

**United States Agency for International Development
Regional Economic Development Services Office
(USAID/REDSO)**



**BURUNDI
HIV/AIDS STRATEGIC PLAN
2005 - 2007**

January 21, 2005

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LIST OF ACRONYMS

ABUBEF	Association Burundaise de Bien Etre Familial
ADRA	Adventist Development and Relief Agency
ANC	Antenatal care
ANSS	Association National de soutien aux Seropositifs et Sideens
ARV	Antiretroviral
BCC	Behaviour Change Communication
CNLS	Conseil National de Lutte Contre le SIDA
CRS	Catholic Relief Services
DHS	Demographic and Health Survey
DRC	Democratic Republic of Congo
FVS	Famille pour Vaincre le SIDA
GIPA	Greater Involvement for People with AIDS
GLIA	Great Lakes Initiative against AIDS
IDP	Internally Displaced Persons
ISP	Integrated Strategic Plan
KABP	Knowledge, Attitude, Behavior and Practice
LPC	Limited Presence Countries Office
MAP	Multi-sectoral AIDS Program
MOH	Ministry of Health
OFDA	Office of Foreign Disaster Assistance
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
SIPAA	Support for International Partnership Against AIDS in Africa
STI	Sexually Transmitted Infections
SWAA	Society for Women Against AIDS
TB	Tuberculosis
VCT	Voluntary Counseling and Testing

1. CONTEXT

(i) Country Situation

Burundi is a country in the early stages of transition from civil war to a post-conflict democratic society. The country has completed the three year transition as mandated by the Arusha Accord and successfully handed over the presidency from a Tutsi to a Hutu at the 18 month mark. The government is struggling to involve all political factions in the transition. The National Independent Electoral Commission was established and an election calendar, including an early referendum on the constitution, was established and an election calendar, including an early referendum on the constitution, was announced that would be completed during a six-month extension of the transitional government. A practical demobilization plan was developed that includes incorporation of all armed groups into the army, a disarmament program to be carried out by the UN Peacekeeping Mission before the elections, and phase demobilization of approximately 15,000 soldiers per year over five years. Fighting in the countryside has ceased, but one holdout rebel group continues to fight in the province surrounding the capital. Access to Burundi improved in 2004 and allowed increased technical visits by REDSO for monitoring of activities and program design. Basic services are increasingly important as refugees and displaced people return and burden the fragile systems.

With 6.8 million people as of 1999 and 215 persons per square kilometer, Burundi ranks second in population density among all countries in sub-Saharan Africa. In a largely agrarian society, the conflict has created food insecurity by displacing people, preventing them from taking care of their fields and livestock, discouraging them from making sustainable investments in their lands, and reducing the perceived benefits of managing natural resources for the long term. Eighty-nine percent of the population lives on less than \$2 per day; 58% live on less than \$1 per day.

The social consequences of conflict, poor governance and dismal economic performance have been grim. Burundi's UN Human Development Index was 0.337 in 2001, ranking it 171st of 175 countries.¹ Infant mortality increased from 100/1000 in 1993 to 116/1000 in 2003. At 1900/100,000 live births, maternal mortality is nearly the highest in the world; overall life expectancy dropped from 55 years in 1993 to 40.8 years in 2003; and there is less than one hospital bed per 1000 population. Forty-five percent of children less than 5 years old were underweight during 1995-2001 and 57% were under height for age. There are an estimated 25,000 war orphans, 14,000 child soldiers and 5,000 street children.

USAID designed an Integrated Strategic Plan (ISP) to support Burundi's transition from conflict to peace and from relief to renewed development over an interim period of three years, 2003-2005. Cognizant of the uncertain conditions that prevail, the ISP sets forth a modest goal of "transition to peace and socioeconomic recovery underway" and presents three Strategic Objectives (SOs): SO 6: Good Governance Enhanced; SO 7: Food Security Enhanced; and SO 8: Access to Basic Social Services Improved. The HIV/AIDS Program operates under SO8.

¹ Human Development Report, 2003. United Nations Development Program

The conflict and destabilization continues to impact communities throughout Burundi and has undoubtedly contributed to the spread of HIV/AIDS by displacing populations, disrupting family and community structures, increasing sexual exploitation, violence and abuse, and destroying health infrastructure. In addition to 800,000 Burundian refugees and 230,000 internally displaced persons (IDP), WHO reports that there are roughly 30,000 refugees from other countries, primarily the Democratic Republic of the Congo (DRC), residing in Burundi. There has been a steady repatriation of Burundian refugees from neighboring countries particularly during the past year.

(ii) Regional Context

The most powerful argument for USAID to fund HIV/AIDS in Burundi is the continuing instability in the Great Lakes Region causing constant refugee, internally displaced persons (IDP) and military flows throughout the region. AIDS knows no borders and massive population movements undermine any and all efforts of individual countries to address the pandemic. There is a clear connection between fragile, disintegrating civil and state organizations and the increase of HIV prevalence. "AIDS in conflict" needs more direct and focused consideration, especially in this region. Tensions are increasing in the Great Lakes Region once again among the neighboring countries of Rwanda, Burundi, DRC and Uganda. Even though conflict in Burundi has abated at present, the political/security situation continues to be extremely volatile, as the Gatumba massacre illustrates so vividly. Dealing with the political, economic and humanitarian agenda is an overwhelming task for Burundi's interim government. HIV/AIDS is playing and will continue to play a spoiler's role in every aspect of that agenda, as it sucks the lifeblood out of the populace and weighs down the government with exorbitant costs to the health sector and the human resources pool. It presents a real threat to Burundi and the region at large that political will alone cannot resolve.

