



USAID
FROM THE AMERICAN PEOPLE



Final Report

Roads to a Healthy Future (ROADS II) Project in Burundi

Associate Cooperative Agreement No 623-A-00-08-00061
September 29, 2008 to March 31, 2014

Submitted to the United States Agency for International Development (USAID)

by Family Health International (FHI 360)

DUNS # 067180786

FHI 360 Headquarters

2224 E NC Hwy 54, Durham, NC 27713 USA
T 1.919.544.7040 / F 1.919.544.7261

Washington, DC Office

1825 Connecticut Avenue NW, Washington, DC 20009 USA
T 1.202.884.8000 / F 1.202.884.8400

Web: www.fhi360.org

Acronyms

ABS	Alliance Burundaise contre le SIDA
ABUBEF	Association Burundaise pour le Bien-Etre Familial
ACQKA	Association des Chauffeurs Qualifiés de Kayanza
AMAVS	Association des Miséricordieux pour l'Assistance aux Vulnérables du SIDA
ANSS	Association Nationale de Soutien aux Séropositifs et Malades du SIDA
APECOS	Association de Prise en Charge des Orphelins du SIDA
ART	Antiretroviral Therapy
ARV	Antiretroviral
BADEC	Bureau d'Appui pour le Développement et l'Entraide Communautaire
BDC	Bureau de Développement Communautaire
BDS	Bureau du District Sanitaire
BPS	Bureau Provincial de la Santé
CBO	Community Based Organization
CHW	Community Health Worker
CPAJ	Collectif pour la Promotion des Associations des Jeunes
CSO	Civil Society Organization
CSW	Commercial Sex Worker
DBS	Dried Blood Spot
HD	Health District
FHI 360	Family Health International
FNTT	Fédération Nationale des Travailleurs du Transport
FP/GBV	Family Planning/Gender Based Violence
FY	Fiscal Year
FSW	Female Sex Worker
HTC	HIV Testing and Counseling
IEC	Information Education Communication
MARPs	Most-at Risk Populations
MPHFA	Ministry of Public Health and the Fight against AIDS
MNH	Maternal and Newborn Health
NMR	Neonatal Mortality Rate
OIs	Opportunistic Infections
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
OVC	Orphans and Vulnerable Children
PBF	Performance-Based Financing
PCR	Polymerase Chain Reaction
PE	Peer Education
PITC	Provider-Initiated Testing and Counseling
PEP/PPE	Post Exposure Prophylaxis/Prophylaxie Post-Exposition
PMTCT	Prevention of Mother-To-Child Transmission of HIV
PLHIV	People Living with HIV
RBP+	Réseau Burundais des Personnes Vivant avec le VIH
RENAJES	Réseau National des Jeunes Engagés contre le SIDA
ROADS	Regional Outreach Addressing AIDS through Development Strategies
ROADS II	Roads to a Healthy Future
RBP+	Réseau Burundais des Personnes Vivant avec le VIH
RPR	Rapid Plasmin Reagin
STI	Sexually Transmitted Infections
SWAA	Society of Women Against AIDS in Africa
USAID	United States Agency for International Development

Contents

Acronyms	ii
Contents	iii
Executive Summary	iv
1. Background Information	1
1.1 Regional Context.....	1
1.2 Country Context.....	1
2. Project Description.....	4
2.1 Goals and Objectives.....	4
2.2 Project Zones.....	4
2.3 Beneficiaries and partners	5
2.4 Technical Approaches and Innovations	7
3. Accomplishments and highlights	13
3.1. HIV prevention Services	13
3.1.1. Prevention of Mother to Child Transmission of HIV (PMTCT)	13
3.1.2 HIV Testing and Counseling (HTC).....	17
3.1.3. Sexual and behavior risk prevention.....	19
3.1. 4 Post-Exposure Prophylaxis (PEP)	21
3.2 Care services for PLHIV	23
3.2.1 Cotrimoxazole prophylaxis against opportunistic infections	24
3.2.2 Other clinical care and treatment (ARV) services	24
3.2.3 Orphans and Vulnerable Children (OVC)	25
3.2.4 Home-based care (HBC)	27
3. 3. HRM and Health System Strengthening	27
3.3.1 Improving state of infrastructure	27
3.3.3 Support Performance-based financing.....	28
3.3.2 Training for Human Resources for Health and Capacity Building.....	28
3.4 Family planning and Gender-Based Violence (FP/GBV).....	31
3.5 Maternal and Newborn Health (MNH) Activities.....	35
3.6 National Events	35
4. Management Approach	38
4.1 Management and Staffing	38
4.2 Monitoring and Evaluation	40
4.3 Financial management	41
5. Summary of Key Findings, Challenges and Lessons Learned.....	43
5.1 Key Successes	43
5.2 Key Challenges	45
5.3 Lessons learned.....	46
Appendix 1: ROADS II- FHI Implementing partners in Burundi	48
Annex B: Award Summary Sub-Recipients Inventory	49

Executive Summary

Introduction

The Roads to a Healthy Future (ROADS II) Project Burundi was a five-year Associate Award and a follow-on program to a three-year ROADS I Project (2006 – 2008). The Associate Award falls under the regional Leader with Associate Awards funded by USAID/East Africa and managed by Family Health International (FHI 360). Since inception in 2005, the ROADS project has worked with vulnerable communities along the transport corridors of 11 countries in East, Southern and Central Africa. The main goal of ROADS II Burundi was to increase access to multi-sectoral HIV/AIDS, health and other related services for the Burundi population in Kayanza, Karusi, Kirundo, Muyinga, provinces and the Municipality of Bujumbura. Other integrated services provided included malaria, family planning/reproductive health, maternal, newborn and child health in target sites. The project aimed to:

- (i) Build on previous successes and implement effective programs that increase services in prevention, care and treatment for HIV/AIDS, malaria, FP/RH, and MNH.
- (ii) Strengthen the capacity of local organizations to ensure sustainability of HIV/AIDS services provision

The targeted groups included: transport workers such as truck drivers and their assistants, female sex workers (FSW) and their partners; men having sex with men (MSM), out-of-school youth; PLHIV; orphans and most vulnerable children (OVC/MVC); and other at-risk community men and women living in hot spots, including women engaged in transactional sex who do not self-identify as FSW living in the four target sites of the project.

The project focused on six program areas:

- *HIV prevention services* comprising prevention of mother-to-child HIV transmission (PMTCT), HIV testing and counseling (HTC), sexual and other behavioral risk prevention, post-exposure prophylaxis, and prevention with positives;
- *(2)Care services* for persons infected and affected by HIV/AIDS (cotrimoxazole prophylaxis against opportunistic infections, integration of TB/HIV services, support to antiretroviral therapy, home-based care and OVC services);
- *Health systems strengthening* (support to laboratory services, training for human resources for health and performance-based financing);
- *Capacity building of civil society organizations;*
- *Family planning including gender-based violence.*
- *Maternal, newborn and child health (MNCH)*

This report provides a summary analysis of the project's accomplishments and results achieved during the 2008 – 2013 period, discussed by program area and highlights key performance indicators demonstrating levels of success in each area.

Key Successes

Although much has been achieved, the following are some of the key successes:-

1. Responding to National HIV – AIDS Strategic Plan (2012-2016): ROADS II contributed to achieving the following Government of Burundi strategic axis:

- *Strategic axis 1* : Reduction of HIV/STI transmission
 - Program area 1.1: Reduction of sexual transmission of HIV
 - Program area 1.3: Prevention of mother-to-child transmission
- *Strategic axis 2*: Improve the wellbeing of people living with HIV:
 - Program area 2.4: Prophylaxis, diagnosis and treatment of opportunistic infections
 - Program area 2.5: Universal access to ARVs for adults and children
 - Program area 2.6: Psychosocial and nutritional support of PLHIV
- *Strategic axis 3*: Reduction of poverty and other determinants leading to HIV vulnerability
 - Program area 3.8: Care for OVC

2. HIV Prevention Services: ROADS II supported service delivery points to provide PMTCT services including antenatal services, HTC, diagnosis and management of sexually transmitted infections (STIs), safe obstetrical practices, counseling for safe infant feeding and exposed-infant follow-up until 18 months of age. Sexual partners of pregnant women were sensitized on the need to be tested for HIV. Within HTC delivery points where data was available, an increased number of male partners were tested for HIV. In addition, the most vulnerable pregnant women received food supplementation. Antiretroviral prophylaxis was also administered to infants born to HIV-positive mothers according to the national protocol. A total of 583 staff members were trained on provision of PMTCT services. There was a significant increase in the number of PMTCT service delivery points, from 44 in 2008 to 163 in 2013. There was an increase in the number of pregnant women who were tested for HIV from 59,932 in 2009 to 135,626 in 2013. The number of those tested and received their results increased from 41,373 in 2009 to 130,040 in 2013. The number of pregnant women who tested positive and were enrolled in PMTCT increased from 427 in 2009, to 957 in 2013.

ROADS II promoted access to HTC services. The number of HTC service outlets increased from 46 in 2008 to 165 in 2013, and the number of people accessing these service increased from 46,953 in 2008 to 360,446 in 2013. The project also increased the number of adults and children living with HIV who received clinical care and treatment, including ART, through expansion of outlets and improvements to laboratory services. Consequently, the number of PLHIV on cotrimoxazole prophylaxis increased from 3,606 in 2008 to 9,950 in 2013.

ROADS II strengthened laboratory services through provision of equipment and supplies, and training, supervision and mentoring staff. Supported laboratory activities included HIV testing, and biological follow-up (biochemistry, hematology analysis and CD4 count) for PLHIV under clinical care including ART. HIV test kits, reagents and other laboratory supplies, materials and equipment were provided to HTC service outlets, and to laboratories attached to ART sites.

In partnership with the Clinton Foundation and the Laboratory of the National Institute of Public Health, ROADS II started and sustained HIV diagnosis in infants born to HIV+ mothers using Dried Blood Spots HIV Polymerase Chain Reaction (DBS-PCR) technique.

In addition to clinical care and treatment services, ROADS II also supported non-clinical care and support services for PLHIV families and provided support for orphans and vulnerable children infected with or affected by HIV. A total of 6,602 eligible clients received food and other nutritional services; 10,387 eligible clients benefited from psychosocial support, food and other nutrition services by the end of the project cycle. The number of OVC served increased from 6,000 in 2009 to 11,935 in 2013.

3. Maternal and Child Health: MCH activities were funded by USAID/EA. ROADS II supported two facilities (Bunyari and Burara Health Centers) to deliver improved antenatal care, immunization, labor and delivery, growth monitoring, and family planning services, and to provide nutritional support for infants and mothers, and offer services to mitigate gender-based violence. Twenty-four traditional birth attendants (TBAs) and 18 community health workers were trained on different MCH topics including labor and delivery management. The two health centers and nine health centers in Busoni/Kirundo also received equipment to support MNH services. Between 2011 and 2013, 980 women in Bunyari, and 623 in Burara delivered under skilled care. In the same period, 603 women in Burara and 859 in Bunyari benefited from active management of the third stage of labor (AMTSL) services.

4. Family Planning and Gender-Based Violence: Through the program, facilities were offered a range of contraception methods, including pills, injectables, IUCD (insertion and removal), male condoms, spermicides and counselling clients on natural family planning.

In 2010, a pilot project was launched to integrate the Standard Days Method (SDM) into the range of contraceptive methods in four health centers (Kayanza and Rubura in Kayanza, and Kigozi, Murore in Kirundo province). This led to an increase in the number of clients who adopted this method in the four pilot sites. An evaluation conducted with the technical assistance of the Institute of Reproductive Health (IRH) of Georgetown University showed that the Standard Days Method was acceptable and feasible in Burundi and that introducing it gave clients who preferred natural methods an effective choice.

Community health workers (CHW) disseminated FP messages to community members in Kayanza, Muyinga and Karusi, and also conducted sensitization about gender-based violence (GBV) and rape. Rape survivors received care, treatment and other services from appropriate facilities.

ROADS II also improved awareness of the community members on GBV and its effect. This further led to reduced number of GBV cases and increased number of individuals accessing GBV recovery services. It also led to reducing GBV as a barrier to accessing FP and MNH services. The project mentored the supported health facilities and surrounding communities in Kayanza (*Kayanza, Gahombo, Matongo, Musema, Rubura, Gasenyi and Gatara*), Kirundo (*Kirundo, Bunyari, and Murore*) and Muyinga (*Muyinga HC*) provinces to provide quality FP and GBV services.

5. Capacity strengthening: ROADS II Project also strengthened capacities of civil society organizations thereby promoting sustainability of project gains. This was done through

training and mentorship to enable these organizations design programs to address HIV and broader health in their communities.

Lessons learned

1. Fostering teamwork improves collaboration and communication among partners, stakeholders, CBOs and beneficiaries. The strong collaboration among the stakeholders contributed to the overall program success.
2. Qualified and committed human resources are essential for project implementation and quality health care services provision.
3. Improvement of infrastructure and health facility environment increases facility attendance and uptake of services: When the project started to renovate and equip health facilities for HIV-related services provision, other existing services in the facility were utilized.
4. Decentralization of antiretroviral treatment (ART) to health center level is possible: Although the national ART protocol recommends provision of ART in settings where there are medical doctors only, ROADS II piloted an ART decentralization program where the services were decentralized from district hospitals to selected health centers. This initiative brought ARV services closer to the clients, thereby promoting their uptake.
5. Peer-led outreach programs can increase ART enrolment. Evidence shows that through testimonies, PLHIVs' confidence and self-esteem was improved, and social stigma reduced and led to more people enrolling on ART.
6. Gender-focused efforts: GBV is a community issue and stakeholders need to work together devising strategies targeting men and women to address the vice.

1. Background Information

1.1 Regional Context

ROADS II Project is a Leader with Associates (LWA) Award¹ supporting project implementation in African countries along transport corridors in East, Central and Southern African region. Since inception in 2005, the project has supported interventions in: Burundi, the Democratic Republic of Congo, Djibouti, Ethiopia, Kenya, Mozambique, Rwanda, South Sudan, Tanzania, Uganda and Zambia. Funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID) East Africa and bilateral missions, ROADS II implemented HIV prevention, care and support services, and broader health programming in "hotspot" communities in these countries. The project was designed to further FHI 360's contribution towards strengthening community-based HIV and broader health programming.

1.2 Country Context

Burundi is a low-income developing country. The UNDP 2010 Human Development Report ranked the country at an index of 167 out of 177 countries worldwide. The country has a population of 10 million, with an annual growth rate estimated at 2.4 percent.² It is one of the most densely populated countries in Africa, with 367 people per square kilometer.

The 2010 Poverty Reduction Strategy Paper³ reported that northeastern and eastern provinces are prone to drought, and experience low yields and limited access to inputs⁴. Burundi also has a high rate of poverty, estimated at 67 percent. The majority (about 70 percent) of Burundi's poor live in rural areas. These estimates were based on an adult-equivalent poverty line of BIF627 per day in urban areas and BIF525 per day in rural areas. According to the IMF analysis, in 2010, the poorest people were located mostly in Kirundo, followed by Muyinga and Karusi⁵. Other social indicators were generally lower than regional averages.

Maternal health is an ongoing concern in Burundi⁶. According to Maternal Mortality Estimation Interagency Group (MMEIG) estimates, the maternal mortality rate fell from 1100 to 800 maternal deaths per 100,000 live births between 1990 and 2010, an overall reduction of 27%. According to the assessment of EmONC needs carried out in 2010, maternal deaths are due mainly to direct obstetrical complications such as hemorrhaging, obstructed labor and infections. Hemorrhaging is the most common cause of maternal death and post-partum hemorrhaging occurs in over 72% of hemorrhage cases. The assessment showed that uterine rupture was the main cause of death. The case fatality rate per hemorrhage (3.3%) is three times higher than the acceptable case fatality rate (1%). The data available on family planning

¹ Associate Cooperative Agreement No. 623-A-00-08-00061 Under LWA No. 623-A-00-08-00049-00

² Burundi, Enquête Démographique et de Santé 2010, page 2

³ The 2010 PRSP is based on data from the 2006 Core Welfare Indicator Questionnaire for Burundi (CWIQ). The CWIQ was developed by the World Bank with UNDP and UNICEF

⁴ IMF, 2010. Burundi: Poverty Reduction Strategy Paper.

⁵ IMF, 2010. Ibid.

⁶ 2010 Demographic and Health Survey (DHSB 2010)

shows increasing use of modern contraceptive methods: from 4% in 1990 to 21.9% in 2011. This trend is related notably to the lack of shortages in stocks of contraceptives since 2006, to the training of service providers in long-acting methods of contraception (IUDs and implants) and to performance-based funding.

According to a UNICEF Situation Analysis (2009), 19% of young people started sexual activity before 10 years, 35% at ages 10-14, and 35% at ages 15-19⁷. In 21% of cases, the partner was either a parent or a family friend, and only 19% of those surveyed used condoms during their first sexual intercourse⁸. 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 sexual behavior include mobility and displacement related to the political and ethnic crisis, alcohol abuse, and poverty. Political and ethnic conflict has caused disruptions in agricultural production, and forced people into migrant labor and prostitution, putting them at increased risk of HIV infection. The lack of economic opportunities, gender inequity and gender-based violence (GBV) has heightened HIV risk across age and socio-economic groups.

Available data shows that HIV continues to be a growing priority public health threat in Burundi. In 2005 sentinel surveillance data showed that HIV infections among antenatal clinic attendees in Bujumbura had risen from 12.6% in 2004 to 18%; the infection rates among the young (15-24 years) ANC clients almost doubled from 8.6% in 2004 to 15.5% in 2005. The HIV prevalence among women in the rural areas also doubled. The HIV prevalence for women was 3.8% while it was 2.6% for the men. The HIV testing outcomes were also low; very few people who were tested received their results. National health information systems were weak and provided little reliable recent data on HIV/AIDS. According to the 2007 sero-prevalence survey⁹, adult HIV prevalence was 2.97% 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.

Since then, significant progress has been made in terms of prevention and treatment with positive effects on reducing sero-prevalence and reducing mortality. Despite this progress, additional efforts were still needed to deal with the worrying rise in rural areas, where over 90% of the population live, and to increase the coverage of key interventions contained in the 2012-2016 national strategic plan to combat HIV/AIDS. HIV/AIDS was stabilizing in semi-urban and urban areas, but increasing in rural areas, and affecting certain very high-risk groups. Women are generally more affected than men, in particular at an early age. Sex workers have a much higher prevalence rate estimated at 38%¹⁰ in 2009. Younger sex workers in rural areas had the highest prevalence rates, perhaps due to high mobility near borders with other high-prevalence countries. Other most-at-risk populations (MARPs) included truckers, military, and men who have sex with men (MSM), although no reliable data is available. HIV/tuberculosis co-infection is an additional complication for persons living with HIV and is the cause of numerous deaths. There were more than 800,000 orphans and highly deprived children living in Burundi¹¹.

⁷ UNICEF's Situation Analysis of Children and Women in Burundi (2009)

⁸ Burundi Operational Plan Report FY 2012 Pefar Facts Info

⁹ Behavioral Surveillance Survey 2007

¹⁰ NAC, 2007

¹¹ FHI/ROADS II project. 2007. Program Description in Burundi 2008-2010. USAID/EA

1.3 Intensifying efforts against HIV/AIDS

The Government of Burundi (GOB) is fully engaged in the fight against HIV/AIDS, with a vision 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."¹² The national response is coordinated by the Ministry of Public Health and the Fight against AIDS (MPHFA). HIV/AIDS care and treatment services are integrated into the basic health care package delivered at public and private/faith-based health facilities. The national supply agency, which procures ARVs and most HIV-related commodities, and the national laboratory system required reforms, especially outside Bujumbura. Programs designed to meet the demographic goals of Vision 2025 are implemented by several ministries and units, with the support of local and international partners. Most 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+) through GOB and external donor support. OVC programs are coordinated by the National AIDS Control Council.

¹² As stated in the National HIV/AIDS Strategy (2007-2011)

2. Project Description

In early 2006, Family Health International (FHI)/Burundi was integrated into USAID/East Africa's Regional Outreach Addressing AIDS through Development Strategies (ROADS) Project, which was addressing HIV/AIDS in Eastern Africa by targeting transport corridors, supporting limited presence countries, and promoting regional coordination of prevention, care, and treatment activities. In September 2008, FHI was awarded the second cooperative agreement for the Roads to a Healthy Future (ROADS II) Project, by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through U.S. Agency for International Development (USAID) Burundi. ROADS II was a five-year award (2008 – 2013) and a direct follow-on program to the previous 3-year ROADS Project (2006 – 2008).

