Burundi

Operational Plan Report

FY 2012

Operating Unit Overview

OU Executive Summary

Country context

Burundi is a low-income developing country (185 out of 187 in the Human Development Index-UNDP 2011 Human Development Report) with a population of 8.7 million and more than 300 inhabitants per square kilometer. This makes Burundi the country with the second-highest population density in sub-Saharan Africa, behind Rwanda. 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 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). Economic activity and government services are recovering gradually, but unlike neighboring Rwanda, Burundi's HIV/AIDS epidemic is largely neglected by international donors.

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 second 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). Only 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 between 15-49 years stated that one could reduce the risk of contracting the AIDS virus by using condoms and limiting sexual partnerships. However, only 14% of men and women, involved in MCP stated that they used condoms during their last sexual intercourse.

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% 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.

In an effort to improve the national response to HIV/AIDS, 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. The New Partnership for Africa's Development, to which Burundi adheres, offers other opportunities for the accomplishment of the African Union Objectives related to HIV/AIDS and of the Millennium Development Goals.

Since 2002, Burundi drafted three national HIV strategic plans (NSPs) with the objective of defining clear priorities to orient the interventions of various donors. The most recent NSP 2012-2016 was prepared with the technical assistance from PEPFAR and sets realistic objectives for prevention, treatment, care and support in light of the current financial environment. The implementation of the 2007-2011 NSP led to substantial achievements in the area of HIV testing sites, ART sites, and care and support for people living with HIV/AIDS. The USG assistance in HIV/AIDS is aligned with the national strategic plan and regular consultations with the government of Burundi are frequently held. Before the USG developed the COP 12, a PEPFAR retreat involving key stakeholders at the national level was organized to ensure that the proposed intervention areas were aligned with the GOB national vision as well as civil society.

The Global Fund (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.

To efficiently manage the grants provided by the GF, Burundi has established the Country Coordinating Mechanism (CCM). The 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. With a new restructuring of the CCM in 2010 and some uncertainties on potential conflicts of interest, the USG decided not to stand as a candidate for the first two years which run until April 2012. In the meantime, the USG continued to participate in the CCM meetings as an observer. Additionally, the USG regularly participated in the donor community preparatory meetings that take place every time to discuss about the CCM meeting agenda and its content. Currently, the USG is prepared to stand as candidate and become a CCM voting member starting from April 2012. In addition, the Partnership Framework for Health and Development led by the MOHA 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.

PEPFAR focus in FY 2012

USAID focus

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 the 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 the jointly identified cross-cutting areas. The USG will build on its work already underway through the Malaria, PEPFAR and MCH programs to strengthen further 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 Agency, 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. 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 partners and in close collaboration with the Belgian Technical Cooperation Agency, 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 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 funding, COP 12 proposes a program that mixes 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 program design (described in details in the technical area narratives of the COP) is intended to ensure that gaps in services are filled in order ensure a continuum of care in the intervention provinces. The USG program will attempt to support 100% of health facilities in the four focus provinces and gradually increase the PMTCT coverage in the four additional provinces. The model is to integrate PMTCT, TC, diagnosis and care of STI and opportunistic infections (OI), lab support, and behavior-change communication (BCC) for prevention into all primary health care facilities, with support to strengthen links with and quality of ART services (with ARVs provided by the Global Fund). Community-based services by local sub-partners will liaise with the health facilities to create increased demand for PMTCT and TC and promote safer sexual behavior through community mobilization, BCC campaigns, and peer education targeting MARPs. The USG will support home-based care and support for PLWHA and OVC care and support provided by local CSOs. Facility and community services and mobilization will be linked through CHWs, who will ensure that regardless of

patients' entry point; they are retained within the continuum of care and support. Additionally, in 2012, PEPFAR will finance seven indicators related to HIV/AIDS in the four provinces supported by PEPFAR. In the PMTCT Acceleration program, PEPFAR will also support two indicators directly linked to PMTCT services.

To build civil-society capacity, the USG will support sub-grants and technical assistance to local organizations, including the RBP+ (Burundian Network of People Living with HIV/AIDS), 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.

