international development partners such as DFID, which has invested in reducing facility-level stock outs of tracer products. The goal for the USG is to support and work through the Burundian national supply chain system, however, significant performance improvements must be made and challenges resolved before the USG can allow commodities to be managed by it.

The USG is constantly striving to improve efficiencies and implement evidence based interventions by coordinating between the USG and its implementing partners. For example, the USG is strengthening:

- Internal USG alignment among the MCH, malaria, HIV/AIDS, and FP partners by coordinating on MCH activities, approaches, and lessons learned;
- Expanded community level integrated service provision, conducting joint USG planning, monitoring, and evaluation;
- The harmonizing of care and support messages among USG partners, including anti stigma and



*discrimination campaigns;*

- *Development of national community based strategies with community packages of integrated services, including good governance and harmonized community messages among donor partners and stakeholders.*

*Cross-cutting elements such as public-private partnerships, key vulnerable populations, and health systems strengthening will be addressed under each specific heading.*

#### *Adult and Pediatric Care & Support*

*The USG currently supports 139 facilities which offer a high-quality, comprehensive package of PMTCT services. This package includes routine ANC services in conjunction with maternal and child health services, screening for syphilis, HTC, infant feeding information, early infant diagnosis, a complete course of ART prophylaxis to HIV+ mothers and their babies, mother-to-child follow-up, and preventive therapy using cotrimoxazole prophylaxis to infants exposed to HIV. During FY 2011, 49,803 pregnant women were tested for HIV and received their results. To increase the uptake of PMTCT services, the USG will assess each new site to determine renovation and equipment needs to ensure confidentiality, comfort and functionality for PMTCT activities as well as provision of refresher trainings for health care providers following the national curriculum. The training modules include the HIV/AIDS epidemiological situation globally and in Burundi, the pathology of HIV/AIDS, how HIV is transmitted from mother to infant, how to provide testing and counseling, specific interventions for PMTCT (including the national protocol for clinical services), infant and child nutrition in the context of HIV infection, stigma and discrimination linked to HIV, mother/child follow-up, support for PLWHA (including sexual prevention, FP, and partner reduction), and prevention of counselor burnout/fatigue. The PEPFAR program will mobilize the community for PMTCT services using community networks, specifically the network of PLWHA, to promote couples counseling and testing, encourage pregnant women to bring their spouses/partners to check ups, provide all needed supplies, develop appropriate IEC materials, and provide nutritional support to vulnerable HIV+ women during the weaning period.*

*Developing strategies to promote follow-up and adherence of mothers and babies will be achieved through community outreach/referral as well as through health facilities. Community outreach will be the back bone of effective linkages between the community and the health facilities. If patients already enrolled in the PMTCT program are not adhering to scheduled clinical check-ups, the community health workers (CHWs) will systematically follow-up. The CHWs will also be actively involved in minimizing missed opportunities for PMTCT services.*

*Pregnant women testing positive for HIV will systematically be screened for ART eligibility and enrolled under PMTCT prophylaxis programs when applicable. At delivery, ARV prophylaxis will be given to the infants. Mothers will be counseled on infant feeding in accordance with national protocols. HIV positive women also benefit from CTX prophylaxis. When ART is needed for their own health post pregnancy, women will be referred to ARV facilities for continued services, including TB screening. Through a local network of PLWHAs, the USG will continue to support the funding of transportation fees for referrals, medical and hospitalization fees, and the provision of hygiene kits (soap, gloves, oral rehydration salts, petroleum jelly, thermometer, scissors, adhesive bandages, a water container, towels, tongue depressors, and nail clippers). Psychosocial, medical, and nutritional support will be provided as needed and identified by facility- or community-based health workers. When applicable, children born to HIV+ mothers will benefit from OVC programs. The OVC program includes medical and education support as well as other types of assistance.*

*The USG will strengthen critical services for treatment, care, and support for women living with AIDS, their children, and families in accordance with international recommendations based on evaluated evidence. People living with HIV (including women) will benefit from interventions to prevent illness with CTX chemoprophylaxis against common opportunistic infections such as pneumonia, diarrhea, and other clinical conditions. Other critical interventions that HIV infected individuals will have access to are: 1) TB screening, 2) insecticide-treated bed nets for pregnant women and children under five years in conjunction with the national malaria control program, and 3) full nutritional assessments.*



### *TB/HIV*

*HIV/TB co-infection rate in Burundi exceeds 20% and TB is the common OI among PLWHV. TB activities in Burundi are almost completely supported by Global Fund, Round 7. In regard to HIV/TB co-infection, the Global Fund in close collaboration with other partners is currently implementing the following activities: (1) systematic HIV testing among TB patients through the integration of HIV testing in all centers of care for TB and the application of the innovative strategies such as provider-initiated HIV testing; (2) surveillance of HIV seroprevalence among TB patients; (3) the systematic integration of HIV prevention messages in the structures in charge of management of tuberculosis; (4) early initiation of antiretroviral therapy for patients on TB treatment as soon as they meet the criteria for initiation of ART treatment; and (5) capacity building of centers for diagnosis and treatment so that they are able to provide quality services with a regular supply of medicines, equipment and consumables necessary for the diagnosis and treatment of co-infected patients.*

*PEPFAR program will complement the above described activities in ensuring systematic TB screening among HIV positive people and in reinforcing the cross-referral system between HIV/AIDS and TB settings wherever indicated. More specifically, PEPFAR program will assist in ensuring the training of health providers on the management of co-infection TB / HIV and other opportunistic infections. It will help to improve the access of TB patients to HIV services, including pre-test counseling, testing for HIV counseling and post-test counseling to give the result. For co-infected patients, additional messages on the relation between HIV and TB, the importance of cotrimoxazole prophylaxis and antiretroviral therapy will be given to the patients. They will also be screened for ARVs. Similarly, HIV+ patients using health care services will be systematically screened for HIV. If the screening is positive for at least one of the symptoms (presence of cough for more than three weeks, night sweats for three weeks or more, fever for more than 3 weeks, weight loss of more than 3 kilos in the month, recent contact with a TB patient) the patients will be oriented to a TB setting for diagnosis. A patient diagnosed for TB will be immediately treated for TB according to the national guidelines.*

### *Orphans & Vulnerable Children*

*The increasing incidence of trafficking in the region compounds the difficulty in service provision to populations. UNICEF reports that trafficking occurs in 33% of East and Southern African countries. Rwanda, Tanzania, the Democratic Republic of the Congo, and Uganda are Tier 2 countries for trafficking in persons. Burundi is listed on the Tier 2 Watch List for trafficking in persons along with Kenya. In Burundi, children are trafficked within the country and across borders for the purposes of child soldiering, domestic servitude, and commercial sexual exploitation. If rescued from being trafficked, many of these victims need medical and psychosocial care. The GOB provides little if any protective services to all categories of trafficking victims. Traffickers often prefer to take trafficked children across borders as they are most helpless where they have no legal status, family or friends, and poor abilities to communicate in the local language. To combat cross-border trafficking, a response along the transport corridors is vitally important. While the primary determinants of trafficking continue to be debated, the secondary determinants are quite clear: conflict, HIV/AIDS, low living standards, and the lack of public service and protection.*

*The USG provides a family-centered care approach using home-based care providers to identify and provide care and support for OVC. Through sub-grants and TA to local organizations, the USG plans to support 15,000 OVC with a needs-based package that includes psychosocial support, school and hygiene kits, and health-care and hospitalization assistance for those over 5 years of age (the GOB provides free health care for pregnant women and children under 5). The USG will continue to collaborate with other programs and donors, such as Food for Peace, the United National High Commission on Refugees (UNHCR), and UNICEF, to increase coverage and strengthen support for OVC activities, including in the policy areas of legal support and domestic violence reduction and mitigation (including trafficking).*

### *Public-Private Partnerships (PPP)*

*Discussions with local business organizations and leaders suggested that the private sector can be an additional source of funding and is willing to involve itself in AIDS and other health interventions. While the USG does not currently have a specific PPP in care and support for PLWHA, it will encourage the use of core competencies of the*

private sector to provide business skills and other support to vulnerable groups to establish small private companies along sound business lines. Business models will focus on generating employment by mobilizing and engaging the private sector to bring the public sector and communities together. This strategy primarily targets low income women and older OVCs selected through a community vetting process based both on need and motivation. It focuses on addressing three basic determinants of their vulnerability: unemployment, health status, and food insecurity. Thus it works to improve the outcomes of investments in treatment, prevention and care by providing adequate food to those on treatment, reducing multiple partners for low income women by facilitating alternative employment opportunities, and giving PLWHA, their families and care givers additional financial resources. The USG will collaborate with local businesses and will provide some initial seed capital and technical assistance for establishing companies and initiating enterprises.

At the present time, the USG has a PPP with Coca-Cola for the water/sanitation sector and a Development Credit Authority (DCA) agreement with a private bank to promote lending in the agriculture sector. In addition, the USG is negotiating two more PPPs: one with an insurance company to support HIV/AIDS programs (already described in the prevention TAN) and a second one with a commercial bank to support the Burundi malaria program. The USG believes there are many additional opportunities for PPPs with information technology companies, U.S. companies involved in the coffee sector, and suppliers of petroleum products. The USG in Burundi will remain in constant communication with those companies to track each opportunity. Opportunities to leverage private-sector resources are increasing rapidly as Burundi's role grows in the EAC.

#### Gender

Gender inequity and gender-based violence (GBV) heighten HIV risk across age and socio-economic groups. According to UNICEF's Situation Analysis of Children and Women in Burundi (2009), 19% of children had their sexual debut before age 10, 35% at ages 10-14, and 35% at ages 15-19. In 21% of cases, the partner was a parent or a family friend, and only 19% of those surveyed used condoms during their first sexual intercourse. One in five (19%) said that sexual violence had occurred in their school. Project data and anecdotal evidence suggest that other factors contributing to high-risk behavior include alcohol abuse and poverty. The area of greatest concern is GBV against women and girls. Additional sources revealed that in 2010, at least 2,330 rapes were committed in Burundi (note that only a small percentage of rapes are reported); more than 95% of survivors were women. A recent study (2010) by the Ministry of National Solidarity and Gender also noted 3,707 other cases of violence based on gender, of those that were reported. These gender-based rapes and acts of violence are usually committed at home, the workplace, school, or in the fields, according to the study which stated that perpetrators use "cunning, strength, weapons or abuse of authority".

Alcohol was identified by the community clusters (the USG community model for service delivery) as a serious, interrelated constraint to effective health activities.

The PEPFAR Program in Burundi has already identified GBV (especially sexual violence) as one of the potential key factors contributing to new HIV infections. The USG will work to increase the skills, resources, and capacity of cluster group members to address gender issues related to alcohol abuse. USG partners will initiate open community discussions on previously taboo subjects and will support local government and cluster group-led analyses of the extent and causes of GBV in the communities, offering TA to communities on innovative ideas addressing alcohol and GBV.

In the provinces where the PEPFAR program will expand, the USAID MCH program is currently implementing a best-practice intervention called "mamans lumières," which focuses on providing high-quality nutritional support to pregnant and lactating women. The MCH program also promotes BCC campaigns geared toward changing gender and social norms and behavior and promoting primary and secondary education for girls. In addition, the FP program is implementing activities in Muyinga for returning refugees. These activities are being evaluated to document how to improve GBV and FP services in post-conflict and emergency settings. The USG will work closely with these programs to integrate expanded PMTCT and other HIV/AIDS activities as appropriate (more details on GBV are detailed in the Governance and Prevention TAN).

### *Most -At -Risk Populations (MARPs)*

*The 2007 NAC survey showed that the HIV prevalence among sex workers (SWs) nationally is estimated at 38%, with higher prevalence in rural areas (46%) than in the capital, Bujumbura (29%), perhaps due to high mobility near borders with other high-prevalence countries. A Behavior Sentinel Surveillance focused on groups at high risk has been conducted and the results have been released in June 2011. The survey was focused on sex workers (SWs), men having sex with men, seasonal workers, prisoners, and uniformed services. The results of the survey are summarized below:*

*--The HIV prevalence in SWs is 19.80% (still very high but with significant decrease if compared to the NAC survey results). The average age of the first sexual intercourse is 16 years and the first paid sex is 20 years. The average time spent in the practice of prostitution is 5.8 years. The reasons of entry into prostitution are numerous but the most cited is the search for survival. Almost all sex workers (98%) practice vaginal intercourses. During the seven days preceding the survey, each sex workers received an average of 5.48 clients and the average payment was 7,049 Burundi francs (± US\$ 5). 71.2% of the sex workers reported having used condoms consistently in the last 30 days preceding the survey. Those who have not used it said among other things that the customers paid more to have unprotected sex. 71.3% of CSWs reported having already done the HIV test.*

*--The HIV prevalence in MSM is 2.40%. The average age of the first sexual intercourse is 14.6 years and the average age for the first sexual contact with a man is 16 years. 68% of MSM declared having received payment in cash or in nature after the first sexual contact with a man. On average, each MSM had 3.2 sexual partners during the last six months, 1.8 in the last 30 days and 0.9 sexual partners the last seven days. During their first sexual intercourse with a man, only 49.3% of MSMs used a condom and only 39.8% reported having already done the HIV test. Although not explicitly mentioned in the report, it appears that MSMs have also heterosexual intercourses.*

*--The HIV prevalence in seasonal workers is 1.4%. The group is made of people who leave their homes for some months in year and go to work in local factories. It also includes fishermen. The average age of the first sexual intercourse is 20 years. Only 5% of seasonal workers use condoms with regular partners; 49% use condom with commercial partners; and 36.2% use condoms with occasional partners. There are many reasons of not using condoms but the common one is that "it was not necessary to use it". 36.7% of seasonal workers reported having already done the HIV test.*

*--The HIV prevalence in prisoners is 3.0%. The average age of the first sexual intercourse is 18 years for women and 19 years for men. The majority of prisoners reported having no sexual partners. The use of condoms is not systematic for prisoners and 10% declared having used it systematically. 68.7% of men and 84.6% of women reported having already done the HIV test.*

*--The HIV prevalence in uniformed services is 0.4%. This group includes military and police. The average age of the first sexual intercourse is 23 years. During the last sexual intercourse with a regular partner, only 10.7% used the condom. For the last sexual intercourse with a commercial partner, the percentage reaches 52.9%. 90.5% of uniformed services declared having already done the HIV test.*

*To reduce sexual transmission of HIV, the GOB, other donors involved in HIV/AIDS, and PEPFAR partners/sub-partners will implement evidence-based communication and small-group/individual interpersonal interventions targeting the general population (including youth), military communities, and MARPs (especially SWs and truckers), with the balance among specific targets to be refined as a better understanding of the dynamics of HIV transmission emerges with the DHS. PEPFAR will also support the State Department's Voice of America activity to develop and broadcast programming promoting HIV prevention, testing, care, and stigma reduction.*

*Improved prevention services will also be fully integrated into clinical services, including PwP services and messages targeting discordant couples and clients who test HIV-negative. Activities will address underlying factors that contribute to HIV risk, including GBV, alcohol abuse, social and cultural norms, and family communication around reproductive health. Behavior Change Communications, peer education, and community mobilization by health workers, CHWs, and local organizations will help meet the following objectives:*

- Reducing high-risk behaviors in the general population (including youth) and among MARPs;*
- Increasing knowledge and awareness among high-risk groups of STIs and their interaction with HIV;*
- Increasing rates of correct and consistent condom use; and*
- Increasing demand for HTC and PMTCT services.*



*Reaching communities through youth, low-income women and PLWHA cluster group members is one approach that may be used to educate communities on the benefits of ITNs, and to distribute them to one of the most vulnerable populations to malaria: PLWHA. Cluster group volunteers will be trained to visit beneficiary households to demonstrate proper use and care of the nets with the goal of reducing household expenditure on malaria treatment. Interventions will also target transport workers, a group that reportedly suffers a high level of malaria morbidity that results in down time and added cost to transported goods.*

*A specific package for sex workers (SWs) has been already defined and includes:*

*Prevention services (STIs/HIV/AIDS) through IEC/BCC activities aimed at improving knowledge of SWs and reduction of their high risk behavior for HIV/STIs mainly:*

- *Training/retraining of peer educators for SWs;*
- *IEC/BCC services for groups of SWs;*
- *Distribution of prevention kits and condoms;*
- *Information/awareness on the rights of SWs.*

*Screening and treatment of STI/HIV/AIDS and OIs for SWs made of:*

- *Training providers to offer friendly services to SWs;*
- *Diagnosis and treatment of STIs for SWs;*
- *Voluntary HIV testing and delivery of results;*
- *ARV treatment and medical management of OIs;*
- *Promotion of reproductive health, family planning and PMTCT;*
- *STI treatment for partners of SWs.*

*Improving the socio economic situation of CSWs in Bujumbura and Rumonge cities and the outskirts through income generating activities (IGA) including:*

- *Organizational support, training management in IGA (Income Generating Activities), solidarity towards HIV positive SWs;*
- *Choice and support /assistance of SWs for the execution of the chosen IGA;*
- *Support vocational/professional training for CSWs.*

*PEPFAR will support the implementation of that package in its assisted areas.*

#### *Human Resources for Health (HRH)*

*Health care infrastructure and HRH are major barriers to access care and support services for PLWHAs. Burundi has one health facility per 12,700 residents and one hospital per 170,265 people (2008), with unequal distribution resulting in higher ratios and poorer access in rural areas. As already stated in the Governance and Systems TAN, Structural problems such as lack of motivation (low salaries and living conditions more difficult), staff turnover and lack of a plan for human resources development affect the health system. The workload burden coupled with scarce human resources directly affects the quality of health care delivered in those health facilities.*

*At the provincial and district levels, COP 2012 funding will support provincial health structures and strengthen CSOs to deliver services. USG assistance will be used to train provincial health directorates in supervision, quality assurance, and M&E of health services in their districts. Facility-based health providers will receive extensive in-service training (including refresher training for already-trained sites) in PMTCT, TC, prevention with positives (PwP), and prevention for discordant couples and for HIV-negative clients. In addition to the other activities proposed in the Governance and Systems TAN, PEPFAR believes that a decisive implication of the community level is critical in this area. The GOB is planning to strengthen the community health cadres already in place to improve and expand health services for the general population. Within the MOH, there is a Department of Health Promotion, Hygiene, and Sanitation in charge of community health cadres. One of the Department's mandates is to harmonize the work of community health workers country wide. Although the GOB is not planning to provide salaries to community workers, there is a common understanding among stakeholders that incentives of various kinds are important to consider. In that regard, the PEPFAR program will explore in close collaboration with the MOH and other donors, ways of incorporating the CHWs into the PBF scheme. Currently this is only occurring at the health center and hospital level, but there is a strong belief that the CHWs need incentives to perform their work well. The program will work closely with the Ministry of Public Health and Fight against AIDS to further define the*



role of the community health worker and to develop methods to sustain CHWs and to reduce attrition. While the PEPFAR program is planning to continue existing investments in BCC, it will be open to innovative approaches as scale-up continues. A particular emphasis will be brought to:

- Strengthening cross-referral relationships between community workers and local health facilities. If people who need care and support services at the facility level are not seen at the planned time, CHWs will systematically follow-up;
- Minimizing delayed care seeking by providing community cadres with adequate training and low-literacy messaging materials to promote discussion and action around the importance of seeking timely assistance;
- Supporting community health cadres in changing social norms and promoting healthy behaviors such as encouraging men to engage in the process of partner HTC and seeking care for members of their families. Furthermore, community workers will be critical in promoting new perspectives that reduce stigma and discrimination towards PLWHA;
- In consultation with the Department of Health Promotion, Hygiene, and Sanitation, the PMTCT program will strengthen the health promotion technician position to correctly oversee the work of CHWs.