2.1 Goals and Objectives

The overall goal of ROADS II Burundi was to increase access to multisectoral HIV/AIDS, health and other related services for the population in Karusi, Kayanza, Kirundo and Muyinga provinces.

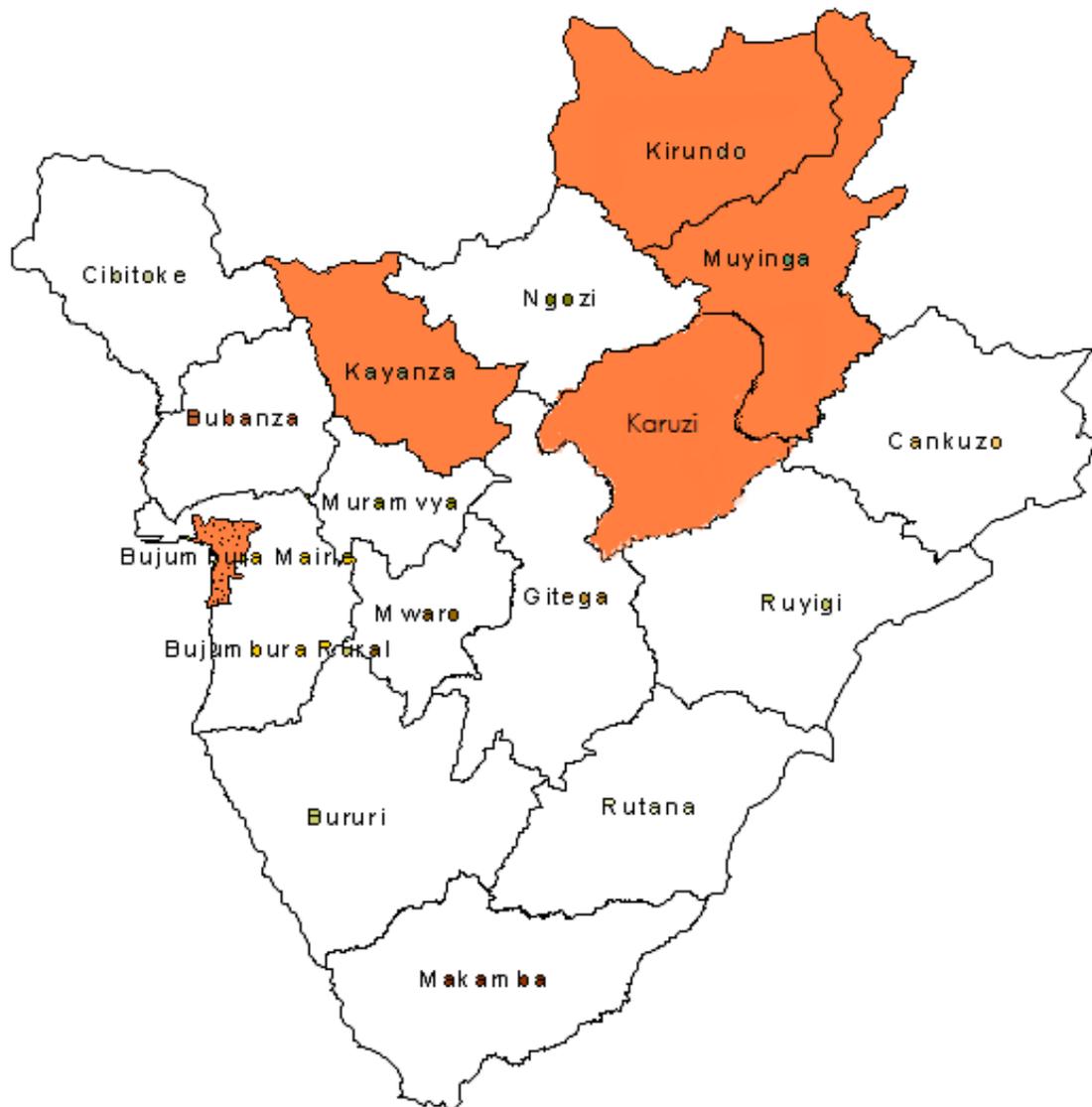
The project aimed to:

- (i) Build on the previous successes and implement effective programs that increase access to services in prevention, care and treatment for HIV/AIDS, malaria, family planning/reproductive health and maternal newborn health.
- (ii) Strengthen the capacity of local civil society organizations to ensure sustainability of HIV/AIDS services provision.

2.2 Project Zones

ROADS II supported interventions in Karusi, Kayanza, Kirundo, Muyinga, and later Bujumbura provinces. Figure 1 below shows ROADS II project sites during the five-year period.

Fig 1: ROADS II Project sites in Burundi



2.3 Beneficiaries and partners

ROADS II target groups included pregnant women, low income women, youth, orphans and other vulnerable children affected by AIDS, general population, and female sex workers. In Bujumbura City, the project targeted long distance drivers, and taxi operators in Kayanza province.

The project was implemented by FHI 360 and 45 partners. The strong collaboration between public and private partners and the Government of Burundi was a key success during project implementation.

Table 1: Local implementing partners

Implementing Agency	Province/Location	Activities
From public sector		
Buhiga Health District	Karusi	PBF for HIV indicators & HTC/PMTCT/PT
Buhiga Hospital	Karusi	ART/PT
Nyabikere Health District	Karusi	PBF for HIV indicator & HTC/PMTCT/PT
Gahombo Health District	Kayanza	PBF for HIV indicator
Kayanza Health Center	Kayanza	HTC/PMTCT/PT
Kayanza Health District	Kayanza	PBF for HIV indicator
Kayanza Hospital	Kayanza	ART/PT
Kayanza Provincial Health Bureau	Kayanza	HTC/PMTCT/PT
Musema Health District	Kayanza	PBF for HIV indicator
Musema Hospital	Kayanza	ART/PT
Busoni Health District	Kirundo	PBF for HIV indicator
Kirundo Health District	Kirundo	PBF for HIV indicator
Kirundo Hospital	Kirundo	ART/PT
Kirundo Provincial Health Bureau	Kirundo	HTC/PMTCT/PT
Mukenke Health District	Kirundo	PBF for HIV indicator
Mukenke Hospital	Kirundo	ART/PT
Vumbi Health District	Kirundo	PBF for HIV indicator
Gashoho Health District	Muyinga	PBF for HIV indicator
Giteranyi Health District	Muyinga	PBF for HIV indicator
Muyinga Health District	Muyinga	PBF for HIV indicator
Muyinga Hospital	Muyinga	HTC/PMTCT/PT/ART
Muyinga Provincial Health Bureau	Muyinga	HTC/PMTCT/PT
From private sector		
ABUBEF	Bujumbura, Kirundo	HTC/PMTCT/PT
ADDF Karusi	Karusi	BCC
Croix Rouge Karusi	Karusi	BCC
ACQKA	Kayanza	BCC
AMAVS	Kayanza	OVC
Banga HC	Kayanza	HTC/PMTCT/PT
Maramvya HC	Kayanza	HTC/PMTCT/P
Ngozi Diocese	Kayanza	HTC/PMTCT/PT
PUMA KARATE	Kayanza	BCC
SWAA Kayanza	Kayanza	BCC /HTC
RBP +	Kayanza, Kirundo- Muyinga, Karusi	HBC/OVC
ANSS	Kirundo	ART/PT
Centre Izere	Kirundo	HTC/PMTCT/PT
CPAJ	Kirundo	BCC
Marembo HC	Kirundo	HTC/PMTCT/PT
Nyamabuye HC	Kirundo	HTC/PMTCT/PT
Rutare HC	Kirundo	HTC/PMTCT/PT
APECOS	Kirundo	OVC
BDC, Diocèse Muyinga	Muyinga	OVC
Kagari Health Center	Muyinga	HTC/PMTCT/PT
SWAA Muyinga	Muyinga	BCC /HTC
RENAJES	Muyinga	BCC
Diocèse Catholique de Muyinga	Muyinga, Kirundo	HTC/PMTCT/PT

ROADS II Burundi also collaborated with seven strategic partners as presented in Table 2 below:

Table 2: Strategic partners and a brief of their roles

Strategic partner	Role
JHU/CCP¹³/ AFRICOMNET	Strategic health communication to improve health and save lives; reaching audiences with persuasive messages
JHPIEGO	Strengthen FP/RH , malaria, MCH and TB services, as well alcohol treatment in the context of HIV and care for survivors of gender-based violence
Howard University	Training pharmacists and auxiliary workers on HIV prevention, treatment and counseling
Solidarity Centre	Work with transport worker unions and associations to enhance HIV education and uptake of services
North Star Foundation	Extend health services to mobile transport workers
PATH¹⁴	Behavior change communication activities
DAI¹⁵	Food Security and Economic Strength

Furthermore, the project strengthened its partnerships with other USAID-funded partners working in the same intervention area to avoid duplication and foster synergy. These included Supply Chain Management System (SCMS), Engender Health, Measure Evaluation, University Research Co, and MSH. To maximize results, ROADS II also collaborated with programs/activities supported by the Global Fund and the Belgian Cooperation. It also supported quarterly coordination meetings organized by Provincial Health Bureaus.

2.4 Technical Approaches and Innovations

2.4.1 HIV prevention services

Prevention of Mother to Child Transmission (PMTCT) of HIV: During the five-year implementation period, ROADS II supported service delivery points providing PMTCT services including antenatal clinics, HIV testing and counselling, diagnosis and management of sexually transmitted infections (STIs), safe obstetrical practices, nutritional support, including counseling for safe infant feeding, and exposed-infant follow-up until 18 months of age. The program ensured that pregnant women attending their 1st ANC clinic were counseled, tested and given their test results and those newly identified as HIV-positive were enrolled on ART. Sexual partners of the pregnant women were sensitized on the need to test for HIV as part of promoting male involvement in PMTCT. The program also administered antiretroviral prophylaxis to HIV-exposed infants according to the national protocol, and provided early infants diagnosis using the DBS-PCR technique, through the National Reference Laboratory.

¹³ Johns Hopkins University Bloomberg School of Public Health Center for Communication Programs

¹⁴ Program for Appropriate Technology in Health (PATH)

¹⁵ Development Alternatives, Inc

HIV Testing and Counseling (HTC): HTC services were extended to the general population, including pregnant women and exposed infants. It also included capacity building for human resources through training and hiring of additional staff. Moreover, from 2012, test kits, laboratory supplies, and materials, were supplied through SCMS to ROADS II-supported service delivery facilities¹⁶, ensuring uninterrupted service provision.

Sexual and other risky behavior prevention: ROADS II targeted youth (15 to 24 years old), low income women (LIW) and MARPs with services related to sexual and other risk prevention. Prevention services offered included peer education through small group and one-on-one communication, distribution of IEC materials and condoms, and referral for appropriate services. These services were also extended at *SafeTStop* recreation centers to reduce HIV transmission, improve care, and lessen the impact of HIV and AIDS among long distance truck drivers along the transport corridor. Prior to their establishment, assessments were conducted to identify the most appropriate ‘hot-spot’ sites in three sites: Kayanza, Muyinga and the truckstop in Bujumbura. The project provided education sessions on correct and consistent condom use, HIV testing messages and referral. Long distance truckers and their assistants, particularly, benefited from these services.

Post Exposure Prophylaxis (PEP): According to the national protocol, emergency antiretroviral prophylaxis should be initiated within 72 hours after exposure (professional and non-professional exposures or sexual exposures through rape and sexual assault), and continued for 28 days. PEP services were provided in supported ART service delivery points

Prevention with Positives (PwP): PwP services targeted people living with HIV (PLHIV), and included a minimum package of six prevention interventions intended to protect their health and reduce the spread of HIV to their sexual partners and children. These included:

- (1) Assessment of sexual activity and provision of condoms (and lubricants) and risk reduction counseling (if indicated),
- (2) Assessment of partner status and provision of partner testing or referral for partner testing,
- (3) Assessment for STIs and (if indicated) provision of/or referral for STI treatment and partner treatment,
- (4) Assessment of family planning needs and (if indicated) provision of contraception or safer pregnancy counseling or referral for family planning services,
- (5) Assessment of adherence and (if indicated) support or referral for adherence counseling,
- (6) Assessment of needs and (if indicated) refer or enroll the PLHIV in community-based programs such as home-based care, support groups, post-test clubs.

2.4.2 Care services for people infected and affected by HIV

Services offered in the framework of care included clinical services offered to PLHIV and support services offered to PLHIV through home-based care and Orphans and Vulnerable Children (OVC) services; strengthening existing service outlets offering HIV prevention and care services through partnership with MPHFA and in accordance to established guidelines.

¹⁶Note that prior to 2012, all procurements were done by FHI360

Similarly, mobilizing community networks such as networks of people living with HIV (PLHIV) to promote access to services like couple counseling and testing, PwP and focusing interventions to households. Clinical services include clinical staging according to WHO guidelines, prophylaxis of opportunistic infections using cotrimoxazole against opportunistic infections, support to antiretroviral therapy, and integration of TB/HIV services.

Support services extended to OVC included education support (school kits and uniforms, school fees), health care support, hygiene and shelter improvement (hygiene materials, rehabilitation of houses), as well as psychosocial counseling. The emphasis was on family centered approach according to the new PEPFAR guidance. The second component was home-based care (HBC) services targeting PLHIV to provide psychosocial support, nutritional counseling and food supplementation, health care support as well as hygiene and shelter improvement, etc.

2.4.3 Maternal and Newborn Health

MCH activities were funded under a separate mechanism from USAID/EA. Among the services offered were antenatal care, immunization, labor and delivery, growth monitoring, family planning, nutritional support for infants and mothers and services to mitigate gender-based violence.

A rapid assessment conducted in March 2010 showed that the key limitations affecting MCH activities included inadequate staffing in both quantity and quality and a shortage of technical facilities, equipment and consumables. There was need therefore, to train health providers and to equip health facilities. In addition, the assessment recommended further training of community *relays* and the traditional birth attendants (TBAs) to promote maternal and child health.

Subsequently, TBAs in Bunyari HC and Burara HC were trained on the following areas: general reproductive health; the four delays that kill; delivery planning; focused antenatal care (ANC), with emphasis on prevention of anemia, malaria, mother-child HIV transmission and the importance of delivery assisted by skilled attendants. Health providers, including nurses and nurse assistants were also trained on focused ANC care, emergency obstetric care and newborn care. Particular emphasis was placed on the delivery planning, the four delays that kill, and Active Management of Third Stage of Labor (AMSTEL) to prevent death from postpartum hemorrhage. The two health centers also received two delivery beds (2), two gynecological tables and small equipment and supplies.

2.4.4 HRH and Health Systems Strengthening

An initial assessment study was conducted in 2012 to provide evidence to develop continued quality improvement strategies for ART, PMTCT and HTC in ROADS II- supported sites¹⁷. The study examined competence, standards, availability of standard equipment required to

¹⁷ See ROADS II Project- Burundi M&E Plan 2011-2013 for more information

perform quality services, adherence, service integration, accessibility, availability, and client satisfaction. Key recommendations included the training for human resources for health, strengthening of laboratory services, performance-based financing, capacity building and family planning including gender-based violence:

- a) *Training and mentoring health care providers to become more effective and efficient.* The health care providers undertook in-service training and refresher trainings on different HIV programmatic areas among them specific intervention for PMTCT, HIV testing and counseling, support for PLHIV, STI clinical management, ARV services, DBS samples for PCR testing, maintenance of CD4 Count machines, and M&E fundamentals and data quality assurance. In addition, training materials and guides were developed, training modules were adapted, orientations provided and interpersonal communication offered. ROADS II also provided training and mentorship to health care workers in different areas including PMTCT and care and treatment for PLHIV.
- b) *Strengthened laboratory services* are indispensable for the biological follow-up needed to manage and monitor PLHIVs' clinical care. ROADS II, in collaboration with SCMS¹⁸, ensured that laboratories were regularly supplied with reagents and other consumables needed for HIV testing, biochemistry and hematology analysis, as well as CD4 count. ROADS II also supported lab services through supervision and mentoring, equipment maintenance and training of laboratory technicians based at hospitals and health centers to perform more rigorous laboratory tests related to HIV.
- c) *Building capacity for Performance-Based Financing (PBF):* ROADS II collaborated with District Health Offices to support achievement of the following seven HIV indicators in the four provinces: number of HIV-positive pregnant women provided with ART, number of newborns from HIV-positive mothers provided with follow-up care, ARVs to newborn, number of people tested for HIV, number of new patients provided with ART, number of ART patients monitored semi-annually, number of cases of STI treated and male circumcision. In addition, the project supported 156 health facilities to improving their performance and quality of health service delivery. These were distributed as follows: Karusi (29), Kayanza (40), Kirundo (44) and Muyinga (43).
- d) *Reinforcing the capacity of local organizations to ensure sustainability of HIV/AIDS service provision:* The project strengthened capacity for civil society organizations in HIV institutional development in order to graduate them for direct USG funding. Six CBOs, (Alliance Burundaise de Lutte Contre le SIDA (ABS), Association Burundaise pour le Bien-être Familial (ABUBEF), Association Nationale de Soutien aux Séropositifs et Malades du SIDA (ANSS), Collectif pour la Promotion des Associations de Jeunes (CPAJ), Réseau Burundais des Personnes Vivantes avec le VIH SIDA (RBP+), and Society for Women Against AIDS (SWAA)) are already considered leaders in the fight against HIV/AIDS in Burundi.

¹⁸ The Supply Chain Management Services (SCMS) was later moved to CAMEBU (Centrale d'Achat des Médicaments du Burundi)

Prior to this, an assessment to identify their capacity needs covering organizational capacity and competence; management and governance, finance and administration; and technical service delivery was conducted. The assessment tools used were the HIV/AIDS Service Delivery Capacity Building Assessment Tool for CSOs and NGOs and the Quick Start Administration and Finance tool, developed by MSH. Results showed that in management and governance, all the assessed organizations had defined governance structures in place. However, some gaps in management expertise were noted. Some of the identified weaknesses included; strategic planning particularly sustainability; human resources management; monitoring and evaluation, particularly qualitative evaluations; and data utilization beyond donor reporting.

Regarding finance and administration, the organizations were capable of meeting individual donor requirements but lacked harmonized organization-wide systems for administrative and financial management. Accounting software was minimally to not-utilized at all, meaning that transactions and reports were manually processed, which was extremely time-consuming and prone to error. Furthermore, finance and administration staff often lacked adequate training and in many cases one staff member handles all financial and administrative functions, limiting internal controls.

In terms of technical service delivery, the organizations were generally strong, observed all relevant Ministry of Health and Fight against AIDS guidelines and provided high level clinical care and psychosocial support. There were still significant needs for mentoring and capacity building to improve the quality of services. Few mechanisms existed for documenting and sharing best practices across programs, and access to information about global advances in HIV care and treatment and methods of behavior change communication was limited by technological and language barriers. For organizations providing clinical care, management of stock of drugs and commodities was handled manually and none of the organizations visited had documented policies for handling infectious medical waste.

While specific trainings and capacity building workshops were recommended, many of the recommendations were on internal knowledge exchange and mentoring in organizations and sometimes across organizations. This was not limited to clinical expertise but also general management. In line with the formulated recommendations and the expected results, FHI 360 developed capacity building plans for the six local organizations to address the identified gaps.

2.4.5 Family planning and Gender-Based Violence

Family Planning and Gender-Based Violence (FP/GBV): The program added FP services and reproductive health into the core services in Kayanza, Muyinga and Kirundo Provinces. The project further addressed gender norms, gender-based violence and other social barriers that inhibit the uptake of FP services through training and community sensitization. The project also provided basic equipment and supplies and supported routine monitoring and supervision to ensure service delivery. The project also supported facilities to adhere to national and international standards and guidelines on service delivery.

The project offered mentoring to staff in the supported facilities and surrounding communities to provide quality family planning (FP) and gender-based violence (GBV) services. It also strengthened integration of FP/RH/GBV and HIV/AIDS services in existing sites to increase access to quality services, reduce unmet needs for FP and to address GBV.

A training module on FP and GBV was completed and translated into French. The module was adapted and finalized in September 2009. The development of new modules in GBV by ROADS partners took considerable time due to the rigid regulatory framework in the country. The modules were reviewed and approved by the Ministry of Public Health and trainings were conducted.

Peer education strategy and Magnet Theater was used to reach target groups (low-income women and youth) and community members, especially in program components that promote behavior change, increase access to condoms, counseling and testing services and promotion of FP and GBV services. These activities included implementation of evidence-based communication and small group/individual interpersonal interventions targeting high-risk populations and linking them to health services.

