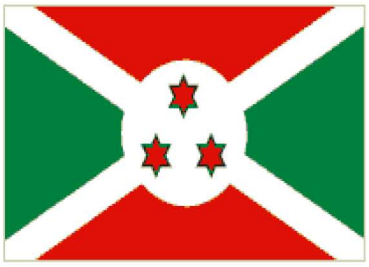
REPUBLIC OF BURUNDI

COUNTRY COORDINATING MECHANISM



EIGHTH CALL FOR PROPOSALS

« PRIDE/BURUNDI »

INTENSIFICATION AND DECENTRALIZATION PROGRAM FOR THE FIGHT AGAINST AIDS IN BURUNDI

Investissons dans notre avenir

Le Fonds mondial

De lutte contre le SIDA, la tuberculose et le paludisme

June 2008

Applicant Name	Burundi CCM		
Country	Burundi		
Income Level *(Refer to list of income levels by economy in Annex 1 to the Round 8 Guidelines)*	Low Income		
Applicant Type	☉ CCM	○ Sub-CCM	○ Non-CCM

Round 8 Proposal Element(s):

	Disease	Title	HSS cross-cutting interventions section *(include in one disease only)*
☑	HIV[1]	« PRIDE/BURUNDI » Intensification and Decentralization Program for the fight against AIDS in Burundi	○
☐	Tuberculosis[1]		○
☐	Malaria		○

Currency	☉	USD	or	○	EURO

Deadline for submission of proposals: **12 noon, Local Geneva Time, Tuesday 1 July 2008**

[4] Please refer back to the definition in s.2 and found in the *Round 8 Guidelines*.

INDEX OF SECTIONS and KEY ATTACHMENTS FOR PROPOSALS

'**+**' = A key attachment to the proposal. These documents **must** be submitted with the completed Proposal Form. Other documents may also be attached by an applicant to support their program strategy (*or strategies if more than one disease is applied for*) and funding requests. Applicants identify these in the 'Checklists' **at the end of** s.2 and s.5.

1. Funding Summary and Contact Details

2. Applicant Summary (including eligibility)

+ Attachment C: Membership details of CCMs or Sub-CCMs

Complete the following sections for each disease included in Round 8:

3. Proposal Summary

4. Program Description

4B. HSS cross-cutting interventions strategy **

5. Funding Request

5B. HSS cross-cutting funding details **

** *Only to be included in one disease in Round 8. Refer to the Round 8 Guidelines for detailed information.*

+ Attachment A: '**Performance Framework**' (Indicators and targets)

+ Attachment B: '**Preliminary List of Pharmaceutical and Health Products**'

+ Detailed Work Plan: Quarterly for years 1 – 2, and annual details for years 3, 4 and 5

+ Detailed Budget: Quarterly for years 1 – 2, and annual details for years 3, 4 and 5

IMPORTANT NOTE:

Applicants are strongly encouraged to read the *Round 8 Guidelines* fully before completing a Round 8 proposal. Applicants should continually refer to these Guidelines as they answer each section in the proposal form. All other Round 8 Documents are available here.

A number of recent Global Fund Board decisions have been reflected in the Round 8 Proposal Form. The *Round 8 Guidelines* explain these decisions in the order they apply to this Proposal Form. Information on these decisions is available at:
http://www.theglobalfund.org/en/files/boardmeeting16/GF-BM16-Decisions.pdf.

Since Round 7, efforts have been made to simplify the structure and remove duplication in the Round 8 Proposal Form. The *Round 8 Guidelines* therefore contain the **majority of instructions** and examples that will assist in the completion of the form.

ROUND 8 – HIV

1. FUNDING SUMMARY AND CONTACT DETAILS

1.1. Funding summary

Disease	Total funds requested over proposal term					
	Year 1	Year 2	Year 3	Year 4	Year 5	Total
HIV	18.572.938	22.742.207	35.981.258	39.626.538	42.182.146	159.105.086
Tuberculosis						
Malaria						
HSS cross-cutting interventions within *[insert name of the one disease which includes s.4B. and s.5B. only if relevant]*						
					Total Round 8 Funding Request ➔:	159.105.086