When the 400,000 Burundian refugees in Tanzanian camps return home, plus the demobilized soldiers, an extremely high risk group, and IDP, there will be added health concerns:

- If a large number of the men remain in the refugee camps and more women return to Burundi (as occurred with the Rwanda refugees in Tanzanian camps a few years ago), it will mean an increase in the already numerous female-headed households most vulnerable to HIV.
- The return of large numbers of refugees who have enjoyed fairly good and constant health care facilities in the Tanzanian camps will place an incalculable pressure on the fragile health structure and limited supply of health workers in Burundi.
- Health status could deteriorate significantly
- Mortality rates could increase from the present 114 per 1000 for infants and 190 per 1000 for under fives
- As this happens, the escalation of AIDS case will exacerbate all these problems.

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(iii) **HIV/AIDS in Burundi:**

(a) **Current Status of the Epidemic**

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Burundi ranks among those countries highly affected by the HIV/AIDS epidemic. At 6%, the country's HIV prevalence is similar to that of Kenya, Uganda and Rwanda. In comparison, Burundi has the same number of adults living with HIV as Rwanda but had more deaths and more orphans in 2003.

Table 1: Comparison of Burundian and Rwandan AIDS Epidemics

	Population	Deaths	Orphans	Adults Living with HIV
Burundi	6.8 million	25,000	200,000	250,000
Rwanda	7.9 million	22,000	160,000	250,000

Source: UNAIDS 2004 report

These latest estimates of 250,000 people living with HIV/AIDS (PLWHA) in Burundi include 130,000 women ages 15-49 and 27,000 children under the age of 15 years. As in many African countries, the Burundian epidemic has taken a terrible toll on women of reproductive age: 52% of people living with HIV in Burundi in 2003 were women ages 15-49. HIV prevalence among pregnant women in Bujumbura in 2003 was 13.6%. Prevalence rates among females 15-24 years of age are reported by UNAIDS to be twice as high as that of males in the same age group.

HIV/AIDS has become the leading cause of adult mortality in Burundi, with AIDS patients occupying over 70% of hospital beds in Bujumbura. In 2003, UNAIDS estimates 25,000 deaths were related to AIDS. The epidemic appears to be spreading rapidly to the rural areas and prevalence in rural and semi-urban surveillance sites is reported to range from 3-17%. HIV infection was highly correlated to sexually transmitted infections (STI), which still occur at alarming rates throughout the country. Nearly 20,000 cases of syphilis and gonorrhea were reported in 2000. These STI rates indicate that there is still a high rate of unprotected sex among the Burundi population.

The conflict has disrupted data collection, surveillance activities and research for the last ten years. It has created large gaps in behavioral data that limit understanding of the factors of the growth of the epidemic. However, according to the Government of Burundi's (GOB) 2000 Knowledge, Attitude, Behavior and Practice (KABP) Survey, 10.6% of the adult population (15-49 years) had non-regular sexual partners in the last 12 months, and men were more likely to have non-regular sexual partners than women (14.4% versus 7.3%).

Some factors contributing to HIV prevalence in other countries such as early sexual debut and high rates of pre-marital sex were less evident in Burundi in the past, but the latest data suggest this may be changing. In 1987, UNAIDS reported that the median age for

Burundian women at sexual debut was 20.4 years of age, but the 1994 Demographic and Health Survey (DHS) reported this age had decreased to 17.6 years. The KABP survey conducted in 2000 also reported that 18.4% of the 15-19 year old age group was sexually active.

(b) Needs in Prevention, Treatment, Care and Support

Burundi has a core of dedicated and qualified health professionals who have been able to establish relatively sophisticated HIV/AIDS programs albeit on an extremely limited basis. There are over 70 voluntary counseling and testing (VCT) sites in the country, the majority of which are run by CARITAS and are integrated with some level of follow up care and support. Prevention of mother to child transmission (PMTCT) interventions are in their infancy with services available only in the Bujumbura, Kayanza, Bururi, Bubanza and Gitega areas. While nearly 80% of pregnant women access prenatal care in antenatal care (ANC) clinics, the high number of home deliveries currently limits access to PMTCT interventions.

The GOB has stated its commitment to provide free antiretroviral (ARV) treatment. In 2002, the GOB established a fund of \$100,000 per year to buy ARV drugs; in 2004, it announced the new policy of free treatment, with a goal of extending the current limited coverage nationally. A local NGO reported in May 2003 that 873 people were on ARVs, 42 of whom were children.²

The delivery of reliable, high-quality services including ARV treatment is hampered by the lack of quality control and standardized guidelines. Some advanced care and treatment is available and is being provided by a variety of organizations. Guidelines for management of HIV disease, including nutrition issues, prophylaxis and treatment of opportunistic infections, diagnosis and treatment of STI, use and monitoring of ARV therapies, and PMTCT need to be agreed upon and put in place. Protocols for clinical care are still under development. Additional factors that restrict the delivery of care and treatment services include weak commodity and drug distribution systems resulting in intermittent stock-outs and weak referral systems and links between health services.

A major limitation on service delivery is the absorptive capacity of the public sector, which has been severely weakened by the years of conflict. Some of the gap in public sector services has been filled by the mission hospitals that provide 40% of the country's health services and by the international and local NGOs that provide most care and treatment services. Several NGOs have started to establish day care for PLWHA. Care and treatment services are provided on a very small scale and most areas of service urgently need strengthening, particularly outside Bujumbura. It is critical to expand comprehensive HIV/AIDS programs to the rural areas where 85-90% of the population lives and where HIV incidence is increasing.

² Reported by Association National de soutien aux Seropositifs et Sideens (ANSS)

There is an urgent need to address issues of care and mitigation, particularly in rural areas, focusing on the growing number of AIDS orphans and affected families. Most communities are not reached with home-based care, and there is a lack of professionals trained in psycho-social support. Although there are outstanding examples of individual programs providing education, food, and livelihood support to orphans, many more children are in need of support. Save the Children-UK has documented the impact of the loss of household members to AIDS, which aside from direct health issues includes the reduction of household income and increased debt.