Some key lessons learned in FP/GBV in Burundi

1. Conducting baseline assessment on knowledge, attitudes and practices in the community and facility prior to program design is critical. It helps to identify gaps that a program can address, thereby contributing to effective systems strengthening and effective use of resources.
2. Expanding the roles of community-based health workers and drug shops/pharmacies attendants is strategic in delivering messages on FP and STIs/HIV, and can lead to increased uptake of services at facility level
3. Linking CHWs to the nearest facility for supportive supervision, supplies and referrals improves quality of services in the community
4. The availability of basic or adequate equipment, materials and supplies at facilities increases the use of services. This has been supported by feedback from MOH in participating countries.
5. Collaboration with district authorities ensures sustainability of services (e.g. the establishment of secondary posts in Burundi)
6. Training of facility-based providers in LAPM helps in providing a wider choice of methods to clients at facilities. These include IUDs, Implants and permanent methods for both men and women.
7. By training health providers at community and facility levels, ROADS has observed an increased awareness and expertise in handling GBV cases at all sites. The community, both men and women, can now openly discuss GBV issues.

8. There is improved male involvement on FP/RH issues albeit slow. CBDs report being able to visit couples more and more as opposed to before, where they counselled women only without their partners. This way, more men get to listen and receive counselling.
9. Using national trainers approved by the MOH to train peer educators and CBDs has been found to be effective Well-trained PEs and CBDs are confident in providing counselling and answering questions correctly several months after training.
10. Having full time ROADS RH Technical Officers in Burundi facilitated project implementation and monitoring.

3. Accomplishments and highlights

Summary of key achievements by program areas

This section provides a summary of the key accomplishments achieved through ROADS II in Burundi since its inception in 2008. Initial findings indicate that the program targets were largely met or exceeded during the life of the project.

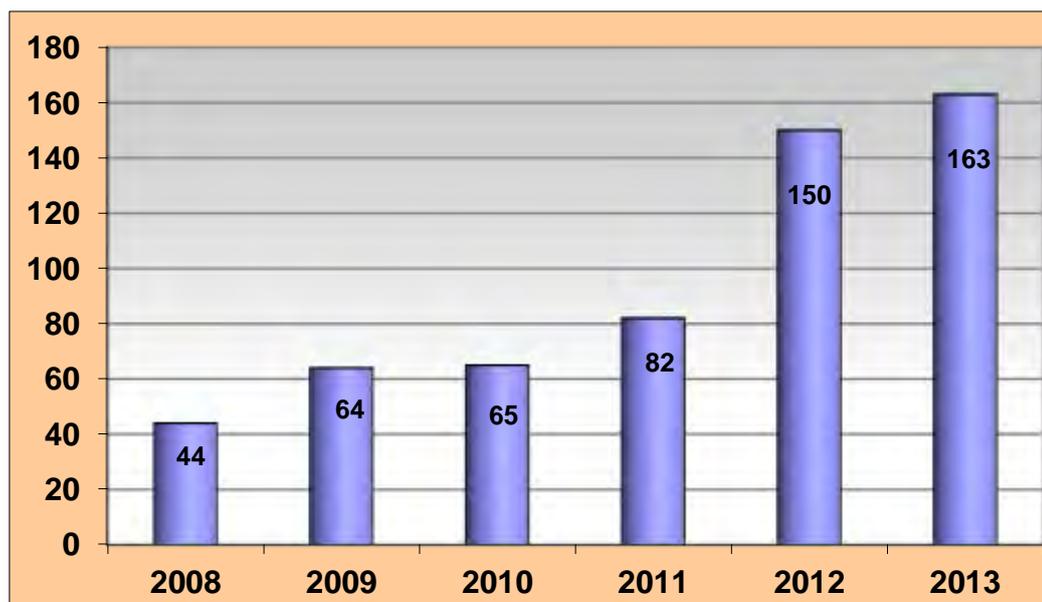
3.1. HIV prevention services

These services included: PMTCT, HTC, sexual and behavior risk prevention, PEP and PwP. During the project implementation, these services were scaled up, promoting their uptake. Most targets PMTCT, HTC and sexual and behavior risk prevention targets were surpassed. Groups reached included out-of-school youth, low-income women, truck/taxi drivers, and female sex workers.

3.1.1. Prevention of Mother to Child Transmission of HIV (PMTCT)

The activities implemented under PMTCT component were geared towards increasing demand and access to PMTCT services. This includes uptake for PMTCT prophylaxis and referral to care, ART and community-based support. The PMTCT component of the program was implemented in all four ROADS II-supported sites.

Fig 3.1.2. Increased in no. of operational service outlets offering PMTCT services over project-period



The number of operational service outlets offering PMTCT increased from 44 in 2008 to 163 in 2013. Similarly, the number of ANC attendees increased from 59,932 in 2009 to 135,626 in 2013.

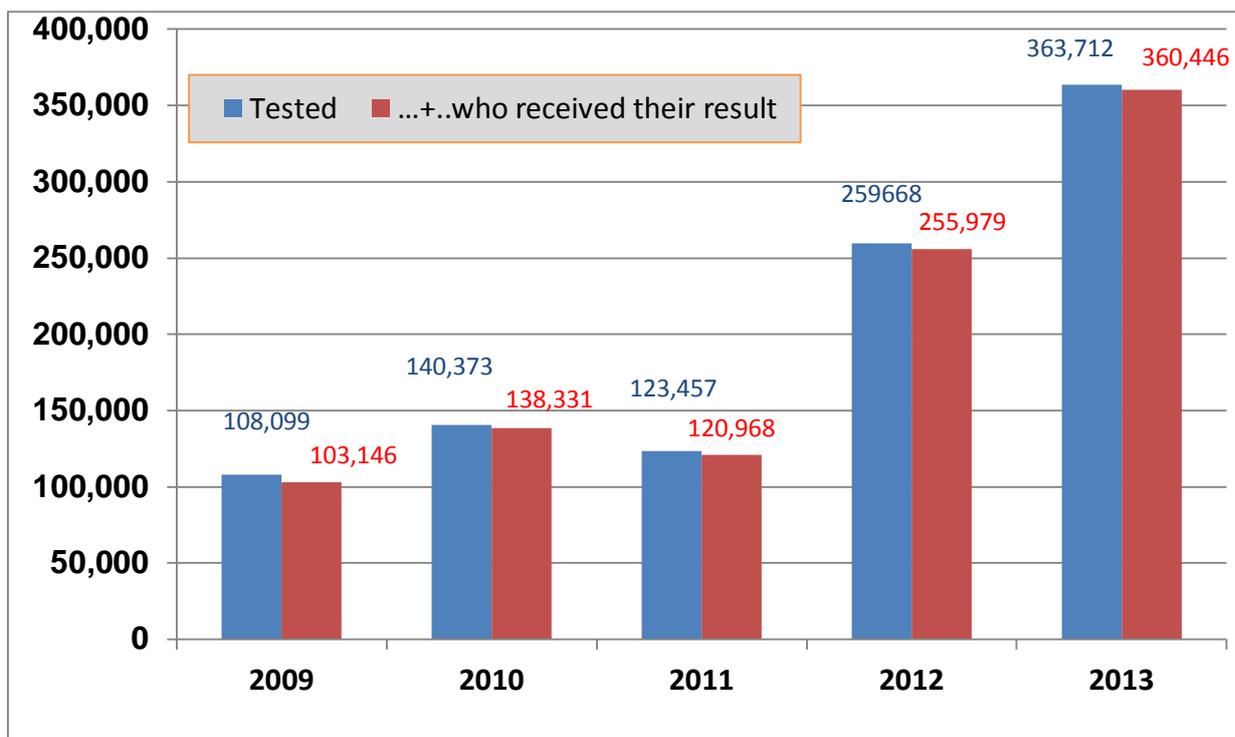
Table 3.1.3 Distribution of PMTCT/HTC Outlets by Province, Health District and Commune, FY2013

Province	Health District	Commune	Clinical service outlets
Kayanza (41)	Gahombo	Gahombo (4)	Gahombo HC, Nzewe HC, Rukago HC, Gasenyi II HC
		Gatara (5)	Ngoro HC, Gakenke HC, Kibaribari HC, Maramvya HC, Gatara HC
		Muhanga (4)	Ceyerezi HC, Muhanga II HC, Mubogora I HC, Muhanga I HC
	Kayanza	Kabarore (5)	Kabarore HC, Rubura HC, Ryamukona HC, Rugazi HC, Jene HC
		Kayanza (6)	Kabuye I HC, Gahahe HC, Kayanza HC, Kayanza Hospital, Murima HC, SWAA Kayanza
		Muruta (3)	Mubuga HC, Remera HC, Rwegura HC
	Musema	Butaganzwa (5)	Musema HC, Ninga HC, Nyarurama HC, Buraniro HC, Musema Hosp.
		Matongo (4)	Burarana HC, Matongo HC, Kabuye 2 HC, Banga HC
		Rango (5)	Gikomero HC, Rango HC, Gaheta HC, Karehe HC, Gasenyi I HC
Kirundo (49)	Busoni	Busoni (9)	Bunyari HC, Burara HC, Kabanga HC, Mukerwa HC, Nyagisozi HC, Sigu HC, Vyanzo HC, Marembo HC, Murore HC
	Kirundo	Bugabira (6)	Kiyonza HC, Muyange HC, Rugasa HC, Ruhehe HC, Nyamabuye HC, Kiri HC
		Kirundo (11)	ABUBEF Kirundo Clinic, ANSS Kirundo, Cumva HC, Gaharo HC, Gakana HC, Kirundo HC, Rukuramigabo HC, Izere HC, Rutare HC, Kigozi HC, Kirundo Hospital
	Mukenke	Bwambarangwe	Bugorora HC, Buhoro HC, Kibazi HC, Kimeza HC, Mukenke

		(6)	HC, Mukenke Hospital
		Gitobe (5)	Bucana HC, Gitobe HC, Nyenzi HC, Shore HC, Tonga HC
	Vumbi	Ntega (7)	Mugendo HC, Mugina HC, Murungurira HC, Runyankezi HC, Rushubije HC, Ntega HC, Kinyovu HC
		Vumbi (5)	Gikomero HC, Muramba HC, Nyamisagara HC, Vumbi HC, Gasura HC
Muyinga (49)	Gashoho	Gashoho (7)	Gashoho HC, Gisabazuba HC, Nyagatovu HC, Gisanze HC, Kagari HC, Mirwa HC, Musama HC
		Gasorwe (5)	Kigoganya HC, Kizi HC, Gasorwe HC, Bwasare HC, Nyungu HC
	Giteranyi	Giteranyi (10)	Giteranyi HC, Ruzo HC, Mugano HC, Nonwe HC, Mika HC, Tura HC, Masaka HC, Ngomo HC, Kinyami HC, Kidasha HC
		Butihinda (5)	Kamaramagambo HC, Rabiro HC, Gahararo HC, Butihinda HC, Buhorana HC
	Muyinga	Buhinyuza (5)	Gitaramuka HC, Muramba HC, Rugongo HC, Nyarunazi HC, Kibimba HC
		Mwakiro (4)	Kiyanza HC, Mwakiro HC, Rugabano HC, Bonero HC
		Muyinga (13)	Kayenzi HC, Kinazi HC, Munagano HC, Murama HC, Muyinga HC, Muyinga Hospital, Rugari HC, ABUBEF Muyinga Clinic, Cumba HC, Gahororo HC, Kibongera HC, Kinazi HC, SWAA Muyinga
Karusi (32)	Buhiga	Bugenyuzi (4)	Bugenyuzi HC, Kiranda HC, Masabo HC, Rugazi HC
		Buhiga (8)	Buhiga HC, Kanyange HC, Karusi HC, Rutonganyikwa HC, Ruradaza HC, Rukamba HC, Buhindye HC, Buhiga Hospital
		Gitramuka (4)	Gitaramuka HC, Nyakabugu HC, Nyaruhinda HC, Ntunda HC
	Nyabikere	Gihogazi (5)	Gihogazi HC, Mugogo HC, Rusamaza HC, Ruganira HC, Gikombe HC
		Mutumba (4)	Bibara HC, Gisimbarwaga HC, Rabiro HC, Sagara HC
		Nyabikere (4)	Gatonde HC, Nyabikere HC, Rugwiza HC, Nyarunazi HC
		Shombo (3)	Nyabibuye HC, Nyarurambi HC, Rusi HC

By 2013, 363,712 pregnant mothers were tested for HIV. The trend shows that the number rose significantly from 2009 to 2013. Figure 3.1 below shows trends in the number of pregnant women with known HIV status from 2009 to 2013.

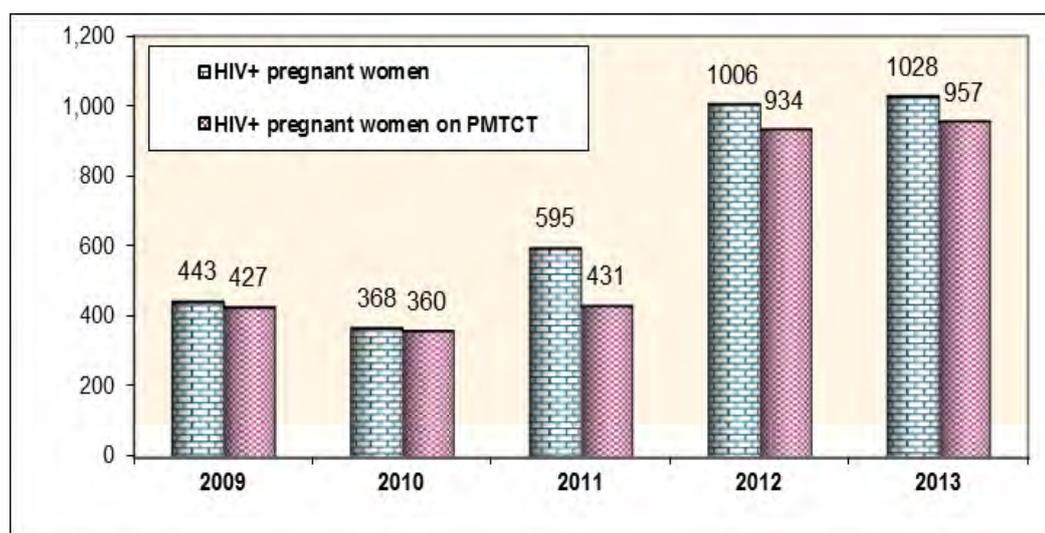
Fig 3.1.4: Distribution of Pregnant women tested in PMTCT setting over the project-period



There was an increase over the five years in the number of pregnant women with known HIV status (includes women who were tested for HIV and received their results). Overall, a total of 363,712 were tested of whom 360,446 were counseled, tested and received their HIV test results.

The proportion of women who tested positive over the years reduced from 1% in 2009 and stabilized at 0.7% in 2013. Almost all the women who tested positive were enrolled for ARV prophylaxis.

Fig 3.1.1: Uptake of PMTCT Prophylaxis over the project-period



Infants born to HIV positive women were tested for HIV using dried blood spots/polymerase chain reaction (DBS/PCR). By 2013 only 31 percent of such infants had received an HIV test

within 12 months of birth. The PCR test is still inaccessible because it is only available at the National Reference Laboratory based in Bujumbura. Additionally, the PCR machine often broke down during the project period. Serological HIV diagnosis is available in every health facility, but can only be done after 18 months of life, according to the national HIV testing algorithm.

Case profile 1: Nasra – A symbol of Hope to People living with HIV



Kayanza. Nasra Tinyimana's smile is infectious. In her burgundy and cream dress, she looks like a typical four-year old. She has no idea that she kept her father in prayer for nine agonizing months. Since the day Aisha broke the news of her pregnancy to Ismail, her husband, he kept praying for a miracle. Nine months later, he held that miracle in his hands and befittingly called her Tinyimana, a Kirundi name loosely translated as "fear God".

Ismail had every reason to name his daughter Tinyimana. He had tested positive for HIV and so had his wife. "I never believed a HIV positive couple could give birth to a HIV negative child," he says. Ismail was not alone. According to Andrew Ndayizeye, Society for Women Against AIDS in Africa (SWAA) Kayanza Coordinator, "people here never believed a HIV positive couple would get a HIV negative child."

Prior to testing for HIV, Aisha had three miscarriages. When she tested positive for HIV, she knew her dreams and hopes of bearing a child had come to an end. "It was very painful but I was ready to never become pregnant again."

Together with her husband, Aisha was enrolled for Antiretroviral Therapy (ART). During one of her clinic days, she asked the medical provider the possibility of giving birth to a HIV-negative child. "When he told me I could get a baby, I was decided to try," says Aisha. One month later, she conceived.

She was very determined to give birth to a HIV-negative baby. "I observed everything I was told. I did not want to commit a single mistake which would cost me my baby," she remembers. She attended her antenatal care (ANC) regularly and nine months later, she gave birth to Tinyimana in Kayanza Hospital.

Six weeks after birth, Aisha took her baby to test for HIV. She tested negative. Three subsequent tests at 6, 12 and 18 months confirmed that Tinyimana was indeed HIV negative. "I am very happy for the support I got from SWAA to get a HIV negative baby. Even if I was to die tomorrow, I would die peacefully knowing that I have left behind a HIV negative baby."

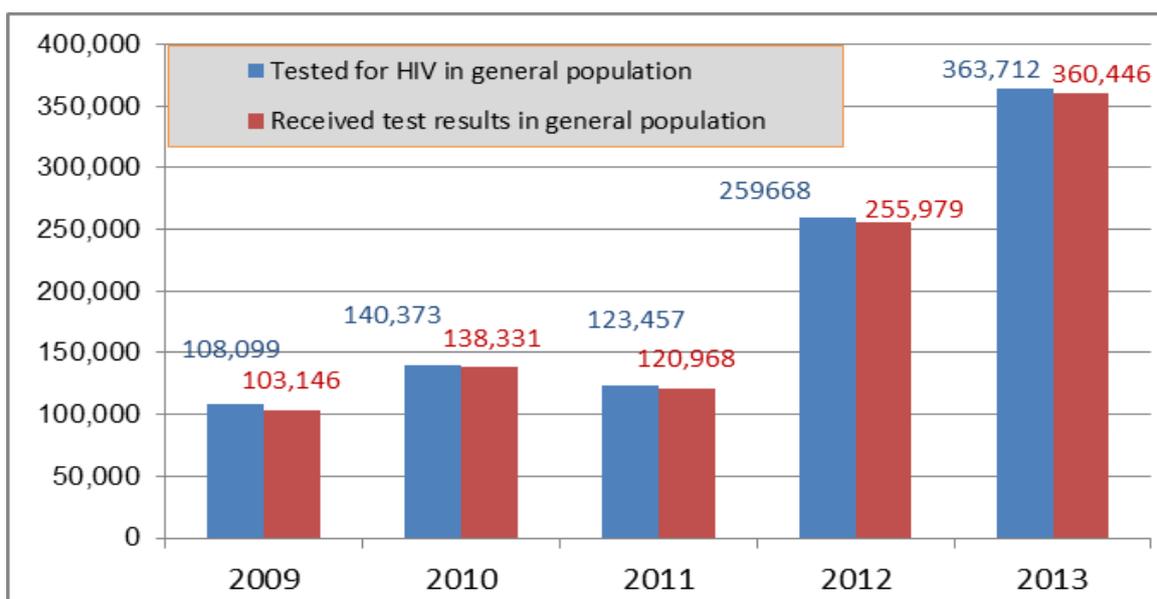
Ismail and Aisha are some of the clients supported by SWAA, a ROADS II's implementing partner, whose activities are funded by the President's Emergency Plan for AIDS Relief (PEPFAR) through USAID.

Ismail and Aisha are in no hurry of getting another baby, at least not for now. "When she turns 15 years, we will go back to the doctor and ask for advice," volunteers Ismail. To other HIV positive couples, he says they should seek for medical advice from health facilities before getting pregnant. As Ismail and Aisha's miracle turned four years on December 7, 2013, she remains a clear testament; zero mother-to-child HIV infections is possible.

3.1.2 HIV Testing and Counseling (HTC)

HTC services were extended in all the four provinces. The number of HTC sites increased from 44 in 2009 to 165 in 2013. Consequently, there was an increase in the number of individuals who received voluntary testing and counseling services for HIV and who received their test results as illustrated in figure 3.2.