1.2. Contact details

For the governmental PR

	Primary contact	Secondary contact
Name	NDAYISHIMIYE FRANCOISE	NDUWIMANA JEAN
Title	PERMANENT EXECUTIVE SECRETARY TO THE NATIONAL AIDS COMMITTEE	NATIONAL COORDINATOR, APRODIS PROJECT
Organization	PERMANENT EXECUTIVE SECRETARY TO THE NATIONAL AIDS COMMITTEE	PERMANENT EXECUTIVE SECRETARY TO THE NATIONAL AIDS COMMITTEE
Mailing address	B.P. 836 BUJUMBURA	B.P. 836 BUJUMBURA
Telephone	+257 22 24 53 00	+257 22 24 91 09
Fax	+257 22 24 53 01	+257 22 24 91 13
E-mail address	fndayishimiye@cnlsburundi.org	jnduwimana@cnlsburundi.org
Alternate e-mail address	francnd@yahoo.co.uk	jean.nduwimana@gmail.com

For the civil society PR

	Primary contact	Secondary contact
Name	NTUNGUMBURANYE FELIX	NICAYENZI BENJAMIN
Title	RBP+ LEGAL REPRESENTATIVE	RBP+ NATIONAL COORDINATOR
Organization	BURUNDI NETWORK FOR PEOPLE LIVING WITH HIV/AIDS	BURUNDI NETWORK FOR PEOPLE LIVING WITH HIV/AIDS
Mailing address	B.P. 6881 BUJUMBURA	B.P. 6881 BUJUMBURA
Telephone	+257 22 24 84 93	+257 22 24 84 93/ +257 987 802
Fax	+257 22 24 84 94	+257 22 24 84 94
E-mail address	reseaubdipvvih@yahoo.fr	reseaubdipvvih@yahoo.fr
Alternate e-mail address	majanyafeli@yahoo.fr	nicibenjy@yahoo.fr

1.3. List of Abbreviations and Acronyms used by the Applicant

Acronym/ Abbreviation	Meaning
ABR	Burundi Radio Broadcasters Association (Association Burundaise des Radio diffuseurs)
ABS	Burundi AIDS Alliance (Alliance Burundaise contre le SIDA)
ADRA	Adventist Development Relief Agency
AEB	Burundi Employers' Association (Association des Employeurs du Burundi)
AIDS	Acquired Immune Deficiency Syndrome
ALUMA	Action for the fight against Malaria (Action de Lutte contre la Malaria)
AMM	Marketing authorization (Autorisation de Mise sur le Marché)
ANSS	National Association supporting people living with HIV/AIDS (Association Nationale de soutien aux Séropositifs et malades du SIDA)
APRODIS	Support for the Decentralization and Intensification Program to fight AIDS (Appui au Programme de Décentralisation et d'Intensification de la lutte contre le SIDA)
ARDHO	Burundi association for respect for and rights of homosexuals (Association pour le Respect et les Droits des Homosexuels)
ARV	Antiretroviral
BCC	Behavioural Change Communication
BRARUDI	Burundi breweries and soft drinks manufacturers (Brasseries et Limonaderies du Burundi)
CAFOB	Burundi network of gender-related associations and NGOs (Collectif des Associations et ONG Féminines du Burundi)
CAMEBU	Burundi Central Drug Procurement Unit (Central d'Achats des Médicaments Essentiels du Burundi)
CCM	Country Coordinating Mechanism
CFHDP	Concertation Framework for Health Development Partners
CM	Coordinating Mechanism
CSLP	Strategic framework to fight poverty (Cadre Stratégique de Lutte contre la Pauvreté)
CSO	Civil Society Organisation
DBS	Dried Blood Spot
DFID	Department For International Development
DIPECN	Integrated nutritional care measure (Dispositif Intégré de Prise en Charge Nutritionnelle)
DIU	Inter-university Diploma (Diplôme Inter Universitaire)
FHI	Family Health International
FNUAP	United Nations Population Fund (Fonds des Nations Unies pour la Population)
GF	Global Fund
GFATM	Global Fund to fight Aids, Tuberculosis and Malaria
GLC	Green Light Committee
GLIA	Great Lakes Initiative on AIDS
GTE	UNAIDS Enlarged Thematic Group (Groupe Thématique ONUSIDA Elargi)
GTO	UNAIDS Thematic Group (Groupe Thématique ONUSIDA)
GTZ	German Technical Support Agency (Deutsche Gesellschaft für Technische Zusammenarbeit)
HIPC	Heavily Indebted Poor Countries
HIV	Human Immune Deficiency Virus
HSS	Health System Strengthening
IEC	Information Education Communication
IGA	Income Generating Activities
IHIPC	Initiative to support Heavily Indebted Poor Countries
IMCI	Integrated Management of Childhood Illnesses
IMSO	International Medical Solutions
INSP	National Institute of Public Health (Institut National de Santé Publique)
LFA	Local Fund Agent
M&E	Monitoring and Evaluation
MAP	Multi-sector Approach Program
MDG	Millennium Development Goals