In contrast, there are several positive indications of Burundi's ability to address the epidemic. There is an increasing uptake of VCT particularly among women, a growing national interest in providing ARV treatment, and an increase in the numbers of solid community-linked programs, strong local NGOs, and well-trained and dedicated health professionals. PLWHA have taken a leading role in advocacy and service provision and the government recognizes the importance of their participation. As the conflict lessens, the potential to increase the reach of HIV/AIDS activities and to involve more communities in the response to the epidemic will grow. However, the increased uptake of VCT and demand for ARV treatment will undoubtedly place greater demand on health services.

(c) Host Country Strategy, Contributions and Actions

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The national fight against HIV/AIDS is led by the Conseil National de Lutte Contre le SIDA (CNLS), attached to the Office of the President, whose mandate is to coordinate multi-sectoral activities, mobilize and manage resources, set policy, and enlist national support to combat the epidemic. The HIV/AIDS Unit of the Ministry of Health (MOH) is responsible for HIV/AIDS care and treatment and for related training, tools and materials. The Ministry of Social Welfare is responsible for the care and support of orphans and vulnerable children. The recently created Ministry of HIV/AIDS is a representative body from all ministries that also reports to the President. The Ministry of HIV/AIDS primarily has a political role in overall coordination of a multi-sectoral approach and in resource mobilization. A National Action Plan for 2002-2006 was developed and is being implemented by the CNLS, the recently created Ministry of HIV/AIDS, the Ministry of Health, and other relevant sectors supported by multi-sectoral committees at the provincial, community, and local levels.

The five-year plan budgeted at \$233 million sets out 16 priority areas for action, covering prevention, care and mitigation. A broad set of technical activities for HIV control are in place and operational. Donor support of this plan is enthusiastic but international funding falls far short of the \$233 million needed. Support includes a \$36 million World Bank loan; a \$6 million DFID grant to Action Aid under the International Partnership against AIDS in Africa (SIPAA); and bilateral support from the French and Belgian Cooperation. The five-year World Bank Multisectoral AIDS Program (MAP) includes \$9 million for orphan support and a program for sub-agreements with the NGO sector; SIPAA supports capacity-building, primarily in the public sector. Burundi will receive \$8.6 million over three years (2003-2006) from the Global Fund against AIDS, Malaria and Tuberculosis

for treatment including ARVs, PMTCT, NGO capacity building, and an external assessment. A follow-up application has been submitted for \$40 million for 2006-2009. Even if the follow-up application is approved for \$40 million, international support of the national plan will still total less than 43% of the \$233 million needed.

There is a strong program framework for implementing the HIV/AIDS strategic plan within the MOH and to a lesser extent in the Ministry of Defense. Key MOH activities include surveillance, blood safety, HIV testing, procurement, management and distribution of commodities, STI and tuberculosis diagnosis and management, and care of HIV positive persons. The GOB has supported ARV therapy since 2002 through a special fund and recently announced a commitment to provide free ARV treatment on a national scale.

The military has been greatly affected by HIV/AIDS, and AIDS is the most common cause of death in military hospitals. With support from UNICEF, the Ministry of Defense established a program to control HIV in the military, providing both HIV prevention activities and treatment for infected personnel. A special fund that receives 1-3% of all troop salaries is used to subsidize the cost of ARVs. However, at present, only 100 soldiers are receiving ARV treatment.

(d) Other International Organization and Local NGO Initiatives

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The UN Theme Group, led by WHO and UNAIDS, includes all UN Representatives, the CNLS, the MOH, Ministry of HIV/AIDS representatives, and several bilateral donors. The Theme Group coordinates donor contributions supporting the national Action Plan and is in charge of implementing the UN joint activities. To date, most agencies have supported prevention activities. UNDP supports PLWHA organizations under the initiative for Enhancing the Greater Involvement for People with AIDS (GIPA). UNESCO has funded a study on knowledge and practices and educational materials for the military; it also has a program with the Ministry of Education to support in-school HIV/AIDS education.

UN agencies are increasing their funding for health services and care and support activities. WHO provides technical guidance to the CNLS and is leading the 3x5 Initiative to increase treatment (overall to provide treatment to 3 million by the end of 2005). With approximately 1,000 people on treatment at present, the 3x5 target is indeed ambitious and will require considerably increased coordination of effort. UNFPA has supported the government in the provision and procurement of family planning commodities, including condoms, to the private sector. UNFPA also supports five health centers targeting youth that provide reproductive health services and HIV/AIDS prevention and treatment. UNICEF has focused on VCT and PMTCT and is funding a PMTCT site in Buyenzi. The World Food Program supports food aid for HIV/AIDS affected persons and families. In 2002, it supplied food to 5,524 HIV-affected persons and 3,937 HIV/AIDS orphans, as well as to 1,587 AIDS patients.

Several international donors support capacity-building for the health system. The European Development Fund has a two-year project, *Projet Septieme Fed*, which works through the *Bureau Provincial du Sante* to strengthen the health system in five provinces. French Cooperation provides laboratory support and equipment and funded a national HIV sero-prevalence study in 2003. Belgian Cooperation supports the WHO Home-Based Care program and the Programme National de Lutte contre Tuberculose. Germany's Cooperation Enterprise for Sustainable Development (Deutsche Gesellschaft für Technische Zusammenarbeit or GTZ), resumed bilateral cooperation with the GOB in 2004, with three projects focusing on HIV/AIDS, reintegration of refugees and the rebuilding of the judicial system.