#### Laboratory

The laboratory system in Burundi is structured on three levels (health center, district, and national laboratories) with the district laboratory serving as a referral center for all the health center laboratories within the district. The health center laboratories perform a limited number of tests including HIV testing. In addition to the tests performed at the health center level, district hospital laboratories perform more sophisticated testing such as hematology, biochemistry, serology, and CD4 cell counts (see the bulleted information below). The central level is mainly comprised of third level laboratories based in Bujumbura, including the National Institute of Public Health and the University Hospital Laboratory based in Bujumbura. They perform more sophisticated tests (including early infant diagnosis and viral load) and are the reference laboratories for the whole country. One of the crucial challenges for the laboratory sector is that the network is not functional due to the absence of accreditation, quality assurance, and the current functionality of all laboratories at different levels is unknown. The national reference laboratory of the National Institute of Public Health which is responsible for managing the most complicated cases lacks 1) equipment, materials, reagents, and consumables for tests; 2) qualified personnel for certain examinations; and 3) quality control for almost all tests (except for TB). In addition, maintenance-related weaknesses seriously affect the performance of the laboratory. To strengthen HIV/AIDS services the PEPFAR supported minimum package of laboratory services will include:

- Provincial/National Level: CD4 and EID + district level package;
- District Level: CD4, HIV rapid testing kits, liver function test/biochemistry, hematology, reagents, microscope; and
- Health Center Level: Rapid HIV testing.

To reinforce the laboratory system, the following activities will be implemented:

- Trainings for capacity strengthening of laboratory technicians in HIV testing and use of CD4 cell count machines;
- Encouraging supervision and mentoring of laboratory technicians at the health center level by their peers from the district level;
- Building on an initial supply chain management report resulting from a SCMS technical assessment visit planned in November 2011, an assessment of the laboratory system will be conducted. The laboratory assessment will also draw from a review of the national laboratory system conducted through the USG Malaria program to ensure no duplication of effort;
- Standardizing laboratory policies, quality assurance mechanisms, and trainings will be performed where necessary;
- Establishing a sample referral and result distribution between the different levels. This will contribute to reduce missed opportunities.
- Supplying reference laboratories with equipment and reagents for biological follow-up including hematology and biochemistry for HIV+ pregnant women and people under ART.



### *Strategic Information*

*The GOB's M&E framework needs strengthening to track progress and gaps in the HIV/AIDS and health sectors. The USG Burundi will continue to support the capacity of the GOB provincial and district teams and local partners to report consistently and accurately on national indicators. Funds will contribute to Burundi's ongoing health-sector reforms through support for the implementation of PBF to improve public health services, including those delivering HIV/AIDS services. PEPFAR will provide support for achievement of seven indicators in the PBF: number of HIV-positive pregnant women provided with antiretroviral (ARV) prophylaxis; number of newborns from HIV-positive mothers provided follow-up care; number of people tested for HIV; number of new patients provided ART; number of ART patients monitored semi-annually; number of cases of sexually transmitted infection (STI) treated; and number of circumcisions. Additionally, a gap in the current PBF system is the lack of community based indicators which are essential for supporting HIV care and support and prevention interventions. The USG will be discussing with the GOB and other stakeholders about developing community based PBF indicators.*

*At the provincial and district levels, COP 2012 funding will support provincial health structures and strengthen CSOs to deliver and monitor services. USG assistance will continue to train provincial health directorates in supervision, quality assurance, and M&E of health services in their districts. Facility-based health providers will receive extensive in-service training (including refresher training for already-trained sites) in PMTCT, HTC, PwP, and prevention for discordant couples and for HIV-negative clients.*

*The USG will continue to collaborate with the GOB and the Belgian Technical Cooperation to implement the HIV/AIDS portion of the national HMIS, which will monitor ongoing programs and help provide an evidence base to inform program planning. USG technical assistance will support the standardization and harmonization of donor and national HIV/AIDS indicators, and support policy work focusing on developing, updating, and implementing national policies on GBV, human-rights protection (e.g. addressing current laws making homosexual practice illegal), and task shifting to allow ARV prescription by nurses. Specific discussions on how the GOB will increase its contribution to strategic information have not yet occurred but will be included in the Partnership Framework discussion agenda. The information developed in the Governance and Systems TAN also applies here.*

### *Capacity Building Situation*

*Situation analyses in communities concluded that there were dozens of indigenous, predominantly informal groups in each community working on a wide range of important health /HIV/AIDS aspects. However, they seldom collaborated, even while working on the same issue. The USG plans to work with community-based groups with similar interests to build their capacity to provide care and support services, as well as to train them in how to address stigma/discrimination, HIV prevention behavior change, counseling and testing, violence against women/girls, and leadership and conflict resolution skills.*

*To mobilize communities, the USG will continue to implement the cluster model of engaging existing community-based groups of low income women, vulnerable youth, PLWHA, and caregivers and orphans. The clusters have demonstrated effectiveness, building on local initiatives and creating community cohesion and ownership. More than 90% of the cluster member groups are participating in donor-funded activities for the first time and the USG found Magnet theatres to be potentially effective in conveying messages on key issues such as stigma and discrimination, HIV prevention, alcoholism, and GBV. The cluster concept is also unique in the sense that it is based on voluntarism and enhances sustainability.*

*To build civil-society capacity, the USG will continue to support sub-grants and technical assistance to local organizations, including the RBP+, to build their organizational, financial, programmatic, and technical competence to deliver high-quality services and enable them to "graduate" to USG prime-partner status over the next five years. The USG believes that this approach will enhance the dynamic collaboration among the USG, GOB, other health sector donors, and partners to build a more sustainable approach to decentralized care and support in Burundi.*

*PEPFAR funding will support local organizations to expand basic care and support services for PLWHA and OVCs.*



Home-based care will be provided to 11,100 individuals, including monthly psychosocial support visits provided through CHWs and/or members of RBP+.

#### Technical Area: Governance and Systems

Budget Code	Budget Code Planned Amount	On Hold Amount
HVSI	1,005,193	0
OHSS	3,480,169	0
<b>Total Technical Area Planned Funding:</b>	<b>4,485,362</b>	<b>0</b>

#### Summary:

##### Introduction

Burundi is a low-income developing country that ranks 185 out of 187 in the Human Development Index (UNDP 2011 Human Development Report) and, with a population of 8.7 million, has the second-highest population density in sub-Saharan Africa. Burundi remains one of the poorest countries in the world. Its per capita gross national income (GNI) in 2011 was \$368 (source: UNDP 2011 HDI). Burundi is also one of the world's 40 "Heavily Indebted Poor Countries (HIPC)" – defined as developing countries with high levels of poverty (68% in Burundi) and substantial foreign and domestic debt overhang. A 13-year ethnic crisis killed 300,000 people and severely weakened health and social-welfare systems and diminished donor support for Burundi. The crisis ended with the Arusha Peace Accord in 2000, and Burundi recently completed its second set of democratic elections. However, the country continues its struggle to recover from the effects of massive displacement, social disruption, and ethnic and gender-based violence. Economic activity and government services have been recovering gradually, but unlike in neighboring Rwanda, Burundi's HIV/AIDS epidemic has been largely neglected by international donors.

The disease burden is dominated by infectious and communicable diseases, primarily HIV/AIDS, malaria and diarrhea. Respiratory tract infections, malaria, and waterborne diseases; particularly diarrhea, remain the main causes of death in children under five years of age. In adults, AIDS is among the leading causes of death - although, given the stigma attached, it is likely under-reported. In addition, chronic and non-communicable diseases, such as malnutrition, high blood pressure, diabetes and mental illness, also factor into the overall health morbidity and mortality rates. Burundi faces a low-prevalence generalized HIV/AIDS epidemic that continues to be a priority public health threat. National health information systems are weak and provide little reliable recent data on HIV/AIDS. Recent studies include a national HIV survey conducted by the National AIDS Council (NAC) in 2007, and older studies by UNAIDS and the World Bank. The most recent Demographic and Health Survey (DHS) was conducted in 1987; data collection for a new DHS began in September 2010. Preliminary results were published late 2011 and final ones are expected early 2012. With an annual population growth rate estimated at 2.4 %, Burundi's demographic profile reflects a large and growing "youth" bulge. According to GOB statistics, 45% of the population is under the age of 25, and the median age is 17 years. Life expectancy is 46 years for men and 51.8 years for women.

Health care infrastructure and human resources for health (HRH) are major barriers to health and HIV care access. Burundi has one health facility per 12,700 residents and one hospital per 170,265 people (2008), with unequal distribution resulting in higher ratios and poorer access in rural areas. The workload burden coupled with scarce human resources directly affects the quality of health care delivered in those health facilities. The Burundian health system is still facing significant challenges. Some of them are: (1) scarcity and low motivation of health professionals; (2) financial barriers to accessing health care; (3) poor quality of health services; (4) poor access to essential medicines throughout the country; and (5) weak health information system. To deal with the different challenges, Burundi developed the National Health Development Plan 2011-2015, and set the following priorities: (1) improving the health of the mother and the child; (2) fighting



*against communicable and non communicable diseases; (3) strengthening the fight against HIV/AIDS using a multi-sector approach; (4) increasing the demand for health care; (5) strengthening the health system through strategic orientations modeled on the six pillars; and (6) mitigating population growth. One of the four goals of the Burundi Health Development Plan is to enhance the performance of the national health system. PEPFAR supports this goal, since strengthening the system will improve the quality of all health services, including clinical and community HIV/AIDS services. A health district approach is part of the GOB strategy for quality decentralized health services, and the formation of health district teams is underway. An objective of the health district, which is under the supervision of the provincial directorate, is to place the patient at the center of the health system. This will be achieved through the creation of new geographic operational health entities which will be more manageable than the current system for health facilities and community health workers (CHWs).*

*The COP 2012 will prioritize support for this GOB approach. With COP 2012 funds, the USG will provide technical assistance at the central level for institutional capacity building of the MOHA's HIV/AIDS division to improve its ability to provide supervision, quality assurance, monitoring and evaluation (M&E), and training at the provincial level. In addition, technical assistance will be provided to the central pharmacy (CAMEBU) to implement a comprehensive assessment of the national supply-chain system. Capacity building will strengthen CAMEBU forecasting and monitoring of essential HIV/AIDS commodities, including products procured by other donors, allowing the GOB to own the procurement process and remain accountable for commodities brought into the country.*

#### *Global Health Initiative*

*Burundi was identified within the second wave of GHI countries to prepare and submit a GHI Country Strategy by June 2011. The GHI strategy document was approved by the GHI Operations Committee in late September 2011. GHI's objective in Burundi is to reduce neonatal, child and maternal morbidity/ mortality and reduce the incidence of major communicable diseases. This is in line with the GOB's health goal, in its National Health Development Plan 2011-2015, which states that: "By 2015 all Burundian citizens will have increased access to basic health care through strengthened leadership of the Ministry of Public Health and individual and community participation." Accordingly, through the GHI strategy, the USG will continue to build on the successes achieved and lessons learned thus far in Burundi and globally to support GOB priorities in maternal, newborn and child health (MNCH), reproductive health (RH)/family planning (FP), malaria, and HIV/AIDS over the next 5 years.*

*The USG will achieve this through investments and activities that seek to achieve three interrelated results: (1) strengthened health management information systems; (2) improved behavior and demand for health services; and, (3) improved quality of health services. These areas were identified based on GOB and USG health priorities, available resources, and key opportunities for USG leveraging and expected impact. The USG in Burundi will make a concentrated effort to leverage its resources and harmonize its efforts to attain greater impact. The USG will also, through its modest health resources, work in partnership with GOB, other donors, the private sector, civil society and community actors to achieve these objectives. This includes close coordination among USG health teams and other health partners to increase efficiencies, with a particular focus on jointly identified cross-cutting areas. The PEPFAR program strongly supports the GHI principles. Below are some concrete examples that demonstrate how PEPFAR in coordination with other USG programs is attempting to meet some key GHI principles to address the GOB health priorities.*

*The USG Burundi team, working in collaboration with the Burundian government, has supported integrated health service delivery at health centers where USG programs overlap. The USAID malaria, MCH, Food for Peace (FFP), and HIV/AIDS teams are actively seeking to synergize target populations at the provincial level to integrate bed nets and nutritional support as components of the expanding USG-supported home-based care program. With this approach, the link between ANC services and PMTCT has been very effective. The same link exists between the MCH and the malaria program via routine distribution of bed nets to vaccinated children and pregnant women. The MCH program is training CHWs in Community-IMCI and the malaria program takes advantage of the platform to introduce community-based delivery of first line treatment of malaria for children under five. Through GHI, the USG Burundi team will continue to explore opportunities for integration.*



### *Leadership and Governance and Capacity Building*

*The institutional framework for the fight against AIDS in Burundi places the response to HIV/AIDS at the highest level of the country. The Presidency of the Republic and the President of the Republic is also the President of the National AIDS Council (NAC). The mandate of the NAC is to set the guidelines for the national policy to fight against AIDS in line with the needs of the country. Under the NAC, there is the MOH which provides the administrative supervision of the Permanent Executive Secretariat (PES) of the NAC by "delegation" of the Presidency of the Republic. The PES/NAC is responsible for the technical coordination of the implementation of the national HIV/AIDS Strategic Plan. The other national entities in charge of the HIV response are the sector units in charge of the fight against AIDS located in each ministry. They are responsible for the implementation of the sectoral HIV action plan. At the provincial, communal, and local levels, the government has established respectively provincial committees, communal committees, and local committees in charge of the AIDS response at the decentralized level. In early 2011 and with the technical assistance provided by PEPFAR and other donors, the NAC conducted a review of the national strategic plan to fight AIDS (2007-2011) which resulted in a new Strategic Plan for 2011-2015. The latter inspired the new Health Development Plan 2011-2015 prepared by the MOH and its partners. The National Health Development Plan itself draws from the National Poverty Reduction Strategy Paper and the Vision 2025 for Burundi.*

*The Global Fund (GF) is the largest donor in the fight against HIV/AIDS in Burundi. The grants provided by the GF (Round 8- HIV/AIDS) are managed by two local Principal Recipients which are the National AIDS Council (NAC) for the public sector and RBP+ (Burundian network for people living with HIV/AIDS) for the civil society organizations. The Country Coordinating Mechanism (CCM) in Burundi is a non-profit organization legally established in Burundi. Its main role is to set specific guidelines on the use of resources made available to Burundi by the GF. More specifically, the CCM is responsible for: (1) harmonization of GF grants with other resources; (2) development and monitoring of the management of GF proposals; (3) monitoring and evaluation of the grants and the management by the principal recipients; and (4) documentation and communication on the Global Fund activities in the country. In addition, the Partnership Framework for Health and Development led by the MOH is in charge of coordinating all health activities including HIV/AIDS. The health division in charge of HIV/AIDS is the lead institution in the area of the preparation of policies, norms and standards related to prevention and treatment of AIDS. The public, private, and faith-based organizations are providing HIV/AIDS services to the population in need. PEPFAR supported technical assistance to the CCM for the reform process including updating the procedural manual, the internal regulations, and statute documents of the CCM.*

*Early 2011, PEPFAR Burundi completed an assessment to identify the capacity building needs of six local civil society organizations (CSOs) that are working in the HIV/AIDS sector in Burundi. The assessment covered three broad areas of organizational capacity and competence: management and governance; finance and administration; and technical service delivery. The purpose of the assessment was to use the recommendations for targeted interventions to strengthen corporate governance and reinforce service delivery. The ultimate goal is to provide technical assistance to those organizations in order for them to be upgraded to prime partners' status for HIV/AIDS grants in the future.*

*The NAC in coordination with the donors involved in the HIV/AIDS sector has established a monitoring and evaluation framework which will allow progress tracking of the results over time. During the implementation of the activities, regular joint site visits are performed to ensure that the services reach those who need them. Regular coordination meetings will be organized among stakeholders. To gauge the quality of health services, discussions with the direct beneficiaries will be conducted. If the Government of Burundi and PEPFAR develop a Partnership Framework Agreement (PF), critical elements related to reinforcing accountability will be discussed and included in the PF. A tracking system will ensure that progress is being achieved. For increased efficiency, discussions between the two partners on the specific roles and responsibilities of each actor will be organized.*

### *Strategic information*

*Health partners and the MOH in Burundi recognize that the health information system (HMIS) is still weak. The*



MOH does not have a central unit in charge of monitoring and evaluation (M&E). The division in charge of health statistics is responsible for the collection and analysis of epidemiological information but a substantial part of data needed for M&E is still housed in the various services and health programs. The M&E division, which has extremely limited resources, does not collect a significant amount of information regarding health services. For example, data on human resources, materials/supplies, financial services, and health services are collected by the Directorate General of Resources. As an integral part of its coordination efforts, the MOH established a thematic group in charge of M&E to reflect on how to improve the overall situation including the health information system. PEPFAR/Burundi is a member of the thematic group. A recent evaluation of the M&E system in Burundi demonstrated that data collection is occurring in parallel because systems are vertical with each program tracking its own indicators. There are weak human resources and research capacity to generate and use information once gathered. Use of data for decision making is almost insufficient. Finally, HIV/AIDS related data is not yet fully integrated into the national HMIS. In the area of HIV surveillance, specific surveys such as ante-natal clinic (ANC), bio-behavioral survey among MARPs (2010) and a 2010 Demographic and Health Survey (DHS) were conducted to inform programming. PEPFAR will support the ANC surveillance survey and other relevant studies to be undertaken by the MOH. Through the PMTCT Acceleration Plan and COP 12, funding support is programmed to conduct other surveys necessary to inform the situation.

The USG will build on its work already underway through the Malaria, PEPFAR and MCH programs to further strengthen the national HMIS and lay a solid and sustainable foundation in Burundi. Its efforts will first and foremost focus on building national capacity through the transfer of skills to Burundians and their institutions. In addition, the USG will strengthen its work with other donors, especially the Belgian Technical Cooperation, to identify complementary efforts to help the GOB put in place a functioning HMIS with harmonized, realistic and measurable indicators, and help standardize data collection tools and approaches. The USG will build the national capacity at all levels for data quality assessment, analysis and use. It will assist the GOB to strengthen community-level HMIS including data collection and reporting, and promote and improve the feedback system. The use of strategic information for decision-making will be promoted. Through its MCH program, the USG will continue its support in training the health district teams in the USG-supported provinces in management of health information especially improving the use of the HMIS software (GESIS). Through Measure Evaluation and in close collaboration with the Belgian Technical Cooperation, the USG will identify gaps in the HMIS area and will propose specific actions to address them. Given the importance of tracking all gender-related aspects and for better programming, HMIS support will also be a critical monitoring and implementation tool. The PEPFAR program will strengthen its relationship with other organizations involved in strategic information such as UNAIDS, WHO, and UNICEF in order to take advantage of available data and to jointly identify gaps in strategic information.