Fig 3.2: Uptake in HTC services 2009-2013



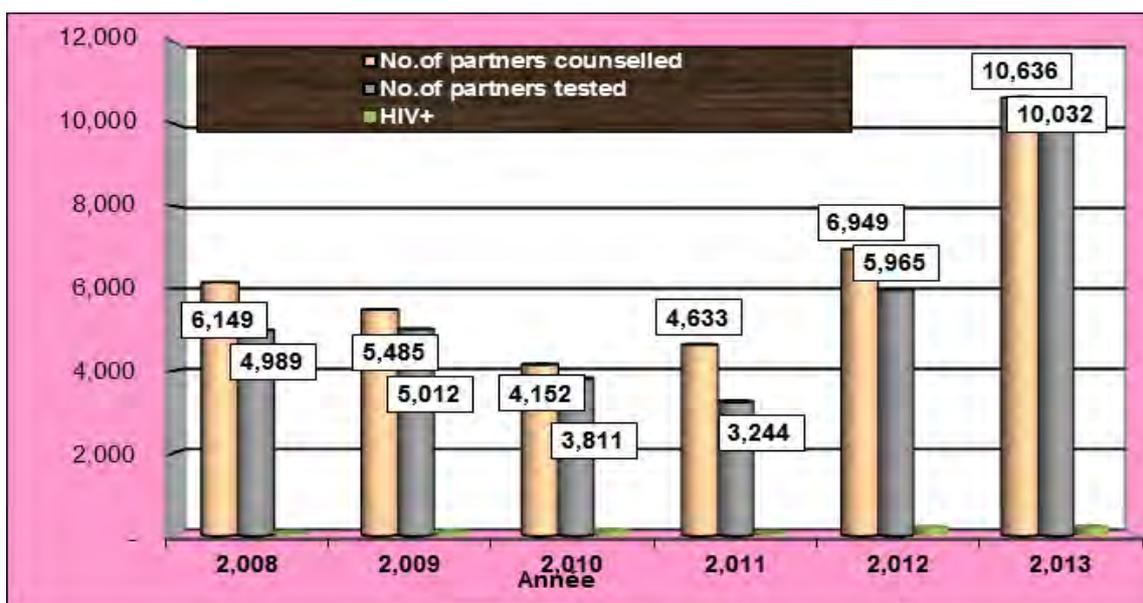
The sero- prevalence rate declined from 3% in 2009 to 0.9% in 2013.

Table 3.2: Performance of HTC program, FY2009 - 2013

HCT Results	2009	2010	2011	2012	2013	Total
FY2009 – 2013						
Sero positivity rate (%)	3.0%	2.3%	1.4%	1.2%	0.9%	1.4%

Results further show that HTC among partners also rose significantly as presented in figure 3.1.5 below:

Fig 3.1.5: HTC results among partners over the project-period



Case profile 2: HIV test Saves Trucker's Life

Kayanza. Celeus Maniragarura is constantly on the road plying Burundi and Uganda transporting cement and construction materials. A typical trip keeps him away from his family for days and weeks. For a long time, Maniragarura engaged in reckless sexual behavior, became a drug addict and an alcoholic. "I would have sex with anyone, because when drunk, I did not even choose who to sleep with," he remembers.

Maniragarura is one of the 147 members of a local association of truck drivers, Association des Chauffeurs Qualifiés de Kayanza (ACQKA), a Roads to a Healthy Future (ROADS II) Project-implementing partner. In his brief sober moments, he would visit the SafeTStop Resource Center before going to look for alcohol (the Resource Center is an alcohol-free facility), and hear HIV prevention and other broader health messages. However, he never heeded to them. But his life changed when one day, he watched a video screened at the center on sexually transmitted infections and HIV. "I was very afraid as it dawned on me that I could have HIV because of my promiscuous ways," he says.



Celeus Maniragarura, one of the truck drivers along East African transport corridors, with his wife. Like many of the truck drivers who spend many days and weeks away from families, Maniragarura's family was saved through intervention by a local truck drivers' association.

Maniragarura confronted his fears and visited Kayanza Health Center to test for HIV. "I was very nervous as I waited for my results." He tested negative for HIV. "I thought the people who tested me were lying," he remembers. During his trip to Uganda, he decided to confirm the results at Kabale Hospital. He tested HIV negative. That marked a beginning of a new chapter in his life. When Maniragarura returned home from his trip, he asked his wife to accompany him to go and test for HIV as a couple. He feared the wife could test positive for HIV, because he had learned of discordancy among couples. They both tested negative for HIV. "When I saw both of us are negative (for HIV), I vowed I will never have sex with another woman except my wife." During one of the couple meetings organized by ACQKA, Maniragarura apologized to his wife in front of his peers and their wives. "I wanted her to know how sorry I was for my past behavior." This marked a new beginning for this couple.

Maniragarura has since changed his behavior and is now a responsible man who meets his family's financial and emotional needs. "If I am not at the Resource Center, you will always find me at home with my family," he says. He has also used his life experience to reach out to other truckers. "Before, he could not listen to anyone telling him to change his behavior," says Bosco, ACQKA coordinator. "We never gave up on him but kept talking to him at every opportunity until he understood the need to change his behavior. He is now a role model among other truckers."

Maniragarura is committed to use his life as an example to influence other truckers. "I will reach my peers here (Kayanza) and during my trips telling them to change their behavior and test for HIV to know their status. I can now see that reckless sexual behavior leads to death and I don't want to lose my colleagues and family to HIV."

3.1.3. Sexual and behavior risk prevention

Prevention activities were conducted through peer education and community mobilization activities, strategic behavior change communication (SBC) messaging, and mainly focused on youth, low-income women and most at risk populations.

During the five-year period, the program reached 12,313 MARPs through individual and/or small group level interventions and 302,023 individuals from the general population were

reached with specific messages including abstinence and/or being faithful and other prevention methods. Other achievements are illustrated in the table 3.3 below:

Table 3.3: HIV Prevention Results FY2009 – 2013

HIV Prevention Results FY2009 – 2013	FY09-13 Results	FY09-13 Targets	% Target Achieved
Number of targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required	302,023	284,480	106%
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	275,104	269,400	102%
MARPs reached with individual and/or small group level interventions based on evidence and/or meet the minimum standards required	12,313	10,350	119%

Case Profile 3: Peer educator transforms sex workers' lives

Muyinga. When Moza Rashid married a man almost three times her age at 14 years, she thought her life would be bliss. She dropped out of school and in the first year of her marriage, she gave birth to her first child. Two years later, she conceived her second child. By that time, the honey she thought was her marriage had turned bitter. Her husband would beat her and pursue other women. At 17 years and expecting her second child, she left him and returned home.

With two children to fend for, Moza ventured into commercial sex. She was to serve here for seven months before life as a sex worker became unbearable. "Life was very difficult for me," she remembers. "Some clients would refuse to pay after we had agreed on the price, I would endure cold nights and at times I would go back to my children empty handed." Moza knew she did not want to continue in this trade.

The opportunity to turn a new page in her life came after she encountered workers from Society for Women against AIDS in Africa (SWAA) who were reaching sex workers with HIV prevention messages including correct condom use and encouraging them to test for HIV to know their status. "This was the first time I realized I was exposing myself to HIV. I was very afraid that I could have contracted it," says Moza. Together with her peer, they visited SWAA clinic, one of the HIV testing and counseling (HTC) sites supported by ROADS II



Moza Rashid, a former sex worker and one of the SWAA-trained peer educators.



Zainabu Hamisi, a former sex worker who changed her behavior after she interacted with a peer educator, who was also a former sex worker.

project in Muyinga province. Moza tested negative for HIV while her friend tested positive. "That was an awakening moment for me. I decided to take care of myself and my children." Moza also decided to reach out to other sex workers but did not have the skills to do so. She was trained by SWAA on peer education and with the skills; she was equipped for her mission.

During one of her outreach, she shared the vital information with Zainabu Hamisi, a commercial sex worker who had been in the trade for three years. "I had heard SWAA people talking about these things but I brushed them off because I thought they don't understand why we do this work," remembers the mother of three. "But when Moza, who had been a sex worker like me talked to me, it was easy for me to trust her. I knew she was aware of what she was talking about because she was one of us." She visited SWAA where she tested for HIV. She tested positive. "I thought I was going to die."

However, Hamisi received post-test counseling and was able to accept her status. "I decided to change my behavior because I was told I needed to take care of my health and use protection if I was to have sex." It is four years since then and Hamisi has no plans of going back to her former life. SWAA is one of the partners supported by ROADS II Project with funding from PEPFAR through USAID to pilot peer education as a model to reach community members with HIV prevention and other broader

messages including FP, GBV, STIs, ARV drugs adherence among others. “This approach has helped clients such as Hamisi who could only trust one of their own such as Moza, to change their behavior,” says Gabriel Nkeshimana, SWAA Muyinga’s Provincial Coordinator. “Without such people, it would be very difficult for us to effectively change the behaviors of such hidden population.”

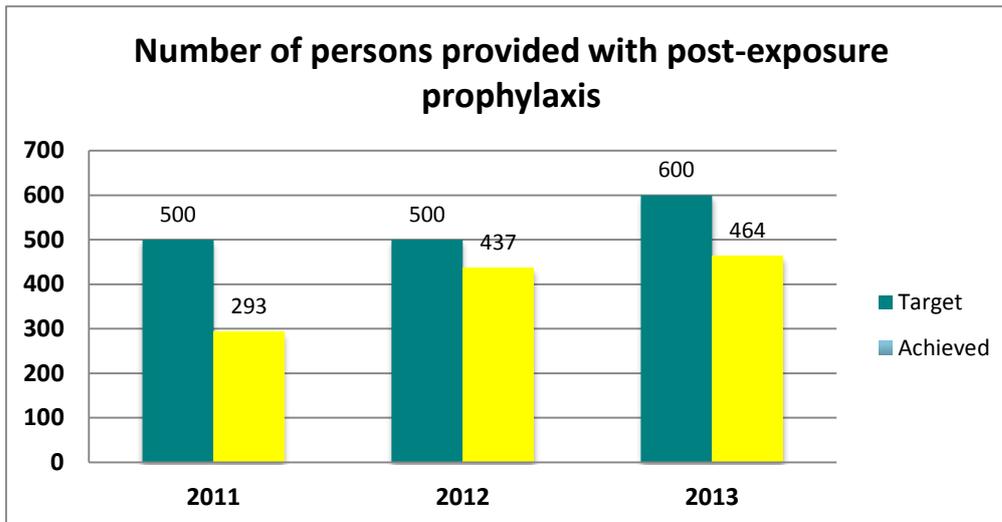
SWAA Muyinga supports nine low-income women associations with 332 members including one of female sex workers composed of 45 members to start alternative income-generating activities. Each of the association has trained peer educators who refer their members to SWAA for health and other services. By working together with peer educators, SWAA Muyinga has tested nearly 20,000 clients since 2009, almost five times the number tested before the PEPFAR Support started. With funding from other sources, SWAA supports 432 clients with antiretroviral therapy (ART).

“I am very grateful to SWAA for training Moza to reach out to people like me,” says Hamisi. “Were it not for her and the training she got here, I wouldn’t have known my HIV status. I would have infected more people and endangered my life even more.”

3.1.4 Post-Exposure Prophylaxis (PEP)

Post-Exposure Prophylaxis (PEP) was provided within ART service delivery points according to the national protocol. A total of 1,194 individuals benefited from PEP services against a target of 1,600 as illustrated in figure 3.3 below. This represented a 75% in uptake of services. Overall, PEP was provided more for sexual exposure risk (rape and sexual assault) than professional and non-professional exposure.

Fig 3.3: Comparison on number of people provided with PEP against targets 2011-2013



Case profile 4: Supporting Clients with Post-Exposure Prophylaxis (PEP) in Muyinga

Muyinga. When Itangishaka Odette's neighbor visited her homestead in March 2013, she thought it was one of the regular visits from neighbor. Her daughter, Erica Humura, 7, and another neighbor's girl were playing outside. The man lured the two girls to his house. At home, he sent his own children and the neighbor's child to the shop. He took the young Humura into his bedroom and raped her. Shortly thereafter, Humura returned home and to her surprise, she found the 50-year old man at her home. After he left, she told her mother what had happened. "I was very angry," says Odette. "I followed him at home and confronted him but he denied." Odette examined her daughter and saw she had been violated.



Erica Humura and her mother Itangishake Odette. Humura is one of the clients who received post-exposure prophylaxis at Muyinga Hospital.

She sought for help at Society for Women against AIDS in Africa (SWAA), one of the implementing partners supported by the Roads to a Healthy Future (ROADS II) Project in Muyinga. She was advised to report the matter to the police station and seek medical treatment at the hospital.

Odette went to Muyinga Hospital, one of the hospitals supported by ROADS II project. At the hospital, Humura's case was referred to the center of care for people living with, and exposed to HIV. "When such cases are reported here, we counsel the clients and explain the different management stages for three months, until we ascertain the client did not contract HIV," explains Jean Népomucène Sindyigaya, the Center's nurse in-charge.

After such a case is reported, the Center's staff conducts a HIV test to know the client's serostatus. If a client tests positive for HIV, they receive post-test counseling followed by a CD₄ count to assess their eligibility for antiretroviral treatment (ART) or cotrimoxazole prophylaxis.

If they test negative for HIV, they are given prophylaxis (*duovir* and *kaetra*) for one month according to the national PEP protocol. After one month, a repeat HIV test is conducted. If the person tests negative, they do not continue with the therapy and they return to the hospital after two months for a final test. "For the four years I have been at this Center, I haven't encountered a single case of someone who tests negative at the first test and tests positive after the one month of taking prophylaxis," adds Sindyigaya.

For post-exposure prophylaxis to be effective, clients are expected to be initiate prophylaxis less than 72 hours after the incident. According to Sindyigaya, most of the report cases are rape and sexual assault, mainly reported by women, and accidental sexual exposure by men who account for 10 percent of clients.

Humura was enrolled on PEP for one month followed by subsequent tests which confirmed she did not acquire the virus from the man, more than seven times her senior. The man confessed to be HIV positive since 2007 after he was arrested. "The treatment she got from here was very good because he would have infected her," says Odette.

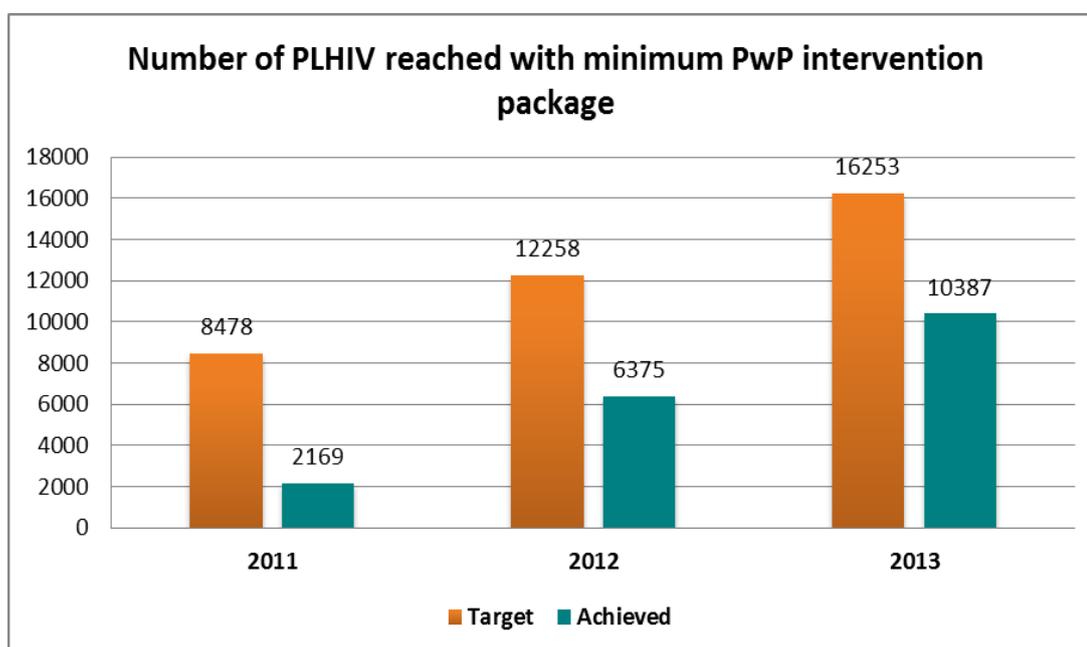
While there is work to be done to eradicate all forms of gender-based violence in Muyinga, Sindyigaya acknowledges good progress has been achieved. Different actors are working together including the justice department, police, community-based organizations who are especially involved in community sensitization and health facilities such as Muyinga Hospital. "Before this project, issues such as Humura's were discussed among communities, but now they report them here because they are aware of the services they can get."

As the man who raped Humura serves his life sentence, Sindyigaya is hopeful that the community will completely uproot gender-based violence in all its forms including rape and sexual assault in Muyinga. But until that happens, he will continue providing post exposure prophylaxis to every client who seeks for his services at Muyinga Hospital.

3.1.5 Prevention with Positives (PwP)

PwP indicators were introduced in 2011 with the Next Generation Indicators and the interventions targeted PLHIV. The number of PLHIV reached with a minimum package of PwP interventions increased substantially from 2,169 in 2011 to 10,387 in 2013. Targets were not fully reached because they were set using a HIV prevalence rate from BSS 2007 (2.97%) higher than the one seen in implementing provinces (1.4%). In addition, the PwP interventions were newly introduced in national facilities. Due to efforts made each year, the achievement rate increased from 27% (95% of 8,478) in 2011 to 61% (95% of 12,258) in 2012 and 64% in 2013.

Fig 5: Comparison on number of people reached with PwP against targets 2011-2013



3.2 Care services for PLHIV

Care services for PLHIV were clinical and support. Under clinical, services include cotrimoxazole prophylaxis against opportunistic infections, clinical care and treatment (ART) and integration of TB and HIV offered in health facilities. Support services include those offered to OVC, and home-based care, offered in communities.

ROADS II's key contribution was working with the community to increase awareness of health seeking behaviors. Patients were also referred to existing facilities for clinical care and treatment. ROADS II collaborated with health facilities in six ART service outlets to provide clinical care including ART to HIV-positive clients.

Key achievements: There was an increase in the service coverage, based on the number of eligible people provided with the services across the clinical care indicators. However, ROADS II did not meet the set targets in five care indicators: Number of HIV+ adults and children receiving a minimum of one clinical service; Number of HIV+ adults and children receiving a minimum of one care service, Number of HIV+ persons receiving cotrimoxazole

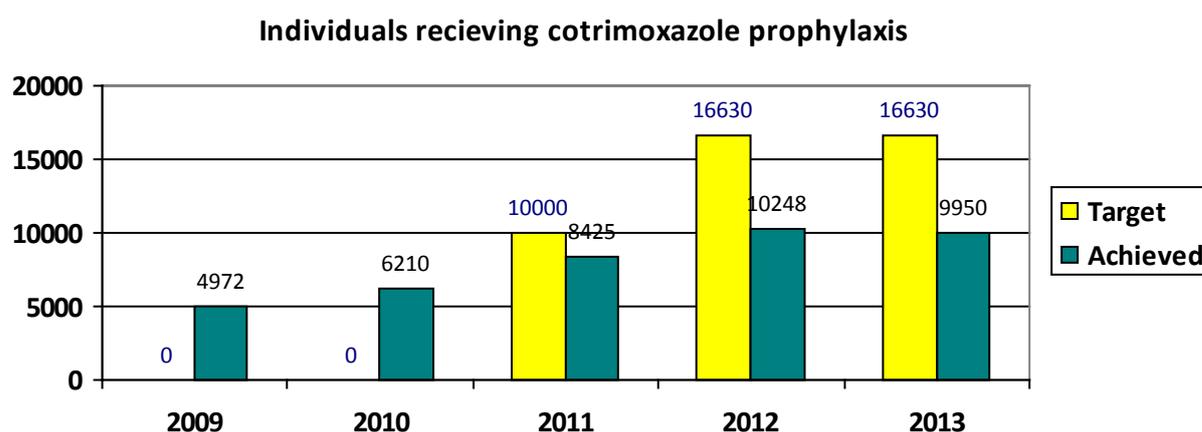
prophylaxis; Number of eligible clients who received food and/or nutrition services; and percentage of HIV+ patients who were screened for TB in HIV care or treatment settings. These targets had been set using the national HIV prevalence rate of BSS 2007 (2.97%), which was higher than that in the ROADS II implementing zone (1.2% in FY 2012, 0.7% in FY 2013), and higher than that in the 2010 DHS (1.4%).

3.2.1 Cotrimoxazole prophylaxis against opportunistic infections

Initially, enrolment for cotrimoxazole prophylaxis was guided by the WHO staging criteria (WHO stage 1 and 2). CD4 count machines were provided to district hospitals and providers trained on their use. By 2013, 9,950 HIV + persons were receiving cotrimoxazole prophylaxis. Figure 6 shows that the number of HIV persons enrolled on cotrimoxazole prophylaxis.

Comparatively the performance of the indicator was average but lower than the set target. This is attributable to the target set using the HIV prevalence rate of 2007 (2.97%) whereas the real rate in supported sites is varies around 0.7%.