Leading international NGOs working in Burundi include the Adventist Development and Relief Agency (ADRA), Catholic Relief Services (CRS), the International Committee of the Red Cross (ICRC), Handicappes International, and GVC, an Italian NGO. Handicappes International is funded by the European Union to build the capacity of NGOs through training in project management and the provision of IEC material. CRS is integrating HIV/AIDS into its existing programs in food security as are World Vision and Africare. GVC is supporting counseling services in Bujumbura and Kirundo. DFID funding to Population Services International (PSI)- Burundi supports a peer education project for truck drivers and sex workers in collaboration with the Great Lakes Initiative against AIDS (GLIA).

Burundi has several well-established local NGOs working in the HIV/AIDS area. These programs are impressive in the scope of their activities, which cover the prevention-to-care continuum and include income generation schemes. Some examples include:

- Society for Women Against AIDS-Burundi (SWAA) has a peer education program, VCT, condom distribution, treatment and medical care for people living with HIV, as well as support groups for PLWA and orphans and vulnerable children.
- Association National de soutien aux Seropositifs et Sideens (ANSS) began activities in 1995. Ninety-five percent of its members are women. Services include health education, support groups, family support, condom and drug supply. ANSS has built a new center with the support of the Belgian Cooperation where it provides VCT, a small day clinic, clinical care for opportunistic infections, and a small ARV program.
- CARITAS runs a network of health centers and hospitals and provides VCT and care services in approximately 40 centers.
- Association Burundaise du Bien Etre Familial (ABUBEF) is the Burundian affiliate of IPPF. They have a youth drop in center in Bujumbura with reproductive health and VCT services. They plan to open a youth-focused VCT center in Bujumbura.
- Famille pour Vaincre le SIDA (FVS) works in three areas: care for orphans, support for families caring for AIDS orphans, and HIV prevention education.
- Kamenga Youth Centre, a Catholic-run organization, is reaching approximately 19,000 youths in northern Bujumbura with a program that combines literacy, reconciliation, HIV/AIDS activities, and work with local associations.

(e) Funding Issues

REDSO was able to allocate \$700,000 in HIV funding for Burundi in FY 04. In contrast, Rwanda is receiving approximately \$40,000,000 in HIV funding in FY05. However, as demonstrated by Table 1 on page 3, the AIDS epidemic in Burundi is more pronounced than that of Rwanda. While it is understood that resource levels in Burundi will not reach those of Rwanda, if the epidemic in Burundi continues unchecked, the impact of AIDS on the population and the society is likely to reach devastating levels. The spillover of the epidemic into Rwanda and Tanzania will also threaten USG Emergency Plan investments in those two focus countries. The borders are porous, and the populations move to and from countries in the region for trade, security and due to family ties.

The GOB has shown its commitment to fighting HIV/AIDS. A Ministry has been created to coordinate the response to the HIV/AIDS epidemic and to reduce its impact on all socio-economic sectors. Burundi has a comprehensive HIV/AIDS national plan and has been very open to working with donors and others to improve the national response to the epidemic. Even so, chronic poverty and livelihood erosion have left many people vulnerable to disease, human rights violations, and high-risk occupations. The systematic targeting and exploitation of women and children, including rape, is a violation of rights and creates a daily nightmare for many.

Despite the enormous challenges, the donor community and international organizations agree on the necessity of positioning their programs in a way that provides maximum support to the GOB. The epidemic is continuing to spread, particularly in the rural areas, creating additional stresses on communities already impacted by conflict. The health-care system is poorly equipped and staffed as a result of 10 years of civil war. Donor support is crucial to strengthen the national response to HIV/AIDS in prevention, treatment, care and support. However, as discussed above, current international support is insufficient to meet the enormous needs and geographical coverage. The National Five Year HIV/AIDS Plan is budgeted at \$233 million and well less than half this amount has been pledged to date. USAID's experience over the last three years (2001-2004) has shown that despite the conflict, it has been possible to expand an HIV/AIDS program to reach all provinces. During this critical period, it is vitally important that USAID continues to make HIV/AIDS programming a key component of the Burundi program in order to minimize the disruptive impact of the epidemic on this already fragile society.

(f) Current USAID program coverage

Direct USAID support for HIV/AIDS activities began in FY 2001 with \$500,000 in field support to expand the existing condom social marketing and IEC program. In FY 2002, USAID funds increased to \$1.75 million, \$1 million to continue previous work and \$750,000 to develop a complementary prevention and care strategy. The FY 2003 funding of \$1.75 million and FY2004 funding of \$700,000 will cover activities up to September 2005.

HIV/AIDS activities in Burundi have focused mostly on prevention and to a lesser degree on care and support. Prevention activities have targeted out-of-school and unemployed youth, high risk populations (truckers, sex workers, and the military) and, linked to the social marketing program, refugee and IDP populations. Some programs, for example those aimed at military, truckers and sex workers, have operated only intermittently. There is a need to expand prevention interventions to other groups of high risk youth (e.g. demobilized child soldiers), to expand prevention to the high risk groups in rural areas, and to involve more faith-based organizations in prevention efforts.

The condom social marketing program, through PSI/AIDSMark and jointly funded with DFID, focuses on HIV prevention through condom social marketing and behavior change communication (BCC) programs. The program has expanded from coverage of nine provinces in 2000 to a national program working in all 17 provinces in 2003. The program supports BCC interventions targeted at high-risk groups (sex workers, and IDP populations) and youth, particularly unemployed youth, through peer education and the production and distribution of BCC materials. There has been an increased emphasis on reaching youth in rural areas. The program has also started discussions with the Lutheran and Pentecostal churches on plans to hold a national conference of faith-based organizations. It has also developed partnerships with local NGOs that are trained to provide peer education and to distribute condoms at the community level.