MSF	*Médecins Sans Frontières*
MSM	Men who have Sex with Men
MSP	Ministry of Public Health (Ministère de la Santé Publique)
MSPLS	Ministry of Public Health and AIDS (Ministère de la Santé Publique et de la Lutte contre le Sida)
MTEF	Medium-term expenditure framework
NAC	National AIDS Committee
ND	Not available
NE	*Nouvelle Espérance*
NEPAD	New Partnership for African Development
NGO	Non-Governmental Organization
NRC	National Reference Center
NSP	National Strategic Plan
OCHA	Office for the Coordination of Humanitarian Affairs
ODPIA+	Watchdog organization for the rights of people living with AIDS (Observatoire des Droits des Personnes Infectées ou Affectées par le VIH/SIDA)
OI	Opportunistic infections
OVC	Orphans and Vulnerable Children
PAN	National Action Plan (Plan d'Action National)
PCR	Polymerase Chain Reaction
PEC	Case Management (Prise En Charge)
PEP	Post-Exposure Prophylaxis
PES/NAC	Permanent Executive Secretary of the National AIDS Committee
PITC	Providers initiated Test and Counseling
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
PNDS	National Health Development Program (Plan National de Développement Sanitaire)
PNSR	National reproductive Health Program (Programme National de Santé de la Reproduction)
PO Box	Post Office Box
PR	Principal Recipient
PRIDE	Intensification and decentralization program for the fight against AIDS
PSI	Population Services International
PSM	Procurement and Supply Management
PSNLS	National AIDS Control Strategic Plan
PV	Proceedings, reports, minutes
RBP+	Burundi network for people living with AIDS (Réseau Burundais des Personnes vivant avec le VIH/SIDA)
RCM	Regional Coordinating Mechanism
RH	Reproductive Health
RIBUP	Strengthening the Burundi initiative for the prevention and management of PLWHA (Renforcement de l'Initiative Burundaise dans le domaine de la Prévention et de la Prise en charge des PVVS)
RO	Regional Organization
ROI	By-laws (Réglèment d'Ordre Intérieur)
SDA	Service Delivery Area
SOB	Basic obstetric care (Soins Obstétricaux de Base)
STG	Standard Treatment Guidelines
STI	Sexually transmissible infections
SW	Sex workers
SWAA	Society for Women against Aids in Africa
SWOT	Strength Weakness Opportunities and Threat
TB	Tuberculosis
TRP	Technical Review Panel
UHC	University Hospital Center
UNAIDS	Joint United Nations Program on HIV/AIDS
UNCTAD	United Nations Conference on Trade and Development
UNDP	United Nations Development Program
UNESCO	United Nations Education Science and Culture Organization

UNFPA	United Nations Fund for Population Activities
UNGASS	United Nations General Assembly Special Session on Aids
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States Dollars
USLS	Sector-based unit for the fight against AIDS (Unité Sectorielle de Lutte contre le SIDA)
VMLS	Deputy minister responsible for AIDS control (Vice Ministère chargé de la Lutte contre le Sida)
VCT	Voluntary Counseling and Testing
WB	World Bank
WHO	World Health Organization
WTO	World trade Organization

ROUND 8 – HIV

2. APPLICANT SUMMARY (including eligibility)

CCM applicants: Only complete section 2.1. and 2.2. and DELETE sections 2.3. and 2.4.
Sub-CCM applicants: Complete sections 2.1. and 2.2. and 2.3. and DELETE section 2.4.
Non-CCM applicants: Only complete section 2.4. and DELETE sections 2.1. and 2.2. and 2.3.