More specifically, the PEPFAR program will focus on the following program areas and activities to improve the policy environment, services delivery, and systems development in 2012:

- Supplying reference laboratories with equipment and reagents for biological follow-up including hematology and biochemistry for HIV+ pregnant women and people under ART. 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;
- Addressing underlying factors that contribute to HIV risk, including GBV, alcohol abuse, social and cultural norms, and family communication around RH. Behavior change communications, peer education, and community mobilization by health workers, CHWs, and local organizations will help reach intended objectives;
- Recognizing the critical role men play in household decision making, USG programs will target men to serve as role models in community-level health activities to promote key health practices as well as target men (the military), and their families for prevention and treatment services. Furthermore, the USG programs will ensure gender equality in training opportunities and promote male participation alongside those of women;
- Supporting income generating activities for vulnerable groups of women and advocating with senior-level policymakers to take a stand against gender discrimination and GBV;
- Ensuring that 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;
- Training will be conducted through a training-of-trainers team, which will initially be led by a USG partner and then be transferred to the MOH. The USG will fund the procurement of test kits to test 80% of

pregnant women and 6% of the general population in the four provinces. CSOs will receive sub-grants and technical and organizational support to work at the community level to increase awareness of and demand for services;

- Improving access to testing and counseling, including provider-initiated testing and counseling (PITC);
- Increasing access to PMTCT services (please see PMTCT acceleration plan for detailed description of an expanded scale up to four additional provinces);
- Improving the quality and effectiveness of services by increasing the uptake of PMTCT prophylaxis and referral to care, ART, and community-based support;
- Supporting a modest male circumcision program; primarily focused on supporting male circumcision PBF indicators and technical assistance at the provincial level in line with national plan;
- 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;
  - Standardizing laboratory policies, quality assurance mechanisms, and trainings will be performed where necessary;
  - Establishing a sample referral and result distribution between the different levels, to reduce missed opportunities.

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. Additionally, prevention will include expanded interventions relating to post-exposure prophylaxis (PEP) 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.

It is worth noting that apart from 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 is 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. If the USG/Burundi receives additional funding, it will consider expanding direct involvement in ART treatment services, which is a critical need in

the country.

DoD Focus

Since 2005, DOD had been implementing HIV/AIDS behavior change communication activities, and providing technical support to voluntary counseling and testing activities to assure high quality services among military personnel. DOD as a PEPFAR member team will reinforce the support to the Ministry of Defense in fighting HIV/AIDS in collaboration with other partners.

More specifically, DOD/PEPFAR program will focus on the following program and activities:

1. Contribute to the readiness of soldiers for peacekeeping missions. This will be based on communication, testing and counseling for all peacekeepers. More than 6,000 troops will be reached through those campaigns and referral system to care and treatment will be reinforcing for those who are positive. Women who represent about 2% of troops will receive specific sessions. Family planning will be offered to all women. Post-exposure prophylaxis will be available as there are many cases of sexual assault reported from troops in peacekeeping missions. Also a community-based communications campaign among soldiers, their sexual partners, and surrounding communities in brigades and battalions to increase safer sexual behaviors will be conducted.
2. Studies show that most of the militaries have already had sex (80 % in 2004 and 84% in 2007) but condom use rate is low among militaries about 18.6 %. In order to raise the rate of using condoms, sensitization and demonstration of using condoms are essential. Accessibility and availability of condoms are required for all militaries. Thus, DOD will make available more than 6 million condoms per year for all military members. The strengthening of the distribution and control system will be provided. All peacekeepers will be sensitize to the use of condoms and have provision in departure kit.
3. Approximately 1,500 military personnel and their families will receive counseling and testing 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.
4. Capacity building activities such training, supervision and supplying reagents for testing and counseling will be reinforce.

PF/PFIP Monitoring

Burundi does not have a Partnership Framework or Implementation Plan.

Country Ownership Assessment

The institutional framework for the fight against AIDS in Burundi places the response to HIV/AIDS at the highest level of the country. 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, 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 implementating the HIV sector 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 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 2012-2016. 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. Furthermore, 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.

Through the National Management Committee for ARV drugs, OI/STI drugs and other medical and laboratory supplies for the care of PLWHA, required HIV/AIDS-related products are analyzed. 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, failure to follow-up on key action items, and the lack of control of accurate information needed to make good decisions at the right time.