The care program is designed to complement the work in HIV prevention through providing technical assistance and training to the MOH and National AIDS Program; strengthening the delivery of care and support services through selected NGOs; and assisting in the development of a national monitoring and evaluation system. During its first year, the program focused on providing technical assistance at the national level. This included conducting the Behavioral Surveillance Survey (BSS), provision of technical assistance in training in M&E for national staff, and development of a training module for Voluntary Counseling and Testing. The program is now also providing technical assistance in the review of standard of care for HIV/AIDS.

In its second year, the care program began developing sub-agreements with local NGOs involved in direct provision of services, including PMTCT, support for projects with orphans and vulnerable children, and support to ANSS and RNP+ (a PLWA organization) to expand their activities in care. Sporadic insecurity throughout the country has slowed progress in developing programs outside Bujumbura.

2. MISSION STRATEGY

(i) Rationale

The Burundi HIV/AIDS Strategy is an interim three year approach designed as a sub-component of the USG Integrated Strategic Plan for Burundi. The HIV/AIDS strategy is part of the overall ISP focus on supporting Burundi's transition from conflict to peace and from relief to renewed development.

The strategy proposes a three pronged approach: First, to ensure sustainability and service continuation even during periods of insecurity, the strategy will intensify USAID's capacity building efforts with a wider range of private sector partners including faith-based, women's, PLWHA, and youth organizations to provide clinical as well as community/home based programs. Second, to reach a wider audience of high risk groups and create synergies among programs, this strategy proposes a new multi-sectoral focus that integrates HIV/AIDS into the activities of other USAID programs in Burundi. For instance, the HIV/AIDS program will partner with conflict mitigation and relief organizations to address gender related violence issues and the nutrition needs of PLWHA. And finally, to encourage greater ownership and harmonization of interventions, the strategy proposes to build the capacity of the public sector to establish policy, manage data collection and to develop standards and protocols for interventions.

USAID activities will continue to focus on high risk groups: at-risk youth (i.e., demobilized child soldiers and unemployed youth), sex workers, truckers, and refugee and IDP populations, particularly in the rural areas where the majority of the population resides. There will also be an increased focus on the uniformed services.

This HIV/AIDS strategy builds on past USAID programs and current activities. The three year strategy is intended to provide a strong foundation for a much expanded program in the future that – given a favorable political situation – could contribute more directly to strengthening the delivery of HIV/AIDS services on a national scale.

(ii) Critical Assumptions

The new three-year HIV/AIDS strategy is an interim approach designed to contribute to the transition from relief to renewed development. USAID's HIV/AIDS programs have been able to continue and even to expand activities in the past two years despite the intermittent conflict; however, the strategy and the ISP rest on the critical assumption that the transition to a democratic government will take place. The approach presented in this strategy will provide the basis for a scaled-up program. There are several critical assumptions underlying this strategy:

- The schedule of the Arusha Peace Agreement will hold, elections will take place, and the Transitional Government will be succeeded by a democratically elected government.

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- Humanitarian assistance will continue to address the needs of the population as they rebuild the neglected health, education, and agriculture systems and receive returning displaced people, ex-combatants and refugees to their communities.
- Given the critical position of Burundi in the region, USAID funding for HIV/AIDS activities will increase over the strategy period.

(iii) Special Concerns:

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A major concern in developing the strategy is the dynamic change expected to occur in Burundi during the next three years. The transition to peace has already resulted in a rapid increase in the number of returning refugees and IDPs. As discussed above, this movement of population may create conditions that facilitate the spread of HIV as communities absorb returnees.

The issues mentioned below highlight the challenges presented in Burundi:

- Reintegration of ex-combatants into communities. Prevalence in the military, though not published, is believed to be high. The military has begun a program of HIV testing and counseling prior to demobilization, but the reintegration of combatants will still represent a risk of spreading the epidemic.
- The influx of returning refugees and displaced people to rural communities. In April 2004, there were over 30,000 facilitated refugees, with nearly 2,000 spontaneous refugees from January-April 2004.³
- The possibility of massive return of nearly half a million refugees currently in camps in Western Tanzania.
- The weakened health system and other social structures will need to absorb an increased case load.
- Human resource constraints: medical and laboratory personnel are limited.⁴ Donors have emphasized the need for additional training in HIV/AIDS prevention and care.
- The conflict has disrupted HIV surveillance and other data gathering. There is a lack of comprehensive baseline data on HIV prevalence and risk behaviors.
- A high number of orphans and vulnerable children, including demobilized child soldiers, resulting from HIV/AIDS and conflict.
- Low status of women and women's rights. Women already have higher prevalence rates and the above issues will further increase their vulnerability

(iv) Intermediate Result

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The HIV/AIDS program supports Intermediate Result 8.2 of the Interim Strategic Plan, "HIV/AIDS and Infectious Disease Prevention, Care and Support Programs Expanded". To achieve this Intermediate Result, three sub-intermediate results will be addressed:

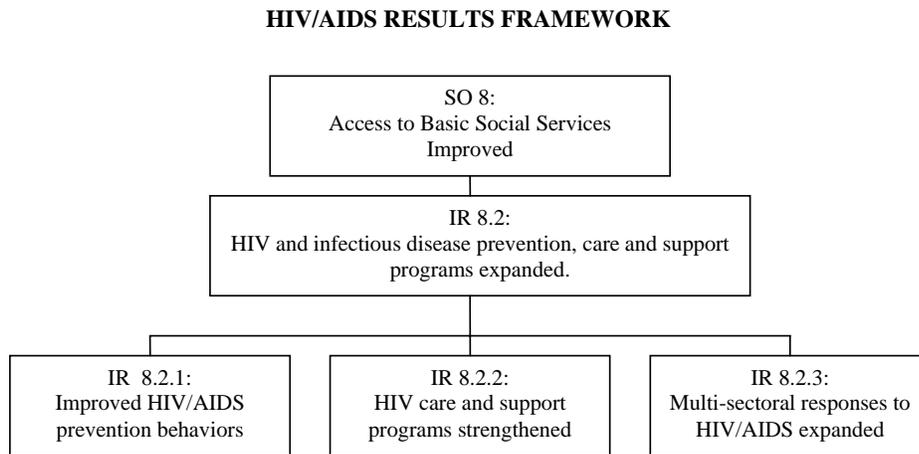
³ OCHA Great Lakes Briefing, May 2004.