#### *Service Delivery*

A continuum of response implies that despite the entry point, each beneficiary will be able to benefit from all other services he/she needs regardless of the status of the institution which is providing them. For example, if a person tests HIV positive, the required services for them will be made available. This includes but not limited to (1) a possibility of having CD4 cell count to see if there is an indication of ART and once screened receiving ART treatment; (2) a possibility of accessing biological follow-up; (3) access to prevention of opportunistic infections by cotrimoxazole; (4) access to FP services as needed; and many other health and social services not necessarily related to HIV/AIDS. More specifically, the GOB and PEPFAR will strengthen the referral system between PMTCT services and the regular ART program. A national reference protocol between the two services will be established and coordinated. The medical teams will ensure that all mothers and HIV infected children will be integrated into regular ART services after leaving the PMTCT program. This will be implemented through information channels that will be established by the national division in charge of HIV/AIDS by establishing networks of prescribing physicians, meetings, quality assurance and supportive supervision, review of medical records, and mentoring by senior doctors. The CHWs, the health mediators, the nurses, and all health professionals in general will be instrumental in supporting this referral system. The foundation of the continuum of the response will be based on the GF program which is funding most of the ARVs used in the ART program. All these efforts will be sustained if the Burundian health system is strengthened to provide integrated services. For that purpose, the pillars of a health system like Laboratory, SCMS, HRH, Quality Improvement and Supportive Supervision, and SI, Surveillance and



*M&E will be reinforced. To make sure that services are functional at a high level, quality improvement activities will be implemented in the various sites by an expert organization identified by the USG team.*

#### *Human Resources for Health*

*It is recognized that the lack of HRH as well as unequal distribution to the detriment of rural areas remains one of the characteristics of the health system in Burundi.*

*The total number of 15,941 medical officers is split among 5,957 nurses, 418 doctors and trainees, 16 midwives, and 827 other paramedical staff trained and 8,739 other staff.*

*Regarding physicians, the overall ratio for the whole country is one doctor per 19,231 inhabitants while the standard WHO recommends a ratio of one doctor per 10,000 inhabitants, Burundi is very distant from that reality. The ratio of nurses per capita is satisfactory with one nurse for 1,349 inhabitants (the WHO standard is one nurse for 3,000 inhabitants).*

*Burundi is also facing an acute shortage of midwives (only one midwife for 124,312 women of reproductive age). Note that more than 50.5% of physicians and 21% of nurses are concentrated in Bujumbura (source: PNDS II 2011-2015) which has a population of less than 10% of the total. Structural problems such as lack of motivation (low salaries and poor living conditions), staff turnover and lack of a plan for human resources development seem also to affect the health system. Following the multiple claims, the GOB revised upwards the salaries of health personnel.*

*Recently, the GOB began a process of redeploying staff to areas in critical need. Although this is not likely to improve the situation completely, it is a signal that the GOB is willing to deal with formidable challenges. During the development of the Health Development Plan 2011-2015, performance based financing (PBF) was identified as the vehicle to continue support for the motivation and stabilization of health personnel. There are several advantages of PBF because it can support disadvantaged or remote areas by offering a bonus of equity. It allows for the recruitment of health providers to key positions that could not be filled under salaries offered by the Civil Service. In addition to financial motivation, the encouragement to healthcare facilities to develop their own plan is an additional source of motivation and the basis of capacity building of national structures. The assessments completed on PBF show very positive results in the improvement of health indicators and in motivation and stabilization of health personnel.*

*PEPFAR decided to support this initiative and has financed six PBF indicators related to HIV/AIDS in COP 2011. In FY 2012, PEPFAR will finance seven indicators related to HIV/AIDS in the four provinces supported by PEPFAR. In the PMTCT Acceleration program, PBF will also support two indicators directly linked to PMTCT services. In that regard, the implementation of activities related to the main axes of the policy of human resource development will constitute a solid foundation. Those axes are: 1) enhancing the production of human resources with the required qualifications for a better functioning of health services; 2) developing career plans for all staff; 3) improving the distribution of health professionals in different geographical areas of the country; 4) improving staff motivation; and 5) effectively decentralizing the management of human resources. While the above activities are mainly the responsibility of the GOB, specific support from PEPFAR will include:*

- Maintaining the training of health providers and CHW. Training modules in HIV prevention will include: the HIV/AIDS epidemiological situation globally and in Burundi; the pathology of HIV/AIDS; how HIV is transmitted from mother to infant; how to provide HTC; specific interventions for PMTCT (including the national protocol for clinical services); infant and child nutrition in the context of HIV infection; stigma and discrimination linked to HIV; mother-child follow-up; support for PLWHA (including sexual prevention, FP, and partner reduction); and prevention of counselor burnout. Other training modules will include specifics related to ART and care and support for PLWHA.*
- Promoting the use of the task shifting approach, especially for the prescription of ARV for PMTCT prophylaxis and for ART.*
- Providing assistance in the development of the required national documents and guidelines.*
- Assessing the health curriculum in developing a SOW for an evaluation of the current health provider training curriculum. The assessment will show which level of health providers are most needed and work to train individuals in these areas. All the trainings will meet global standards.*



PEPFAR Burundi recognizes that having enough health providers in each healthcare facility is critical to improve the health of mothers and children. For that purpose, it will be increasing the number of health providers through PPPs, public, private, and faith-based organizations wherever possible. PEPFAR Burundi is aware that it has to contribute to the mandatory requirement of at least 116 new health providers by 2014. It is exploring ways to achieve this. Among others, it is in the process of discussing with some local training institutions (National Reference Center for AIDS (CNR) and the Medical Faculty in Bujumbura) to identify gaps in training curriculum related to HIV prevention, treatment, care and support. PEPFAR is planning to support the production of new healthcare workers through the pre-service training approach.

PEPFAR believes that empowering the pre-graduate nurses with HIV/AIDS knowledge will allow them easy prescription of ARVs when they start working. It is already exploring ways to work with the Ministry of Public Health and Fight against AIDS to include and support the inclusion of an HIV/AIDS module for all the pre-graduates of nursing schools. This approach will allow the Ministry to have more than 116 new health providers each year that are ready to provide HIV/AIDS services. PEPFAR will also work with the government to reallocate funding to meet HRH objectives. This will also be raised with the government as part of the Partnership Framework to discuss what changes are necessary to have enough health providers to manage an expanded HIV/AIDS program as well as other health programs.

#### Laboratory Strengthening

The laboratory system in Burundi is spread throughout the various health facility levels. The health center laboratories perform a limited number of tests including HIV testing. In addition to the tests performed at the health center level, district hospital laboratories can perform more sophisticated testing such as hematology, biochemistry, serology, and CD4 cell counts. The district laboratories serve as reference laboratories for the health center laboratories. The central level is mainly comprised of third level laboratories based in Bujumbura, including the National Institute of Public Health and the University Hospital Laboratory based in Bujumbura. They perform more sophisticated tests and are the reference labs for the whole country. One of the crucial challenges for the laboratory sector is that the network is not functional due to the absence of accreditation, quality assurance, and the current functionality of all laboratories at different levels. The national reference laboratory of the National Institute of Public Health, which is responsible for managing the most complicated cases, lacks 1) equipment, materials, 2) reagents and consumables for tests, 3) qualified personnel for certain examinations, and 4) quality control for almost all tests (except for TB). In addition, maintenance-related weaknesses affect seriously the performance of the laboratory. To strengthen HIV/AIDS services, the PEPFAR supported minimum package of laboratory services will include:

- Provincial/National Level: CD4 and EID + district level package;
- District Level: CD4, HIV rapid testing kits, liver function test/biochemistry, hematology, reagents, microscope; and
- Health Center Level: Rapid HIV testing.

To reinforce the laboratory system, the following activities will be implemented:

- Training for capacity strengthening of laboratory technicians in HIV testing and use of CD4 cell count machines;
- Encouraging supervision and mentoring of laboratory technicians at the health center level by their peers from the district level;
- Building on an initial supply chain management report resulting from a SCMS technical assessment visit planned in November 2011, an assessment of the laboratory system will be conducted. The laboratory assessment will also draw from a review of the national laboratory system conducted through the USG Malaria program to ensure no duplication of effort;
- Standardizing laboratory policies, quality assurance mechanisms, and trainings will be performed where necessary;
- Establishing a sample referral and result distribution between the different levels. This will contribute to reduce missed opportunities.
- Supplying reference laboratories with equipment and reagents for biological follow-up including hematology and biochemistry for HIV+ pregnant women and people under ART.

### *Health Efficiency and Financing*

*According to the most recent national health accounts (2007) the total expenses for health was 147,115,839,630 Burundi francs (\$ 122,596,533). Of this, the public health expenditures represent 17%; direct household payments (37%), life insurance (6%) and the international aid (including USG) 40%. The per capita spending was \$ 17.4 (WHO norm is \$34). This represents 13.8% of the Growth National Product (\$ 126 per capita). The percentage of the national budget allocated to health was 7% in 2011. The absorption capacity of the budget is appreciable because it represents 61%, 81%, 83% and 61% respectively for staff salaries, drugs and services, investment and operations. The high contribution of households in financing health care limits their access to care especially for the poorest households which have little to no disposable income. In 2006, the GOB decided to grant free health care for children under 5 and pregnant women, however, these measures are costly.*

*Available forms of insurance such as private insurance and mutual health insurance represent a marginal contribution as they cover a small proportion of the population. As it is noticeable in the analysis of the national health accounts, the external contribution to health is still important. Unfortunately, this support is not predictable and can even stop without any advance notice. While the USG does not directly support the GOB budget, it will use other means to support them by:*

- Collaborating with other donors to support free access to all HIV/AIDS services including HIV testing, treatment, care and support;*
- Prioritizing cost-effective interventions in its programming;*
- Supporting the HIV/AIDS related indicators through PBF, to contribute to the Burundian Health System financing;*
- Participating in different forums where health financing is discussed such as the Partnership Framework for Health and Development and the Health Financing Thematic Group established within the MOH;*
- Promoting cost-efficient oriented approaches such as pooled purchases of commodities, and conducting cost estimates and expenditure analysis that will help to inform future programming.*

### *Supply Chain and Logistics*

*The Directorate of Pharmacies, Medicines, and Laboratories (DPML) is the division of the MOHA charged with the responsibility of providing oversight to the pharmaceutical sector. The DPML oversees the central purchasing and warehousing agency: CAMEBU. In principal, procurement and management of all public sector pharmaceuticals destined for public health facilities (both government and faith-based) is the responsibility of CAMEBU.*

*Occasionally, public and private facilities purchase supplies and drugs from the private sector, despite no provision existing for quality control of drugs purchased through the private sector route. Quantification of pharmaceutical supplies appears to be based more on districts' requests rather than any prior forecasting or planning by the DPML or CAMEBU. Health center staff collects supplies from the district-level, paying by cash or credit. Orders are generally requested for a three-month period to cover district and health center needs. In the future, with donor support, CAMEBU plans to establish an on-line computerized system for submitting orders. In addition to CAMEBU, the Permanent Executive Secretariat of the NAC oversees the quantification and identification of ARV needs for Burundi. Almost all ARVs in Burundi are procured by the GOB with funds provided by the GF. Under decentralization, each health district is responsible for the management of health commodities and each health district pharmacy supplies health centers and hospitals. For HIV/AIDS related products, district pharmacies collect the consumption and needs data from the health centers and hospitals, which they then send to CAMEBU for replenishment of the district stocks. In addition to the purchases made by the NAC, partners use other channels to procure health commodities for health facilities. Coordination and efficient use of resources remain persistent challenges among stakeholders in Burundi.*

*Currently, the USG does not buy ARVs but does procure diagnostic equipment, HIV rapid test kits, and laboratory reagents for clinical monitoring of people living with HIV/AIDS. With FY 2012 COP funding, the USG will purchase a limited number of ARVs for PMTCT, post-exposure prophylaxis, cotrimoxazole, drugs for treatment of sexually transmitted infections, and other products for PLWHA through a USG implementing partner. Given the deficiencies of the national supply chain system, the products are still procured and managed through a separate system. In*



November 2011 the first part of a supply chain assessment was conducted by SCMS to better understand the situation related to procurement and supply chain and to provide practical recommendations on how to improve the national supply chain system. PEPFAR activities will leverage the existing technical support provided by PMI as well as international development partners such as DFID, which has invested in reducing facility-level stock outs of tracer products. The goal for the USG is to support and then work through the Burundi national supply chain system for a more sustainable response.

#### Gender

Gender inequity and gender-based violence (GBV) heighten risk across age and socio-economic groups. The USG conducted a Health Sector Assessment on November 2009 which took gender issues into consideration. Women and girls represent the large portion (more than 60%) of beneficiaries of USG assistance. The area of greatest concern is sexual GBV against women and girls. Some sources revealed that in 2010, at least 2,330 rapes were committed in Burundi; more than 95% of survivors were female. A recent study (2010) conducted by the Ministry of National Solidarity and Gender also noted 3,707 other cases of violence based on gender. These gender-based rapes and acts of violence are usually committed at home, the workplace, school, or in the fields, according to the study which stated that perpetrators use "cunning, strength, weapons or abuse of authority". To understand more deeply the problem of sexual violence, the USG through its PEPFAR program conducted a Sexual Violence Assessment in 2011 to inform future programming. Two key findings from the assessment are stated below:

- Burundi's discriminatory legislation, stereotypes and prejudice against women all contribute to attitudes that value girls less than boys, impede girls' education, and also put women in a secondary position within their homes. They also contribute to the exclusion of women from inheriting land and obtaining jobs, and participating in decision making at all levels. This deeply entrenched gender inequality has provided an enabling environment for high levels of sexual violence. The civil war in Burundi exacerbated this violence, which continues today, with near total impunity.
- Data on the prevalence of sexual violence are available, but not collected in a coherent and coordinated manner. There is also significant underreporting of violence due to a number of factors. First, discussion about sex is taboo in Burundian society. As sex is not talked about, neither is sexual violence. Second, stigmatization of the victim can lead to her exclusion from her family home. As well, the acceptance and normalization of the crime, the ignorance of the fact that sexual violence is a crime, the lack of victim protection, the lack of access to legal services, the distrust of the police and negative attitudes from service providers in general discourage victims from denouncing the crime. Widespread impunity discourages women to trust and use the legal system.

Regarding access to health services, women and girls will remain the primary targets of all USG efforts in the health sector in Burundi. Under the MCH, FFP, malaria and HIV/AIDS programs, the USG will support a package of services to respond to the special needs of women and children. Recognizing the critical role men play in household decision making, the USG programs will target men to serve as role models in community-level health activities to promote key health practices. In the HIV/AIDS sector, the USG also targets men (the military), and their families for prevention and treatment services. Furthermore, the USG programs ensure gender equality in training opportunities and promote male participation alongside those of women. PEPFAR will promote other gender-related activities such as:

- Ensuring gender equity in selecting the beneficiaries of various trainings;
- Ensuring that the recruitment process of new employees takes into account gender;
- Supporting income generating activities for vulnerable groups of women;
- Working in concert with the GOB and other partners to increase gender equity in the health sector;
- Contributing to the second gender assessment planned by the USG in 2012;
- Developing BCC initiatives to dismantle gender stereotypes and prejudices;
- Advocate with senior-level policymakers to take a stand against gender discrimination and GBV; and

In order to ensure that USG assistance contributes optimally to gender equality, performance management systems and evaluations at the program level will include gender-sensitive indicators and sex-disaggregated data. When reporting on GHI and PEPFAR, quantitative indicators will be disaggregated by sex and gender-related narratives will be used to demonstrate how gender particularities are taken into consideration in the programming and



implementation stages.

#### Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	2,015,249	0
<b>Total Technical Area Planned Funding:</b>	<b>2,015,249</b>	<b>0</b>

#### Summary:

(No data provided.)

#### Technical Area: Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
HVAB	750,064	0
HVCT	1,171,475	0
HVOP	3,728,492	0
MTCT	2,906,618	0
<b>Total Technical Area Planned Funding:</b>	<b>8,556,649</b>	<b>0</b>

#### Summary:

##### *Epidemic Overview*

*In Burundi, the burden of disease is dominated by infectious and communicable diseases, primarily HIV/AIDS, malaria and diarrhea. However, chronic and non-communicable diseases such as high blood pressure, diabetes and mental illness also factor into the overall health morbidity and mortality rates in Burundi. Respiratory tract infections, malaria, and waterborne diseases, particularly diarrhea, remain the main causes of death in children under five years of age. In adults, AIDS is among the leading causes of death (although, given the stigma attached, it is likely under-reported). Burundi faces a low-prevalence generalized HIV/AIDS epidemic, which continues to be a growing priority public health threat. National health information systems are weak and provide little reliable recent data on HIV/AIDS. The most recent Demographic and Health Survey (DHS) was conducted in 2010, the first since 1987, and the final results are expected to be released in the first quarter of 2012. In 2007, the National AIDS Council (NAC) supported a survey which demonstrated an adult HIV prevalence of 2.9%, with higher prevalence in urban and peri-urban areas (4.6% and 4.4%) than in rural areas (2.8%), where 90% of the population lives. According to the MOH, HIV prevalence in rural areas quadrupled between 1989 (0.6%) and 2002 (2.5%). The NAC reported roughly equal HIV prevalence among women (2.9%) and men (2.8%), although further studies are needed to confirm this data.*

*Available data suggest that main drivers of the epidemic include heterosexual transmission through multiple concurrent partnerships (MCP), including transactional, intergenerational, and commercial sex; low condom use; and weak knowledge about HIV. In the NAC survey, only 22.6% of young people (ages 15-24) and 18.6% of adults (ages 25-49) reported using condoms during paid sex. More than 70% of youth reported having had at least one casual sexual encounter in the previous 30 days, with only 11.8% using condoms. Only 10.7% of survey participants knew three ways to prevent HIV infection (condoms, fidelity, and abstinence). About 17.3% had ever*



received an HIV test. Four-fifths (82%) knew that ARVs can prevent HIV transmission from mother to child, and a WHO study in 2010 showed that 43% of men were circumcised. Preliminary results from the DHS 2010 indicated that 80% of the men and women aged 15-49 years stated that using condoms and limiting sexual intercourse to one uninfected partner can reduce the risk of contracting the AIDS virus. However, only 14% of men and women of the same age group involved in multiple sexual partnerships stated using condoms during their last sexual intercourse.

#### *Alignment with Government Strategy and Priorities*

The overarching goal of the expanded FY 2012 PEPFAR program in Burundi is to strengthen the capacity of the Burundian government, civil society, and the private sector to plan, deliver, monitor, and evaluate high-quality, sustainable HIV/AIDS prevention, care, and treatment services. Given massive unmet needs and limited initial funding, COP 2012 proposes to continue a program based on linked service delivery in priority technical areas, technical assistance for national and local capacity building, and preparation for longer-range policy and structural interventions.

The MOH has initiated sweeping changes in health policies, including: the provision of free medical coverage for pregnant women and children under five years of age; decentralization of health services through the health districts; the adoption of performance based financing (PBF); and the move toward a sector wide approach to support the International Health Partnership put in place with the donor community. In addition, the MOH has completed a new National Health Development Plan, a National HIV/AIDS Strategic Plan, and a Poverty Reduction Strategy Paper. Over the past two years, the government of Burundi (GOB) has also successfully concluded major new commitments with its donor partners, including UNICEF, WHO, Belgium, Germany and the Global Fund (for HIV/AIDS, Malaria, and Tuberculosis).

A recent USG-supported review of the HIV/AIDS national program concluded that while much was accomplished, a lot still needs to be done. The GOB and the Burundian beneficiaries greatly appreciate the USG contributions in the health sector. The USG believes that building upon the mutual confidence, several actions should be undertaken in the short term to improve the efficiency and performance of the HIV/AIDS program. Opportunities exist to work in a more integrated fashion with on-going health projects in the portfolio, other USG programs, USG health programs in neighboring countries, regional programs, and the programs funded by other donors. If additional resources become available, activities that would be targeted and scaled up are HIV/AIDS, FP, monitoring and evaluation, and MOH capacity building. A USG assessment conducted in 2009 concluded that despite recent increases in investments in the health sector, much more is needed to meet the most basic health needs of the population. The key recommendation was for the USG to begin the design of a major new Integrated Health Service Delivery Project, and an integrated national Health Systems Strengthening Project in line with the National Health Development Plan.

There are four key health sector strengths in Burundi that constitute the foundation of quality health care services, specifically:

1. **Government Commitment to Health:** The GOB is very clearly committed to improving investments in health and reorganizing its health sector to better respond to the needs of Burundians. The MOH is accessible and is willing to work in close coordination with the donor community to implement recommended programs. With strong support from the donor community, Burundi completed the National HIV/AIDS Strategic Plan 2011-2015 as well as its related Operational Plan and M&E Framework. Burundi also completed the Health Development Plan 2011-2015 (along with its supporting document such as the Mid-Term Expenditure Framework 2011-2013 and the M&E Framework). In the Poverty Reduction Strategy Paper 2011-2015, the health sector, and HIV/AIDS in particular, occupy a significant part. Burundi is part of NEPAD's regional health strategy and aspires to achieve the Millennium Development Goals by 2015.

2. **Key MOH Reforms:** The MOH is focused on implementing dramatic system-wide reforms -- including decentralization of health services, PBF, creating a broad platform for improving the delivery of health services, and improving the availability and the quality of Human Resources for Health. Burundi is currently benefitting from the Highly Indebted Poor Countries (HIPC) loan forgiveness programs, and through HIPC the GOB has budgeted approximately \$20,000,000 annually for the health sector. As the amount of financial resources for the health sector



increases, Burundi's absorption capacity also increases. It is worth noting that GHI principles and PEPFAR recommendations push for integration of health services (also the vision for the GOB).

3. *Donor Community:* There are several bilateral and multilateral donors present in Burundi working to help the country emerge from conflict and successfully transition to a developing country. There is an active donor partnership network (the Partnership Framework for Health and Development [CPSD]), of which the USG is a member.

4. *Non-governmental (NGO) Partnerships:* Because of the conflict that led to the collapse of the central government, civil society organizations and NGOs play a critical role in providing essential health services in rural communities. The NGOs demonstrate strength in providing HIV/AIDS services, as well as being key partners in delivering services through USG programs.