The NAC in coordination with the donors involved in the HIV/AIDS sector 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 GOB 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 conducted.

The MOH, with USG and other donor support, has initiated sweeping changes in health policies, including: the provision of free medical coverage for pregnant women and children under five years of age; performance-based financing; decentralization of health services through the health districts; and the move toward a sector wide approach to support the International Health Partnership put in place with the donor community. Over the past two years, the GOB successfully concluded major new commitments with its donor partners, including UNICEF, WHO, Belgium, Germany and the Global Fund.

There are four key health sector strengths in Burundi that constitute the foundation of sustainability and quality health care services which are:

1. Government Commitment to Health: The GOB is clearly committed to improving investments in health and reorganizing its health sector to respond better 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 has 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 in general, and HIV/AIDS in particular, occupy a significant part. Burundi also subscribed to NEPAD's regional health strategy and to the Millennium development Goals;
2. MOH Key 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 HIPC loan forgiveness programs. 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 support the integration of health services which is also the GOB vision;
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: Due to the conflict that led to the collapse of a 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.

The GF is the biggest donor in HIV/AIDS in Burundi. The grants provided by the GF (Round 8- HIV/AIDS) are managed by two local Principal Recipients which are the NAC for the public sector and RBP+ for the civil society organizations. The public, private, and faith-based organizations are providing HIV/AIDS services to the population in need. PEPFAR supported a technical assistance to the CCM for the reform process, including updating the procedural manual, the internal regulations, and statute documents of the CCM.

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.

Challenges

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. Some of the primary challenges are:

1. Scarcity/low motivation of health professionals. According to the National Health Development Plan 2011-2015, the total number for all categories for health providers in the public sector is 15,941, primarily constituted of 6,784 nurses, 418 doctors and medical students, and 8,739 support staff. The overall ratio for the whole country is one doctor per 19,231 inhabitants while the WHO standard recommends a ratio of one doctor per 10,000 inhabitants. Yet, this ratio hides very important disparities between urban and rural areas. Burundi is also suffering from an acute shortage of midwives, pharmacists, and medical specialists. Increasing the number of trained health care workers is a key issue to be addressed by the MOH, donors and implementing partners. The increasing number of training institutions should be able address the issue of quantity of health providers but may not resolve the issue of quality of health providers.
2. The financial barriers to accessing health care remain significant. Data show that about one-third of the population does not seek healthcare when it is needed, and among those 80% indicated that the prohibitive cost of health services was the main reason. The GOB is moving towards making some services free (e.g., delivery for pregnant women, and services for children under five years of age),

but a substantial proportion of the Burundian population is still unable to afford basic primary care. In supporting free HIV/AIDS services in the focus provinces, PEPFAR will contribute to the alleviation of the burden of health care expenditures for the population. In addition through the PBF approach, PEPFAR will be contributing to the free health care package for children under five and for pregnant women.

3. The quality of health services is very low. Given the reasonable physical access that most communities have to health facilities, the low usage of key preventive and promotional services probably reflects, at least partly, limited demand. This limited demand appears to come from the perception of poor-quality services in health facilities, and that diagnosis is often made without means for adequate treatment. PEPFAR in conjunction with other USG health programs will contribute to the integration of quality health services in line with the GHI principles.

4. Low public health expenditure. Despite recent efforts, the level of both external (donor) and government total health expenditure remains among the lowest in Sub-Saharan Africa. The out-of-pocket contribution by households to health care still remains very high. Again, in supporting free HIV/AIDS services in the focus provinces, PEPFAR will contribute to the alleviation the burden of health care expenditures for the population. In addition through the PBF approach, PEPFAR will be contributing to the free health care package for children under five and for pregnant women.

Central Initiatives

Burundi is not implementing any central initiatives.