⁴ UNDP estimates that in 2002 there was one physician per 100,000 population in Burundi.

- Sub-IR 8.2.1. Improved HIV/AIDS prevention behaviors
- Sub-IR 8.2.2. Strengthened HIV/AIDS care and support programs
- Sub-IR 8.2.3. Expanded multi-sectoral response to HIV/AIDS

The Results Framework is followed by descriptions of the overall purpose and illustrative activities for each of the sub-IRS.

3. HIV/AIDS RESULTS FRAMEWORK



(i) Sub-Intermediate Results and Proposed Activities

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To achieve the sub-Intermediate Result of “HIV and infectious disease prevention, care and support programs expanded”, the HIV/AIDS strategy focuses on strengthening prevention, care and support services and on expanding HIV/AIDS responses in other, particularly non-health, sectors. The strategy will greatly enhance HIV prevention efforts through increased support to the national social marketing program and other critical behavior change interventions targeting the high risk populations that serve as infection “bridges” to the general population. It will expand support to the national response by building capacity in the public and private sectors to deliver care and support services through state of the art technical assistance, strengthening HIV and behavioral surveillance systems, and training of health personnel and community participants. The strategy will also expand the reach of HIV/AIDS interventions through a multi-sectoral approach to reach a wider population.

Security and political conditions may affect program implementation and the number of provincial sites and communities in which activities will be conducted. Nevertheless, even if conditions deteriorate, USAID will continue support of the faith based and other local and

international organizations that carry on activities and services in the provincial areas. As long as these organizations continue working, USAID will continue to support them.

(ii) IR 8.2.1. Improved HIV/AIDS prevention behaviors

The rate of HIV infection can be stemmed if individuals who are most at risk of infecting others or being infected reduce or eliminate risky behavior. This requires them to adopt key attitudes, to acquire a set of skills, and to be given access to appropriate services and interventions. USAID activities under this sub-IR will thus continue to target high risk groups including at-risk youth (i.e., demobilized child soldiers and unemployed youth), sex workers, truckers, and refugee and IDP populations, particularly in the rural areas where the majority of the population resides. There will also be an increased focus on the uniformed services. Messages and interventions related to abstinence, being faithful, and consistent and correct condom use (ABC) will be targeted as appropriate for each audience. Sex workers, for instance, will be targeted with partner reduction and consistent condom use messages and interventions, while youth will be encouraged to abstain or return to abstinence. Prevention programming will also address the creation of new community norms conducive to healthy behaviors. For example, gender inequalities and gender violence breed vulnerability to HIV infections. Thus activities under this sub-IR will address the gender dimension of sexual behavior, including issues related to cross-generational sex, domestic violence, and the issues particular to IDP and refugee women.

Knowledge of one's HIV status is critical to practicing the appropriate preventive behaviors. If negative, a person must continue with or adopt behaviors that will ensure continued negativity (i.e. continue with or adopt abstinence, faithfulness, or condom use as appropriate); if positive, the person must equally adopt behaviors that will protect others from infection or him/herself from re-infection. An important part of the program will thus include support to local NGOs to develop youth-friendly VCT and the social marketing program will be linked with VCT services. For example, both VCT and condom sale sites will be particularly targeted in those areas frequented by the high risk groups and VCT sites will be linked to care and support services for those testing HIV positive.

By the end of the ISP period, depending on funding above the FY 2004 level, HIV/AIDS behavior change interventions including condom distribution will reach a wider number of groups at high risk of infection and a greater number of individuals within these groups. Expanded prevention interventions will also include standardization and quality assurance of VCT services and linkages to post-test care and support programs for HIV/AIDS infected and affected individuals. For instance, HIV positive individuals who are also at high risk for tuberculosis (TB) will be able to access TB testing and treatment as necessary; HIV positive women will be referred as appropriate to reproductive health or antenatal care that includes PMTCT services. During this ISP period, USAID will also work with a wider range of partners, including the churches, conflict mitigation and relief organizations, and women's and youth organizations to change norms and reduce the stigma of HIV/AIDS.

(iii) IR 8.2.2. Strengthened HIV/AIDS care and support programs

The strategy will use two major approaches to strengthen HIV/AIDS clinical services and community and home based care and support programs:

- Increased support to a wider variety of local and international NGOs including faith based, PLWHA and women's organizations to expand access to clinical care and community and home based support services. This will complement HIV/AIDS services in the public sector and will contribute to the achievement of the national goals.
- Provision of state of the art technical assistance and training to support improved quality of services, including linked VCT services, PMTCT, clinical care of STI, and community and home based care of those infected and affected by HIV/AIDS, including OVC and PLWHA.

A major focus of this sub-IR is to promote improved quality of care through creating, harmonizing, and validating documents such as protocols and guidelines that establish standards for HIV/AIDS clinical services and care and support programs. A key intervention in scaling up services will be intensive training to increase the number of qualified service providers and the range of services to support a more comprehensive program. Clinical training will emphasize adoption of universal precautions for safe handling of blood and body fluids. VCT services targeting high risk groups will be increased through clinical and non-clinical settings to ensure broad accessibility and confidentiality. PMTCT will be expanded by USAID and its partners and linked to VCT, treatment services for STI, and psychosocial and legal support programs supported by the various levels of government, USAID and other donors. Given the urgent need for capacity-building within the public sector, it is essential that all programs should look for opportunities to involve MOH and other ministry personnel in training.⁵

USAID will devote special attention to the development of services for orphans and vulnerable families and the provision of home and community-based care and support services for PLWHA. In this, IR 8.2 will support faith-based, women's and other community-based organizations to implement appropriate palliative and home-based care and support programs and train providers at all levels. As much as possible, the project strategy will seek to engage organizations that reach large sectors of the population such as faith-based organizations (e.g. the Catholic dioceses) and civil society groups (e.g. SWAA) in care and support activities. Linkages will also be established with USAID's Health Program to make family planning services available to HIV+ women, and to train CS and FP/RH providers in HIV/AIDS issues.