IMPORTANT NOTE:
Different from Round 7, 'income level' eligibility is now set out in s.4.5.1 (focus on poor and key affected populations depending on income level), and in s.5.1. (cost sharing).

2.1. Members and operations

2.1.1. Membership summary

Clarified Table 2.1.1.

	Sector Representation	Number of members
☑	Academic/educational sector	1
☑	Government	12
☑	Non-government organizations (NGOs)/community-based organizations	8
☑	People living with the diseases	1
☑	People representing key affected populations[2]	2
☑	Private sector	1
☑	Faith-based organizations	3
☑	Multilateral and bilateral development partners in country	5
	Other *(please specify):*	0
	Total Number of Members: *(Number must equal number of members in 'Attachment C'[3])*	33

2.1.2. Broad and inclusive membership

Since the last time you applied to the Global Fund (and were determined compliant with the minimum requirements):

(a) Have non-government sector members (*including any new members since the last application*) continued to be transparently selected by their own sector; and ☐ No ☒ Yes

(b) Is there continuing active membership of people living with and/or affected by the diseases. ☐ No ☒ Yes

2.1.3. Member knowledge and experience in cross-cutting issues

Clarified Section 2.1.3.

Health Systems Strengthening

The Global Fund recognizes that weaknesses in the health system can constrain efforts to respond to the three diseases. We therefore encourage members to involve people (from both the government and non-government) who have a focus on the health system in the work of the CCM or Sub-CCM.

(a) Describe the capacity and experience of the CCM (or Sub-CCM) to consider how health system issues impact programs and outcomes for the three diseases.

The structure of the Burundi CCM is made up of 3 bodies, namely the general meeting, the executive committee and the executive secretariat. It is chaired by the Minister of Public Health and AIDS, with the assistance of two vice-chairmen from the non-governmental sector, namely the legal representative of RBP+ (Burundi network for People Living with HIV/AIDS) and the representative of the World Health Organization (WHO) in Burundi on behalf of the multilateral development partners.

The Burundi CCM is a multidisciplinary team of 33, with **12** members representing the governmental sector and **21** the non-governmental sector, that is to say, a representation of 36% and 64% respectively.

Among the Burundi CCM members from the governmental sector are, in particular, the Executive Secretary of the National AIDS Committee and technical officers from the other two Global Fund National Disease Control Programs (tuberculosis and malaria), along with 7 other people representing key ministries, **one representative from the National Assembly and one from the Senate.** This representation creates a synergy among the programs and the necessary links between the CCM and other coordinating mechanisms. Furthermore, such organization of the CCM also provided the opportunity to consider and discuss the impact of health system problems on the implementation of the three disease programs financed by the GFATM. Several examples speak for themselves, such as the reference and counter-reference system, the drugs procurement system and the weakness of human resources.

Among the **21** Burundi CCM members from the non-governmental sector, there is a representative from PLWHAs, a representative from an NGO called « Action against Malaria », 3 representatives from the major faith-based organizations in the country, namely the Conference of Catholic Bishops of Burundi, the National Council of Churches of Burundi, and the Islamic Community of Burundi, 5 representatives from the multilateral and bilateral development partners, one representative from the university/education sector, one representative from the private sector and 8 representatives from non-governmental and community-based groups.

Regarding its capability to evaluate the impact of health system problems on programs and outcomes for the three diseases and its experience in the matter, the Burundi CCM is a multidisciplinary team comprising the managers of the national programs to control the three diseases (HIV/AIDS, tuberculosis and malaria) and people with expertise in public health, community health and community health system strengthening.

One third of the members of the Burundi CCM are public health executives involved in running health programs. They manage the daily challenges facing the health system as it deals with the three diseases.

Due to the post-conflict situation in Burundi, most members of the Burundi CCM are engaged in the reconstruction and strengthening of the health system. In recent years, they have developed their capabilities in various aspects of health system strengthening, including human resources management, lobbying for funding for the sector and the health information system.

The fact that civil society organizations with experience in community-based approaches form part of the CCM will ensure the transition from an emergency response approach to a community-based response by strengthening the capability of families, communities and systems, enabling the most vulnerable OVCs and PLWHAs to access a basic minimum health care package.