#### *Contributions from or Collaboration with Other Development Partners*

The USG is currently not a voting member of the Global Fund Country Coordinating Mechanism (CCM) in Burundi but (participating as an observer) requested and is prepared to be included as a voting member in the coalition in April 2012. The USG in Burundi is well positioned to support the CCM with substantial assistance to the health sector in Burundi. The USG participates actively in the national Strategic Coordination Forum for Health and HIV/AIDS, led by the Vice President's office; the CPSD, led by the MOHA, which will also be decentralized at the provincial and district levels; the health M&E thematic group; and the network of civil society organizations. The USG is also planning to participate in the five thematic groups of the CPSD.

The USG plays a leadership role in private-sector development activities in Burundi. USAID completed four years as lead donor for coordination of all private-sector investments. The USG continues to work with the Ministry and Chamber of Commerce to champion policy and program causes to reignite private-sector activities following the crisis years, which had particularly negative effects on infrastructure, capital formation, entrepreneur in-country presence, and private domestic and foreign investment. The PEPFAR Burundi team recognizes that better coordination with the GOB and with other donors is imperative as the national and PEPFAR programs scale up.

#### *HIV Testing and Counseling & PMTCT*

HIV testing and counseling (HTC) targeted the general population in the three provinces but with an emphasis on MARPs. HTC services were provided in 82 service outlets distributed in the three supported provinces. A total of 138,514 individuals were tested and 135,470 (M: 35,175; F: 101,771) of them received their test results. Among them, 1,912 (M: 594; F: 1,318) were found HIV positive with an HIV prevalence rate of 1.4 percent. It is clear that the demand for voluntary HIV testing in men remains low and a special attention will be required at this level.

In 2011 a total of 82 service outlets offering PMTCT services were operational. The entry point for the majority of cases was ANC. During the reporting period, 76,875 pregnant women attended the first ANC visit. Among them 51,312 (67%) accepted HIV testing and 49,803 received their HIV test results. The HIV prevalence rate among pregnant women tested was 0.6 percent (294 HIV positive pregnant women) in the three provinces but was 3.8% in the only site supported by the USG in Bujumbura. It is worth noting that 301 pregnant women knew their HIV positive status prior to first ANC visit, which totals 50,104 pregnant women with known HIV status. Antiretroviral prophylaxis was administered to 431 pregnant women out of the 595 identified (73% of enrollment under PMTCT prophylaxis). For exposed infants, 412 received ARV prophylaxis while they were waiting for the HIV test at 18 months of age. In the four intervention provinces where the USG implements a comprehensive PEPFAR program (excluding treatment), the USG will prioritize scale-up of PMTCT and health facility-based TC services. In accordance with GOB guidelines, these services are integrated in ANC and primary health care, with strong linkages to HIV/AIDS care and treatment (supported by the GOB and the Global Fund) as well as to MCH and other services (vaccination, nutrition, etc.) and to community-based care and support. To increase access for pregnant women and the general population, the USG will support the expansion of PMTCT and TC services to 139 sites in the four provinces. PEPFAR will support an aggressive roll-out of intensive in-service training for health care providers, including refresher trainings for health care providers currently implementing PMTCT and TC. Extensive details on the PMTCT scale up plan, which expands comprehensive services to four additional provinces, is available in the Burundi PMTCT Acceleration Plan.



*The DOD supports HIV prevention and TC services for the military, their families, and surrounding communities. The DOD plans to build a clinic for these target populations and to use PEPFAR funding to support HIV prevention and HTC for those target populations. Scaled-up PEPFAR activities will be managed mainly by USAID and DOD, with oversight and guidance by an inter-agency coordination body comprising all USG agencies in the country.*

#### *Voluntary Medical Male Circumcision*

*In March 2008, a regional consultation was held by WHO to sensitize countries about integrating voluntary medical male circumcision in the package of key HIV prevention interventions. In response, a technical steering committee on male circumcision was established by the MOHA. A World Bank funded study of feasibility and acceptability of male circumcision was implemented sampling the sexually active population in Burundi. The study demonstrated a male circumcision rate of 43%. The evaluation of prevalence by region showed rates ranging from 68.78% in the west-central region to 27.5% in the northern region. Regarding the feasibility of male circumcision the study assessed the overall experience of health facilities to perform male circumcision, and found that 63% of health facilities reported practicing male circumcision for medical reasons or on voluntary requests.*

*Currently, the Global Fund is the only partner that supports the decentralization of VMMC in Burundi. It plans to pursue its support through the funding of Phase 2 of the Round 8.*

*The northern region of Burundi where PEPFAR interventions are performed, recorded the lowest rate compared to the rest of the country. The PEPFAR program in Burundi will be adding a modest male circumcision program to the prevention portfolio. It will primarily focus on supporting male circumcision PBF indicators and technical assistance at the provincial level in line with national technical directions. In addition, PEPFAR has already joined the national steering committee on voluntary medical male circumcision.*

#### *Positive Health Dignity and Prevention*

*In FY 2011, positive health, dignity and prevention services (PwP) was provided to 2,169 (M: 716; F: 1,453). In 2012, emphasis will be placed on HIV prevention with PLWHA and discordant couples. Primary prevention will include promoting correct and consistent condom use, ensuring that quality condoms are accessible for those who need them, and equipping the target population with the knowledge and skills to use them properly. Primary prevention of HIV will also include expanded interventions relating to post-exposure prophylaxis in cases of rape or occupational exposure and prevention of MTCT. The PEPFAR program will mobilize the community for PMTCT services using community networks, specifically the network of PLWHA, to promote couples counseling and testing, encourage pregnant women to bring their spouses/partners to check ups, provide all needed supplies, develop appropriate IEC materials, and provide nutritional support to HIV+ women during the weaning period. To strengthen HIV prevention in women of childbearing age, PEPFAR will provide awareness sessions to women who attend ANC and curative services at the health facility level. The messages will include enhanced prevention counseling to women who test negative for HIV to reduce the risk of acquiring HIV during pregnancy. Sexual risk reduction counseling will focus on messages of partner reduction (including the reduction of multiple concurrent partnerships) and mutual monogamy to a partner of known HIV status. Behavior change communication (BCC) messages will also be provided by CHWs, peer educators, and other media outlets.*

#### *Most -At- Risk Populations*

*A Behavior Sentinel Surveillance focused on groups at high risk was conducted and the results released in June 2011. The survey was focused on sex workers (SWs), men having sex with men (MSM), seasonal workers, prisoners, and uniformed services. The results of the survey are summarized below:*

- The HIV prevalence in SWs is 19.80%. The average age of first sexual intercourse is 16 years and first paid sex is 20 years. The average time spent in the practice of prostitution is 5.8 years. The reasons of entry into sex work are numerous but the most cited is survival. Almost all SW (98%) practice vaginal intercourse. During the seven days preceding the survey, each sex worker received an average of 5.48 clients and the average payment was 7,049 Burundi francs (± US\$ 5). 71.2% of SW reported having used condoms consistently in the last 30 days preceding the survey. Those who did not use condoms cited among other things, that customers paid more to have*



unprotected sex. 71.3% of CSWs reported having received an HIV test.

- The HIV prevalence in MSM is 2.40%. The average age of first sexual contact with a man is 16 years. 68% of MSM declared receiving payment in cash or in kind after the first sexual contact with a man. On average, each MSM had 3.2 sexual partners during the last six months, 1.8 in the last 30 days and 0.9 sexual partners the last seven days. During their first sexual intercourse with a man, only 49.3% of MSMs used a condom and only 39.8% reported receiving an HIV test. Although not explicitly mentioned in the report, it appears that MSMs also engage in heterosexual intercourse.
- The HIV prevalence in seasonal workers is 1.4%, with the average age of first sexual intercourse being 20 years. Seasonal workers are defined as people who leave their homes for a period of time to work in local factories, fisheries, agriculture etc. The survey reported that only 5% of seasonal workers used condoms with regular partners; 49% used condom with commercial partners; and 36.2% used condoms with occasional partners. There were many reasons cited for not using condoms but the most prevalent one is that "it was not necessary to use it". 36.7% of seasonal workers reported receiving an HIV test.
- The HIV prevalence in prisoners is 3.0%, with the average age of first sexual intercourse being 18 years for women and 19 years for men. The majority of prisoners reported having no sexual partners. The use of condoms is not systematic for prisoners and 10% declared having used condoms systematically. 68.7% of men and 84.6% of women reported having received an HIV test.
- The HIV prevalence in uniformed services is 0.4%. This group includes military and police. The average age of the first sexual intercourse is 23 years. During the last sexual intercourse with a regular partner, only 10.7% used a condom. During the last sexual intercourse with a SW, the percentage was significantly higher, 52.9%. 90.5% of uniformed services declared having received an HIV test.

The USG will extend services to high-risk populations representing a large portion of the country's new HIV infections which are underserved in other health and social areas. In addition to core HIV/AIDS services, there will be additional integrated services such as malaria and FP/RH if funding is available. These activities will enhance the integration of health and social services into existing regional and bilateral economic growth, trade, conflict and anticorruption programming in these geographical areas. To reduce sexual transmission of HIV, the GOB and PEPFAR partners and sub-partners will implement evidence-based communication and small-group / individual interpersonal interventions targeting the general population (including youth), military communities, and MARPs (especially SWs and truckers), with the balance among specific targets to be refined as a better understanding of the dynamics of HIV transmission emerges with the DHS and the planned evaluation of the National Strategic Plan. PEPFAR will also support the State Department's Voice of America activity to broadcast programming promoting HIV prevention, testing, care, and stigma reduction.

Improved prevention services will also be fully integrated into clinical services, including PwP services and messages targeting discordant couples and clients who test HIV negative. Activities will address underlying factors that contribute to HIV risk, including GBV, alcohol abuse, social and cultural norms, and family communication around reproductive health (RH). Behavior change communications, peer education, and community mobilization by health workers, CHWs, and local organizations will help meet the following objectives:

- Reducing high-risk behaviors in the general population (including youth) and among MARPs;
- Increasing knowledge and awareness among high-risk groups of STIs and their interaction with HIV;
- Increasing rates of correct and consistent condom use; and
- Increasing demand for TC and PMTCT services.

#### General population

In FY 2011, sexual and other risk prevention services were provided through 302 trained peer educators who reached, 47,559 people (M: 24,383; F: 23,216) with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required. The target for 2011 was to reach 50,000 people; the USG achieved 95% of the target.

Community health workers, particularly peer educators, are deeply involved in USG-supported activities. In FY 2012, services provided will continue to address underlying factors that contribute to HIV risk including sexual violence, alcohol abuse, social and cultural norms, and family communication around RH and HIV. The purpose of

BCC, peer education, and community mobilization by CHWs is to: 1) reduce high-risk behaviors in the general population (including youth and pregnant women) and among MARPs; 2) increase rates of correct and consistent condom use; and 3) increase demand for HCT as well as PMTCT. USG activities will work to create a dynamic physical linkage between the community and the health facilities for all HIV/AIDS-related services. Integration of PMTCT into MCH programs will enable CHWs supporting MCH to encourage pregnant women to attend ANC and to be tested for HIV. The same CHWs will sensitize pregnant women on the importance of using FP methods for spacing pregnancies in order to improve the health of both the mother and the child. To equip them with the required knowledge and skills, specific in-service, pre-service, and refresher trainings, as well as supportive supervision visits will be regularly organized.

The USG will continue to implement the following interventions to prevent infections and provide treatment and care for those infected with HIV/AIDS:

- HCT and PICT (provider initiated counseling and testing) to increase the number of people who know their HIV status and take appropriate action;
- Supporting the acceleration or scale-up of ARV treatment; prevention and management of opportunistic infections; care for PLWHA, including nutrition, malaria, palliative care and end-of-life care; and prevention for PLWHA against infecting others and vulnerabilities to opportunistic infections that increase their viral loads;
- Maximizing Burundi's health sector contribution through trainings and providing services for HIV prevention, including PMTCT, prevention of sexual transmission, prevention and management of STIs, male circumcision, prevention of HIV transmission through injecting drug use (harm reduction), and prevention of HIV transmission in the health care setting; and,
- Multi-sector care of orphans and vulnerable children (health, economic, psycho-social).

#### *Health Systems Strengthening/Human Resources for Health*

Despite the strengths listed above in the overview section, the challenges that Burundi faces in the health sector remain significant. There is still considerable work to be done to move the country out of its humanitarian response mode and into a more strategic development model based on a sustainable health system. For extensive details on HSS and HRH, please see the PMTCT Acceleration Plan, the Governance and Systems TAN, and the Executive Summary.

#### *Medical transmission*

Given limited funding, the COP 12 does not include support for blood safety, injection safety, and medical waste management. The USG will continue to promote implementation of the national protocol for injection safety and waste management in the four PEPFAR-supported provinces and the additional PMTCT provinces. The protocol for syringe is disposal after one use and destruction within the health facility. The MOH encourages all health facilities to have incinerators on site; additionally, hygiene and the safe disposal of waste are part of the PBF indicators. If exposure to HIV occurs to a health care worker, PEP is provided according to the national protocol. Regarding blood safety, the GF supports the national blood center, which supplies blood and blood products to most hospitals. All blood is tested for HIV, hepatitis B and C, syphilis, and malaria. Donors who test positive for HIV are followed up by counselors and referred to care and treatment services.

#### *Gender*

Gender inequity and gender-based violence (GBV) heighten HIV risk across age and socio-economic groups. According to UNICEF's Situation Analysis of Children and Women in Burundi (2009), 19% of children had their sexual debut before age 10, 35% at ages 10-14, and 35% at ages 15-19. In 21% of cases, the partner was a parent or a family friend, and only 19% of those surveyed used condoms during their first sexual intercourse. One in five (19%) said that sexual violence had occurred in their school. Project data and anecdotal evidence suggest that other factors contributing to high-risk behavior include alcohol abuse and poverty.

Prevention activities will prioritize gender analysis and mitigation of gender-related risks for HIV infection. In the short term, this will include BCC targeting young girls and family communication, procurement of PEP kits for health centers, and training to ensure that CHWs, teachers, and health workers are capable of screening for and



*addressing risks for GBV, including providing or referring GBV victims for PEP, care, and legal services. The USG will also begin a longer-range initiative to address social and gender norms conducive to GBV and high-risk behavior by funding a partner to work with the Ministries of Gender, Justice, and Social Affairs, as well as relevant CSOs, religious leaders, and women's associations, to develop a strategy for BCC, advocacy, and policy analysis and reform. Other specific activities related to gender have been developed in the Governance and Systems TAN.*

#### *Orphans and Vulnerable Children*

*In FY 2011, 6,053 OVs (M: 3,073; F: 2,980) received educational support, health care support, shelter, and psychosocial services. In FY 2012, to mobilize communities, the USG will adopt variations of the successful ROADS strategy that forms "clusters" of existing community-based groups of low income women, vulnerable youth, PLWHA, and caregivers and orphans. The USG observed that the clusters demonstrated effectiveness, building on local initiatives and creating community cohesion and ownership. More than 90% of the cluster member groups are participating in donor-funded activities for the first time and the Magnet theatre intervention appear to be potentially effective in conveying messages on key issues such as stigma and discrimination, HIV prevention, alcoholism, and GBV.*

*Income Generation and Job Creation through Public-Private Partnerships is an intervention which primarily targets low income women and older orphans selected through a community vetting process based both on need and motivation. It focuses on addressing two basic determinants of their vulnerability--unemployment and food insecurity. Thus it works to improve the outcomes of investments in treatment, prevention and care by providing adequate food to those on treatment, reducing multiple partners for low income women by facilitating alternative employment opportunities, and giving PLWHA, their families and care givers additional financial resources. The USG will collaborate with local businesses and will provide some initial seed capital and technical assistance for establishing companies and initiating small scale activities.*

*Rounding out a family-centered care approach, home-based care providers will help identify and provide care and support for OVC. Through sub-grants and technical assistance to local organizations, the USG plans to support 15,000 OVC with a needs-based package that includes psychosocial support, school and hygiene kits, and health-care and hospitalization assistance for those over 5 years of age (the GOB provides free health care for pregnant women and children under 5). The USG will continue to collaborate with other donors, such as Food for Peace, the United National High Commission on Refugees (UNHCR), and UNICEF, to increase coverage and strengthen support for OVC activities, including in the policy areas of legal support and domestic violence reduction and mitigation.*

#### *Public-Private Sector Partnerships*

*Ongoing discussions with national and international business organizations and leaders suggest that the private sector is ready and willing to involve itself in AIDS and other health interventions. This dialogue will encourage the use of core competencies of the private sector to provide business skills and other support to vulnerable groups to establish small private companies along sound business lines. The PEPFAR program has already identified a PPP with a local private insurance company. PEPFAR/Burundi and BICOR Insurance Co. have agreed to establish a partnership in the prevention against HIV/AIDS for 20,000 motorcycle taxi drivers. Motorcycle taxi drivers are a good target audience for HIV prevention outreach because they are young and highly mobile, have disposable income, and have access to large numbers of often young and vulnerable customers -- making them potential vectors both for HIV transmission through casual sex and for HIV prevention messages. Proposed partnership activities include purchasing identification vests for taxi-drivers bearing HIV prevention messages; establishing links with mass media to discuss attitudes of taxi drivers vis-à-vis the HIV epidemic and how to change harmful social and cultural behaviors; and organizing sessions on identification of risk factors specific to taxi drivers and their sexual partners and on communication for adoption of behaviors that are conducive to good health. The HIV prevention activities will be implemented in conjunction with a USG partner, which is preparing a rest center for international truckers in Bujumbura, which will also be used by the motorcycle taxi drivers. The center could serve as a distribution point for HIV prevention messages, condoms, and referral for HTC. Currently, PEPFAR and BICOR are refining the proposed activities for a smooth start up of the activities.*



### Strategic information

The goal for the PEPFAR program is to increase the number of people served with HIV/AIDS prevention, care, clinical care interventions, and support services through the implementation of effective programming.

Overall goals for the PEPFAR program are:

- Increased number of PMTCT services offered including routine antenatal care services, screening for syphilis, counseling and testing for HIV, infant feeding, provision with a complete course of ARV prophylaxis to HIV+ mothers and their babies, mother to child follow-up, and preventive therapy using cotrimoxazole prophylaxis to infants exposed to HIV;
- Increased number of individuals reached through community outreach that promotes HIV/AIDS prevention by abstinence and/or being faithful;
- Increased number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful;
- Increased number of targeted condom service outlets;
- Increased number of individuals provided with HIV-related palliative care (including TB/HIV);
- Increased number of orphans and vulnerable children served by OVC programs;
- Increased number of individuals who received counseling and testing for HIV and received their test results;
- Increased number of individuals receiving ART at the end of the reporting period (includes PMTCT+ sites);
- Increased number of health workers trained to promote HIV/AIDS prevention, counseling and testing, deliver ART and PMTCT services, and HIV-related palliative care;
- Increased number of providers/caretakers trained in caring for OVC; and
- Results showing the achievement in terms of capacity building for local civil society organizations.

The planned activities will be monitored using the next generation indicators through routine data collection and a tracking system with standardized recording and reporting protocols for all types of services offered. Data Quality Assessments (DQAs) will periodically be conducted to ensure the quality of the data. An end of project evaluation for the activities implemented by FHI 360 will be conducted after Year 5 (2013-2014) to objectively assess the effectiveness of the innovations and their potential for scale-up.