Activities will include the following:

⁵ Burundi is subject to Section 508 of the FY2004 Foreign Operations, Export Financing, and Related Appropriations Act which limits assistance to any government that came to power in a military coup. There may be some assistance to public health clinics under this activity. However, this activity is covered by the "notwithstanding authority" of Section 522 of the FY 2004 Appropriations Act, which provides that bilateral assistance for child survival or disease programs, including HIV/AIDS, may be provided notwithstanding any provision of law (except the provisions contained in the CSH appropriation and those contained in the HIV/AIDS Authorization Act). This notwithstanding authority is self executing and does not need to be formally invoked. Africa Bureau policy, however, requires that the AA/AFR approve the use of all notwithstanding authority. In accordance with that policy, an Action Memo was submitted to AA/AFR and was approved on March 8, 2004.

- Technical support to VCT and PMTCT services in selected geographical areas
- Support RBP+, a national network of People Living with AIDS, to strengthen the ability of its constituent groups to provide psychosocial support and home-based care services
- Support to the FVS program in Bujumbura and its environs in order to strengthen community approaches to OVC
- Support to ABUBEF and CPAG for youth-friendly VCT services and youth activities.
- Technical support to ANSS to develop improved clinical services in Kirundo, Gitega, and Bujumbura through funding clinic services, a home-based care activity and training for personnel.

(iv) IR 8.2.3. Expanded multi-sectoral response to HIV/AIDS

HIV/AIDS is a health condition but its effects are felt in all sectors as teachers, farmers, rick drivers, military personnel, and others are stricken by the disease, resulting in the loss of skilled personnel that cannot be replaced easily. All sectors must not only realize the scope of the epidemic but also take action to stop the spread of the disease and to help those affected by it. The HIV/AIDS program and its implementing agencies will thus link closely with other USAID sector offices working in Burundi to develop an integrated, multi-sectoral response that responds to the epidemic in a more effective, synergistic manner. While it is important to link with activities in Infectious Disease under IR 8.2 and in Health under IR 8.1: “Access to Basic Social Services Improved, it is equally important to link with the SO 6 for Democracy and Governance and USAID’s Office of Foreign Disaster Assistance (OFDA).

IR 8.2 and SO 6 (Democracy and Governance) are exploring opportunities for collaboration to respond to the expected increase in returning refugees, resettlement of IDP, and demobilization of combatants. Should adequate funds be available, IR 8.2 would expand its geographic coverage to target these populations for HIV/AIDS prevention and control awareness, adoption of prevention behaviors, and improved support services. As one aspect of this activity, radio broadcast communications will incorporate key HIV prevention messages. SO6 has negotiated free air time on two major radio stations that is available for airing HIV/AIDS programs and messages. IR 8.2 will also engage in critical efforts with SO 6 to support the legal rights of HIV/AIDS affected persons and families, including women’s rights.

IR8.2 will also strengthen collaboration with USAID’s OFDA. OFDA’s primary partners - CARE, AFRICARE, CRS, and World Vision - have already started to integrate HIV/AIDS into their programs and have expressed interest in collaborating on condom social marketing, BCC material development, and peer education interventions. There is an opportunity to collaborate with these NGOs to strengthen follow-up care of vulnerable individuals and families with increasing numbers of PLWAs.

This sub-intermediate result will particularly address activities that:

- Integrate HIV/AIDS interventions into existing health programs, such as OFDA’s community support and the nutrition centers, and the Mission’s education and agriculture/food security programs.
- Focus on key technical areas such as impact mitigation and stigma and human rights issues that have already been identified as gaps by programs in other sectors.
- Increase access to populations not served or underserved by extant HIV/AIDS programs e.g. to refugee and IDP populations.

(v) Relationship of Major Planned Interventions to Other Initiatives

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The USAID program in Burundi will contribute to the national plan through its support of PMTCT, VCT and community and home based support for PLWA. For instance, USAID will support the VCT and community support for PLWHA portions of the PMTCT Project financed by the European Development Fund, and will also work with other donors to strengthen technical and programmatic coordination.

If feasible, USAID/REDSO’s HIV/AIDS office will also include Burundi in regional programs, both in meetings related to exchange of information, and in direct implementation of cross-border activities. Burundi is a key member state in the fragile Great Lakes region and therefore it must be included in larger regional efforts to combat HIV/AIDS. The center piece of REDSO’s recently launched SO8 is the Transport Corridor Initiative, an innovative, multisectoral and truly regional program covering the major transport route from East African coast of Kenya through Uganda and into the Great Lakes region and beyond. Burundi must be included in this important HIV/AIDS project.

(vi) Implementation Modalities

The HIV/AIDS prevention and care program will continue to be implemented through field support mechanisms. Joint funding with DfID for the social marketing program will also continue throughout the life of this strategy.