In addition and when required, the Burundi CCM uses the services of other experts, both nationals and expatriates, who are not members of the CCM.

Thus, in drawing up this proposal and to better understand the impact of health system problems on programs and outcomes for the three diseases, the Burundi CCM used not only staff in the Ministry of Public Health and AIDS, but also tapped into the range of technical support provided by the various development partners and local organizations and institutions. For example, the working group of the national proposal writing committee looking at health system strengthening was supported by an expert made available to the Burundi CCM by the WHO.

Gender awareness

The Global Fund recognizes that inequality between males and females, and the situation of sexual minorities are important drivers of epidemics, and that experience in programming requires knowledge and skills in:

- methodologies to assess gender differentials in disease burdens and their consequences (including differences between men and women, boys and girls), and in access to and the utilization of prevention, treatment, care and support programs; and
- the factors that make women and girls and sexual minorities vulnerable.

(b) Describe the capacity and experience of the CCM (or Sub-CCM) in gender issues including the number of members with requisite knowledge and skills.

Serving on the Burundi CCM are people who, on account of their roles, operate at the very core of gender-related issues. They are: the resident UNFPA representative, a member of the CCM in her capacity as chairperson of the UNAIDS Thematic Group (GTO), the representative of the Society for Women against AIDS in Africa (SWAA), the representative of the Burundi network of gender-related associations and NGOs (CAFOB), the representative of the Burundi AIDS Alliance (ABS) which defends sexual minorities among others, the representative of the National Association supporting People living with HIV/AIDS (ANSS) which operates especially in the field of the management of MSM, and the representative of the Ministry of National Solidarity, Human Rights and Gender who is charged in particular with gender-related matters in the context of controlling pandemics and gender-related inequalities.

On the other hand, in drawing up this proposal, we have included a representative of a group (currently being set up) comprising people from sexual minorities, and we have benefited from their support as to the specific needs of this group. This person is the representative of ARDHO, the Burundi association for the respect for and rights of homosexuals. The Burundi CCM is also in the process of including a representative from the MSM association.

In addition to the people mentioned above, other members of the CCM are very active in the field of gender-related matters, HIV and development. Every day, they follow the various debates across the world on gender-related matters, and ensure the implementation of recommendations aimed at integrating all dimensions of gender in the fight against HIV/AIDS.

The contribution of CCM members also fits in with the promotion of education for girls, the promotion of presidential measures for free primary school education, free health care for children under 5 and assistance for mothers at childbirth.

Lastly, this proposal aims to strengthen the capabilities of CCM members and non-members in the integration of gender-related issues in the development, implementation, monitoring and evaluation of health programs.

Multi-sectoral planning

The Global Fund recognizes that multi-sectoral planning is important to expanding country capacity to respond to the three diseases.

(c) Describe the capacity and experience of the CCM (or Sub-CCM) in multi-sectoral program design.

Since 2002, a multi-sector institutional framework has been set up to combat AIDS. This facilitates a better understanding of multi-sector and participative planning.

Thus during the planning stage, all government sectors, civil society and the private sector work together to do the job. Planning also takes account of the various elements of national life, in particular, health, education, youth and the social sector.

The Burundi CCM is made up of people who have sound capabilities and experience in developing multi-sector projects.

Most of the members of the Burundi CCM took part in drawing up the 2002-2006 National Action Plan to control AIDS and the 2007-2011 National Strategic Plan to control AIDS. This experience has given them a very broad understanding of the process of multi-sector planning.

Apart from skills in public health matters, the CCM has various members with excellent knowledge and experience in strategic project management and cross-cutting issues such as gender, HIV/AIDS and the fight against poverty.

The other not inconsiderable guarantee in terms of multi-sector project development is the already existing broad partnership.

The composition of the Burundi CCM is thus inclusive in character, comprising representatives from the non-governmental

sector (civil society, private sector, faith-based organizations, people infected with/affected by diseases, multilateral and bilateral development partners and the university/education sector), representing 64% of the membership, and representatives from the governmental sector (Ministry of Public Health and AIDS, Ministry of National Solidarity, Human Rights and Gender, Ministry of Finance and Development Cooperation and Parliament), representing 36% of the membership. This multifaceted partnership ensures a multidimensional vision and constitutes the guarantee of effective multi-sector planning.