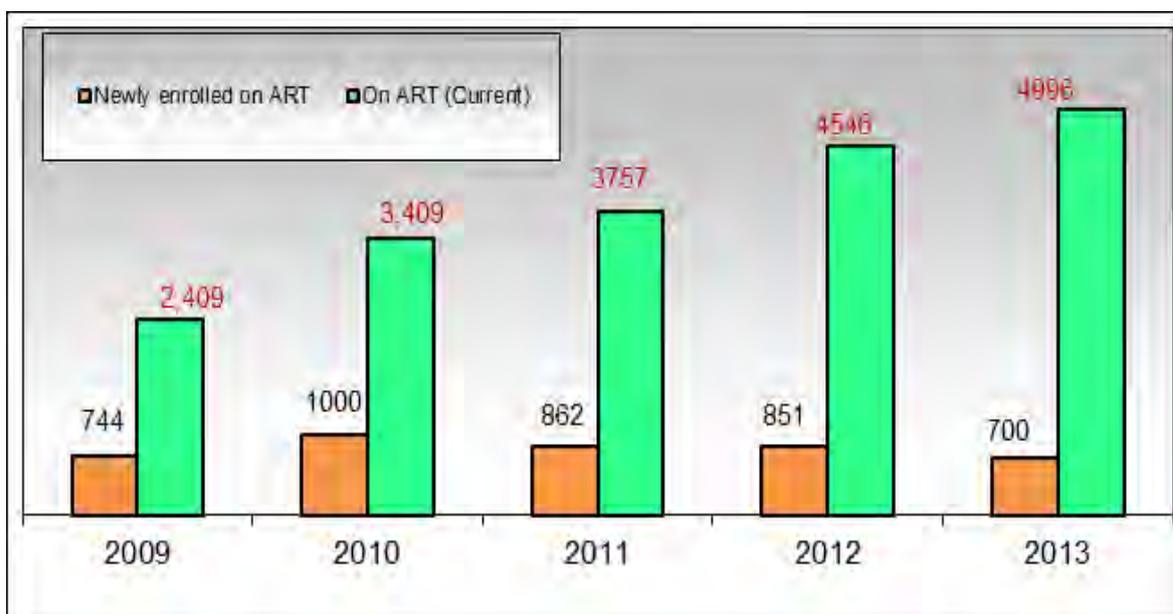
Fig 6: Comparison of PLHIV who received cotrimoxazole against targets 2009-2013



3.2.2 Other clinical care and treatment (ARV) services

Clinical services include assessment of the need for interventions (for example assessing pain, clinical staging, and eligibility for Cotrimoxazole, or screening for tuberculosis) and provision of the appropriate interventions, including: prevention and treatment of TB/HIV, prevention and treatment of other opportunistic infections (OIs), alleviation of HIV-related symptoms and pain, and nutritional rehabilitation for malnourished PLHIV.

Table 3.4 Clinical Care and Treatment ARV Services



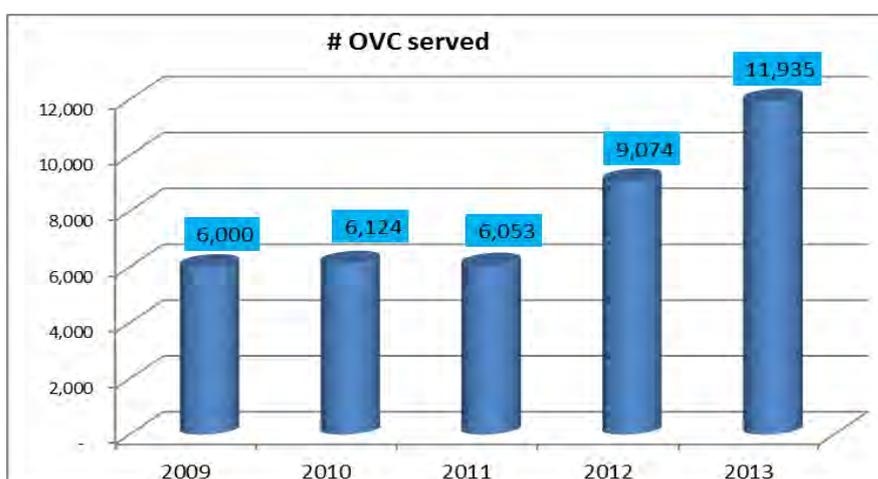
In addition, all adults and children with a CD4 count less than 350 cells or at WHO stage III or IV were enrolled for ARVs. A total of 4,996 PLHIV (M =1,718 ,F= 3,278) were enrolled for ART during the project life.

Integration of TB/HIV services: TB/HIV services integration was done at all stages in the health system. TB patients were screened for HIV and those with HIV were screened for TB. During the project cycle, 61% of HIV positive patients were screened for TB in HIV care or treatment settings against a target of 95%. This indicator was tracked from 2011.

3.2.3 Orphans and Vulnerable Children (OVC)

By 2013, a total of 11,935 OVC were reached by the program against a target of 12,012 (5,748 boys and 6,187 girls).

Fig 3.6: Number of OVCs reached by different OVC services 2009-2013



OVC services were implemented as part of support services to PLHIV, which included education support, health care support, hygiene and shelter improvement and psychosocial counseling.

Case Profile 5: Supporting Vulnerable Children in Kirundo

Kirundo. When her father succumbed to HIV, Béatrice Mukarukundo did not know her life would turn out so bad. But it did. Her mother realized she could not fend for her six children on her own. She encouraged two of her elder daughters to get married. Béatrice is the third born of six children. When her mother asked her to get married, she refused. “I wanted to go to school,” she says. “When I look at the way people here struggle with life, I know my only ticket out of this life is school.”

For defying her mother, she had a heavy price to pay. Her mother took their last born and went to Rwanda. She would only visit at the end of the school term briefly and go back. Béatrice was left to fend for her two siblings. Her fourth born brother went to Kirundo town to eke out a living as a casual laborer and was left to take care of her one sibling. “Life became very hard for me. When I came out of school, I could go to look for vegetables which I would cook. That was the only meal for us.” She would also move from one house to another seeking for support with school books. Their tiny mud house used to leak and when it rained it made their lives difficult. To make nights worse, they did not have any blanket and were covering themselves with a *kitenge* making their nights very cold. This negatively affected her school performance.

Her fortune turned when the community shared her plight with APECOS’ Committee for the Protection of OVC rights. APECOS is an organization supporting children affected by HIV through death of one or both parents. The organization is one of the many supported by the Roads to a Healthy Future (ROADS II) project with funding from the President’s Emergency Plan for AIDS Relief (PEPFAR) through USAID. The project supports 2,696 children like Béatrice in three communes of Vumbi, Ntega and Gitobe in Kirundo province.

The organization supports children such as Béatrice with varied support including educational support (buying school uniform, books and paying school fees), medical, psychosocial, house renovation and in some cases, judicial assistance where children risk losing property left behind by their deceased parents. The organization extends these services through three social workers (one per commune) and committee members.

Since APECOS came to her rescue, Béatrice’s life has changed. She secretly organized for a meeting between her mother and social worker who talked to her about the need to take care of her children. Her effort bore fruit and now the mother stays at home and takes care of her and her three siblings. “We have observed considerable progress between children like Béatrice and their caregivers,” says Jean Pierre Nijimbere, APECOS Coordinator in Kirundo. He adds that dropout rates of children such as Béatrice have reduced because the project enables them to access the basic requirements they need such as school fees and uniform.

The project also supported Béatrice with nutritional support and also supports three of her siblings including the brother who had gone to Kirundo to look for a job. The project helped renovate her house and provided her with blanket, cutlery and water carrying jerrican. “This project has helped me get my mother back and enabled me and my siblings go to school. This would not have been possible without the project’s support.”

Béatrice is so determined to pursue her studies to the extent that when a young man continued pursuing her on her way from school, she preferred to walk a further distance and change to another school, 30 minutes further to avoid him. “I don’t want anything that can distract me from my goal,” says the fourth year student at Murungurira Communal College. “I want to study hard and become a medical doctor.”



Béatrice, one of the 2,696 vulnerable children supported by the project aspires to be a medical doctor.

3.2.4 Home-based care (HBC)

ROADS II extended HBC services in the four sites (provinces) using trained PLHIV volunteers, leading to an increase in the number of individuals who received these services. Activities included awareness and support for use of health services, psychosocial support, nutrition counseling and food supplementation for the poorest PLHIV, hygiene and shelter improvement among others. Through these services, 6,602 clients received food and other nutritional services and 10,387 benefited from psychosocial support, food and other nutrition services. Table 6 below presents the details of HBC services by indicator and year.

Table 3.5: HBC services from 2009 through 2013

Indicator	2009	2010	2011	2012	2013	Total
Psychosocial support	16217	4261	4880	9072	11048	11,048
Health care assistance	1965	622	4713	5604	6273	6,273
Nutrition services	3051	504	730	1546	3486	6,602
Prevention with PLHIV	N/A	N/A	6833	12721	10387	9,317
Shelter improvement			30	30	120	180
Funeral assistance	51	10	19	31	31	142

3.3. HRM and Health System Strengthening

The activities supported include laboratory services, training for human resources for health, performance-based financing, and capacity building.

3.3.1 Improving state of infrastructure

Before providing clinical activities, ROADS II upgraded health centers in the project sites. The project renovated 215 health centers and 14 hospitals.



Fiscal year	HC	Hosp.
2009	20	3
2010	39	3
2011	19	0
2012	63	1
2013	74	7
Tot.	215	14

Source: Building housing HIV and maternity services

Buhinga Health Center

A minimal set of infrastructural upgrades included: incinerators and biomedical waste disposal in line with national standards; repairs and basic furnishings in the waiting areas, in-patient wards and renovations to accommodate new services.

3.3.2 Laboratory services

During the first years of ROADS II implementation, laboratory equipment, materials and consumables were directly supplied by the Project through sub-agreements to district hospitals. These included CD4 count machines, hematology counters and biochemistry machines along with accessories, laboratory reagents and other consumables, which were provided to laboratories in the supported hospitals. From 2012, ROADS II worked closely with USAID-funded Supply Chain Management System (SCMS) project implemented by Management Services for Health (MSH) to ensure that laboratories in district hospitals and HTC service outlets within the project sites were well equipped and stocked for HIV management. ROADS II supported equipment maintenance during the project period.

By 2013, six laboratories were upgraded and equipped to perform clinical laboratory tests while 3,613 health workers successfully completed in-service training programs as illustrated in Table 3.6 below:

Table 3.6: Comparison of HSS indicators achievement against targets FY2009 – 2013

HSS component Results FY2009 – 2013	FY09-13 Results	FY09-13 Targets	% Target Achieved
Number of facilities(laboratories) with capacity for performing clinical laboratory test	6	6	100%
Number of health care workers who successfully completed in-service training	3613	2790	129%

3.3.3 Support Performance-based financing

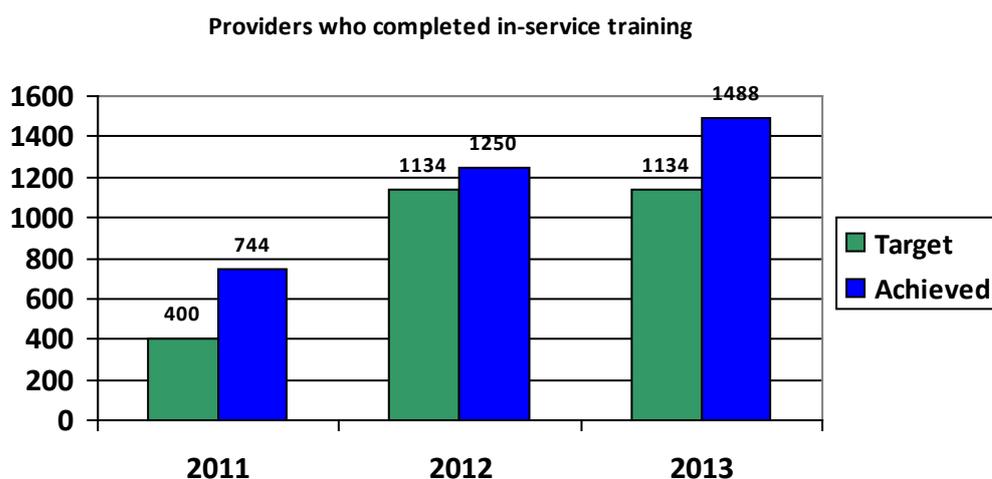
ROADS II collaborated with District Health Offices to support performance-based financing in 156 health facilities distributed by province as follows: *Karusi (29), Kayanza (40), Kirundo (44), and Muyinga (43)*. Services supported were related to the seven HIV indicators:

- (a) Number of HIV-positive pregnant women provided with antiretroviral prophylaxis;
- (b) Number of newborns from HIV-positive mothers provided with monitoring, ARVs to new born;
- (c) Number of people tested for HIV;
- (d) Number of new patients provided ART;
- (e) Number of ART patients monitored semi-annually;
- (f) Number of cases of sexually transmitted infections (STI) treated;
- (g) Male circumcision.

3.3.2 Training for Human Resources for Health and Capacity Building

Through training and mentoring health care workers, the program achieved more than 100% of its set targets having trained 744 in 2011 against a target of 400; 1,250 against a target of 1,134 in 2012 and 1,488 against a target of 1,134 in 2013.

Fig 3.7: Successful health care workers in training



Several sessions were organized to train providers on PMTCT, HTC, HIV diagnosis with rapid tests, training of trainers, sexual transmitted infections (STIs) clinical management using syndromic approach, STIs management; ARV services, DBS sampling for PCR testing, use and maintenance of CD4 Count machine, OVC support services, PwP interventions and diarrhea management, HIV prevention, FP and GBV awareness, and M&E fundamentals and data quality assurance. A total of 6,446 individuals and 4,032 health providers benefitted from the trainings during the project period.



Providers' training IST, Karusi

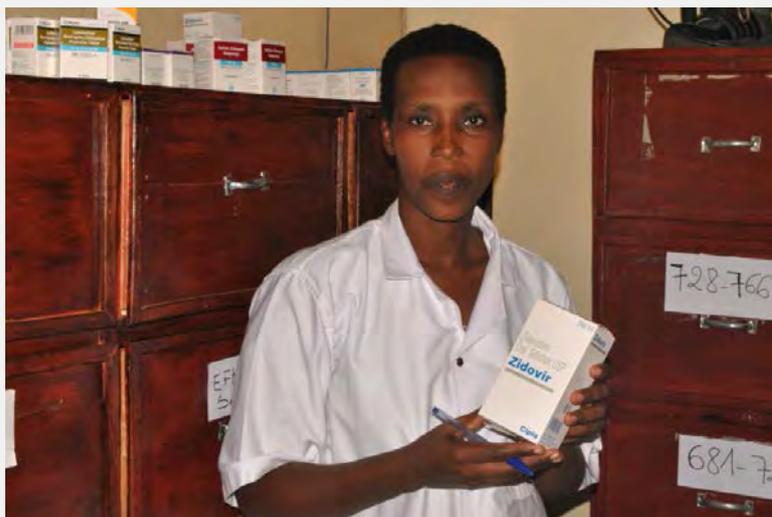
Training area	2009	2010	2011	2012	2013	Total
PMTCT	132	33	186	162	70	583
HTC	135	126	68	160	64	553
Laboratory	65	35	166	197	145	608
Clinical care	86	127	231	257	362	1063
Home-based care	348		63	186	175	772
OVC care and protection	43	45	39	88	557	772
BCC	275	280	181	236	30	1002
Family Planning (FP)	148	239	181	84		652
MNCH		40		76	0	116
Project management	89	40		78	25	232
M&E				67	26	93
TOTAL	1,321	965	1,115	1,591	1,454	6446
Health providers	755	286	744	843	667	4032

ROADS II also supported capacity building of six civil society organizations (CSOs) in strategic plan development, institutional capacity building, and on USAID regulations, among

others. The success of this initiative was demonstrated by the Association Nationale de Soutien aux Séropositifs et Malades du SIDA (ANSS) which received financial support from the project to design its Strategic Plan to Fight against AIDS, 2013-2017 and to organize dissemination and validation workshops in Bujumbura.

The project further supported the Society for Women against AIDS in Africa (SWAA) in Burundi to develop its 2013-2017 Strategic Plan which has the following axes: (a) strengthening HIV prevention, sexual and reproductive health, prevention and management of GBV; (b) care for PLHIV; (c) reducing the socio-economic impact of HIV; (d) coordination of implementation, resource mobilization, advocacy and lobbying. Furthermore, the project organized training for key staff of six organizations (Alliance Burundaise de Lutte Contre le SIDA (ABS), Association Burundaise pour le Bien-être Familial (ABUBEF), Association Nationale de Soutien aux Séropositifs et Malades du SIDA (ANSS), Collectif pour la Promotion des Associations de Jeunes (CPAJ), Réseau Burundais des Personnes Vivantes avec le VIH SIDA (RBP+), and Society for Women Against AIDS (SWAA) on USAID regulations.

• **Case Profile 7: Training staff to support people living with HIV**



Médiatrice Niyonsaba, one of the nurses at Kirundo's Center for People Living with HIV (PLHIV).

When you step into her office at Kirundo Hospital, you may not make sense of what is around her. Numbered cabinets with files coded in a way that only someone like her would understand. And inside each file, there are small booklets. To you and me, these may look like ordinary booklets. But to Médiatrice Niyonsaba, each has a story. And by looking at each of these coded booklets, she can amaze you at how connected she is to each story; a story of hope. When she came to this unit, established in 2007 during the Roads to a Healthy Future (ROADS II) project's predecessor, ROADS I, there were only three clients. There was no need for a cabinet and it's only the hospital director who was expected to know anything and everything about the clients. But not anymore. As more clients started filtering in, so did the need for more staff to support

them. This is when Niyonsaba found her way in this unit. "When I joined, I did not have enough skills to care for people living with HIV (PLHIV)," says the PLHIV Center's nurse. She came from the maternity unit where she helped mothers bring forth their bundles of joy. "I knew antiretroviral drugs consisted of a combination of three treatments, but I did not understand what those treatments were."

To support Niyonsaba and four of her nursing colleagues, the ROADS II project trained them on PLHIV management and care. They also seconded a medical doctor, a specialist in HIV management. Through the training and by working alongside the doctor, Niyonsaba perfected the skills. "The doctor mentored us and supported us until we could handle the unit on our own." They only refer complicated cases to the doctor who is also consulted by his peers in the hospital regarding HIV cases. "We are very lucky to have this doctor because we can't refer such cases to other doctors because they may not have the experience he has." The training has proved valuable to Niyonsaba who is now able to deal with the 1,000 clients on their care and management. She supports them on positive living, prevention with positives, advice on family planning, sexually transmitted infections and Tuberculosis.

But having come from the maternity, she has a soft spot for prevention of mother-to-child transmission (PMTCT). She is passionate as she explains the different ways she ensures that mothers such as Jacqueline Kampayano, a HIV positive mother of a two-week old baby, deliver and rear a HIV-negative child. "We closely monitor pregnant HIV-positive mothers during their

pregnancies and delivery. We also tell them if they are to deliver at other health facilities, they should disclose their status to the health care providers so that they can be supported deliver HIV-negative babies.” She explains the different types of ARV prophylaxis and ARVs that pregnant women should take during the different stages, what their children should be given during and after birth, the tests to be carried out on the infant and regimens of their mothers depending on their CD4 count.

Niyonsaba is grateful for different support extended to the center including ROADS II’s purchase of CD4 count machine and related supplies and reagents and collaboration with different actors such as associations supporting PLHIV. “It is not easy for medical staff to reach people in the community (loss to-follow-up) and have them resume ART. But by working with volunteers such as those of RBP+’s, this is possible.” RBP+ volunteers were also trained by ROADS II. Niyonsaba observes that ROADS II’s support has greatly assisted her clients whose general wellbeing has been commendable. “They access ARV, medical assistance cards, STI diagnosis and treatment, different test results for free and payment of hospital bills to those admitted.” As a result of this support, she notes that “PLHIV on ARVs are healthier than me. I wish we could always be in a position to extend these services to them.”

At the end of each day, Niyonsaba goes home a satisfied person. “I have seen very many patients come here in very bad condition and worked with them to improve their health. Some came very weak and could not work, and now they are back on their feet and working again. Nothing gives me so much joy than knowing that I have the skills to bring hope to such people.” And as she signs off for the day, she knows tomorrow is another day to extend hope to more of her clients.