### Technical Area: Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
HTXD	1,208,202	0
HTXS	521,289	0
PDTX	420,840	0
<b>Total Technical Area Planned Funding:</b>	<b>2,150,331</b>	<b>0</b>

### Summary:

#### Adult Treatment

Burundi is classified in the category of Low Income Countries with low treatment coverage (< 33%). Despite an HIV/AIDS epidemic similar to Rwanda, and bordering high prevalence countries on all sides, Burundi has often been referred as the “doughnut” in the region. With its very limited funding for Burundi



*(historically \$3.5 per year but currently increasing progressively), PEPFAR is not directly engaged in treatment for people living with HIV/AIDS (PLWHA). Most of the ARVs used for treatment come from Global Fund (GF). Particular efforts to train health care staff and strengthen of the health facilities are on-going.*

*Burundi, in its effort to integrate into the East African Community, has contributed in the harmonization of treatment protocols and public health policies. Therefore, Burundi has already revised and harmonized the ARV drug regimens in accordance with the recent recommendations from WHO related to ARV treatment. Antiretroviral therapy has substantially increased over the last five years. The number of ARV treatment sites increased from 46 in 2007 to 95 in 2010 and the number of people on treatment increased from 10,928 in 2007 to 22,735 in 2010. Despite these strides, access to treatment sites is available at approximately only 16% of total health facility in the country. Initially, civil society organizations (CSO) were supporting the largest number of beneficiaries, however, now the majority of treatment is being administered at health structures. The move towards facility based clinical care has improved the retention rate. On average after 24 months, patient adherence on ART has stabilized at 82% in 2009 and 2010.*

*Despite significant improvements, decentralization of ART services remains a challenge. The majority of ART sites are located in peri-urban settings, limiting ART access to people living in remote or rural areas. Access to treatment is considerably more difficult for children living with HIV. In 2009, 11% of children in need of ARV treatment were receiving it. In 2010, Burundi revised its protocol management of HIV in accordance with the new WHO recommendations. The important sections of the protocol include: (1) when to start ARV treatment; (2) principles of choice for the first line of treatment; (3) first-line ARV regimens; (4) choice of 2nd and 3rd lines of ARV treatment in case of treatment failure of previous lines; (5) adherence to ARV treatment; (6) recommendations on the initial clinical and biological evaluation; (7) clinical and biological monitoring; (8) the management of side effects of ARVs; (9) recommendations for pregnant women and infant feeding; and (10) specific situations in pregnancy, accidental exposure to HIV, and co-infection HIV/TB.*

*As already indicated above, as soon as the WHO guidelines were released, the GOB with the assistance of partners, decided to update the treatment guidelines to reflect the WHO recommendations for adult and pediatric treatment as well as for PMTCT. The final version of the new ARV treatment regimens were approved by the Minister of Health in December 2010. For adults and adolescents, the first-line treatment recommended is: AZT + 3TC/FTC + NVP/EFV or TDF + FTC/3TC + EFV/NVP. In infants and children, first line treatment is AZT+3TC+NVP. This was a significant shift with substantial implications as the thresholds for initiation of ART were moved from 200 to 350 cells/mm<sup>3</sup>. Some of the implications are that: (1) the number of estimated people in need of ART has almost doubled and is now estimated at 70,000 people; (2) the health providers had to be trained in the new ART protocol; (3) the drugs proposed in the new protocol which were not available in the country had to be procured and (4) the biological follow-up for people under ART had to be redefined in accordance with the properties and side effects of the new drugs. The GF is supporting treatment in the country but at a limited scale (because there are few ART sites). In the future, the GF alone may not be able to support the treatment needs of the increases in number of eligible patients. Due to long procurement processes, problems related to stock-outs of ARVs in the country are occurring.*

*In FY 2011, PEPFAR began to modestly grow the USG funded HIV/AIDS program in Burundi. Due to the budget size, the USG was not permitted to being an ART program. Therefore, PEPFAR is not procuring ARVs for treatment, yet is involved in supporting PLWHA in various ways. In the PEPFAR supported provinces, care and support interventions are built around home based care services for PLHWA. For example, PEPFAR supports (1) home-based care packages for improved quality of life; (2) free medical care when needed at health facilities, (3) home visits and psychosocial support by community health workers; (4) prevention services for discordant couples; and (5) training for health providers to be able to take care of PLWHA. In ART sites, PEPFAR ensures systematic TB screening among HIV positive clients and reinforces the cross-referral system between HIV/AIDS and TB settings wherever indicated. More specifically, PEPFAR programs assist in ensuring the training of health providers on the management of co-infection TB/HIV and other opportunistic infections. It improves the access of TB patients to HIV services, including pre-test counseling and post test counseling. For co-infected patients,*



*additional messages on the relationship between HIV and TB, the importance of cotrimoxazole prophylaxis, and adherence to ART are provided.*

*Going along with treatment is the nutritional support for people living with HIV/AIDS under ART treatment. Malnutrition in Burundi remains a health problem that affects the whole population in general but it has a special character for people living with HIV/AIDS. Exacerbated by the long socio-political crisis that affected the country until very recently, malnutrition is currently fueled by cyclical factors such as plant diseases (cassava mosaic, banana wilt), the climatic disturbances, and recurrent drought in certain parts of the country. The most recent baseline survey conducted in 2008 provides the following situation: The rate of underweight among children aged 6 to 59 months in Burundi is estimated at 35.2%. The rate of stunting among children aged 6 to 59 months in Burundi is estimated at 46.0%. The rate of wasting among children aged 6 to 59 months in Burundi is 5.6%. The World Food Program had a nutrition component for people living with HIV / AIDS on antiretroviral treatment. However, as a result of reduced funding, the program has reduced its geographical coverage and currently provides individual rations instead of family rations. UNICEF supports the programs of nutritional supplementation for children under 5 years assisted by USAID, which includes the component pregnant and lactating women in two provinces of the country. The government of Burundi decided to integrate the monitoring and nutritional supplementation in the minimum package of health centers and in the complementary package of hospitals. In addition, the management of acute malnutrition approach at the community level by using the ready-to-use therapeutic food is being implemented. A national protocol for integrated management of global acute malnutrition was finalized in 2010.*

#### *Quality and Oversight*

*For the efficiency and the quality of the treatment programs in Burundi, ART treatment protocols are developed and implemented in all treatment facilities. Periodic visits from the central level and other partners involved in HIV/AIDS are organized to verify that protocols are respected. The provincial and district teams are tasked with ensuring that national treatment protocols are applied. All ART treatment is initiated by a medical doctor, which may increase the chance of high quality treatment but limits the number of beneficiaries (medical doctors are only at the hospital level). As part of supporting treatment, PEPFAR will be working on the decentralization of ART at the peripheral level especially for PMTCT along with quality supportive supervision and mentoring from treatment experts. Before initiating treatment, compliance sessions will continue to be provided to promote adherence which is essential to the success of quality treatment. The availability of biological follow-up is also important and PEPFAR will continue to ensure that the required equipment and supplies are in good condition for use whenever needed. The evaluation of ART treatment failure is conducted at three levels: (1) clinical assessment of the disease progression in using the WHO clinical staging; (2) immunological measurement of CD4; and (3) virological surveillance by measuring the viral load. The discovery of a treatment failure is one of three levels that justify the switch to the second line of treatment.*

#### *Sustainability and Efficiency*

*Burundi has not yet conducted an expenditure analysis and cost modeling activities related to ARV treatment, although these activities are in the pipeline. However, with the lack of actual data, literature information is used as a proxy (e.g., WHO, UNAIDS, etc) to inform programming. The selection process for the ART regimens takes into account among other criteria the low cost or the cost-effectiveness of the protocol to minimize overall costs over time, to the extent possible. As in most countries, Burundi is currently using generic formulas in its treatment protocols. At the end of 2009, Burundi conducted an estimation of resource flows and expenses allocated to fighting HIV/AIDS (REDES). The study demonstrated that the distribution of financial resources with respect to various areas of HIV interventions were the following: Prevention: 22.13%; Care and treatment: 33.66%; Orphans and vulnerable children: 10.15%; Management and program administration: 23.30; Human Resources: 5.39%; other social protection and services: 3.24%; enabling environment: 1.71%; and Research related to HIV: 0.4%.*

*PEPFAR uses the most up-to-date information on cost-effectiveness interventions to inform programming. For example, the recent guidance for the prevention of sexually transmitted HIV infections was instrumental in proposing PEPFAR interventions in Burundi for FY 2012. As the USG takes on a larger role with PMTCT, PEPFAR*



*anticipates conducting an expenditure analysis. PEPFAR will begin with cost estimates through reviewing GF and implementing partner data. In the meantime, the program will use cost estimates from other countries and will use best estimates based on that information. Within the upcoming year, the Burundi PMTCT program will collect this information to produce an accurate cost analysis. The program will also identify cost-effective programs and practices to determine efficiencies that can be captured. If deemed relevant and in consultation with the Government and other partners, COP funds will be used for the costing analysis. S/GAC recommended drafting a SOW to invite a costing specialist to get the necessary information. Technical assistance for costing and expenditure analysis will be requested for early 2012. Once this data is available and projects are awarded or initiated, the program will be able to provide costing and an expenditures analysis.*

#### *Pediatric HIV treatment*

*Burundi experienced a significant delay in the care of children infected by HIV. Pediatric treatment was only generalized in 2008 with the training of medical doctors and nurses in the management of pediatric HIV/AIDS. The technical assistance was initially provided by the African Network for the Care of Children Affected by AIDS (ANECCA) with funding from the USG. ANECCA trained 162 medical doctors and 146 nurses in the comprehensive care of pediatric AIDS while 106 other nurses were trained on child nutrition in the context of HIV with the support of UNICEF. Recognizing the special nature of pediatric HIV, the GOB elaborated a national PMTCT and pediatric HIV treatment policy with a corresponding scale up plan. The recent launch of the PMTCT global plan in October 2011 was an opportunity for the GOB officials to highlight the importance of the national documents and programs they represented.*

*Due to its limited funding, PEPFAR is not purchasing ARVs for pediatric treatment. However, it supports all the other aspects of the pediatric treatment and care (e.g., training of the health providers in pediatric treatment and care, support to the laboratory, home-based care and psychosocial support, orphans and vulnerable children services). The National AIDS Council reported less than 12% of children who had access to HIV treatment in 2010. This demonstrates that children who are HIV + still do not have adequate access to ART. The ART regimens for infants and children were defined by a national commission which was working on the revision of ART treatment protocol. There is no specific working group at the national level that focuses on pediatric ARV drug forecasting, procurement, and distribution. This is supposed to be done by the National Management Committee of ARV drugs, OI/STI drugs and other medical and laboratory supplies for the care of PLWHA. When the country was facing reoccurring stock outs for ARVs and reagents, it was affecting both adults and children. It was recommended that the management committee should be more dynamic, organize regular meetings and anticipate threatening situations. More importantly, PEPFAR will be tracking all eligible children in PEPFAR-supported PMTCT services and will ensure that they are referred to facilities that provide ART services. PEPFAR will also work with the Government and other partners to establish a technical group in charge of pediatric treatment and care. Through the technical assistance brought by SCMS, the work of the management committee will be improved to avoid and anticipate stock outs (additional details in the supply chain section).*

*Burundi was selected as a PMTCT Acceleration Country in July of 2011. As part of the acceleration process, the USG was required to prepare and submit a PMTCT Acceleration Plan based on the national scale up plan. The vision for the PMTCT Acceleration Plan is to achieve the elimination of new HIV infections among children while keeping their mothers healthy. PEPFAR plans to scale-up quality PMTCT services in four additional provinces (bringing total to eight). Budget permitting, the goal is to expand services into additional provinces each year until there is national coverage (total of 17 provinces). This plan builds on the key principle of leveraging opportunities to strengthen synergies within existing programs for HIV, maternal, newborn, and child health (MCH), family planning (FP), and orphans and vulnerable children (OVC). Prior to pregnancy and the cessation of breastfeeding, HIV prevention and treatment needs of mothers and children will be met within the continuum of care of comprehensive programs to provide HIV prevention, treatment, care and support for those in need. Close and regular coordination with the GF will be critical to the success of the PMTCT Acceleration Plan.*



*The GF is a key player in the health sector, providing a significant share of funding to combat HIV/AIDS in Burundi. Through the implementation of the Round 8 HIV/AIDS grant (Phase I with \$36,789,591), the GF is providing:*

- 1) Prevention services among the general population and for specific at risk populations;*
- 2) Improved diagnosis and treatment of sexually transmitted infections in health facilities;*
- 3) Enhanced prevention of HIV through blood transfusions, providing better case management of accidental exposure to blood, and to victims of sexual violence;*
- 4) Expanded primary prevention of HIV infection in women of reproductive age;*
- 5) Strengthened PMTCT services by integrating reproductive health services.*

*PEPFAR will be working closely with the GF to ensure that the children who graduate from PMTCT services transition smoothly to ART services. The ART treatment protocol in Burundi placed adolescents in the same category as adults. The PEPFAR program in collaboration with the other actors will ensure that the adolescent sub-group is considered.*

*It is worth noting that except for the purchase of ARVs for PMTCT, PEPFAR is not planning to procure ARVs for ART treatment for adults and adolescents in the next two years. The reason being that the PEPFAR budget is still relatively small compared to unmet need, and Burundi made the decision to concentrate its efforts on effective prevention, care, and support interventions. Therefore, no specific priorities and goals were set by the PEPFAR program in Burundi. If the USG/Burundi receives additional funding, it will consider expanding direct involvement in ART treatment services.*

#### *The Supply Chain Management System*

*The international procurement and supply chain stakeholders in Burundi are primarily the GF through the GOB and the USG. In addition, there are other stakeholders that are using other channels to procure drugs and reagents. The GF support limited technical assistance in procurement and supply chain on a need basis. The Clinton Health Access Initiative provided technical support to the NAC for quantification and procurement of HIV/AIDS commodities but the assistance ended in 2011. The USG is planning to provide quantification and forecasting support to the MOH and partners in 2012.*

*Through the National Management Committee for ARV drugs, OI/STI drugs and other medical and laboratory supplies for the care of PLWHA. The committee was created to solve the recurring problem of drug stock-outs. The management committee has to compare that the selection and quantification of ARV drugs (based on consumption data), OIs, reagents, consumables, and other supplies for the care of PLWHA are based on real needs and are in line with defined national protocols. It also ensures that the process of procurement is conducted according to outlined national standards and that purchases correspond to the selected products. The committee has significant weaknesses, including irregularity of meetings, follow-up on key action items, and the lack of control of accurate information needed to make good decisions at the right time.*

*The country does not have a mitigation strategy to prevent stock outs. Until very recently, Burundi was experiencing serious stock outs for ARVs and HIV test kits. The Minister of Health convened a meeting to discuss supply chain and procurement issues. As already stated, in November 2011, a supply chain assessment was conducted by SCMS (with funding from PEPFAR) to better understand the situation related to procurement and supply chain and to provide practical recommendations on how to improve the national supply chain system.*

*A number of the issues PEPFAR would like to see addressed are:*

- A definition of minimum and maximum stock levels to manage health care commodities at the service delivery level and at the central level;*
- A national forecast and appropriate quantification of HIV/AIDS commodities;*
- The development of a procurement plan for HIV/AIDS commodities; and*
- The development of supply chain system indicators.*



*The ultimate goal is to build a strong national supply chain system that all partners can access in the near future.*

#### *Laboratory*

*The challenges in the laboratory sector and the proposed activities are described in greater detail in the Governance and Systems TAN. Therefore, the proposed strategies and interventions in this section are a summary. The USG will continue to support laboratory activities in the focus provinces. During the next two years, more than 400 sites across 10 to 12 provinces will be supported by the USG through regular provision of HIV rapid tests. The program will support required trainings for capacity strengthening of laboratory technicians in HIV testing and use of CD4 cell count machines. To ensure that results given to clients meet international standards, a quality assurance/quality control system will be established. Ten percent of the samples will be sent to the National Standard Laboratory for control purposes. Laboratory technicians from the district hospital will supervise their colleagues working at the health center level. The USG will assist in providing laboratory equipment for hematology and biochemistry for biological follow-up of people living with HIV/AIDS. It will also supply CD4 count machines and all the reagents used in the biological follow-up of people under ART. All the laboratory activities will be carried out in strict compliance with standards and procedures established by the MOHA. At the national level, PEPFAR will support an assessment of the national laboratory system, which will provide practical recommendations that will be used to provide appropriate support to the laboratory system in Burundi.*

#### *Gender*

*Sexual gender-based violence against women and girls, especially sexual violence, is very disconcerting in Burundi. Some sources revealed that in 2010, at least 2,330 rapes were committed in Burundi; more than 95% of survivors were women. A recent study (2010) conducted by the Ministry of National Solidarity and Gender also noted 3,707 other cases of violence based on gender. These gender-based rapes and acts of violence are usually committed at home, the workplace, school, or in the fields.*

*Although gender disaggregated data can be tracked at the health facility level, the national monitoring and evaluation system of HIV/AIDS activities does not systematically track all information. The 2010 NAC report for example shows that 22,735 people were enrolled under ART at the end of 2010 but does not disaggregate it by gender. No specific considerations are made regarding access to HIV treatment for women and girls. As PEPFAR is not directly supporting ART in Burundi, it is not currently reporting on people under HIV treatment. Some sources show that more than 65% of the beneficiaries of ART services in PEPFAR supported sites are women and girls. The 2007 HIV survey does not show a significant difference between the HIV prevalence in men and in women (respectively 2.8% and 2.9%). Data on the prevalence of sexual violence is limited and not collected in a coherent and coordinated manner. There is also significant underreporting of violence due to a number of factors. PEPFAR will work with other partners to make sure that there are no gender-related barriers for the access to treatment. Through sensitization messages, men will be encouraged to seek HIV/AIDS services and to encourage reluctant women to seek services. PEPFAR will encourage other partners to systematically consider gender aspects in their programming and in their M&E system.*

*Using PEPFAR funding, the USG conducted an assessment which recommended some key activities for implemented. This included the development of mapping zones where PEPFAR plans to implement activities against sexual violence. The mapping will be a compilation of information from the field and will focus on the following aspects:*

- Health facilities offering family planning services, HIV/AIDS care, and care for victims of sexual violence;*
- The presence and activities of the family development centers;*
- Medical and police personnel trained in sexual violence; and*
- The presence and activities of community-based organizations, and the various donors involved in the programs regarding sexual violence.*

#### *Capacity Building*

*The USG goal for capacity building is to develop the GOB's ability to lead a strong national HIV/AIDS response in*



*collaboration with its partners. The NAC is in charge of coordination of the national response. As the technical arm of the NAC, the Permanent Executive Secretariat of the NAC ensures the technical coordination of the response. Burundi has also a national Country Coordinating Mechanism (CCM) which deals with all Global Fund related aspects. USG/PEPFAR will continue to work with the CCM to identify technical assistance needs. The USG will seek to integrate the CCM as a full member to be able to bring its contribution in that forum.*

*In 2011, the NAC conducted a review of the National AIDS Strategic Plan 2007-2011 with the technical assistance from PEPFAR. The findings from the review were used to draft the National AIDS Strategic Plan for 2011-2015 and PEPFAR played a critical role in providing technical assistance. In implementing HIV/AIDS activities either funded by PEPFAR, GF or any other partner, the leadership from national institutions will be critical. As the NAC is in charge of procurement of ARVs and other medical supplies and CAMEBU in charge of managing them, PEPFAR through will strengthen their capacity to be able to manage the iterative sock outs of drugs, reagents and test kits.*

*The national health information system/SI is another critical area which continues to suffer from many deficiencies. The short term objective is to have a reliable HIV/AIDS data base fully integrated with other health information. The USG will work with the entity in charge of the health statistics and the program in charge of HIV/AIDS M&E to address the situation. In addition, the NAC will also be supported to supervise clinical HIV/AIDS activities and to have antenatal sentinel sites fully functional. In conjunction with other partners, PEPFAR will identify and conduct necessary studies/surveys that will be essential to inform future HIV/AIDS programming.*

*The Human Resources for Health is also critical for the improvement of HIV/AIDS Services and other health services. While PEPFAR plans to continue in-service trainings for the various categories of health providers, it will work closely with selected education institutions to organize pre-service trainings to contribute to the production of new health providers. PEPFAR/ Burundi completed an assessment to identify the capacity building needs of six local civil society organizations (CSOs) that are working in the HIV/AIDS sector in Burundi. The purpose of the assessment was to receive recommendations on targeted interventions to strengthen their corporate governance and reinforce their service delivery. The ultimate goal is to provide technical assistance to those organizations in order for them to be upgraded to prime partners' status for HIV/AIDS grants in the future. PEPFAR will continue to seek opportunities to leverage the private sector in provision of HIV/AIDS services wherever possible.*

#### *Most at Risk Populations (MARPs)*

*As described in the Prevention TAN, Burundi conducted a Behavior Sentinel Surveillance in 2010. The survey was focused on sex workers (SW), men having sex with men (MSM), seasonal workers, prisoners, and uniformed services. The HIV prevalence was 19.80% for sex workers, 2.40% for MSM, 1.4% for seasonal workers, 3% for prisoners, and 0.4% in uniformed services. However, besides the 2010 survey the HIV/AIDS epidemic in Burundi has not yet been thoroughly assessed to determine the contribution of MARPs in the number of new HIV infections. PEPFAR will consider supporting an incidence by modes of transmission (MOT) study which is a mathematical modeling analysis building on multiple data including size estimates, HIV prevalence, behavioral and determinants of transmission. Once conducted and the results available, the MOT study will allow Burundi to know the estimated number of new HIV infections by sub populations including MARPs. Currently, some characterize the Burundi HIV/AIDS epidemic as low generalized epidemic, others as a mixed epidemic. In both cases, it assumed that both the general population and the MARPs contribute significantly to the occurrence of new HIV infections. Therefore, HIV prevention and treatment activities will target both the general population and MARPs. In the area of HIV treatment, the current monitoring system does not disaggregate the beneficiaries of treatment programs by subgroups. In addition, the approximate number of MARPs is not known, hence the impossibility of estimating the proportion of people receiving ARV treatment. PEPFAR will conduct MARPs population site estimates which will allow appropriate programming for MARPs, if funding is available.*

#### *Human Resources for Health*

*As described in the Governance and Systems TAN, HRH is a serious barrier to the access of quality HIV/AIDS services. Doctors are the only medical staff permitted to prescribe and initiate ARV treatment. Unfortunately, doctors are very rare in Burundi and are only present in hospitals sites. This limits the access to ART services. As*



*mitigation measures, PEPFAR has already started and will continue a successful approach of decentralizing ART services in satellite health centers. The nurses from these health centers are trained and are supervised by doctors from the reference hospital and once ART has been initiated, they continue the follow-up for clients who have no side effects and refer them to the doctor if required. This approach has contributed to reducing the distance for ART clients to travel and has increased ART uptake and the compliance rate. PEPFAR will continue in-service trainings for the health providers in ART especially for the revised ART regimens. As proposed in the PMTCT Acceleration Plan, PEPFAR will continue the advocacy of task-shifting especially for ART prescription by trained nurses and will provide the technical assistance required for implementation. Given the importance of performance-based financing in the motivation and stabilization of health providers, PEPFAR will continue the support to the HIV/AIDS-related indicators as established by the MOH.*

*PEPFAR will assist in assessing the health curriculum in developing a SOW for an evaluation of the current health provider training curriculum. The assessment will show which level of health providers are most needed and work to train individuals in these areas. This will include working with education institutions to revise the training curriculum where necessary in order to have graduates ready to provide critical HIV/AIDS services. All the trainings will meet global standards.*

*Given the importance of human resources in the health sector, the USG will consider negotiating with the GOB the development and implementation of a national HRH plan. This will be discussed during the negotiation of a Partnership Framework Agreement between the GOB and the USG and will incorporate the work completed by the GOB and its partners, particularly the Belgian and Swiss Cooperations.*



### Technical Area Summary Indicators and Targets

Future fiscal year targets are redacted.