4. RESULTS AND REPORTING

(i) Magnitude and Nature of Expected Results

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The HIV/AIDS program will be implemented as a stand-alone program with cross-cutting results in collaboration with other donors, USAID sectors and NGOs to ensure maximum impact. The result expected at the Intermediate Result 8.2 level is “HIV/AIDS prevention, care and support programs expanded.” This will contribute to the three major objectives of the Government of Burundi’s 2002-2006 National Plan for HIV/AIDS: (1) prevent the transmission of HIV/AIDS, (2) care and support of people living with AIDS and their families, and (3) strengthening institutional capacity and training. During the two year period of the new strategy the program will focus on increasing the scope of prevention measures,

strengthening the quality of care and support services and expanding their reach, expanding HIV/AIDS activities into other non-health sectors, and strengthening monitoring and evaluation, especially behavioral surveillance.

(ii) Performance Indicators and Targets

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The overall indicator of program results at the strategic objective level is “Number of service outlets/programs funded by USAID.”

The indicators for the sub-IRS are as follows:

IR 8.2.1. Improved HIV/AIDS prevention behaviors (data gathered through BSS)

- Number and percentage of young people who correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission
- Number of persons reporting condom use at last sex with non-regular partner

IR 8.2.2. Strengthened HIV/AIDS care and support programs (program data)

- Number of people trained to provide HIV/AIDS care and support services
- Number of facilities providing HIV care and support services

IR 8.2.3. Expanded multi-sectoral response to HIV/AIDS (program data)

- Number of HIV/AIDS interventions implemented in conjunction with other sectors

In addition, program activities and progress will be monitored using selected indicators from the President’s Emergency Plan on AIDS Relief. Data will also be recorded and disaggregated by gender in accordance with the guidelines for the Emergency Plan.

(iii) Contribution to International (UNGASS), Presidential Initiative, and Expanded Response Goals

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The Burundi HIV/AIDS program will contribute directly to the UNGASS goals and the Emergency Plan targets for prevention, care and support. The UNGASS targets that are directly applicable to the Burundi HIV/AIDS program are:

- Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT
- Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
- Percentage of young people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner.

(iv) Planned Surveillance, Surveys and Other M&E Activities

In 2004 USAID funded the first national Behavioral Surveillance Survey and this survey will contribute to the baseline for the HIV/AIDS strategy. It is expected that the BSS will be repeated every two years.

To the extent possible, the HIV/AIDS Program will use surveillance and survey data collected by PNLs, UNFPA, and other partners and donors. However, the Mission has identified several critically needed special studies that will be carried out by its implementing partners. These will include:

- a series of population-based consumer tracking studies
- product delivery system surveys to measure the quality and effectiveness of this system focus groups
- in-depth interviews with each target group to ensure that IEC materials are acceptable and appropriate
- event impact surveys

The performance monitoring plan will need these data as well as program data to monitor the progress of activities under this HIV/AIDS strategy.

5. RESOURCES

(i) Expected Level of Program Funding

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This strategy covers the period FY 2005-2007 and is designed to build upon USAID's substantive investment in prevention programming and to establish its leadership in care and support interventions. The strategy will also serve as the pilot phase for the creation of a model multi-sectoral response to the epidemic. The expected funding level is \$5 million annually. At this level, programs can 1) leverage current investments to reach greater numbers of high risk individuals (e.g. the military, IDP, refugees), 2) develop critically needed new activities and services (e.g. PMTCT, OVC programs), 3) expand program impact by integrating HIV/AIDS into other sectors, and 4) extend critically needed services into the rural areas where 85-90% of the population lives. It is vital that funding reach at least the \$5 million level.

(ii) Program Outputs and Results at High and Lower Resource Levels

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With an additional support of \$1 million, bringing total funding to \$6 million per year, prevention efforts could be intensified and a longer-term approach could be developed to reach youth, including working with parents, educational systems, churches, and community organizations. With this higher funding level, USAID could also provide increased support to Burundi's National ARV treatment strategy, which would be in line with the objectives of the President's Emergency Plan and also more in line with the USG's commitments at the Geneva Donors Meeting in 2002.

Funding at lower levels (e.g. the \$700,000 funded for FY 04) would decimate USAID's HIV/AIDS program in Burundi and this would negatively impact the national program as well as Emergency Plan and other USG funded programs in neighboring countries. The bulk of the USAID activities would abruptly be terminated. For instance, all technical assistance to the GOB, the MOH, and faith based organizations and local NGOs would be immediately eliminated; the behavioral surveillance survey critical to understanding and addressing the behavioral bases of the epidemic would be cancelled; assistance to the country's burgeoning VCT program would be concluded; and donor collaboration on PMTCT would be diminished by USAID's withdrawal from the area. Social marketing activities, which are jointly funded with DFID, would be the only activity that would continue. However, USAID's participation would have to be restricted to Bujumbura with some minimal support in surrounding provinces.

(ii) Management

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Management of the HIV/AIDS program is currently provided through USAID/REDSO's Limited Presence Countries Office (LPC), with technical assistance provided by the REDSO HIV/AIDS Office at the request of LPC. A stronger USAID management presence on the ground is strongly recommended to manage the program, work with GOB officials and coordinate with other donors.

This strategy recommends that a local hire FSN, PSC, or TCN be appointed as technical manager for the Health and HIV/AIDS components of the Burundi program. Qualifications for the position would include an MPH or similar degree in social sciences, 5 years management experience in HIV/AIDS programs, and previous experience working in Africa, preferably in a conflict setting. The new manager will report to the USAID representative based in Bujumbura. This appointment should be made as soon as possible.

The REDSO HIV/AIDS Office will facilitate a Statement of Collaboration among USAID partners that will foster joint programming and implementation of joint program goals, milestones and responsibilities to which all partners would commit.

Security considerations permitting, it is recommended that the LPC office carries out a semi-annual field monitoring visit together with the HIV/AIDS and Health Offices. During this visit, a coordination meeting of all partners working on the USAID program can be held to update partners on each others' programs and maximize opportunities for integrating HIV/AIDS into the different sectors.