3.4 Family planning and Gender-Based Violence (FP/GBV)

In order to improve maternal and child health (MCH), ROADS II worked to improve focused antenatal care, immunization, labor and delivery, growth monitoring, family planning, nutritional support for infants and mothers and interventions against gender-based violence. The integration of family planning (FP), reproductive health (RH), gender-based violence (GBV) services was initiated with baseline assessments in 2009, in order to support health facilities and surrounding communities in supported sites. Using the findings, the project strengthened capacity for provision of FP services at participating facilities, and improved commodities security including procurement of essential equipment and increased demand and awareness for and on FP services at the selected facilities and in the community. The project further addressed gender norms, gender-based violence and other social barriers inhibiting uptake of FP services.

As part of promoting integration of HIV and FP/GBV services, the project conducted training on FP and GBV for community health workers (CHW), and PLHIV peer educators and volunteers. A total of 355 peer educators and 99 PLHIV volunteers were trained. ROADS II also trained 273 clinic-based health providers involved in ARV treatment, FP and GBV. Special emphasis was on FP and ARV.

Case profile 7: Demonstration of the use of the Standard Days Method



Substantial progress was made to increase awareness and demand for FP services. Community sensitization on FP/GBV was conducted through the trained CHWs. The program developed strategic communication tools, produced and distributed pamphlets on FP methods at facility and community level. A booklet focusing on MNH, FP and GBV was produced and disseminated with JHU technical assistance.

Audiovisual kits (TV, camera, CD-player, CDs and DVDs) were made available in the five program sites to provide community members with messages about FP and gender-based violence.

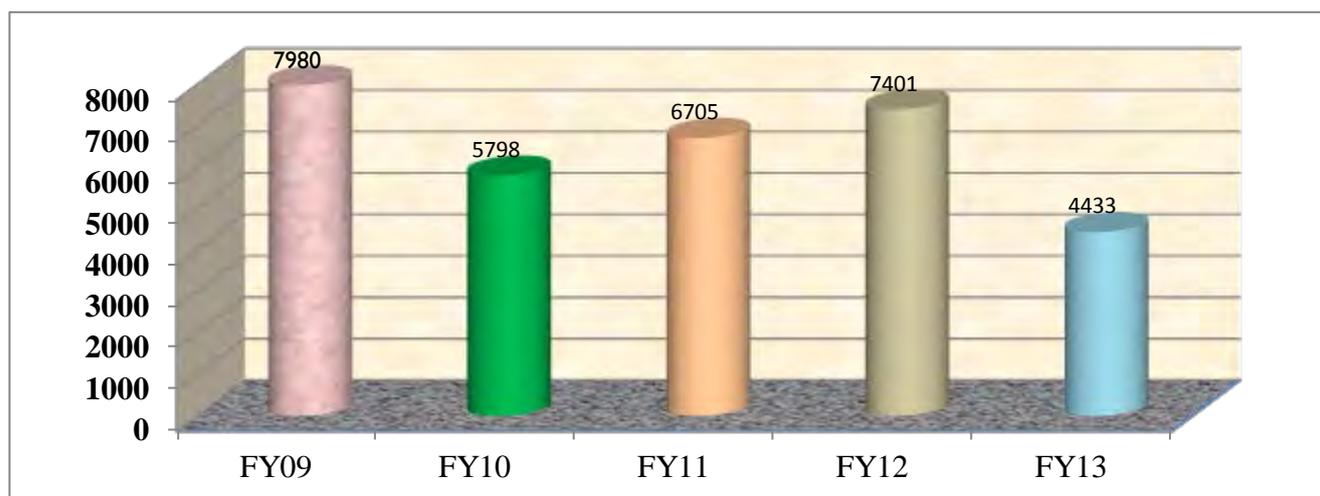
Community component: The number of individuals reached with FP messages rose from 2,529 in 2009 to 27,386 in 2013. Of these, 11,364 were male and 16,022 were female. Different contraception methods were discussed including oral contraceptives and condoms. A total of 2,002 individuals received condoms (1,801 male and 201 female) and 1,643 were referred to health facilities for provision (536 female and 237 male).

Clinical component: A total of 25,125 women were protected. A total of 4,371 new clients and 11,851 old clients were served over the project period. Quantities of the different family planning methods utilized at the end of the project were as illustrated in the table. The method most popular was injection, followed by pills, condoms, Implant, IUD, Femidom and Standard Days Method (SDM).

Method	New clients	Old clients	Quantities utilized
IUD	212	133	285
Injectables	2428	9089	11,698
Pills	671	1633	6,636
Implant	875	226	1,093
Standard Days Method	42	679	12
Condoms	121	89	5,318
Femidom	22	2	83
Total	4371	11851	

The number of people who received FP increased over the years. However, data on enrolment into the FP program does not show a steady continuous growth in new enrolments (2009(7,980); 2010(5,798); 2011(6,705); 2012(7401); (2013)4,433) as illustrated below.

Fig 3.5.1 Growth of new clients enrolled in FP in the fiscal year 2009-2013



Numerous reasons have contributed to the fluctuations including commodities logistics, training, ongoing campaigns and mobilization efforts. Various steps were taken to attract and bring new clients into the program and to improve retention among the enrolled clients.

The standard Days Method (SDM) was piloted in 2011 in four health centres. Evaluation results demonstrated SDM's efficacy and the method recommended for scale up. The program was gradually extended to 12 new sites (both public and faith-based health centers).

Case Profile 9: Program supports Faith-Based Health facility offer family planning method



Martha Nisembereze and her husband, Lucien Minani together with their two-year old son. Nisembereze is one of the clients supported by Gatara Health Center to use the Standard Days Method (SDM).

Kayanza. Every morning after saying their prayers, Martha Nisembereze and her husband, Lucien Minani embark on what has become a ritual. She takes her cycle beads and adjusts the movable rubber ring on the direction of the arrow. Each day, she moves the rubber ring helping her manage her monthly cycle. They have done this for the last 18 months until it has become one of her normal daily activities

Before embarking on this family planning method, Nisembereze had tried other methods without success. "I used injectable but the side effects were unbearable," says the mother of four. "Afterwards, we decided to use the natural methods, but I did not have the required knowledge on the method so I became pregnant."

When their son Claver Gahimbare was only four months, the couple heard about the Standard Days Method. "I knew this is what I needed," remembers Nisembereze. "I would have no side-effects, and I was at peace with this method."

Nisembereze and Minani visited Gatara Health Center, a faith-based health facility where they were taught how to use the method correctly. The health center is one of the - faith-based health facilities supported by the Roads to a Healthy Future (ROADS II) project to extended family planning methods to the communities.

In using this method, clients use cycle beads (33 colored beads) with the movable rubber band. The first bead is black with a white arrow; the next one is red followed by six brown beads. There are also 12 white ones and the last 13 brown beads. All of them, except the black one represent a day. The woman can have unprotected sex when the rubber ring is on the brown beads, while she should abstain or use protection on the days when the rubber ring is on the white beads.

Community health workers and peer educators sensitized 7,386 individuals in different provinces on FP, GBV and rape. Similarly, many people were exposed to GBV prevention messages and services (18,706 in 2010; 17,383 in 2011; 11,416 in 2012 and 15,993 in 2013).

The case profile 9 below illustrates how the program supported communities in addressing GBV.

Case Profile 10: Program supports communities address Gender Based Violence

Karuzi. When he came home one day, he reached for a dry piece of *Munyare* tree and broke a piece of it. He aimed at her knee and hit it very hard. “I felt as though my leg had broken,” recounts Cornélie Muryoryo, 56. This was not her first time at the hands of her husband, Aaron Mushahara, 57. Theirs had been a marriage ridden with conflict and wife battering. Another day, he came home drunk and picked a quarrel with his wife; again. She could not take it anymore. She fought back. When he almost overpowered her, the children came to her rescue and beat him instead to teach him a lesson. The following day, she left him and put up a hut in the village with the help of her children. They moved with everything, including all the food in Mushahara’s house. He was left in the house alone.

Mushahara was one of the well-known men in the village – albeit for all the wrong reasons. His household was always laden with conflict (neighbors were always coming to the wife’s rescue); he was despised in the village because he was always drunk and violent; police were more often than not looking for him; he felt dishonored having been beaten by his wife and children; and here he was, alone and desolate as his wife and children lived in a hut not far from his. “I felt this was not the kind of life which I wanted,” says Mushahara. “I needed to change and get peace and rest.”



Aaron Mushahara and wife Cornélie Muryoryo. Mushahara was violent and a wife batterer until a peer educator came to his rescue.

His silent prayer was answered through his neighbor, Elie Manirakiza. Manirakiza was one of the peer educators trained by Red Cross in Karuzi to reach community members with different messages among them gender-based violence and HIV testing and counseling. He was always intervening at Mushahara’s house and with the information he got during the training, he wanted to share the messages he had with him. “I showed him the dangers of his behavior to his wife and to his own health,” adds Manirakiza. After sharing the messages with Mushahara and other neighbors, Manirakiza invited them to test for HIV. Mushahara alongside his wife (who had returned to him by then), together with nine other couples tested for HIV. They all tested HIV-negative. For Muryoryo, this was the greatest news for her. “My husband had threatened me he would bring HIV to me. So when we tested and I saw I did not have the virus, I was overjoyed.” The results of that test and the continued messages from Manirakiza saw a new page open for Mushahara and his wife.

Manirakiza is one of the 151 peer educators trained by Red Cross, one of the Roads to a Healthy Future (ROADS II) project implementing partners in Karuzi, whose activities are funded by the President’s Emergency Plan for AIDS Relief (PEPFAR) through USAID. Red Cross works in all the seven communes constituting the province and supports implementation in one third of the hills making up a commune. In each of the identified hills, they select three peer educators (man, woman and youth).

The peer educators were trained on the different forms of gender-based violence, HIV prevention including HIV testing and counseling, family planning among other topics. They were also trained on how to disseminate this information to their peers and how to refer them to appropriate care facilities. “The peer educators have reached communities with these messages so that they now know where to seek for the services including medical and legal support,” says Sylvetsre Ntahiriya, Red Cross Health Technical Advisor in Karuzi. “The peer educators also know the chain of command from the lowest level to this office so that they can report any cases requiring our support.” The peer educators have sensitized the communities on GBV, FP and HTC with remarkable uptake of these services. “Most people are embracing modern contraception and are testing for HIV,” adds Ntahiriya. Red Cross will continue

working with the volunteers such as Manirakiza, who volunteer two hours per week as Red Cross members to reach other members like Mushahara.

Mushahara has since seen the light and turned to religion which has also helped him to be the good husband and father he has turned out to be. “He is a role model because many people know how he used to be,” says Manirakiza. And in place of the pain that once tormented her heart, Mushahara’s wife is nothing but praise for her husband. “He is the best gift for me. He spends time with me and by sunset he will always be at home. I also know that I can expect a *kitenge* after every two months. If you come home now, you can see we are no longer warring, but instead we are two angels in the house,” she concludes.

Program efforts led to reduced cases of GBV as many couples explained how messages from peer educators on the effects of GBV had positively impacted their marriages. It was critical for the project to have sensitized both men and women as men are most often the perpetrators of GBV. Male involvement in program efforts further improved awareness of gender norms and other social barriers inhibiting uptake of FP services. The implication of men as decision makers, partners and administrators therefore remains the cornerstone for the success of the FP/GBV program.

3.5 Maternal and Newborn Health (MNH) Activities

ROADS II-supported facilities achieved the following: (a) 13,004 pregnant women attended ANC services, (b) 2,717 deliveries were conducted with skilled birth attendants, (c) 2,374 women were provided with Active Management of the Third Stage of Labor (AMSTEL), (d) 2,636 newborns received essential care, (e) 916 post-partum visits occurred within 3 days after delivery.

In the community, trained CHW sensitized 6,508 new cases with messages related to MNH, they referred and escorted 1,606 pregnant women for antenatal care, 898 for skilled attendant assisted delivery and 360 women for post-partum consultations.

These efforts resulted in increased number of assisted deliveries in supported health facilities with an average of 82 assisted deliveries a month against an average of 55 previously.

Although significant achievements were realized, a series of constraints limited performance:

- a) Consumables and supplies stock outs due to increasing number of deliveries obliging women to buy some consumables (e.g. gloves) in community pharmacies;
- b) For those who delivered at home, there were still some socio-cultural barriers that hindered women from consulting health care workers when they did not feel sick. Thus, unawareness of the importance of post-natal care (cultural barriers, long-distance to health facility) is still a challenge to early post-partum consultations;
- c) Oxytocin remains unavailable at health centers for AMSTL (Methergine is used instead of oxytocin) despite the MPHFA approval to include it in the range of pharmaceutical products used at health center level.

3.6 National Events

Each year, ROADS II joined the Government of Burundi in celebrating national and World AIDS Day events in sensitizing communities in the fight against HIV. The project also

supported national programs such as the National Program for the Reproductive Health (NPRH) in the organization of the National Week dedicated to Reproductive Health (RH). Such events provided ROADS II with an opportunity to share best practices with other stakeholders in RH, especially on FP and GBV.

Case profile 11 : Program supports couple embrace positive living in Kayanza



Concilie Kayabera giving a testimonial on positive living during the 2013 World AIDS Day Celebration in Kayanza. A member of Burundi's (Réseau Burundais des Personnes Vivant avec le VIH) RBP+, it took her three years to accept her status and publicly disclose the same.

Kayanza. More than 500 Kayanza residents of all ages have gathered at Gatwaro Zone Center. Men, uniformed corps, women with babies strapped on their backs, young men and women, small boys and girls have all come together. As the events of the day unfold, groups of actors perform short skits encouraging people to test for HIV, prevent HIV and adhere to antiretroviral drugs. During testimonial time, the master of ceremony signals Concilie Kayobera. She is not ashamed to publicly declare her HIV status during such an important day in the global calendar as the whole world gathers to mark the World Aids Day. "Everyone should get tested for HIV to know their status and get the necessary treatment," she says. "If you test positive like me that is not the end of life for you.

Kayobera, 37, has walked a long journey. More than five years ago, she would never tell anyone she was HIV positive. "I was ashamed and wondered what other people would say if they knew about my status." She tested for HIV one year later after her husband tested positive. "I was very angry because I knew I had been faithful and here I was with the virus."



Bizimana and Kayobera. The couple has embraced positive living and are protecting themselves as they care for their two HIV-negative children.

Together with her husband, Kayobera joined RBP+ an association supporting people living with HIV and one of the implementing partners in the USAID's Roads to a Healthy Future (ROADS II) Project. She is one of the 1,840 members supported by the association with funding from the President's Emergency Plan for AIDS Relief (PEPFAR) through USAID.

It was while at RBP+ that her life changed. "It (RBP+) helped me to accept myself and my status as I interacted with other people like myself." Having waited for 12 years without a child, Kayobera was concerned about getting HIV-negative children. "When I was told I could give birth to HIV-negative children, I was elated. I sought medical advice and followed their advice." The couple has two HIV-negative children aged five and three.

And as they look forward to their future, Kayobera and Bizimana are optimistic. "We are hopeful of a very bright future. We are taking care of ourselves so that we can take care of our children for many years to come," says Bizimana. "We also want people to know their status so that they can make meaningful and positive changes to their behavior," concludes Kayobera

Case profile 12 : Support each other, advises HIV positive couple in Kayanza



Abel Hicumunsi and his wife Marie Rose Itangishaka together with their four-year old son giving a testimony to the more than 500 community members during 2013 World AIDS Day celebrations at Kayanza. With support from RBP+, the couple has publicly declared their status and is encouraging couples to test for HIV and support each other.

Kayanza. He was frequently sick and was in and out of health facilities. During one of his visits to the health center, a nurse advised him to test for HIV. He was obliged. However, he could only test together with his wife. After a few days, he went back accompanied by his wife. He had a swollen leg and the wife thought he was bewitched.

“I never thought my husband could be having HIV because HIV does not cause people’s legs to swell,” remembers Marie Rose Itangishaka. As they waited for their HIV test results, she never entertained the thought of a positive test result. The husband expected any outcome. They both tested positive for HIV. “I felt my world falling apart,” says Abel Hicumunsi. “I was very disappointed and thought we were

going to die,” adds Itangishaka. Her disappointment was relieved through post-test counseling. She was enrolled on cotrimoxazole while her husband was enrolled for Antiretroviral Therapy (ART) and cotrimoxazole. Itangishaka’s health deteriorated rapidly and she was also enrolled on ART.

The couple did not disclose their status to anybody. But their neighbors kept guessing they could be HIV positive. Due to the stigma associated with HIV, they could not openly tell or ask them. One year later, the couple joined Society for Women against AIDS in Africa (SWAA) and was referred to RBP+, an association supporting people living with HIV.

After joining RBP+, the couple attended different trainings. Due to his active participation, Hicumunsi was identified as a peer educator. “This training has helped me to gain skills to reach out to other people including HIV-positive couples.”

While at RBP+, Itangishaka learned she could deliver a healthy baby, free of HIV. “I sought medical advice and was told what to do.” A month later, she conceived and the news was music to her husband’s ears who had two children from his deceased wife. “I had always feared that when she was angry she could mistreat my children, but now, that we were to get one (child) together, I was elated because I knew she would treat all of them equally,” says Hicumunsi.

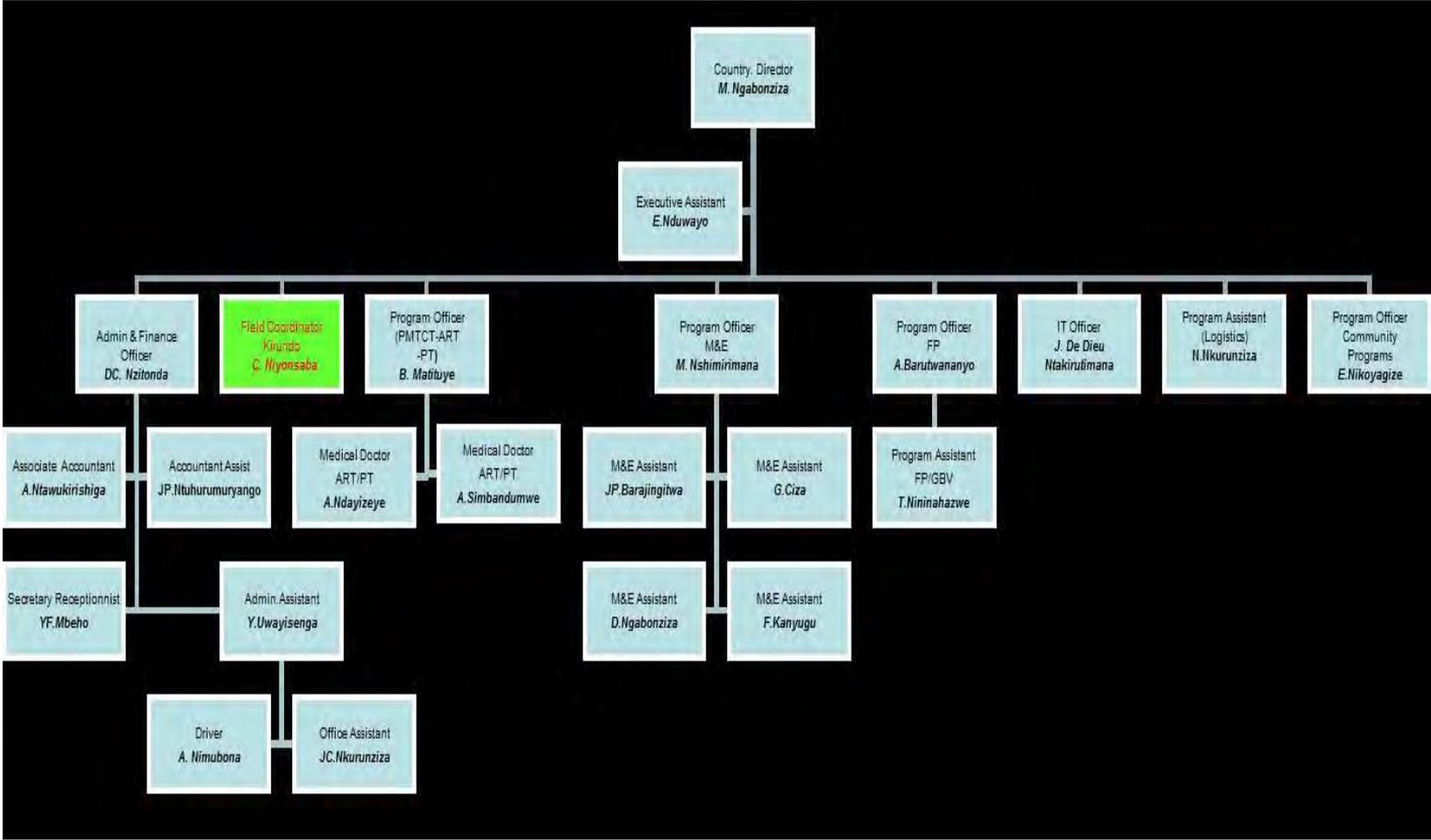
Hicumunsi had to live by example. He took care of his wife during pregnancy ensuring she fed well and rested, reminded her of her appointments and escorted her for her antenatal care. “My husband really supported me and am very grateful for the training we received in RBP+ on how we should support one another.” As advised during the ANC, Itangishaka delivered her HIV-negative baby boy at Kayanza hospital. The couple took their baby for all required tests until 18 months which confirmed he is HIV negative.