Indicator Number	Label	2013	Justification
P1.1.D	P1.1.D Percent of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	n/a	Redacted
	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	125,595	
P1.2.D	P1.2.D Number and percent of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery	95 %	Redacted
	Number of HIV-positive pregnant women who received antiretrovirals (ARVs) to reduce risk of mother-to-child-transmission	1,169	
	Number of HIV-	1,230	



	positive pregnant women identified in the reporting period (including known HIV-positive at entry)		
	Life-long ART (including Option B+)		
	Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery)		
	Maternal AZT (prophylaxis component of WHO Option A during pregnancy and delivery)		
	Single-dose nevirapine (with or without tail)		
	Newly initiated on treatment during current pregnancy (subset of life-long ART)		
	Already on treatment at the beginning of the current pregnancy (subset of life-long ART)		
	Sum of regimen type disaggregates		
	Sum of New and		



	Current disaggregates		
P6.1.D	Number of persons provided with post-exposure prophylaxis (PEP) for risk of HIV infection through occupational and/or non-occupational exposure to HIV.	625	Redacted
	By Exposure Type: Occupational	125	
	By Exposure Type: Other non-occupational	125	
	By Exposure Type: Rape/sexual assault victims	375	
P7.1.D	P7.1.D Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of 'Prevention with PLHIV (PLHIV) interventions	n/a	Redacted
	Number of People Living with HIV/AIDS reached with a minimum package of 'Prevention of People Living with HIV (PLHIV) interventions	13,497	
P8.1.D	P8.1.D Number of the targeted population reached with	n/a	Redacted



	individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required		
	Number of the target population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required	104,500	
P8.2.D	P8.2.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of the target population reached with individual and/or small group level HIV	66,000	



	prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required		
P8.3.D	P8.3.D Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	12,250	
	By MARP Type: CSW	1,560	
	By MARP Type: IDU	0	
	By MARP Type: MSM	40	
	Other Vulnerable Populations	10,650	
	Sum of MARP types	12,250	
P11.1.D	Number of individuals who received T&C	311,898	Redacted



	services for HIV and received their test results during the past 12 months		
	By Age/Sex: <15 Male	3,743	
	By Age/Sex: 15+ Male	77,350	
	By Age/Sex: <15 Female	4,678	
	By Age/Sex: 15+ Female	226,127	
	By Sex: Female	230,805	
	By Sex: Male	81,093	
	By Age: <15	9,357	
	By Age: 15+	302,541	
	By Test Result: Negative		
	By Test Result: Positive		
	Sum of age/sex disaggregates	311,898	
	Sum of sex disaggregates	311,898	
	Sum of age disaggregates	311,898	
	Sum of test result disaggregates		
C1.1.D	Number of adults and children provided with a minimum of one care service	24,009	Redacted
	By Age/Sex: <18 Male	6,867	
	By Age/Sex: 18+ Male	3,385	
	By Age/Sex: <18 Female	6,098	



	By Age/Sex: 18+ Female	7,659	
	By Sex: Female	13,685	
	By Sex: Male	10,324	
	By Age: <18	12,965	
	By Age: 18+	11,044	
	Sum of age/sex disaggregates	24,009	
	Sum of sex disaggregates	24,009	
	Sum of age disaggregates	24,009	
C2.1.D	Number of HIV-positive individuals receiving a minimum of one clinical service	15,429	Redacted
	By Age/Sex: <15 Male	1,543	
	By Age/Sex: 15+ Male	4,166	
	By Age/Sex: <15 Female	1,389	
	By Age/Sex: 15+ Female	8,331	
	By Sex: Female	9,875	
	By Sex: Male	5,554	
	By Age: <15	2,932	
	By Age: 15+	12,497	
	Sum of age/sex disaggregates	15,429	
	Sum of sex disaggregates	15,429	
	Sum of age disaggregates	15,429	
C2.2.D	C2.2.D Percent of	95 %	Redacted



	HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis		
	Number of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	14,658	
	Number of HIV-positive individuals receiving a minimum of one clinical service	15,429	
C2.4.D	C2.4.D TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting	80 %	Redacted
	Number of HIV-positive patients who were screened for TB in HIV care or treatment setting	12,343	
	Number of HIV-positive individuals receiving a minimum of one clinical service	15,429	
C4.1.D	C4.1.D Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth	50 %	Redacted



	Number of infants who received an HIV test within 12 months of birth during the reporting period	584	
	Number of HIV-positive pregnant women identified in the reporting period (include known HIV-positive at entry)	1,169	
	By timing and type of test: virological testing in the first 2 months	117	
	By timing and type of test: either virologically between 2 and 12 months or serology between 9 and 12 months	467	
C5.1.D	Number of adults and children who received food and/or nutrition services during the reporting period	4,121	Redacted
	By Age: <18	0	
	By Age: 18+	0	
	By: Pregnant Women or Lactating Women	2,473	
	Sum of age disaggregates	0	
H1.1.D	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests	10	Redacted



H2.1.D	Number of new health care workers who graduated from a pre-service training institution or program	116	Redacted
	By Cadre: Doctors	40	
	By Cadre: Midwives	0	
	By Cadre: Nurses	76	
H2.3.D	The number of health care workers who successfully completed an in-service training program	1,600	Redacted
	By Type of Training: Male Circumcision	0	
	By Type of Training: Pediatric Treatment	0	



## Partners and Implementing Mechanisms

### Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
14342	Engender Health	Private Contractor	U.S. Agency for International Development	GHP-State	300,000
14343	University of North Carolina at Chapel Hill, Carolina Population Center	University	U.S. Agency for International Development	GHP-State	500,000
14352	International Broadcasting Bureau, Voice of America	NGO	U.S. Department of State/Bureau of African Affairs	GHP-State	100,000
14592	Population Services International	NGO	U.S. Department of Defense	GHP-State	572,412
14593	Partnership for Supply Chain Management	Private Contractor	U.S. Agency for International Development	GHP-State	3,541,567
16663	TBD	TBD	Redacted	Redacted	Redacted
16664	TBD	TBD	Redacted	Redacted	Redacted
16665	Abt Associates	Private Contractor	U.S. Agency for International Development	GHP-State	525,000
16666	GH Tech	Private Contractor	U.S. Agency for International Development	GHP-State	200,000
16668	Management Sciences for Health	NGO	U.S. Agency for International Development	GHP-State	250,000

Approved



16669	United States Pharmacopeia	Private Contractor	U.S. Agency for International Development	GHP-State	250,000
16770	Abt Associates	Private Contractor	U.S. Agency for International Development	GHP-State	700,000
17095	Training Resources Group	Private Contractor	U.S. Agency for International Development	GHP-State	50,000
17119	TBD	TBD	Redacted	Redacted	Redacted



## Implementing Mechanism(s)

### Implementing Mechanism Details

<b>Mechanism ID: 14342</b>	<b>Mechanism Name: Engender Health GH-08-2008 RESPOND</b>
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Engender Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

<b>Total Funding: 300,000</b>	
<b>Funding Source</b>	<b>Funding Amount</b>
GHP-State	300,000

### Sub Partner Name(s)

(No data provided.)

### Overview Narrative

*The objective of the RESPOND activity is to improve sexual violence (SV) prevention and response efforts in Burundi. The proposed activities will be articulated around 3 specific objectives which are:*

- *Objective 1: Health sector response for SV survivors strengthened (Supply)*
- *Objective 2: Gender norms transformed to prevent SV and support survivors (Enabling environment)*
- *Objective 3: Capacity of communities and civil society to prevent SV Increased (Demand)*

*The RESPOND activity will be implemented in two of the four provinces currently supported by PEPFAR: Muyinga and Kayanza. The selection of these provinces is based on the need of building upon the relationships existing between the MCH and the PEPFAR programs. The target population is 1.5 million.*

*To implement specific SV activities, RESPOND will identify and partner with local NGOs. With the technical assistance from RESPOND, the identified NGOs will train Health providers in medical response, counseling of survivors, and the ethical management of survivors' information. They will also coordinate community mobilization interventions and link with local authorities.*

*RESPOND will track the number of people trained as well changes in the knowledge, attitudes, and skills based pre*



and post-tests and follow-up visits three to six months after the training. It will also track the number of survivors assisted.

### Cross-Cutting Budget Attribution(s)

Gender: GBV	300,000
Gender: Gender Equality	50,000
Human Resources for Health	70,000

### TBD Details

(No data provided.)

### Key Issues

Implement activities to change harmful gender norms & promote positive gender norms  
 Increase gender equity in HIV prevention, care, treatment and support  
 Increasing women's legal rights and protection

### Budget Code Information

<b>Mechanism ID:</b>	14342		
<b>Mechanism Name:</b>	Engender Health GH-08-2008 RESPOND		
<b>Prime Partner Name:</b>	Engender Health		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	300,000	0
<b>Narrative:</b>			
<p><i>In order to understand more deeply the problem of sexual violence, the USG, through PEPFAR, conducted a sexual violence assessment in 2011 to inform programming. Two key findings from the assessment are stated below:</i></p> <ul style="list-style-type: none"> <li>• <i>Burundi's discriminatory legislation, stereotypes and prejudice against women all contribute to attitudes that</i></li> </ul>			



value girls less than boys, impede girls' education, and also put women in a secondary position within their homes. They also contribute to the exclusion of women from inheriting land and obtaining jobs, and participating in decision making at all levels. This deeply entrenched gender inequality has provided an enabling environment for high levels of sexual violence. The civil war in Burundi exacerbated this violence, which continues today, with near total impunity.

- Data on the prevalence of sexual violence are available, but not collected in a coherent and coordinated manner. There is also significant underreporting of violence due to a number of factors. First, discussion about sex is taboo in Burundian society. As sex is not talked about, neither is sexual violence. Second, stigmatization of the victim can lead to her exclusion from her family home. As well, the acceptance and normalization of the crime, the ignorance of the fact that sexual violence is a crime, the lack of victim protection, the lack of access to legal services, the distrust of the police and negative attitudes from service providers in general discourage victims from denouncing the crime. Widespread impunity discourages women to trust and use the legal system.

As a first step toward strengthening the referral system for SV survivors and building capacity for SV prevention and response, RESPOND will map existing services for SV survivors in the two target provinces. Methods will include facility audits and a stakeholder's community consultation. Results will inform the development of a training strategy, help select the health facilities to work with and highlight the urgent equipment needs for facilities to better respond to SV.

In addition, RESPOND will undertake a formative study of social norms around SV. The project will conduct a literature review as well as in-depth interviews, focus group discussions, and other qualitative methods with men and women in the target provinces. In partnership with the Ministry of National Solidarity, Human Rights and Gender, and NGOS, RESPOND will use the results of the social norms study to develop a BCC strategy to transform the inequitable gender norms that underlie SV.

The project will develop BCC/IEC messages and materials based on the results of the social norms study and materials already available in Burundi and similar contexts. Messages and materials will be pre-tested with the target audience, refined, produced, and disseminated. With the assistance of RESPOND's local consultant, the NGOs will put in place a referral network for the SV survivors at the provincial level that will encompass:

- linkages with trained health care providers to treat SV survivors
- active referral of the survivors, as appropriate, to legal aid, the police, and social support services
- organization of community activities aiming at transforming gender norms and raising awareness around SV (e.g., training of CHWs in SV, group discussions with men, advocacy with religious and traditional leaders). The interventions will be based on the recommendations from the BCC strategy that will have been developed before.

**Implementing Mechanism Details**

Mechanism ID: 14343	Mechanism Name: GH 01-2008 MEASURE Phase III MMAR
Funding Agency: U.S. Agency for International	Procurement Type: Contract



Development	
Prime Partner Name: University of North Carolina at Chapel Hill, Carolina Population Center	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

<b>Total Funding: 500,000</b>	
<b>Funding Source</b>	<b>Funding Amount</b>
GHP-State	500,000

### Sub Partner Name(s)

(No data provided.)

### Overview Narrative

*The Measure Evaluation activity has the objective of contributing to the improvement of the health information system in Burundi especially for HIV/AIDS. It will also be contributing to the implementation of the GHI Country Strategy in which one of the three priority areas is a "Strengthened Health Management Information System (HMIS)". The activity will have a national coverage with a particular focus on the PEPFAR-supported provinces. Measure Evaluation will be working with the national service in charge of health management information system with the purpose of strengthening its capacity and to comply with the local capacity building principle. Measure Evaluation will track the results of its activities by tracking some indicators like: integrated M&E system and tools in place, HMIS coordination system in place and fully functional, percentage of health facilities that use integrated M&E tools for data collection, and percentage of health facilities that regularly provide complete and accurate reports.*

### Cross-Cutting Budget Attribution(s)

Human Resources for Health	250,000
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### TBD Details

(No data provided.)



**Key Issues**

Increase gender equity in HIV prevention, care, treatment and support

**Budget Code Information**

<b>Mechanism ID:</b>	14343		
<b>Mechanism Name:</b>	GH 01-2008 MEASURE Phase III MMAR		
<b>Prime Partner Name:</b>	University of North Carolina at Chapel Hill, Carolina Population Center		
<b>Strategic Area</b>	<b>Budget Code</b>	<b>Planned Amount</b>	<b>On Hold Amount</b>
Governance and Systems	HVSI	500,000	0

**Narrative:**

*MEASURE Evaluation will implement the following activities to assist the national Health Management Information system.*

*1. Develop a coordination plan with the MOH of Burundi, USAID Mission Burundi, and Belgian Technical Cooperation (BTC).*

*MEASURE Evaluation will determine clearer roles and responsibilities after a first scoping visit. The BTC has recently committed €7-8 million for the development of Burundi's Health Management Information System devoted primarily to computerization of hospitals and related services and training. MEASURE Evaluation will conduct an assessment (including desk review) of HMIS to determine any gaps in BTC support, develop costed Capacity Building Plans, and assist with implementation of the plans.*

- 2. Performance of Routine Information System Management (PRISM) monitoring and assessment tools activities*
  - a. Train central, sub national/district level core trainers*
  - b. Carry out an assessment on the HMIS and then provide technical assistance to the MOH in the development of a detailed action plan to help strengthen the HMIS*
  - c. Dissemination workshop for sharing results and next steps*

*The PRISM framework develops operational definitions of (1) RHIS performance, (2) self-efficacy or confidence*



*level for RHIS Tasks, (3) competence level of RHIS tasks, (4) transmission, completeness and accuracy processes, (5) RHIS data demand, (6) problem solving skills, and (7) a culture of information. The PRISM framework is the first to offer empirical tests of relationships between technical, behavioral and organizational factors and RHIS processes and performance. It creates opportunities to identify whether determinants of performance act directly or indirectly through behavioral determinants or processes, or in interaction with each other, to influence RHIS performance.*

*3. Introduce Routine Data Quality Assessment (RDQA) as a means to check data quality on regular basis*

*The RDQA will use standard tools to trace program data to its sources, and assess quality components at each level of the data flow. This activity will also include a Training of Trainers to build sustainable capacity within Burundi to implement future RDQA activities.*

**Implementing Mechanism Details**

<b>Mechanism ID: 14352</b>	<b>Mechanism Name: VOA HIV prevention</b>
Funding Agency: U.S. Department of State/Bureau of African Affairs	Procurement Type: Inter-Agency Agreement
Prime Partner Name: International Broadcasting Bureau, Voice of America	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:
<b>Total Funding: 100,000</b>	
<b>Funding Source</b>	<b>Funding Amount</b>
GHP-State	100,000

**Sub Partner Name(s)**

(No data provided.)

**Overview Narrative**

*The VOA activity's goal is to raise awareness of the Burundian population especially the youth about HIV prevention through specific HIV radio programs. This activity will contribute to the implementation of the Burundi GHI strategy particularly one the three cross-cutting areas: "Improved behavior and increased demand for health services". The geographic coverage of the VOA program is nationwide and more that 8.5 million populations will*



*be covered. The program will be articulated around a weekly 30 minutes radio program in Kirundi (Burundian local language spoken country wide) that focuses on HIV/AIDS, Tuberculosis, gender-based violence and to some extent Maternal and child health. For more sustainability and capacity building purposes, the program will be prepared and disseminated through local media in particular RPA which has already working relationships with VOA. VOA will conduct extensive research and monitoring of its shows to demonstrate reach and impact. VOA's outside contractor, Intermedia will include questions about effectiveness of the radio program, its quality, and impact on audiences.*

**Cross-Cutting Budget Attribution(s)**

(No data provided.)

**TBD Details**

(No data provided.)

**Key Issues**

- Implement activities to change harmful gender norms & promote positive gender norms
- Increase gender equity in HIV prevention, care, treatment and support
- Increasing women's legal rights and protection
- Military Population

**Budget Code Information**

<b>Mechanism ID:</b> 14352			
<b>Mechanism Name:</b> VOA HIV prevention			
<b>Prime Partner Name:</b> International Broadcasting Bureau, Voice of America			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	100,000	0
<b>Narrative:</b>			



*VOA, whose mission is to deliver news and facts-based information, will interview and consult with leading national and international health officials as it develops stories and features about health topics of vital importance to the people of Burundi. Some of the stories and features include:*

- *Healthy lifestyles, including ending multiple partners, faithfulness and drug avoidance;*
- *HIV testing, treatment and care;*
- *Mother –to- child transmission of HIV*
- *Gender-based and sexual violence*
- *Tuberculosis, prevention measures and treatment*

*Using a network of stringers across the country, a trained medical doctor, professional journalists and radio dramas, VOA will give a voice to Burundi's young majority, allowing them to have a say in helping combat the HIV/AIDS epidemic and other critical health issues. The program will also concentrate on women empowerment in the struggle against gender-based and sexual violence. VOA will conduct extensive research and monitoring of its shows to demonstrate reach and impact. VOA's outside contractor, Intermedia will include questions about effectiveness of the radio program, its quality, and impact on audiences.*

### Implementing Mechanism Details

<b>Mechanism ID: 14592</b>	<b>Mechanism Name: PSI HIV prevention</b>
Funding Agency: U.S. Department of Defense	Procurement Type: Cooperative Agreement
Prime Partner Name: Population Services International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

<b>Total Funding: 572,412</b>	
<b>Funding Source</b>	<b>Funding Amount</b>
GHP-State	572,412

### Sub Partner Name(s)

(No data provided.)