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV	150,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Adults 15-49 HIV Prevalence Rate	01	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Children 0-14 living with HIV	28,000	2009	UNAIDS Report on the global			

			AIDS Epidemic 2010			
Deaths due to HIV/AIDS	15,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Estimated new HIV infections among adults						
Estimated new HIV infections among adults and children						
Estimated number of pregnant women in the last 12 months	283,000	2009	State of the World's Children 2011, UNICEF.			
Estimated number of pregnant women living with HIV needing ART for PMTCT	7,300	2010	Global HIV/AIDS response: epidemic update and health sector progress towards universal access: progress report 2011			
Number of people living with HIV/AIDS	180,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			
Orphans 0-17 due to HIV/AIDS	200,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			

The estimated number of adults and children with advanced HIV infection (in need of ART)	68,000	2010	Global HIV/AIDS response: epidemic update and health sector progress towards universal access: progress report 2011			
Women 15+ living with HIV	90,000	2009	UNAIDS Report on the global AIDS Epidemic 2010			

Partnership Framework (PF)/Strategy - Goals and Objectives

(No data provided.)

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

In what way does the USG participate in the CCM?

Observer

What has been the frequency of contact between the Global Fund Secretariat (Fund Portfolio Manager or other Geneva-based staff) and any USG team members in the past 12 months? If there has been no contact, indicate the reason.

4-6 times

What has been the frequency of contact between the Local Fund Agent (LFA) and any USG team members in the past 12 months? If there has been no contact, indicate the reason.

None

If None why not?

The USG team did not have many opportunities to interact with the Local Fund Agency. Most of the information the USG team needed was provided by the Fund Portfolio Manager based in Geneva.

Has the USG or is the USG planning to provide support for Round 11 proposal development? Support could include staff time, a financial contribution, or technical assistance through USG-funded project.
CCM is not planning to submit proposals

Are any existing HIV grants approaching the end of their Phase 1, Phase 2, or RCC agreement in the coming 12 months?
Yes

If Yes, please indicate which round and how the end of this grant may impact USG programming. Also describe any actions the USG, with country counterparts, is taking to enable continuation of any successful programming financed through these grants.
The phase I of Round 8 for HIV/AIDSb ended on December 2011. The GF granted to Burundi the phase II funding under Round 8 (HIV/AIDS). The GF is procuring ARVs for the entire country, for all ART services including those supported by PEPFAR. PEPFAR will continue to complement the GF's work in improving treatment services by the required technical assistance, laboratory and equipment improvement.

In your country, what are the 2-3 primary challenges facing the Global Fund grant implementation and performance (for example, poor grant performance, procurement system issues, CCM governance/oversight issues, etc)? Are you planning to address those challenges through any activities listed in this COP?
Redacted

Did you receive funds for the Country Collaboration Initiative this year?
No

Is there currently any joint planning with the Global Fund?
Yes

If Yes, please describe how the joint planning takes place (formal/informal settings; the forums where it takes place (CCM?); timing of when it takes place (during proposal development, grant negotiation, COP development, etc.); and participants/stakeholders). Also describe if this joint planning works well and its effects (has it resulted in changes in PEPFAR programming, better

anticipation of stock-outs and/or TA needs, better communication with PR, etc.)
Redacted

Has the USG stepped in to prevent either treatment or service disruptions in Global Fund financed programs in the last year either during or at the end of a grant? Such assistance can take the form of providing pharmaceuticals, ensuring staff salaries are paid, using USG partners to ensure continuity of treatment, , or any other activity to prevent treatment or service disruption.

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 between USAID/Burundi and BICOR: Prevention of HIV/AIDS Among Motorcycle Taxi Drivers		BICOR Insurance Co.			

Surveillance and Survey Activities

Surveillance or Survey	Name	Type of Activity	Target Population	Stage	Expected Due Date
N/A	Antenatal surveillance	Sentinel Surveillance (e.g. ANC Surveys)	Pregnant Women	Planning	N/A
N/A	MARPs population size estimates	Population size estimates	Female Commercial Sex Workers,	Development	N/A

			Men who have Sex with Men		
N/A	Modes of Tramsmission (MOT) study	Other	Female Commercial Sex Workers, General Population, Men who have Sex with Men	Development	N/A

Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source				Total
	Central GHP-State	GAP	GHP-State	GHP-USAID	
DOD			267,668		**267,668**
State/AF			100,000		**100,000**
USAID			4,632,332	3,500,000	**8,132,332**
Total	**0**	**0**	**5,000,000**	**3,500,000**	**8,500,000**