For now, the Hicumunsi’s are contented with their three children. “What we now want is to protect ourselves and take care of our children. We also want to continue being role models to our communities and share what we have learned with other couples so that HIV does not divide our families.”

4. Management Approach

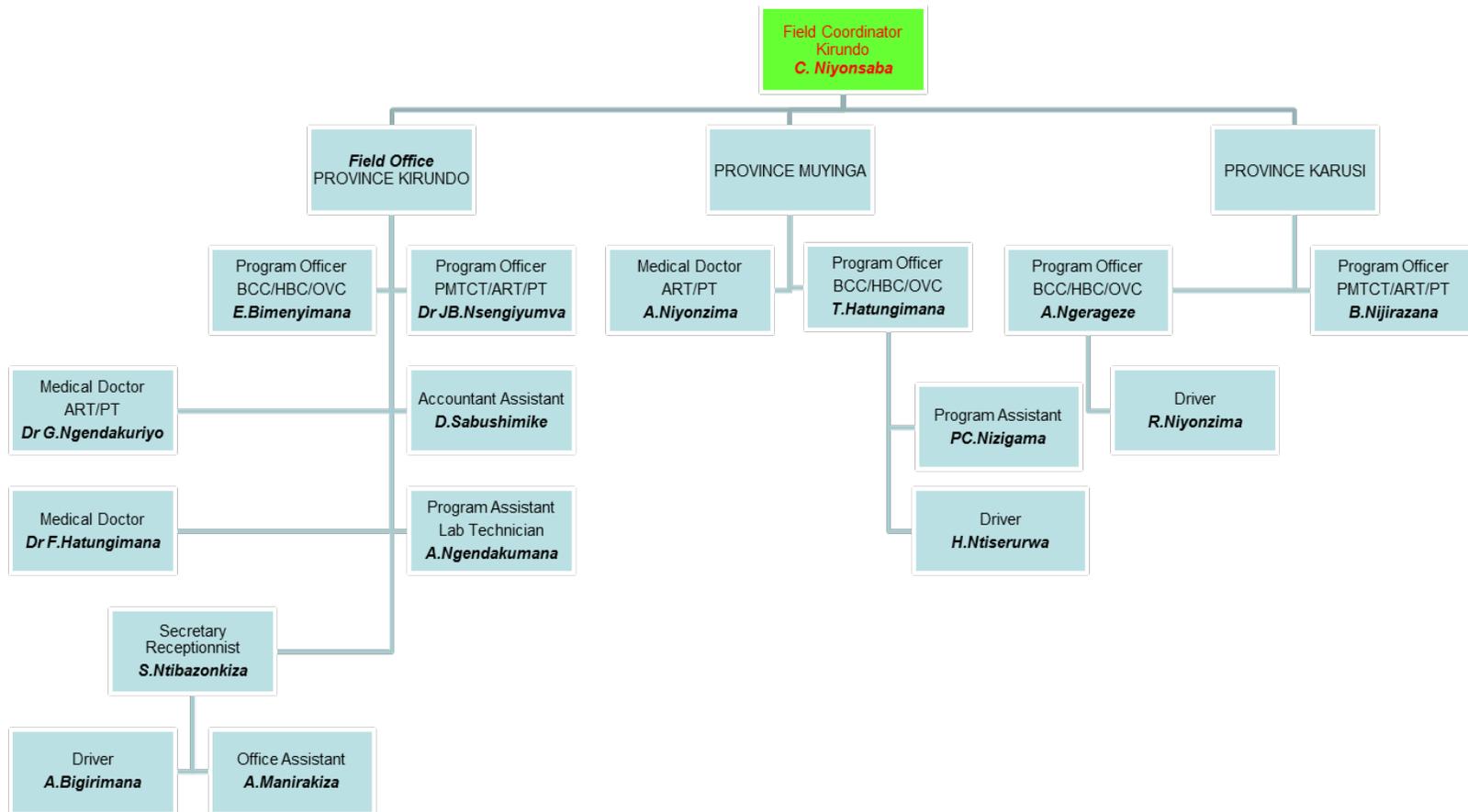
4.1 Management and Staffing

Figure 4.1.1 provides the organizational structure of Burundi ROADS II project team



ROADS II had a fully staffed management team. The project had a permanent technical team of 38 staff under the leadership of the Country Director. The Country Director was supported by seven technical officers, one field Coordinator and one administrative and finance officer. The technical officers assumed day-to-day management of project activities and received technical assistance from in-country teams, FHI 360’s Africa Regional Office in Nairobi, and ROADS II strategic partners JHU/CCP and HU/PACE.

Figure 4.1.2 below provides ROADS II project team, field organizational structure.



4.2 Monitoring and Evaluation

ROADS II was effectively monitored using the Monitoring and Evaluation Plan that was built on existing national requirements, responding to the government's needs, as well as United States Government (USG) requirement. The M&E Plan and Country Operational Plan were updated each year in consultation with the Burundi PEPFAR team. The program focus person was the M&E technical officer who was responsible for collating data for onward submission to the country and regional office in Nairobi.

The M&E system was operational as evidenced by the primary data collection tools developed and information products produced and disseminated. The system collected and analyzed quality program data ensuring data from the field was collected using standard registers and client records and summarized on monthly report forms. It also ensured that the reports were cleaned and validated at sub-grantee level, reviewed by project field office staff and submitted to the project M&E unit. During the implementation period, the project developed a verification system in different templates of the database with formulas which ensured that alerts were automatically displayed when errors were detected. This ensured that program data was of good quality and was utilized to inform program decision making, planning, and was used for program improvement. Data sharing with Government, USAID Mission and implementing partners was done quarterly, semi-annual and annually.

The M&E officer worked with the program coordinator to provide technical support for sub-agreements' managers, Health Information System (HIS) officers and intermediate level supervisors in the supported provinces to build capacity on M&E fundamentals, data management, and data quality assurance which largely improved M&E services for the project. The trainings conducted adhered to national standards and guidelines.

The project also conducted rapid assessments at new sites and baseline data assessments at the facility level in the new sites. Some of the studies conducted include the following:

- Rationale of ART drugs use (2009)
- MCH /FP baseline (2009)
- BSS Baseline among FSWs in Karusi (2012)

The project team also conducted program-linked evaluations and studies to assess the contribution of the program to selected outcomes as well as monitoring the quality and performance of the interventions.

- SDM Evaluation (2010)
- PMTCT quality evaluation (2011)
- Joint Data Quality Assessment (DQA) (2012) by USAID, MPHFA and FHI 360 on PMTCT services.

The project documented the following:

- Analysis and compilation of the OVC database
- PMTCT (Cascade analysis, couple counseling and testing)
- Pediatric AIDS (DBS-PCR at 6 weeks, 6 months and HIV diagnosis with rapid tests at 18 months)
- Home based care (HBC) achievement, and next steps

4.3 Financial management

ROADS II provided strong financial, operational and program management systems to ensure cost effectiveness and compliance with the FHI 360 standards and regulations. As at March 2014, ROADS II obligated amount was \$18,743,191. This was after an earlier modification of assistance was made in September 2013 committing an additional \$984,950 towards the total Estimated Amount to extend the period of performance through December 31, 2013. Prior to this amendment, the total commitment was 17,758,241.

Figure 4.3.1 below provides the breakdown by fiscal year of the amounts obligated against expenditure from the start of the project.

Fig 4.3.1 ROADS II Budget and Obligation Summary FY2009-2013

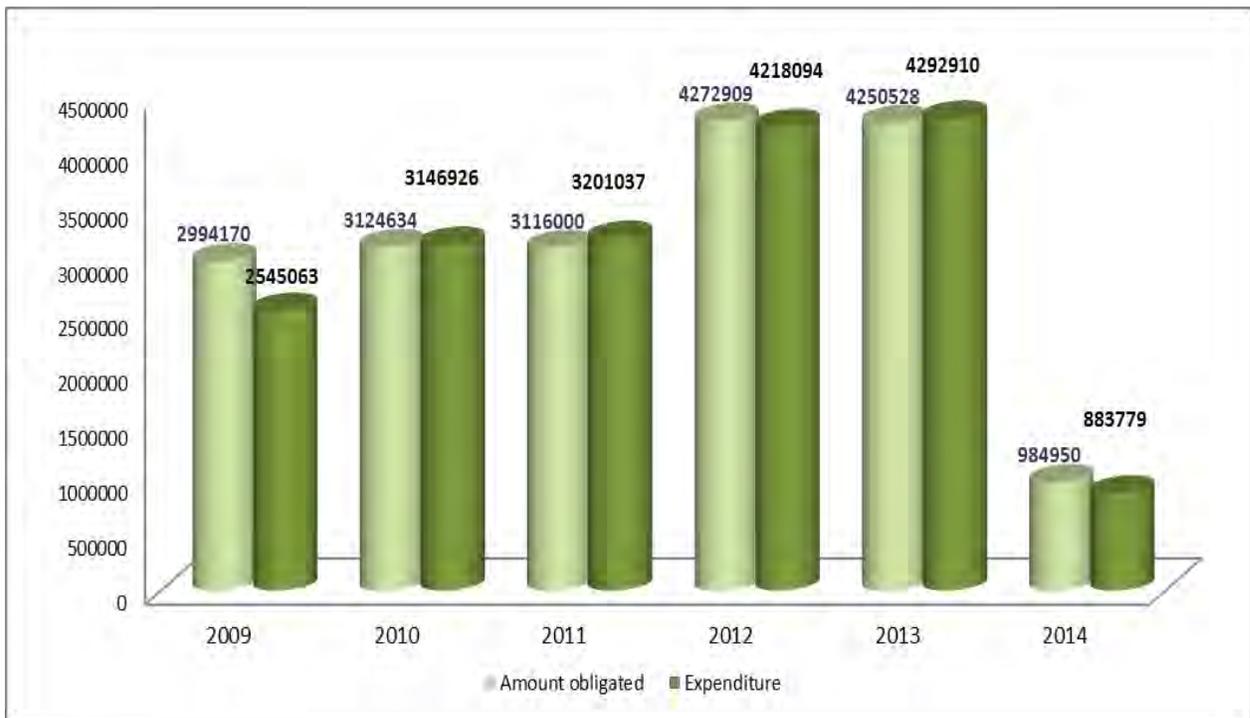


Table 4.3.1 below presents the financial position by fiscal year and total expenditure. FHI 360 spent \$ **18,358,643**.

ROADS II/Burundi	Annual Expenditures by Budget Category for the 5-year period							
Budget Line Items	FY09	FY10	FY11	FY12	FY13	FY14	On-Behalf Partners	TOTAL
PERSONNEL & CONSULTANTS	525,396	603,435	594,468	502,054	434,120	148,508	(5,839)	2,802,141
FRINGE BENEFITS	71,502	104,265	126,529	92,576	92,638	24,271	(2,975)	508,805
TRAVEL	50,923	67,483	70,228	112,033	60,315	23,728	(1,296)	383,415
EQUIPMENT	110,962	59,631	8,344	1,115	29,747	52	(119,451)	90,400
SUPPLIES	201,553	358,943	102,583	35,859	3,383	5,314	(454,814)	252,821
CONTRACTUAL	1,028,288	1,345,202	1,760,649	2,420,453	2,796,115	526,725	616,173	10,493,605
OTHER	161,342	269,475	199,286	527,678	450,440	94,678	(31,798)	1,671,101
INDIRECT COSTS	395,097	338,493	338,949	526,325	426,153	131,337	-	2,156,355
TOTAL	2,545,063	3,146,926	3,201,037	4,218,094	4,292,910	954,618	-	18,358,643

Source: Cash Disbursements Analysis (LOP) September 29, 2008 to March 31, 2014

Sub-recipients awards and Cost Share

ROADS II collaborated with 45 local implementing partners (public and private) and seven strategic partners (JHU/CCP/AFRICOMNET, JHPIEGO, Howard University, Solidarity Centre, North Star Foundation, PATH, and DAI) through its sub-agreement mechanism. FHI 360 through ROADS II made financial resources available to local agencies (see full list in Appendix 2) through its sub-agreement mechanism.

These funds went directly to the communities through the cluster and health facility sub-agreements. At the end of February 2014, a total of \$9,877,649.66 (which excludes Field advances) had been obligated to implementing partners.

ROADS II collected cost shared information to contribute to the Leader with Associate (LWA) award cost share commitment. At the end of March 2014, ROADS II had realized a total cost share value of US\$ 74,154, derived mainly from volunteers' time and supplies and equipment contribution for the various program activities.

Table 4.4.1 below presents the cumulative cost share contribution towards ROADS II (in thousands of dollars)¹⁹

Period of performance October 2008 to December 2013

Partner	Site	Volunteers (Community and Health Providers)	Space	Supplies /EQP	Total (US\$)
RBP+ Kayanza	Bujumbura	9,501	0	0	9,501
RBP+ Kirundo	Bujumbura	12,012	0	0	12,012
RBP+ Karusi	Bujumbura	3,238	0	0	3,238

¹⁹ Cost share contribution of volunteer time toward the USAID-funded ROADS to Healthy Future (ROADS II)

ACKQA	Kayanza	1,681	0	599	2,280
PUMA Karate	Kayanza	3,202	0	498	3,700
SWAA Kayanza	Kayanza	2,940	0	357	3,297
AMAVS	Kayanza	3,339	0	0	3,339
CPAJ Kirundo	Kirundo	10,939	0	507	11,446
Croix Rouge Karusi	Bujumbura	1,012	0	0	1,012
APECOS Kirundo	Kirundo	5,061	0	0	5,061
BDC Muyinga	Muyinga	7,278	0	0	7,278
FNTT	Muyinga	523	0	69	592
RENAJES Hospital	Muyinga	5,155	0	486	5,641
SWAA Muyinga	Muyinga	5,280	0	477	5,757
TOTAL*		71,161	0	2993	74,154

*The items claimed above as ‘cost share’ were not paid for by any United States Government (USG) source of funding nor were they claimed as cost share on any other USG-funded project. The costs are in consideration of hours of work provided free of charge by the volunteers and their social economic group.

5. Summary of Key Findings, Challenges and Lessons Learned

ROADS II collaborated with the Burundi Government, civil society and the private sector to implement the six broad programmatic areas that include HIV prevention services, care services for PLHIV and health systems strengthening.

5.1 Key Successes

Although much more has been achieved, the following are some of the key successes:-

1. Responding to National HIV – AIDS Strategic Plan (2012-2016): ROADS II contributed to achieving the following Government of Burundi strategic axis:

- *Strategic axis 1* : Reduction of HIV/STI transmission
 - Program area 1.1: Reduction of sexual transmission of HIV
 - Program area 1.3:Prevention of mother-to-child transmission
- *Strategic axis 2*: Improve the wellbeing of people living with HIV:
 - Program area 2.4: Prophylaxis, diagnosis and treatment of opportunistic infections
 - Program area 2.5: Universal access to ARVs for adults and children
 - Program area 2.6: Psychosocial and nutritional support of PLHIV
- *Strategic axis 3*: Reduction of poverty and other determinants leading to HIV vulnerability
 - Program area 3.8: Care for OVCs

2. HIV Prevention Services: ROADS II supported service delivery points to provide PMTCT services including antenatal services, HTC, diagnosis and management of sexually transmitted infections (STIs), safe obstetrical practices, counseling for safe infant feeding and exposed-infant follow-up until 18 months of age. Sexual partners of pregnant women were sensitized on the need to be tested for HIV. Within HTC delivery points where data was available, an increased number of male partners were tested for HIV. In addition, the most vulnerable pregnant women received

food supplementation. Antiretroviral prophylaxis was also administered to infants born to HIV-positive mothers according to the national protocol. A total of 583 staff members were trained on provision of PMTCT services. There was a significant increase in the number of PMTCT service delivery points, from 44 in 2008 to 163 in 2013. There was an increase in the number of pregnant women who were tested for HIV from 59,932 in 2009 to 135,626 in 2013. The number of those tested and received their results increased from 41,373 in 2009 to 130,040 in 2013. The number of pregnant women who tested positive and were enrolled in PMTCT increased from 427 in 2009, to 957 in 2013.

ROADS II promoted access to HTC services. The number of HTC service outlets increased from 46 in 2008 to 165 in 2013, and the number of people accessing these service increased from 46,953 in 2008 to 360,446 in 2013. The project also increased the number of adults and children living with HIV who received clinical care and treatment, including ART, through expansion of outlets and improvements to laboratory services. Consequently, the number of PLHIV on cotrimoxazole prophylaxis increased from 3,606 in 2008 to 9,950 in 2013.

ROADS II strengthened laboratory services through provision of equipment and supplies, and training, supervision and mentoring staff. Supported laboratory activities included HIV testing, and biological follow-up (biochemistry, hematology analysis and CD4 count) for PLHIV under clinical care including ART. HIV test kits, reagents and other laboratory supplies, materials and equipment were provided to HTC service outlets, and to laboratories attached to ART sites.

In partnership with the Bill Clinton Foundation and the Laboratory of the National Institute of Public Health, ROADS II started and sustained HIV diagnosis in infants born to HIV+ mothers using the Dried Blood Spots-PCR technique.

In addition to clinical care and treatment services, ROADS II also supported non-clinical care and support services for PLHIV families and provided support for orphans and vulnerable children infected with or affected by HIV. A total of 6,602 eligible clients received food and other nutritional services; 10,387 eligible clients benefited from psychosocial support, food and other nutrition services by the end of the project cycle. The number of OVC served increased from 6,000 in 2009 to 11,935 in 2013.

3. Maternal and Child Health: MCH activities were funded under a separate mechanism from USAID/EA. ROADS II supported two facilities (Bunyari and Burara Health Centers) to deliver improved antenatal care, immunization, labor and delivery, growth monitoring, and family planning services, and to provide nutritional support for infants and mothers, and offer services to mitigate gender-based violence. Twenty-four traditional birth attendants (TBAs) and 18 community health workers were trained on different MCH topics including labor and delivery management. The two health centers and nine health centers in Busoni/Kirundo also received equipment to support MNH services. Between 2011 and 2013, 980 women in Bunyari, and 623 in Burara delivered under skilled care. In the same period, 603 women in Burara and 859 in Bunyari benefited from active management of the third stage of labor (AMTSL) services.

4. Family Planning and Gender-Based Violence: Through the program, facilities were offered a range of contraception methods, including pills, injectables, IUCD (insertion and removal), male condoms, spermicides and counselling clients on natural family planning.

In 2010, a pilot project was launched to integrate the Standard Days Method (SDM) into the range of contraceptive methods in four health centers (Kayanza and Rubura in Kayanza, and Kigozi, Murore in Kirundo province). This led to an increase in the number of clients who adopted this method in the four pilot sites. An evaluation conducted with the technical assistance of the Institute of Reproductive Health (IRH) of Georgetown University showed that the Standard Days Method was acceptable and feasible in Burundi and that introducing it gave clients who preferred natural methods an effective choice.

Community health workers (CHW) disseminated FP messages to community members in Kayanza, Muyinga and Karusi, and also conducted sensitization about gender-based violence (GBV) and rape. Rape survivors received care, treatment and other services from appropriate facilities.

ROADS II also improved awareness of the community members on GBV and its effect. This further led to reduced number of GBV cases and increased number of individuals accessing GBV recovery services. It also led to reducing GBV as a barrier to accessing FP and MNH services. The project mentored the supported health facilities and surrounding communities in Kayanza (*Kayanza, Gahombo, Matongo, Musema, Rubura, Gasenyi and Gatara*), Kirundo (*Kirundo, Bunyari, and Murore*) and Muyinga (*Muyinga HC*) provinces to provide quality FP and GBV services.

5. Capacity strengthening: ROADS II Project also strengthened capacities of civil society organizations thereby promoting sustainability of project gains. This was done through training and mentorship to enable these organizations design programs to address HIV and broader health in their communities.