### Overview Narrative

*The overall goal of this project is to contribute to the reduction of HIV prevalence among the Burundi National Defense Forces (NDF) personnel and their families. This falls under the National Health Development Plan which highlights HIV prevention as one of the major areas of intervention over the next five years and under the National*



*Strategic Plan for the Fight against HIV/AIDS. The project targets NDF personnel and their families'. The number of military personnel and their family members represent a target population of about 100,000 persons. The project interventions will be implemented in collaboration with the Ministry of Health through its National AIDS Council (SEP/CNLS), the NDF health authorities, and other partners. Planned interventions aim to reduce the HIV prevalence among NDF personnel and their families through the accomplishment of four main results: 1) improved access to CT services; 2) improved access to condoms; 3) improved HIV prevention awareness; 4) reinforced NDF staff capacity to implement HIV prevention programs. To assure sustainability, the project will reinforce the capacity of the NDF and involving the SEP/CNLS in project implementation. A monitoring and evaluation plan will be developed to monitor the progress of the project's performance indicators which will include new generation PEPFAR indicators.*

*Vehicles are needed to ensure effective and consistent condom management, distribution and monitoring at the intermediate and peripheral levels throughout the 5 military regions. They are also needed to implement and monitor other project activities. To that end, one vehicle will be purchased through the COP 12 budget to fulfill the needs partially covered by the two vehicles that will be purchased in FY 11.*

**Cross-Cutting Budget Attribution(s)**

Human Resources for Health	150,000
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**TBD Details**

(No data provided.)

**Key Issues**

- Implement activities to change harmful gender norms & promote positive gender norms
- Military Population
- TB
- Family Planning

**Budget Code Information**



<b>Mechanism ID:</b>	<b>14592</b>		
<b>Mechanism Name:</b>	<b>PSI HIV prevention</b>		
<b>Prime Partner Name:</b>	<b>Population Services International</b>		
<b>Strategic Area</b>	<b>Budget Code</b>	<b>Planned Amount</b>	<b>On Hold Amount</b>
Prevention	HVCT	300,000	0

**Narrative:**

*Building on the effective collaboration with the NDF and the MOH, PSI/Burundi will continue supporting the NDF in its efforts to offer CT services to military personnel and their families at the fixed CT “Akabanga®” center located in Bujumbura in the first military region and through 3 mobile CT units throughout the 5 military regions. The number of military personnel in the country is estimated at about 30,000 people out of which the majority are 25-34 years old; the military personnel with their families represent a target population of about 100,000 persons who are spread all over the country in the 5 military regions. Each region is further divided into two brigades composed of six battalions for a total of 60 battalions throughout the country. Burundi is highly engaged in Peacekeeping Mission in Somalia (AMISOM). Troops moving to Somalia need to be sensitized on HIV prevention and HIV tested. Since February 2009, PSI/Burundi has offered CT services to peacekeepers. So far, about 8,000 peacekeepers have been tested prior to deployment to Somalia. During FY 12 this activity will be reinforced. Voluntary or systematic HIV testing will be accompanied by HIV prevention BCC activities which will be conducted through outreach awareness sessions, and production and distribution of IEC printed materials. During FY 10, PSI/Burundi conducted a total of 15 sessions using mobile video units, placed 1,000 posters throughout military camps, and distributed 4,000 leaflets and 1,000 t-shirts promoting CT services during awareness sessions. Concerning NDF care providers’ capacity building, 92 counselors and 10 lab technicians were trained during the previous phases of this project; during the FY 11 a total number of 46 counselors and the 10 lab technician received refresher training. This process will be completed during the FY 12 with a refresher training given to the remaining 46 counselors. During FY 12, about 12,300 clients will be HIV tested. Approximately 1,500 military personnel and their families will receive CT services at the fixed “Akabanga” center; 4,800 military personnel and their families will be HIV tested through mobile CT units throughout the 5 military regions in the country; and 6,000 peacekeepers (6 battalions to AMISOM) will be HIV tested prior to deployment to Somalia. Female peacekeepers will receive tailored counseling on reproductive health with a particular focus on family planning services in addition to CT services. The project will also promote HIV testing for couples. The project will collaborate with the National Institute of Public Health (INSP) and the military hospital to ensure quality of HIV tests and the provision of care and support services to clients who test HIV positive. The capacity of providers at the fixed “Akabanga” CT center will be reinforced to increase their ability to provide support and counseling to clients who test HIV positive. PSI/Burundi will also strengthen the referral system from CT services to providers’ services for HIV positive clients. CT services will not only be supported by BCC activities but will also be accompanied by condom distribution as well as the distribution of IEC materials. The monitoring system will align with the existing*



*national monitoring system defined by the PSNLS 2012-2016 and by the NDF HIV strategic plan. Care providers will be trained to correctly and consistently use existing tools. Data will be collected on a monthly basis.*

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	272,412	0

**Narrative:**

*Prevention of HIV sexual transmission through free condom distribution and behavior change communication (BCC) is an important component of the U.S. DoD HIV program. Condom distribution was introduced to the DOD/DHAPP project during FY 11 in response to the gap left in Burundi by the phasing out of the World Bank program and the cancellation of the GF Round 11 grant cycle. The target population of these interventions for HIV sexual prevention (HVOP) includes military personnel and their families living in the five military regions and military troops involved in the Peacekeeping Mission in Somalia. BCC interventions, mainly interpersonal communication (IPC) activities are important. According to a study conducted by the SEP/CNLS, in 2011 only 32.7% of military personnel know HIV prevention methods and reject rumors/misconceptions related to VIH transmission. The same study reported low condom use among military personnel: only 19.5% used a condom during their first sexual intercourse and 55, 6% during the last sexual act with a commercial partner. These findings corroborate the results from the PSI TRaC study conducted in 2009 which showed a level of 46% for consistent condom use among military with occasional partners compared to 23% in 2007. The condom distribution component added to this project will contribute to increased condom use. PSI/Burundi will train 240 peer educators and 80 military focal persons in HIV prevention messages, IPC techniques and condom promotion, management and distribution. A monitoring system will be put in place with appropriate monitoring tools. Supervision visits in the military camps will be conducted on a regular basis.*

**Implementing Mechanism Details**

<b>Mechanism ID: 14593</b>	<b>Mechanism Name: SCMS Commodity procurement</b>
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Partnership for Supply Chain Management	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:
<b>Total Funding: 3,541,567</b>	



Funding Source	Funding Amount
GHP-State	3,541,567

### Sub Partner Name(s)

(No data provided.)

### Overview Narrative

*The Supply Chain Management System will procure and distribute essential medicines and health supplies. It will also work to strengthen existing supply chains in the field and facilitate collaboration and the exchange of information among key donors and other health providers. This activity contributes to the GHI Burundi goal which is “Improved Health of the Burundian population”, especially for girls and women.*

*The SCMS activity is a support service for the provision of HIV/AIDS prevention, care and support services. This activity will cover especially the eight provinces supported by PEPFAR and will procure and distribute the medical supplies in the eight provinces. Additionally, the strengthening of the supply chain will target the national level. The activity’s targets are the general population, pregnant women and their partners, people living with HIV/AIDS (PLWHA), orphans of AIDS and other vulnerable children, youth, low-income women and most- at- risk populations (MARPs).*

*To be more efficient, the SCMS activity will pool procurements with other countries so that unit prices can be reduced. As already stated above, one of SCM tasks is to strengthen the capacity of the national supply chain, the ultimate goal being to work through the Burundi national supply chain system for more sustainability and country ownership.*

*For the tracking of the progress, custom indicators will be established by the USG team in Bujumbura in collaboration with SCMS.*

### Cross-Cutting Budget Attribution(s)

Human Resources for Health	250,000
Motor Vehicles: Purchased	50,000
Water	70,000

### TBD Details

(No data provided.)



## Key Issues

Child Survival Activities

Safe Motherhood

## Budget Code Information

<b>Mechanism ID:</b> 14593			
<b>Mechanism Name:</b> SCMS Commodity procurement			
<b>Prime Partner Name:</b> Partnership for Supply Chain Management			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	385,171	0

### Narrative:

*This activity will be jointly executed by FHI 360 and SCMS. The FHI 360 service delivery activity will support local organizations to expand basic care and support services for PLWHA. Home-based care was provided to 11,100 individuals, including monthly psychosocial support visits provided through community health workers (CHWs) based in all the communes of Karusi, Kayanza, Muyinga and Kirundo provinces in 2011. In 2012, FHI will continue to support current activities for PLWHA with home-based care services. Additionally, CHWs will deliver a package that includes psychosocial support, health-care and hospitalization assistance, hygiene products, pain relievers and information on sexual prevention and testing. One of the key roles of the CHWs will be to ensure that PLWHAs whose health continues to decline are accompanied to a health facility for further care. Cotrimoxazole prophylaxis against opportunist infection will continue to be supported in all health clinics located in the four targeted provinces. In 2012, it's expected that 28,630 adult and children be provided with a minimum of one care service.*

*FHI funding will complement work supported by the GOB and other development partners in selected provinces. While USG provides no programming addressing HIV/TB co-infection, FHI will collaborate with the Global Fund, Damien Foundation, and Belgian Technical Cooperation, which are supporting the national TB and HIV/TB co-infection programs. During TC for HIV, clients will be screened for common signs of TB. Clients who present with symptoms will be referred to TB centers. The same test-and-referral approach will be adopted for TB patients.*

*The specific role of SCMS will be the purchase of pain relievers, cotrimoxazole for the prevention of opportunistic infections, and clean water devices. In addition, once the people living with HIV/AIDS need biological follow-up*



and PMTCT services, they will use the products purchased and managed by SCMS.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	587,783	0

**Narrative:**

*The Directorate of Pharmacies, Medicines, and Laboratories (DPML) is the division of the Ministry of Public Health (MOPH) charged with the responsibility of providing oversight to the pharmaceutical sector. The DPML oversees the central purchasing and warehousing agency, “Centrale d’Achat de Médicaments Essentiels du Burundi” (CAMEBU). Procurement and management of all public sector pharmaceuticals (both government and faith-based) is the responsibility of CAMEBU. The Permanent Executive Secretariat of the National Council to Fight against AIDS oversees the quantification and identification of ARV needs for Burundi as well as other HIV/AIDS related products.*

*Some assessments and audits have been conducted by the USG (through the malaria program) and development partners on the Burundian pharmaceutical management and supply chain system. To build on the past recommendations and findings for the supply chain system, the USG has requested Supply Chain Management Systems (SCMS) to support Burundi in addressing supply chain design, performance, and planning in order to support the HIV/AIDS program. In December 2011, SCMS conducted an initial assessment of the supply chain system and process analysis. The assessment report provided recommendations on what activities should be implemented to improve the supply chain in Burundi. The proposed activities intend to ensure uninterrupted access to essential HIV/AIDS. They include among others:*

- *Creation of written procedures for the control and supervision of medical prescriptions;*
- *Training for the logisticians on the correct use of the district manual of procedures;*
- *Ensuring feedback after each training;*
- *Applying good definition of logistical tasks at the health facility level;*
- *Provision of written procedures for transportation of medical products;*
- *Ensuring that all overstocked products are distributed to other out-of-stock sites;*
- *Organization of regular discussion forums between medical prescribers and the organisation responsible for ordering stock;*
- *Correct usage of the quantification formula used during the forecasting process;*
- *Implementation of national logistic management information system to facilitate the gathering of accurate consumption data from all the health facilities.*

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	138,000	0

**Narrative:**



SCMS will be complementing the services provided by FHI 360. In FY 2011, FHI 360 continued to support sub partners to provide quality and confidential HTC services in accordance with the national protocol. Thus, 137,913 individuals were tested for HIV and 134,866 of them received their test results. In FY 12, FHI 360 service delivery activities will continue to extend HTC services in the provinces of Kayanza, Karusi, Muyinga, and Kirundo. The target population will be the high risk groups who circulate in those provinces and the communities in high transmission areas in those provinces. The target groups include truck drivers and their assistants, sex workers, general population, low income women, men and other community members. In 2012, it is expected that 220,602 individuals will receive testing and counseling services for HIV and get their test results. HIV CT will also be extended to STI and TB patients. The following strategies will be used to reach the target populations:

- a. Training health providers in HTC. Training will be based on the national guidelines with special attention to improving counseling skills for clients who test positive, discordant couples, and identifying and counseling HTC clients with hazardous drinking behavior;
- b. Actively promoting testing to all family members where the index patient is found to be positive;
- c. Widely promoting provider-initiated testing and counseling. Interventions will emphasize couples counseling and testing among MARPs (truckers, PLWHA, sex workers);
- d. Collaborating with partners to increase referral to HTC services. All STI clients will systematically be counseled for HCT; and
- e. Continuing support for PBF for the following HCT indicator: Number of people tested for HIV.

SCMS will be in charge of purchasing rapid HIV test kits, laboratory equipment, and reagents and will also jointly monitor with FHI 360 the use of the products.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	250,000	0

**Narrative:**

The activity will be jointly implemented by FHI 360 and SCMS. To reduce sexual transmission of HIV, the FHI 360 and other partners will implement evidence-based communication and small-group/individual interpersonal interventions especially targeting CSWs, long distance drivers and their assistants. To facilitate and sustain behavior change, the FHI 360 service delivery activities will strengthen peer education. Peer educators will implement messages that promote behavior change, increase access to condoms, counseling and testing services, SGBV, and alcohol consumption. The FHI 360 activities will also facilitate HIV prevention through positive behavior by working with the PLHIV association and by focusing interventions on the household unit.

The recreation center based in Bujumbura's main parking yard will be selected as a preferred location to reach long distance drivers using the north and the east corridors to reach Uganda, Rwanda, Tanzania, and Kenya. Condoms will be made available in the Bujumbura recreation Center and the FHI 360 service delivery activity will



*continue to refer users to other services such as HTC, ART, and preventive therapy against opportunistic infections. In FY 12, it is expected that 3,550 MARPs will be reached with individual and/or small group level HIV Interventions that are based on evidence and /or meet minimum standards required.*

*In addition, activities will include BCC targeting young girls and family communication, use of post-exposure prophylaxis (PEP) kits for health centers, and training to ensure that CHWs, teachers, and health workers are capable of screening for and addressing risks for GBV, including providing or referring GBV victims for PEP, care, and legal services. As part of a new USG initiative in country, FHI 360 partner with another USG funded partner to begin a longer-range initiative to address social and gender norms conducive to GBV and high-risk behavior by collaborating with the Ministries of National Solidarity, Repatriation of Refugees, National Reconstruction and Social Reintegration, and of Justice and Keeper of the Seals as well as relevant CSOs, religious leaders, and women's associations, to develop a strategy for BCC, advocacy, and policy analysis and reform.*

*The contribution of SCMS will be focused on purchasing rapid HIV test kits, condoms and lubricants, and the drugs for sexually transmitted infections for the most-at-risk populations.*

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	872,792	0

**Narrative:**

*The activity will be jointly implemented by FHI 360 and SCMS. In 2011 PMTCT services were provided in 82 health facilities in four provinces, reaching 76,561 pregnant women who attended the first ANC visit, 51,077 were tested for HIV and 49,568 (97%) received their test results. Antiretroviral prophylaxis was administered to 431 (72%) out of 595 HIV positive pregnant women identified.*

*In FY 2012, FHI 360 will continue to provide service delivery support to strengthen 136 existing outlets and will enroll 15 new sites in the 4 supported provinces with a high-quality PMTCT minimum package. The package includes: (1) routine ANC services, (2) screening for syphilis, (3) counseling and testing for HIV, (3) accurate information on infant feeding, (4) a complete course of ART prophylaxis to HIV positive mothers and their babies, (5) mother and child follow-up, (6) and preventive therapy using cotrimoxazole prophylaxis to infants exposed to HIV. In collaboration with the MOH, FHI's service delivery activities will ensure that infants born to HIV positive mothers are tested for HIV at six weeks using dry blood spot/polymerase reaction chain (DBS/PCR). Nutritional support will continue to be provided to the most vulnerable women. To improve the uptake of PMTCT services, the following activities will be implemented:*

- ? An assessment of the new sites to determine needs. Funds will be made available to respond to the identified needs and to ensure confidentiality, comfort and functionality;*
- ? Training health providers in collaboration with MOH and other partners by organizing in-service training for*



*new staff and refresher trainings for health care providers based on the weaknesses identified by supervisions. The trainings will include the HIV/AIDS epidemiological situation globally and in Burundi, the pathology of HIV/AIDS, how HIV is transmitted from mother to infant, how to provide TC, specific interventions for PMTCT (including the national protocol for clinical services), infant and child nutrition in the context of HIV infection, stigma and discrimination linked to HIV, mother-child follow-up, support for PLWHA (including sexual prevention, family planning, and partner reduction), and prevention of counselor burnout/fatigue;*

*? Mobilizing the community through the network of PLWHA network (RBP+), to promote couple counseling and testing;*

*? Developing appropriate IEC materials in Kirundi for clients and community members;*

*? Continuing the support for PBF for the PMTCT indicators: Number of HIV-positive pregnant women provided with antiretroviral prophylaxis and number of newborns from HIV-positive mothers provided follow-up care, ARVs to new born.*

*The specific contribution of SCMS will be the purchase of rapid HIV test kits, laboratory equipment, reagents, and ARVs for PMTCT prophylaxis as well as their management.*

*The combination of the above described activities will target an estimated 90,602 pregnant women with known HIV status be tested for HIV and receive their results. Ninety six percent (96%) of the HIV+ pregnant women will receive ARVs to reduce risk of mother to child transmission.*

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	1,192,114	0

**Narrative:**

*As already mentioned above, PEPFAR in Burundi will not be buying ARVs except those for PMTCT prophylaxis. However, given the high prevalence of sexual assaults, PEPFAR program proposed to buy a small quantity of ARVs for the survivors of sexual violence. In FY 2011, 293 survivors have been supported by the PEPFAR program. 87% of the beneficiaries were classified post-exposure prophylaxis (PEP) and unprotected occasional sex. In FY 2012, PEPFAR is planning to support 350 individuals for PEP.*

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	115,707	0

**Narrative:**

*The PEPFAR program in Burundi will not support any direct ART provision. The USG strategy will be to wrap critical technical assistance and procurements around existing adult and pediatric ART programs supported by the GOB, Global Fund, and others. Technical assistance will focus on improving the quality of adult and pediatric ART services, such as enhancing clinical and laboratory monitoring and improving the ability of clinical providers to identify treatment failure and ensure appropriate switches to second-line regimens. Procurement of medications*



*will enable health providers in intervention provinces to treat opportunistic infections and STIs. In addition, the USG will continue to procure reagents for testing, laboratory equipment (including for biochemistry and hematology), and lab reagents for biological monitoring.*

*Since 2007, collaboration with the Global Fund resulted in providing ARVs and other essential commodities to FHI to support service delivery activities at six ART sites. By September 30, 2011, Global Fund and PEPFAR were supporting 3,757 patients on ARVs. In FY 2012, the FHI will continue to support medical doctors in the following hospitals: Kayanza, Kirundo, Mukenke, Muyinga and Musema. The physician's main role will be to provide technical support and promote ART decentralization at specific identified health centers in accordance with the national ART guidelines. For this purpose, FHI 360 will train nurses and social workers in the aspects of clinical care for adults living with HIV in order to significantly engage the health centers in day-to-day care and follow-up of patients under the first line of ART regimen. In addition, according to the needs identified during the assessment, lab equipment, reagents and supplies will be provided by SCMS to ensure that basic haematological and biochemistry tests are conducted at the health facility level whenever possible. To reinforce adherence among enrolled patients on ART, service delivery activities will continue supporting the PBF for the following ART indicator: Number of ART patients monitored semi-annually.*

*SCMs will contribute in purchasing laboratory equipment including hematology and biochemistry machines as well as the reagents for CD4 count, hematology, and biochemistry reagents.*

**Implementing Mechanism Details**

<b>Mechanism ID: 16663</b>	<b>TBD: Yes</b>
<b>REDACTED</b>	

**Implementing Mechanism Details**

<b>Mechanism ID: 16664</b>	<b>TBD: Yes</b>
<b>REDACTED</b>	

**Implementing Mechanism Details**

<b>Mechanism ID: 16665</b>	<b>Mechanism Name: Health Finance &amp; Governance (HFG)</b>
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement



Prime Partner Name: Abt Associates	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

<b>Total Funding: 525,000</b>	
<b>Funding Source</b>	<b>Funding Amount</b>
GHP-State	525,000

### Sub Partner Name(s)

(No data provided.)