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency				Total
	DOD	State/AF	USAID	AllOther	
HBHC			901,529		**901,529**
HKID			616,256		**616,256**
HTXD			50,000		**50,000**
HTXS			500,688		**500,688**
HVAB	15,223	100,000	610,321		**725,544**
HVCT	130,445		765,480		**895,925**
HVMS	6,777		773,986		**780,763**
HVOP	115,223		1,071,733		**1,186,956**
HVSI			537,008		**537,008**
MTCT			816,375		**816,375**
OHSS			1,128,700		**1,128,700**
PDTX			360,256		**360,256**
	267,668	**100,000**	**8,132,332**	**0**	**8,500,000**

National Level Indicators

National Level Indicators and Targets

Redacted

Policy Tracking Table

(No data provided.)

Technical Areas

Technical Area Summary

Technical Area: Care

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	901,529	0
HKID	616,256	0
Total Technical Area Planned Funding:	**1,517,785**	**0**

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 that 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 heath 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	537,008	0
OHSS	1,128,700	0
Total Technical Area Planned Funding:	**1,665,708**	**0**

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 entites 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 that 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 that 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 that 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	780,763	
Total Technical Area Planned Funding:	**780,763**	**0**

Summary:
(No data provided.)

Technical Area: Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
HVAB	725,544	0
HVCT	895,925	0
HVOP	1,186,956	0
MTCT	816,375	0
Total Technical Area Planned Funding:	**3,624,800**	**0**

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	50,000	0
HTXS	500,688	0
PDTX	360,256	0
Total Technical Area Planned Funding:	**910,944**	**0**

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/mm3. 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 that 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 that 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	2012	Justification
P1.1.D	P1.1.D Number 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 who were tested for HIV and know their results	85,631	
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	92 %	Redacted
	Number of HIV-positive pregnant women who received antiretrovirals (ARVs) to reduce risk of mother-to-child-transmission	561	
	Number of HIV-positive pregnant women identified in	610	

	the reporting period (including known HIV-positive at entry)		
	Life-long ART (including Option B+)	0	
	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)		
	Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery)	0	
	Maternal AZT (prophylaxis component of WHO Option A during pregnancy and deliverY)	0	
	Single-dose nevirapine (with or without tail)	0	
P6.1.D	Number of persons provided with post-exposure prophylaxis (PEP) for risk of HIV infection	350	Redacted

	through occupational and/or non-occupational exposure to HIV.		
	By Exposure Type: Occupational	0	
	By Exposure Type: Other non-occupational	0	
	By Exposure Type: Rape/sexual assault victims	0	
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	11,014	
P8.1.D	P8.1.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the	n/a	Redacted

	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	71,400	
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 prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence	40,000	

	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	3,550	
	By MARP Type: CSW	852	
	By MARP Type: IDU	0	
	By MARP Type: MSM	38	
	Other Vulnerable Populations	2,660	
P11.1.D	Number of individuals who received T&C services for HIV and received their test results during the past 12 months	179,861	Redacted
	By Age/Sex: <15 Female		
	By Age/Sex: <15 Male		

	By Age: <15	7,770	
	By Age/Sex: 15+ Female		
	By Age: 15+	174,465	
	By Age/Sex: 15+ Male		
	By Sex: Female	139,342	
	By Sex: Male	40,519	
	By Test Result: Negative		
	By Test Result: Positive		
C1.1.D	Number of adults and children provided with a minimum of one care service	16,951	Redacted
	By Age/Sex: <18 Female		
	By Age/Sex: <18 Male		
	By Age: <18	9,154	
	By Age/Sex: 18+ Female		
	By Age: 18+	7,797	
	By Age/Sex: 18+ Male		
	By Sex: Female	9,832	
	By Sex: Male	7,119	
C2.1.D	Number of HIV-positive individuals receiving a minimum of one clinical service	10,880	Redacted
	By Age/Sex: <15 Female		
	By Age/Sex: <15 Male		
	By Age: <15	1,958	