5.2 Key Challenges

1. *Low number of staff and high turnover within governmental facilities:* During the project's period, the numbers of qualified health providers in public health facilities did not meet the national staffing standards. Although ROADS II conducted several training sessions to strengthen the capacity of providers for quality-services, frequent transfers and other staff movement affected the delivery of quality services.
2. *Challenges in the follow-up of mother and child on PMTCT:* Lack of unique ID numbers in the National Health Information System made follow-up of clients receiving PMTCT services very difficult. It was impossible to take advantage of mother and child visits to the health facility and track them for PMTCT services and monitoring until they exited the program. In addition, the PCR test, which is the only technique recommended by the national algorithm for early infant diagnosis (EID) in exposed infants, was not fully accessible. It is only available at the National Reference Laboratory based in Bujumbura. Furthermore, Dried

Blood Spot (DBS) test kits were not regularly provided, and the serological HIV diagnosis, which is available in every health facility, is unfortunately only applicable at 18 months of age, according to the national HIV testing algorithm.

3. Male involvement in PMTCT was very low in all settings where pregnant women were enrolled on a PMTCT program.
4. *Differences between the national and PEPFAR reporting systems:* As the national reporting system does not systematically match with PEPFAR requirements, the project encountered difficulties with data collection tools and timeliness. This was worsened by the lack of integration of HIV services data in the health district's database. Thus, the project was sometimes obliged to create additional tools and request for tight reporting deadlines.
5. *Initial challenges with forecasting/stock outs:* The program also experienced ARV stock outs, due to many reasons, including delays in procurement at the national level. This was resolved through SCMS.
6. *Maternal & Neonatal Health Challenges:* Community myths and misinformation about family planning methods hindered the uptake of FP services. Further, the full range of family planning commodities was not available. Lack of qualified and trained family planning providers was also a challenge. There were also very few staff able to offer the full range of MNH services, because most lacked knowledge and skills on maternal and child health, family planning and emergency obstetric and neonatal care.

5.3 Lessons learned

The following are some of the overarching lessons learned.

1. Fostering teamwork improves collaboration and communication among partners, stakeholders, CBOs and beneficiaries. The strong collaboration among the stakeholders contributed to the overall program success.
2. Qualified and committed human resources are essential for project implementation and quality health care services provision.
3. *Improvement of infrastructure and health facility environment increases facility attendance and uptake of services:* When the project started to renovate and equip health facilities for HIV-related services provision, other existing services in the facility were utilized.
4. *Decentralization of antiretroviral treatment (ART) to health center level is possible:* Although the national ART protocol recommends provision of ART in settings where there are medical doctors only, ROADS II piloted an ART decentralization program where the services were decentralized from district hospitals to selected health centers. This initiative brought ARV services closer to the clients, thereby promoting their uptake.

5. *Peer-led outreach programs can increase ART enrolment.* Evidence shows that through testimonies, PLHIVs' confidence and self-esteem improved, social stigma reduced and led to more people enrolling on ART.
6. *Gender-focused efforts:* GBV is a community issue and stakeholders need to work together devising strategies targeting men and women to address the vice.

Appendix 1: ROADS II- FHI Implementing partners in Burundi

No	Program area	Services	Implementing partners
1	Prevention	Sexual and Other Risk Prevention	ACQKA Kayanza, CPAJ Kirundo, PUMA KARATE, RENAJES Muyinga, SWAA Kayanza, SWAA Muyinga
		HTC/PMTCT/PT	ABUBEF, BPS Kayanza, BPS Kirundo, BPS Muyinga, CDS Kayanza, CDS Maramvya, Centre IZERE, CDS Kagari, Diocèse de Muyinga, Hôpital de Muyinga, SWAA Kayanza, SWAA Muyinga ²⁰ , CDS Banga, CDS Marembo, CDS Nyamabuye, CDS Rutare
2	Care and Support	- Preventive therapy against Opportunistic Infections, - Integration of TB-HIV co-infection services	ABUBEF, BPS Kayanza, BPS Kirundo, BPS Muyinga, CDS Kayanza, CDS Maramvya, Centre IZERE, CDS Kagari, Diocèse de Muyinga, SWAA Muyinga, ANSS, Kayanza Hospital, Kirundo Hospital, Mukenke Hospital, Muyinga Hospital, Musema Hospital
		Antiretroviral therapy Support	ANSS, Kayanza Hospital, Kirundo Hospital, Mukenke Hospital, Muyinga Hospital, Musema Hospital
		Home-based care	RBP+ (Burundian PLHIV Network) Kirundo, RBP+ Kayanza
		OVC services	AMAVS Kayanza, APECOS Kirundo, BDC Muyinga
3	FP/GBV	-	BPS Kayanza, BPS Muyinga, CDS Kayanza, SWAA Kayanza, SWAA Muyinga, CDS Muyinga

²⁰ SWAA Kayanza and SWAA Muyinga are HTC only sites

Annex B: Award Summary Sub-Recipients Inventory

Sub Award Summary Sheet as at March 31, 2014 towards ROADS II (in thousands of dollars)			
Site /Partner	Cost share in \$US	Site /Partner	Cost share in \$US
Strategic partners			
JHU/CCP/AFRICOMNET - ROADS II-B	24,492.49	Solidarity Centre - ROADS II-Bu	160,572.84
JHPIEGO - ROADS II-Burundi	13,643.00	North Star Foundation - ROADS II-	95,515.00
Howard University - ROADS II-Bu	86,723.48	Burundi: PATH - ROADS II-Burundi	5,166.60
DAI: Food Security and Economic Strength	24,470.78		
Local Implementing Partners			
Musema Hospital: ART-PT	166,575.76	Murama HC/Muyinga HDO - FUPS for PBF	2,385.94
Mukenke Hospital: ART-PT	128,642.14	Kinazi HC/Muyinga HDO - FUPS for PBF	3,708.33
ABUBEF: VCT/PMTCT/PT	290,363.98	Kayenzi HC/Muyinga HDO - FUPS for PBF	5,979.16
APECOS: Care for Orphans of AIDS	390,620.84	Rugari HC/Muyinga HDO - FUPS for PBF	6,916.14
Diocese Muyinga: VCT/PMT	659,412.25	Gitaramuka HC/Muyinga HDO - FUPS for PBF	4,097.43
Burundi: ANSS: ART/PT	369,585.84	Rugongo HC/Muyinga HDO - FUPS for PBF	3,400.88
RBP+: PLWHA Home based Care	423,287.12	Kiyanza HC/Muyinga HDO - FUPS for PBF	5,679.91
BPS Muyinga: VCT/PMTCT/PT	423,271.29	Mwakiro HC/Muyinga HDO - FUPS for PBF	3,147.32
BPS Kirundo: VCT/PMTCT/PT	422,410.88	Muyinga Hospital/Muyinga HDO - FUPS for	68,967.58
Kirundo Hospital: ART/PT	215,700.14	Rugabano HC/Muyinga HDO - FUPS for PBF	2,563.28
SWAA Muyinga: VCT	94,212.90	Muyinga HC/Muyinga HDO - FUPS for PBF	19,808.42
Kayanza Hospital: ART/PT	223,015.23	Cumba HC/Muyinga HDO - FUPS for PBF	4,139.92
RENAJES: Youth Cluster Muyinga	71,273.97	Gahororo HC/Muyinga HDO - FUPS for PBF	3,290.02
ACQKA: BCC Drivers Kayanza	67,795.01	Nyarunazi HC/Muyinga HDO - FUPS for PBF	3,874.06
Hopital Muyinga: ART/VCT/PMTCT/PT	267,069.63	Giteranyi - HDO Level - FUPS fo	0.00
Centre IZERE: VCT/PMTCT/PT	87,079.02	Kamaramagambo HC/Giteranyi HDO - FUPS fo	4,862.19
CDS Kayanza: VCT/PMTCT/PT	65,052.86	Rabiro HC/Giteranyi HDO - FUPS for PBF	3,481.18
SWAA Kayanza: Low Income Women CI	109,129.83	Mugano HC/Giteranyi HDO - FUPS for PBF	6,182.57
Burundi: SWAA Kayanza: VCT	64,332.11	Giteranyi HC/Giteranyi HDO - FUPS for PB	4,668.04
SWAA Muyinga: Low Income Women CI	111,440.92	Nonwe HC/Giteranyi HDO - FUPS for PBF	2,036.54
CDS Kagari: VCT/PMTCT/PT	61,798.20	Ruzo HC/Giteranyi HDO - FUPS for PBF	6,160.12
BPS Kayanza: VCT/PMTCT/PT	487,738.68	Burundi: Nyabikere - HDO Level - FUPS fo	0.00
AMAVS: Care for Orphans of AIDS &	500,104.58	Nyabikere HC/Nyabikere HDO - FUPS for PB	3,522.61
BDC Muyinga: Care for Orphans of	439,427.67	Gatonde HC/Nyabikere HDO - FUPS for PBF	4,897.89
CPAJ: Youth Cluster Kay	9,946.31	Rugwiza HC/Nyabikere HDO - FUPS for PBF	2,621.35
CPAJ: HIV/AIDS/BCC	193,137.03	Rusi HC/Nyabikere HDO - FUPS for PBF	3,594.93
CDS Maranyva: VCT/PMTCT/PT	103,340.36	Nyarurambi HC/Nyabikere HDO - FUPS for P	4,845.49
Puma Karate: HIV/AIDS Behavior Ch	87,116.51	Nyabibuye HC/Nyabikere HDO - FUPS for PB	5,295.77
RBP+ Kirundo: PLWHA Home-based Ca	495,994.94	Gisimbawaga HC/Nyabikere HDO - FUPS for	2,667.65
Ngozi Diocese: VCT/PMTCT/PT	298,223.24	Rabiro HC/Nyabikere HDO - FUPS for PBF	3,719.95
Rutare HC: VCT/PMTCT/PT	58,542.45	Bibara HC/Nyabikere HDO - FUPS for PBF	1,427.48
Marembo HC: VCT/PMTCT/PT	49,678.66	Gihogazi HC/Nyabikere HDO - FUPS for PBF	5,108.82
Nyamabuye HC: VCT/PMTCT/PT	38,533.14	Mugogo HC/Nyabikere HDO - FUPS for PBF	4,431.43
Banga HC: VCT/PMTCT/PT	79,547.07	Rusamaza HC/Nyabikere HDO - FUPS for PBF	8,064.00
Burundi: FNNT: HIV Prevention	119,508.95	Musema - HDO Level - FUPS for P	0.00
Nyabikere Health District: VCT/PM	177,761.86	Matongo HC/Musema HDO - FUPS for PBF	4,781.95
Buhiga Hospital: ART/PT	138,675.47	Rango HC/Musema HDO - FUPS for PBF	3,076.58
Buhiga Health District: VCT/PMTCT	170,272.99	Nyarurama HC/Musema HDO - FUPS for PBF	1,222.87
Burundi: Mukenke - HDO Level - FUPS for	0.00	Bururana HC/Musema HDO - FUPS for PBF	2,389.60
Bucana HC/Mukenke HDO - FUPS for PBF	3,313.70	Kabuye II HC/Musema HDO - FUPS for PBF	1,885.93
Buhoro HC/Mukenke HDO - FUPS for PBF	3,735.10	Ninga HC/Musema HDO - FUPS for PBF	1,515.09
Gitobe HC/Mukenke HDO - FUPS for PBF	5,037.96	Karehe HC/Musema HDO - FUPS for PBF	3,098.52
Kimeza HC/Mukenke HDO - FUPS for PBF	4,417.65	Gaheta HC/Musema HDO - FUPS for PBF	2,241.66
Mukenke HC/Mukenke HDO - FUPS for PBF	3,956.72	Musema HC/Musema HDO - FUPS for PBF	767.92
Shore HC/Mukenke HDO - FUPS for PBF	4,635.76	Gasenyi HC/Musema HDO - FUPS for PBF	6,204.93
Bugorora HC/Mukenke HDO - FUPS for PBF	3,084.17	Buranro HC/Musema HDO - FUPS for PBF	25,846.83

Nyenzi HC/Mukenke HDO - FUPS for PBF	4,798.42	Banga HC/Musema HDO - FUPS for PBF	16,011.28
Kibazi HC/Mukenke HDO - FUPS for PBF	5,911.94	Gikomero HC/Musema HDO - FUPS for PBF	1,929.25
Tonga HC/Mukenke HDO - FUPS for PBF	0.00	Musema Hospital/Musema HDO - FUPS for PBF	25,222.07
Mukenke Hospital/Mukenke HDO - FUPS for	14,646.87	Burundi: Gashoho - HDO Level - FUPS for	0.00
Burundi: Kirundo - HDO Level - FUPS for	0.00	Kizi HC/Gashoho HDO - FUPS for PBF	2,284.44
Kirundo HC/Kirundo HDO - FUPS for PBF	18,850.19	Gisabazuba HC/Gashoho HDO - FUPS for PBF	2,697.25
Kiyonza HC/Kirundo HDO - FUPS for PBF	3,764.62	Kigoganya HC/Gashoho HDO - FUPS for PBF	3,486.90
Muyane HC/Kirundo HDO - FUPS for PBF	10,604.19	Gasorwe HC/Gashoho HDO - FUPS for PBF	7,561.31
Ruhehe HC/Kirundo HDO - FUPS for PBF	2,209.97	Nyagatovu HC/Gashoho HDO - FUPS for PBF	9,375.88
Kigozi HC/Kirundo HDO - FUPS for PBF	8,829.69	Gashoho HC/Gashoho HDO - FUPS for PBF	6,145.80
Gakana HC/Kirundo HDO - FUPS for PBF	2,383.88	Kagari HC/Gashoho HDO - FUPS for PBF	6,067.65
Rugasa HC/Kirundo HDO - FUPS for PBF	0.00	Gisanze HC/Gashoho HDO - FUPS for PBF	6,425.43
Cumva HC/Kirundo HDO - FUPS for PBF	8,016.56	Bwasare HC/Gashoho HDO - FUPS for PBF	2,134.94
Kirundo HC/Kirundo HDO - FUPS for PBF	23,811.35	Mirwa HC/Gashoho HDO - FUPS for PBF	2,363.43
Rukuramigabo HC/Kirundo HDO - FUPS for P	2,683.28	Burundi: Buhiga - HDO Level - FUPS for P	0.00
Gaharo HC/Kirundo HDO - FUPS for PBF	2,061.01	Buhiga HC/Buhiga HDO - FUPS for PBF	3,664.30
Burundi: Vumbi - HDO Level - FUPS for PB	0.00	Karusi HC/Buhiga HDO - FUPS for PBF	5,263.17
Gikomero HC/Vumbi HDO - FUPS for PBF	10,656.29	Kanyange HC/Buhiga HDO - FUPS for PBF	4,259.55
Mugendo HC/Vumbi HDO - FUPS for PBF	7,513.39	Rutoganikwa HC/Buhiga HDO - FUPS for PBF	5,963.08
Muramba HC/Vumbi HDO - FUPS for PBF	7,116.09	Bugenyuzi HC/Buhiga HDO - FUPS for PBF	9,204.23
Murungurira HC/Vumbi HDO - FUPS for PBF	4,227.48	Masobo HC/Buhiga HDO - FUPS for PBF	5,014.77
Runyankezi HC/Vumbi HDO - FUPS for PBF	6,598.60	Kiranda HC/Buhiga HDO - FUPS for PBF	4,482.41
Gasura HC/Vumbi HDO - FUPS for PBF	7,348.57	Gitaramuka HC/Buhiga HDO - FUPS for PBF	6,185.47
Ntega HC/Vumbi HDO - FUPS for PBF	13,198.38	Nyaruhinda HC/Buhiga HDO - FUPS for PBF	6,649.68
Mugina HC/Vumbi HDO - FUPS for PBF	3,607.00	Nyakabugu HC/Buhiga HDO - FUPS for PBF	3,513.85
Nyamisagara HC/Vumbi HDO - FUPS for PBF	7,214.09	Buhiga Hospital/Buhiga HDO - FUPS for PB	18,221.95
Rushubije HC/Vumbi HDO - FUPS for PBF	4,534.83	Kayanza - HDO Level - FUPS for	0.00
Vumbi HC/Vumbi HDO - FUPS for PBF	7,919.13	Kayanza HC/Kayanza HDO - FUPS for PBF	7,694.26
Busoni - HDO Level - FUPS for PBF	0.00	Kabuye I HC/Kayanza HDO - FUPS for PBF	5,103.01
Bunyari HC/Busoni HDO - FUPS for PBF	2,261.49	Rubura HC/Kayanza HDO - FUPS for PBF	4,049.15
Burara HC/Busoni HDO - FUPS for PBF	2,624.64	Kabarore HC/Kayanza HDO - FUPS for PBF	5,218.56
Kabanga HC/Busoni HDO - FUPS for PBF	4,268.40	Mubuga HC/Kayanza HDO - FUPS for PBF	4,530.42
Nyagisozi HC/Busoni HDO - FUPS for PBF	1,658.21	Murima HC/Kayanza HDO - FUPS for PBF	8,336.86
Vyanzo HC/Busoni HDO - FUPS for PBF	3,256.05	Ryamukona HC/Kayanza HDO - FUPS for PBF	1,526.57
Murora HC/Busoni HDO - FUPS for PBF	6,884.39	Rugazi HC/Kayanza HDO - FUPS for PBF	1,744.05
Mukerwa HC/Busoni HDO - FUPS for PBF	2,620.99	Remera HC/Kayanza HDO - FUPS for PBF	10,794.35
Sigu HC/Busoni HDO - FUPS for PBF	2,576.73	Rwegura HC/Kayanza HDO - FUPS for PBF	4,976.28
Burundi: Gahombo - HDO Level - FUPS for	0.00	Jene HC/Kayanza HDO - FUPS for PBF	6,825.42
Gahombo HC/Gahombo HDO - FUPS for PBF	3,532.87	Gahahe HC/Kayanza HDO - FUPS for PBF	2,903.91
Ngoro HC/Gahombo HDO - FUPS for PBF	2,358.38	Kayanza Hospital/Kayanza HDO - FUPS for	34,887.00
Nzewe HC/Gahombo HDO - FUPS for PBF	1,756.80	Rutare HC/Kirundo HDO - FUPS for PBF	5,027.25
Gatara HC/Gahombo HDO - FUPS for PBF	5,766.70	Nyamabuye HC/Kirundo HDO - FUPS for PBF	0.00
Maramvya HC/Gahombo HDO - FUPS for PBF	7,192.00	Marengo HC/Busoni HDO - FUPS for PBF	7,739.74
Kibaribari HC/Gahombo HDO - FUPS for PBF	1,308.91	Kibimba HC/Muyinga HDO - FUPS for PBF	0.00
Gansenyi II HC/Gahombo HDO - FUPS for PB	1,413.57	Kibongera HC/Muyinga HDO - FUPS for PBF	0.00
Ceyerezi HC/Gahombo HDO - FUPS for PBF	1,253.15	Butihinda HC/Giteranyi HDO - FUPS for PB	3,413.02
Rukago HC/Gahombo HDO - FUPS for PBF	3,797.21	Nyungu HC/Gashoho HDO - FUPS for PBF	5,594.93
Muhanga I HC/Gahombo HDO - FUPS for PBF	6,734.61	Kidasha HC/Giteranyi HDO - FUPS for PBF	4,747.05
Muhanga II HC/Gahombo HDO - FUPS for PBF	3,272.12	Kinyami HC/Giteranyi HDO - FUPS for PBF	3,567.35
Mubogora I HC/Gahombo HDO - FUPS for PBF	1,218.34	Masaka HC/Giteranyi HDO - FUPS for PBF	0.00
Gakenke I HC/Gahombo HDO - FUPS for PBF	2,295.83	Ngomo HC/Giteranyi HDO - FUPS for PBF	7,594.17
Muyinga - HDO Level - FUPS for	0.00	Tura HC/Giteranyi HDO - FUPS for PBF	4,891.98
Muramba HC/Muyinga HDO - FUPS for PBF	11,002.97	Musama HC/Gashoho HDO - FUPS for PBF	0.00
Munagano HC/Muyinga HDO - FUPS for PBF	4,016.48	Gahararo HC/Gashoho HDO - FUPS for PBF	2,157.43
Ntanda HC/Buhiga DHO - FUPS for PBF	2,192.02	Croix Rouge Karusi: HIV Preventio	108,017.49
RBP+ Karusi: HBC & OVC	239,713.62	Rudaraza HC/Buhiga DHO - FUPS for PBF	1,813.64
ADDF Karusi: HIV Prevention	68,370.51	Buhindye HC/Buhiga DHO - FUPS for PBF	3,828.92
Ruganira HC/Nyabikere DHO - FUPS for PBF	1,263.41	Rugazi HC/Buhiga DHO - FUPS for PBF	5,340.63
Nyarunazi HC/Nyabikere DHO - FUPS for PB	901.28		

Grand Total	9,877,432.39
Payments on Behalf of Partners	616,172.83
	10,493,605.22