### Overview Narrative

*The Burundian Ministry of Public Health and Fight against HIV/AIDS (MPLS) leads the implementation of HIV/AIDS programs. However, it still needs the organizational capacity to effectively fulfill this role. Indeed, in its second National Health Plan 2011-2015, the ministry has acknowledged the need to reinforce its leadership as well as ensuring better multi-sectoral collaboration. The implementation of HIV/AIDS activities is also hampered by the weak capacity of the MSPLS to coordinate the financing and activities of all stakeholders in the sector. There is a lack of monitoring, with limited supportive supervision taking place in the field. These challenges exist at the central, provincial, and health district levels.*

*Within MSPLS, there is recognition of the need to build the capacity of the national HIV/AIDS Program (PNLS) to enable it to better plan, implement and monitor HIV/AIDS programs and activities.*

*HFG's technical assistance will contribute in addressing the above described challenges by focusing on two main areas:*

- 1. Strengthen the organizational capacity of the PNLS as a whole to enable it to fulfill its role in leading, managing, monitoring, and coordinating HIV/AIDS activities.*

*The organizational capacity building approach will be holistic with special emphasis on the PMTCT unit within PNLS. This will enable the PMTCT unit staff to apply what they have learned from the PNLS wide organizational capacity building directly to their day-to-day tasks. Using the experience with the PMTCT unit, HFG will work with other PNLS units in future years to strengthen their capacity in a similar way. In the first year, this activity will focus on the PNLS at the national level. As the management at the national level is strengthened, HFG will extend capacity build*



### Cross-Cutting Budget Attribution(s)

Human Resources for Health	525,000
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### TBD Details

(No data provided.)

### Key Issues

(No data provided.)

### Budget Code Information

<b>Mechanism ID:</b>	16665		
<b>Mechanism Name:</b>	Health Finance & Governance (HFG)		
<b>Prime Partner Name:</b>	Abt Associates		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	525,000	0

#### Narrative:

The HFG's overall focus will be to build the capacity of the PNLs to ensure that it can effectively plan, manage and monitor HIV/AIDS activities with specific applications to PMTCT. As illustration, if HFG strengthens planning systems for PNLs, it will then work intensively with the PMTCT Unit to develop its annual PMTCT plan. This approach will allow HFG to respond to the broader capacity strengthening of PNLs as well as the specific PMTCT program.

HFG will take a very comprehensive view of organizational capacity building and will look to improve effectiveness in all areas of the PNLs: leadership and management, planning and budgeting, monitoring and evaluation, supervision, and coordination. This will be a contribution to the government's National HIV/AIDS Strategic Plan 2012-2016 on its key objective related to building the capacity to coordinate, monitor and evaluate HIV/AIDS activities.

HFG will support the MSPLs in costing its HIV/AIDS services, in particular PMTCT services. This technical support combined with the organizational capacity building complement each other in two ways. It will help to strengthen some of PNLs's organizational functions i.e. supporting the costing activity will



contribute directly to better planning and budgeting of the PNLS, as well as providing valuable data in order to mobilize additional resources. Secondly, the PNLS will be able to apply what it has learned in organizational capacity building directly to a technical activity e.g. with strengthened leadership and management, the PNLS will plan the costing activity, assemble a qualified team for the costing, assign clear roles and responsibilities to team members, and monitor implementation. HFG will work with the PMTCT unit, as well as other necessary stakeholders, to ensure that they lead and are fully involved in the costing activity, with the ultimate objective of the MSPLS conducting its future costing activities without external assistance. Better costing information on HIV services will enable the PNLS to clearly identify the resources necessary to achieving the targets set in the National Strategic Plan for the Fight against AIDS 2012-2016. These improved budgets will be more accurate and evidence-based, and will be a useful tool to advocate both within and without the governments for increase funding.

**Implementing Mechanism Details**

<b>Mechanism ID: 16666</b>	<b>Mechanism Name: Development &amp; Training Services</b>
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: GH Tech	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

<b>Total Funding: 200,000</b>	
<b>Funding Source</b>	<b>Funding Amount</b>
GHP-State	200,000

**Sub Partner Name(s)**

(No data provided.)

**Overview Narrative**

*The GH Tech Project provides ready access to high quality, external technical expertise to support USAID Missions in key functions such as independent evaluations of health projects and programs, rapid formative assessments and studies, project design, procurement, policy analysis, and strategic planning. The project provides Missions with*

Approved



*administrative and managerial support, assistance in specific technical areas, and responds to other needs as appropriate. The mechanism also provides assistance in the planning, organization, implementation, and documentation of meetings, conferences, retreats, workshops, and other events.*

*The GH Tech Project supports Global Health Initiative and PEPFAR principles and is aligned with USAID Forward reforms and the agency's Evaluation Policy. Drawing from a large pool of experienced international consultants, the project provides independent technical experts to conduct assessments and studies, evaluate PEPFAR-funded activities, and support USAID Missions in all phases of project design, implementation, and management. This support help ensures that USAID PEPFAR activities are evidence-based and that performance information is available for informed decision-making.*

### **Cross-Cutting Budget Attribution(s)**

(No data provided.)

### **TBD Details**

(No data provided.)

### **Key Issues**

(No data provided.)

### **Budget Code Information**

<b>Mechanism ID:</b>	16666		
<b>Mechanism Name:</b>	Development & Training Services		
<b>Prime Partner Name:</b>	GH Tech		
<b>Strategic Area</b>	<b>Budget Code</b>	<b>Planned Amount</b>	<b>On Hold Amount</b>
Governance and Systems	OHSS	200,000	0
<b>Narrative:</b>			



USAID/Burundi will provide funding to GH Tech to support the necessary technical expertise to design, manage, and evaluate program activities. A number of the technical assistance services that the team would access are:

- Program Evaluations;
- Health Sector Assessments;
- Program Designs;
- Technical Program Assistance;
- Convening of Consultative Groups;
- Research Tracking;
- Dissemination of Lessons Learned; and
- Technical Reviews.

USAID/Burundi will also use this mechanism to access independent specialists, including those from universities, not-for-profit, and for-profit organizations and to obtain technical services of key experts to support areas of strategic interest to USAID.

**Implementing Mechanism Details**

<b>Mechanism ID: 16668</b>	<b>Mechanism Name: Grants Management Solutions</b>
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

<b>Total Funding: 250,000</b>	
<b>Funding Source</b>	<b>Funding Amount</b>
GHP-State	250,000

**Sub Partner Name(s)**

(No data provided.)



**Overview Narrative**

*The Global Fund is a key player in the health sector and provides a significant share of funding to combat HIV/AIDS, TB, and malaria in Burundi. Through the implementation of the Round 8 HIV/AIDS grant (Phase II with more than \$80,000,000 over three years), the Global Fund provides:*

- *ART treatment for the general population;*
- *Prevention services among the general population and for specific at risk populations*
- *Improved diagnosis and treatment of sexually transmitted infections in health facilities*
- *Enhanced prevention of HIV through blood transfusions, providing better case management of accidental exposure to blood, and to survivors of sexual violence;*
- *Expanded primary prevention of HIV infection in women of reproductive age;*
- *Strengthened PMTCT services by integrating reproductive health services.*

*The PEPFAR program will be working closely with the Global Fund to make sure that necessary synergies are established and efforts to avoid duplication are successful. In fact, the success of PEPFAR programs is intrinsically linked to an effective implementation of GF-supported programs. In order to maximize the chance of successful implementation, PEPFAR will bring its technical assistance through Grant management Solutions (GMS) to help Burundi through the strengthening of the Country Coordinating Mechanism and the principal Recipients of the GF grants.*

**Cross-Cutting Budget Attribution(s)**

Human Resources for Health	150,000
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**TBD Details**

(No data provided.)

**Key Issues**

(No data provided.)

**Budget Code Information**



<b>Mechanism ID:</b>	<b>16668</b>		
<b>Mechanism Name:</b>	<b>Grants Management Solutions</b>		
<b>Prime Partner Name:</b>	<b>Management Sciences for Health</b>		
<b>Strategic Area</b>	<b>Budget Code</b>	<b>Planned Amount</b>	<b>On Hold Amount</b>
Governance and Systems	OHSS	250,000	0

**Narrative:**

GMS has already provided technical assistance to the CCM in Burundi during the period of 2009-2010. Its work focused on the revision of the CCM statutes, the CCM internal regulations, the CCM procedural manual, and the capacity building of the members of the CCM. At the end of 2012, the CCM was renewed and almost 80 percent of the members are new. The CCM has already received technical assistance from the 5 Percent French Initiative to strengthen the capacity of the new members. But there are still technical assistance needs particularly in the implementation of the various GF grants. Based on the identified needs supported by a request from the CCM and the GF PRs, PEPFAR through GMS will provide urgent, short-term, management-related technical support to Global Fund grantees. Depending on the nature of the CCM request, the assistance will be targeting Financial and grant management seeking ways to strengthen financial and management systems and procedures; Monitoring and evaluation (M&E) and reporting and GMS's assistance will range from workshops on how to use the Monitoring and Evaluation Systems Strengthening Tool—a planning process required by the Global Fund—to improving reporting procedures and ensuring adequate M&E staffing.

**Implementing Mechanism Details**

<b>Mechanism ID: 16669</b>	<b>Mechanism Name: Promoting Quality of Medicines</b>
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: United States Pharmacopeia	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

<b>Total Funding: 250,000</b>	
<b>Funding Source</b>	<b>Funding Amount</b>



GHP-State	250,000
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### Sub Partner Name(s)

(No data provided.)

### Overview Narrative

*The pharmaceutical system in Burundi is negatively affected by various challenging issues. The quality assurance for medicines as well as for other medical supplies is one of them. Although the National Institute of Public Health in Bujumbura has been recently accredited as a quality assurance center, it still needs capacity building and the PQM activity will bring its expertise in that process. The PQM activity will:*

- *Strengthen the capacity of the national quality assurance center recently accredited and other national institutions involved in pharmaceutical management;*
- *Bring its technical assistance in the development of key regulatory documents in the area of the pharmaceutical management;*
- *Assure the consistent quality control/quality assurance of HIV-related products including medicines and reagents in the PEPFAR supported areas as well for the products from the Global Fund;*

*PQM will develop an annual work plan and will provide measurable indicators to track progress in this area.*

### Cross-Cutting Budget Attribution(s)

(No data provided.)

### TBD Details

(No data provided.)

### Key Issues

Safe Motherhood

### Budget Code Information



<b>Mechanism ID:</b>	<b>16669</b>		
<b>Mechanism Name:</b>	<b>Promoting Quality of Medicines</b>		
<b>Prime Partner Name:</b>	<b>United States Pharmacopeia</b>		
<b>Strategic Area</b>	<b>Budget Code</b>	<b>Planned Amount</b>	<b>On Hold Amount</b>
Governance and Systems	OHSS	250,000	0

**Narrative:**

The purchase of medicines, laboratory reagents, HIV test kits, and other HIV related commodities for the PEPFAR program in Burundi are bought by SCMS. SCMS makes sure that these products respond to the quality assurance requirements until there are shipped to Burundi. PQM will be responsible of assuring quality control and quality assurance of the products once in Burundi. It will work with the various institutions involved in the pharmaceutical management to build their capacity while contributing to the improvement of the regulatory package of the pharmaceutical sector. More specifically, PQM will bring its expertise in maintaining the efficacy, quality, and safety of medicines at all levels of the distribution chains and throughout their shelf life in promoting: (1) Good Storage and Distribution Practices WHO standards; (2) storage of medicines according to manufacturer's specified conditions; (3) storage of medicines in appropriate facilities; and (4) quality systems. PQM will establish a quality monitoring program which will: cover all the products procured by PEPFAR funding and the Global Fund; perform random sampling from all levels of distribution, testing based on international standards in qualified QC laboratories. The sampling and testing processes will be based on good knowledge of compendial sciences and sampling approaches. For that, it will procure the required minilabs with all needed supplies and will train the relevant staff on sampling of medicines.

**Implementing Mechanism Details**

<b>Mechanism ID: 16770</b>	<b>Mechanism Name: USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project</b>
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Abt Associates	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:



<b>Total Funding: 700,000</b>	
<b>Funding Source</b>	<b>Funding Amount</b>
GHP-State	700,000

**Sub Partner Name(s)**

(No data provided.)

**Overview Narrative**

*The USAID Applying Science to Strengthen and Improve Systems (ASSIST) Project will ensure that PMTCT, ART, and OVC services offered respond to quality requirements. ASSIST project will provide technical leadership and country assistance for the application of modern quality improvement (QI) methods. The goal is to make measurable gains in the quality of health care as well as improve health workforce management. This activity will contribute the implementation of the GHI Country Strategy particularly its cross-cutting area related to the quality of health services.*

*The geographic coverage for this activity is four provinces already supported by PEPFAR and four additional provinces part of the scale up of PMTCT services. The target populations of the QI intervention are service providers and recipients in the selected provinces.*

*The ASSIST project will work primarily through HCN and TCN technical advisers supported through STTA. Over the course of interventions, the capability of the local advisors and their Ministry counterparts are built so that they may lead QI efforts themselves. The core processes of QI are simultaneously built into the Ministry system to ensure continued QI programs without external financial support.*

*In addition to the described country technical assistance, ASSIST project will propose a program of research and evaluation related to spread and institutionalization of best practices and improvement methods, accelerating learning and results, improving the efficiency of QI interventions, adapting QI methods to community-level services, enhancing QI team performance, and documenting the cost-effectiveness and cost implications of QI interventions. vehicle will be needed to implement this activity.*

**Cross-Cutting Budget Attribution(s)**

Human Resources for Health	250,000
Motor Vehicles: Purchased	100,000



**TBD Details**

(No data provided.)

**Key Issues**

- Child Survival Activities
- Safe Motherhood
- TB

**Budget Code Information**

<b>Mechanism ID:</b>	16770		
<b>Mechanism Name:</b>	USAID Applying Science to Strengthen and Improve Systems (ASSIST)		
<b>Prime Partner Name:</b>	Project Abt Associates		
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	700,000	0
<b>Narrative:</b>			
<p>ASSIST’s quality improvement activities in Burundi will contribute directly to the effectiveness of ongoing PEPFAR programs in PMTCT, ART, and OVC services. Interventions are aimed at bringing together service providers in each area to identify specific operational barriers to providing quality services and the overall strategy to overcome them. Streamlines on-site data monitoring systems will be developed to allow for monitoring of process compliance and outcomes at the local site along with comparisons across sites and aggregate-level trend monitoring. The team will provide on-site periodic coaching in order to facilitate front line operations to adapt appropriately to overcome those barriers and produce improved results.</p> <p>Overcoming operational barriers such as patient retention and health facility data reorganization will lead to direct spill-over of the benefits of improved operations across the technical areas identified. In addition,</p>			



those operational improvements will have further spill-over in that they will likely improve the overall operation of facilities and thus the quality of all services provided by those facilities, regardless of the technical area (maternities as opposed to ART clinics, for example). Further spill-over into other areas of the health system will be achieved in the long term through the transfer to the Ministry of the capacity to implement quality improvement activities on its own.

As quality improvement is a management science, the short-term interventions will achieve these improvements in service delivery capacity by addressing local human resources, information/data management, finance, governance, and procurement. By taking a holistic approach to management at the local level while also bringing together groups across regions, changes to these micro systems will be paired with regional management systems in each area. Building the capacity of coaches and quality improvement advisors within the Ministry while also proving the results of the local process improvements undertaken, the foundation for further national-level system strengthening will be built.

### Implementing Mechanism Details

<b>Mechanism ID: 17095</b>	<b>Mechanism Name: AIDSTAR Sector II, Task Order #2</b>
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Training Resources Group	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

<b>Total Funding: 50,000</b>	
<b>Funding Source</b>	<b>Funding Amount</b>
GHP-State	50,000

### Sub Partner Name(s)

(No data provided.)

### Overview Narrative

*The Burundi PEPFAR team will engage the The Strengthening Teams to Achieve Results (TeamSTAR) Project, which uses organizational development methodologies to accelerate the performance and impact of US Agencies*



and USAID country teams at the mission level implementing PEPFAR programs. TeamSTAR provides a broad range of organizational development (OD) services to enable PEPFAR teams to resolve issues, strengthen team performance, and engage stakeholder organizations in ways that promote country ownership of sustainable HIV programs. PEPFAR Burundi has used TeamStar services in the past for strategic planning and COP retreats, which proved to be very successful.

### Cross-Cutting Budget Attribution(s)

(No data provided.)

### TBD Details

(No data provided.)

### Key Issues

(No data provided.)

### Budget Code Information

<b>Mechanism ID:</b> 17095			
<b>Mechanism Name:</b> AIDSTAR Sector II, Task Order #2			
<b>Prime Partner Name:</b> Training Resources Group			
Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	50,000	0
<b>Narrative:</b>			
TeamStar will be able to provide the following support to the Burundi team as needed from the variety of technical assistance listed below:			
<ul style="list-style-type: none"> <li>Situational Assessments, Analysis and Planning to ensure that OD field interventions are customized and responsive to country teams' needs.</li> </ul>			



- Team Support and Skill Enhancement to improve teamwork and team members' ability to work collaboratively.
- Coaching for USG and PEPFAR Staff to enhance their abilities for cross-agency collaborative planning and decision-making.
- Collect Tools and Resources that address team challenges and OD needs.
- Information Dissemination to promote knowledge sharing and adoption of state-of-the-art OD tools, best practices and methods to enhance team performance.
- Coordination with USAID/Washington and OGAC to ensure that TeamSTAR interventions are consistent with guidance, directives and priorities; and to inform participating agencies of issues and implementation challenges.

### Implementing Mechanism Details

<b>Mechanism ID: 17119</b>	<b>TBD: Yes</b>
<b>REDACTED</b>	



## USG Management and Operations

### Assessment of Current and Future Staffing.

Redacted

### Interagency M&O Strategy Narrative.

Redacted

### USG Office Space and Housing Renovation.

Redacted

## Agency Information - Costs of Doing Business

### U.S. Agency for International Development

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
ICASS		1,350,632		1,350,632
Institutional Contractors		305,086		305,086
Non-ICASS Administrative Costs		304,187		304,187
Staff Program Travel		87,774	221,701	309,475
USG Staff Salaries and Benefits			843,512	843,512
<b>Total</b>	<b>0</b>	<b>2,047,679</b>	<b>1,065,213</b>	<b>3,112,892</b>

### U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
ICASS	Administrative services	GHP-State	ICASS provided general services, financial management, administrative support, equipment, supplies, vehicles, and housing for the PEPFAR Deputy Team Leader, the USAID	1,350,632



			Representative, and the planned hires	
Non-ICASS Administrative Costs	Technical support	GHP-State	As regional service platform, USAID/East Africa supplies exetensive technical support to the PEPFAR Operations.	304,187

**U.S. Department of Defense**

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
ICASS		56,091		56,091
Staff Program Travel		20,000		20,000
USG Staff Salaries and Benefits		52,545		52,545
<b>Total</b>	<b>0</b>	<b>128,636</b>	<b>0</b>	<b>128,636</b>

**U.S. Department of Defense Other Costs Details**

Category	Item	Funding Source	Description	Amount
ICASS	Administrative services	GHP-State	Financial management, vehicles, IT, and other necessary support services	56,091