	By Age/Sex: 15+ Female		
	By Age: 15+	8,922	
	By Age/Sex: 15+ Male		
	By Sex: Female	6,963	
	By Sex: Male	3,917	
C2.2.D	C2.2.D Percent of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	95 %	Redacted
	Number of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	10,336	
	Number of HIV-positive individuals receiving a minimum of one clinical service	10,880	
C2.4.D	C2.4.D TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting	95 %	Redacted
	Number of HIV-positive patients who were screened for TB in HIV care or treatment setting	10,336	
	Number of HIV-positive individuals receiving a	10,880	

	minimum of one clinical service		
C4.1.D	C4.1.D Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth	92 %	Redacted
	Number of infants who received an HIV test within 12 months of birth during the reporting period	561	
	Number of HIV-positive pregnant women identified in the reporting period (include known HIV-positive at entry)	610	
	By timing and type of test: either virologically between 2 and 12 months or serology between 9 and 12 months	0	
	By timing and type of test: virological testing in the first 2 months	0	
C5.1.D	By Age: <18	0	Redacted
	By Age: 18+	0	
	Number of adults and children who received food and/or nutrition services during the reporting period	9,326	
	By: Pregnant Women	0	

	or Lactating Women		
H1.1.D	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests	8	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	1,570	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
14281	FHI 360	NGO	U.S. Agency for International Development	GHP-State, GHP-USAID	4,272,907
14315	University Research Corporation, LLC	Private Contractor	U.S. Agency for International Development	GHP-State	300,000
14337	TBD	TBD	Redacted	Redacted	Redacted
14342	Engender Health	Private Contractor	U.S. Agency for International Development	GHP-State	488,783
14343	University of North Carolina at Chapel Hill, Carolina Population Center	University	U.S. Agency for International Development	GHP-State	300,000
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	200,000
14593	Partnership for Supply Chain Management	Private Contractor	U.S. Agency for International Development	GHP-State, GHP-USAID	1,627,079

Implementing Mechanism(s)

Implementing Mechanism Details

Mechanism ID: 14281	**Mechanism Name: FHI service delivery/prevention**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: FHI 360	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 4,272,907	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	1,866,470
GHP-USAID	2,406,437

Sub Partner Name(s)

AMAVS	APECOS	Association Burundaise Pour le Bien-Etre Familial
Association des Chauffeurs Qualifiés de Kayanza	Association Nationale des Seropositifs et des Sideens	Bureau de Developpement Communautaire de Muyinga
Bureau Provincial de Santé de Kayanza	Bureau Provincial de Santé de Kirundo	Bureau Provincial de Santé de Muyinga
Centre de Santé de Kagari	Centre de Santé de Maramvya	Centre Izere
CPAJ Kirundo	Diocese Muyinga	Hopital de Muyinga
Hopital Kayanza	Hopital Mukenke	Hopital Musema
JHPIEGO	Johns Hopkins University Center for Communication Programs / AfriComNet	PUMA Karate
RENAJES Muyinga	Reseau Burundais des Personnes	Society of Women Against AIDS in

	Vivant avec le VIH	Africa Kayanza
Society of Women Against AIDS in Africa Muyinga		

Overview Narrative

The FHI 360 service delivery activity is in its fourth year of implementation. It aims to increase access to quality HIV/AIDS prevention, care and support services for the population of Kayanza, Kirundo, Muyinga, and Karusi provinces. The activity is in line with the priorities and strategies of the USG and the Government of Burundi (GOB) in response to the HIV/AIDS epidemic in Burundi. The interventions target the general population, pregnant women and their partners, people living with HIV/AIDS (PLWHA), orphans of AIDS and other vulnerable children (OVCs), youth, low-income women and most at risk populations (MARPs). Additionally, as part of the PMTCT Acceleration Plan, FHI 360 service delivery activity in Burundi will incorporate the following strategic approaches:

• Build upon the platform of activities to increase and expand the coverage and quality of services;
• Use effective community-based structures to promote a variety of health and related interventions;
• Intensify health and social services linkages;
• Sub contract to local organizations (public and private sectors) for program implementation and for capacity building and sustainability;

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. A end of project evaluation after Year 5 will be conducted to objectively assess the effectiveness of the innovations and their potential for scale-up.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	40,000
Education	510,000
Food and Nutrition: Policy, Tools, and Service Delivery	20,000
Gender: Reducing Violence and Coercion	75,000
Human Resources for Health	1,559,284
Water	10,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Military Population
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**14281**		
Mechanism Name:	**FHI service delivery/prevention**		
Prime Partner Name:	**FHI 360**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	458,000	0
Narrative:			
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.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	586,000	0

Narrative:

Under the FHI ROADS project, the number of OVC served increased from 1,500 in FY 2006 to 6,000 each FY (2009- 2012). FHI provided OVCs with at least two core services including school support or professional training, psychosocial support, medical care, and legal assistance. During COP 2012, FHI 360 will strengthen the capacity of households, local community groups and local administration to respond to the basic needs of OVCs. To achieve this result, FHI 360 will train additional OVC caregivers in comprehensive HIV care and support services. The child status index will be introduced and used to monitor the quality of services provided and to ensure program effectiveness. Services will be linked closely through a strong referral network including health facilities, CBOs, FBOs, NGOs and private sector partners.

FHI will continue programming for orphan-headed households, recognizing their unique vulnerability and needs. FHI 360 will also continue supporting HIV risk-reduction and care strategies specifically for OVCs who are heads of households, linking them with sexual prevention messaging, HCT, and STI diagnosis and treatment for older OVC. In addition, FHI 360 will also facilitate care in cases of rape and sexual assault.

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.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	200,000	0

Narrative:

The FHI 360 will request sub-grantees to submit monitoring data monthly, which will be used to produce quarterly and annual reports to Government of Burundi (GOB) and to the USG. FHI 360 will use the quarterly reports to facilitate feedback sessions with implementing partners that are designed to: (i) build their capacity in using data for decision-making; (ii) ensure that the data are being used by all partners to measure progress toward reaching quantitative targets and reaching/maintaining agreed-upon service quality standards; and (iii) examine barriers to achieving expected results. Such feedback sessions will continue to be part of regular management reviews and will provide a basis for assessing technical assistance needs. Additionally, FHI 360 will continue to conduct trainings, including formal and on-the-job training.

The monitoring system will include routine data collection and a tracking system with standardized recording and reporting protocols for all types of services rendered. FHI 360 will periodically conduct Data Quality Assessments (DQA) to ensure quality of the data.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	525,000	0

Narrative:

In FY 2011, the FHI 360 prevention activities in Burundi reached 47,599 individuals with interventions that are primarily focused on abstinence and/or being faithful (AB) using the peer education strategy. The targeted population is this area is youth, low-income women and truckers in six communes: Kayanza, Busoni, Kirundo, Ntega, Vumbi and Muyinga. This was accomplished in partnership with 302 trained peer educators. In FY 12, the FHI 360 prevention activities will continue to support and strengthen activities implementation in the six existing communes distributed in the three provinces and new communes will be identified in Karusi province. In addition to AB messages, safer sexual behaviors will be promoted, such as reducing alcohol consumption and gender based violence mitigation. Dialogue among couples

will be promoted through family day strategies and community magnet theatre performances.

The FHI 360 prevention activities will strengthen peer education and community outreach to reach 50,000 individuals with HIV prevention interventions that are based on evidence/and or meet minimum standards required. For this purpose, additional peer educators will be trained and the magnet theater will continue to be promoted. In addition, the FHI 360 prevention activities will continue to link AB interventions with other services such as HTC, OVC, PMTCT, ART, and preventive therapy against opportunistic infections.

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.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	574,187	0

Narrative:

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.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	760,000	0

Narrative:

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.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	MTCT	509,720	0

Narrative:

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 out of 595 HIV positive pregnant women identified.

In FY 12, 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 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	HTXS	330,000	0

Narrative:

The USG funding 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.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	330,000	0

Narrative:

The FHI 360 service delivery activity has been supporting ART sites in collaboration with the Global Fund since FY 2007. By September 30, 2011, six supported ART sites were active, with 3,757 clients on ARVs by September 30, 2011. Among them 302 are less than 15 years old.

In FY 2012, FHI 360 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 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. Efforts will be made to enroll more children on ART. The following strategies will be put in place: (1) encourage HTC among children born to HIV positive parents; (2) screen for HIV all malnourished children attending health clinics; (3) train the health providers on paediatric ART treatment including WHO staging for children; and (4) reinforce adherence among enrolled children.

Implementing Mechanism Details

Mechanism ID: 14315	**Mechanism Name: Healthcare Improvement Project QA/WD follow-on**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: University Research Corporation, LLC	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 300,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	300,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Health Care Improvement Project (HCI) will ensure that PMTCT, ART, and OVC services offered in Burundi respond to quality requirements. HCI 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 coverage will be extended as PEPFAR/PMTCT activities expand. The target populations of the QI intervention are service providers and recipients in the selected provinces.

The HCI 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, URC/HCI 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. No purchase of vehicle will be needed to implement this activity.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	150,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	14315		
Mechanism Name:	Healthcare Improvement Project QA/WD follow-on		
Prime Partner Name:	University Research Corporation, LLC		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	300,000	0

Narrative:

HCI'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.

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, 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

Mechanism ID: 14337	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14342	**Mechanism Name: Engender Health GH-08-2008 RESPOND**
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: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 488,783	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	488,783

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 specifics 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: Reducing Violence and Coercion	150,000
Human Resources for Health	50,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's legal rights and protection

Budget Code Information

Mechanism ID:	**14342**		
Mechanism Name:	**Engender Health GH-08-2008 RESPOND**		
Prime Partner Name:	**Engender Health**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	488,783	0
Narrative:			

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:

• 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.

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 Development	Procurement Type: Contract
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: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 300,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	300,000

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	150,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID:	14343		
Mechanism Name:	GH 01-2008 MEASURE Phase III MMAR		
Prime Partner Name:	University of North Carolina at Chapel Hill, Carolina Population Center		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	300,000	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

Mechanism ID: 14352	**Mechanism Name: VOA HIV prevention**
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: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 100,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**

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)

Gender: Reducing Violence and Coercion	10,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors

Increasing gender equity in HIV/AIDS activities and services
Increasing women's legal rights and protection
Military Population

Budget Code Information

Mechanism ID:	**14352**
Mechanism Name:	**VOA HIV prevention**
Prime Partner Name:	**International Broadcasting Bureau, Voice of America**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	100,000	0

Narrative:

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

Mechanism ID: 14592	**Mechanism Name: PSI HIV prevention**
Funding Agency: U.S. Department of Defense	Procurement Type: Grant
Prime Partner Name: Population Services International	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 200,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	200,000

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)

Gender: Reducing Violence and Coercion	10,000
Human Resources for Health	50,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Military Population
TB
Family Planning

Budget Code Information

Mechanism ID:	14592		
Mechanism Name:	PSI HIV prevention		
Prime Partner Name:	Population Services International		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVCT	100,000	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	100,000	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

Mechanism ID: 14593	**Mechanism Name: SCMS Commodity procurement**
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: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,627,079	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	1,627,079
GHP-USAID	0

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	300,000
Water	38,650

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Military Population

Budget Code Information

Mechanism ID:	14593		
Mechanism Name:	SCMS Commodity procurement		
Prime Partner Name:	Partnership for Supply Chain Management		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	409,897	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	324,725	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	162,725	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	274,725	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	264,575	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	50,000	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	140,432	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.

USG Management and Operations

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Redacted

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Agency Information - Costs of Doing Business

U.S. Agency for International Development

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total
ICASS			588,189		588,189
Institutional Contractors			52,027		52,027
Non-ICASS Administrative Costs			132,620		132,620
Staff Program Travel			121,706		121,706
USG Staff Salaries and Benefits			199,021		199,021
Total	**0**	**0**	**1,093,563**	**0**	**1,093,563**

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
ICASS	Administrative Services	GHP-USAID	ICASS provided general services, finanical management, administrative	588,189

			support, equipment, and supplies, vehicles, and housing for the Deputy Team Leader.	
Non-ICASS Administrative Costs	Technical Support	GHP-USAID	As a regional service platform, USAID/East Africa supplies extensive technical support to the PEPFAR operations.	132,620

U.S. Department of Defense

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total
ICASS		6,777			6,777
Staff Program Travel		15,308			15,308
USG Staff Salaries and Benefits		45,583			45,583
Total	**0**	**67,668**	**0**	**0**	**67,668**

U.S. Department of Defense Other Costs Details

Category	Item	Funding Source	Description	Amount
ICASS	Administrative Services	GHP-State	Financial Management, vehicles, and other necessary support services	6,777