In addition, when drawing up this proposal, we consulted beyond the members of the CCM to gather contributions from the various sectors of national life that intervene in the fight against the three diseases, in particular the Ministries of National Education, Youth, and Gender, Human Rights , Women's Matters and National Solidarity. This approach has enabled us to accomplish better multi-sector planning which will, in turn, enable multi-sector and decentralized implementation.

2.2. Eligibility

2.2.1. Application history

'Check' one box in the table below and then follow the further instructions for that box in the right hand column.

☉	Applied for funding in Round 6 and/or Round 7 **and** was determined as having met the minimum eligibility requirements.	➔ ***Complete all of sections 2.2.2 to 2.2.8 below.***
○	Last time applied for funding was before Round 6 **or** was determined non-compliant with the minimum eligibility requirements when last applied.	➔ ***First, go to 'Attachment D' to and complete.*** *(Do not complete sections 2.2.2 to 2.2.4)* ➔ ***Then also complete sections 2.2.5 to 2.2.8 below.***

2.2.2. Transparent proposal development processes

➔ *Refer to the document 'Clarifications on CCM Minimum Requirements' when completing these questions.*

➔ *Documents supporting the information provided below must be submitted with the proposal as clearly named and numbered annexes. Refer to the 'Checklist' after s.2.*

Clarified Section 2.2.2(a): additional supporting documents provided.

(a) Describe the process(es) used to invite submissions for possible integration into the proposal from a broad range of stakeholders including civil society and the private sector, and at the national, sub-national and community levels. *(If a different process was used for each disease, explain each process.)*

As a first step, the Burundi CCM issued two communiques through the media (national radio and the « Renouveau » newspaper), inviting all public, private and community organizations/institutions involved in the fight against AIDS to prepare their contributions for scrutiny and integration into the national proposal for the AIDS component of the Global Fund Round 8 fight against AIDS, tuberculosis and malaria.

These communiques, dated 3rd and 14th of March 2008 respectively, gave a deadline of one month for the organizations/institutions concerned to complete the preparation and submission of their contributions to the Burundi CCM, and indicated that the following documents were at their disposal at the Executive Secretariat of the Burundi CCM: key elements of the proposal for Round 8, the broad outlines of the 2007-2011 National Strategic Plan for the fight against AIDS and the framework to follow for preparing their submissions.

Despite the fact that the Burundi CCM had given a deadline of one month which expired at 12.00 on 4 April 2008, it continued to receive submissions from organizations/institutions until 8 May 2008 in order to maximise the opportunity for candidates wishing to submit a proposal.

In parallel with this process of inviting submissions, the CCM appointed the enlarged national 8th round development team made up of a panel of national players from all parties involved in the fight against AIDS in Burundi. Their first task was to examine the

observations of the TRP on submissions made in Round 7, along with a rigorous analysis of programmatic and financial gaps.

From this second stage, five (5) working groups were set up in the following 5 thematic areas: 1) AIDS prevention, 2) Reproductive Health and Prevention of mother-to-child transmission (RH/PMTCT), 3) PLWHA case management (Case Mgmt of PLWHA), 4) case management of orphans and vulnerable children (Case Mgmt of OVC), 5) Health System Strengthening / Community system Strengthening (HSS/RSC).

The sub-proposals submitted to the Burundi CCM following the invitation for submissions were distributed among the 5 groups mentioned above according to the subject-matter of each sub-proposal. The innovations contained in these sub-proposals were incorporated into the national proposal and the originators of such proposals were retained as Sub-Recipients.

The strengthening of health and community systems was examined in accordance with the integrated disease approach, and all prevention, case management and support programs were considered from a cross-cutting point of view.

This is one of the approaches that will allow us to achieve our decentralisation, social equity and scaling up objectives indicated in the Strategic Plan to fight AIDS and the national health development plan.

The Burundi CCM carried out an exhaustive consultation process among all its members, as well as the representatives of the main public sector, community, bilateral and multilateral partner organizations, to gather their views on the contents of this proposal. The multi-sector and decentralised coverage was the priority that will ensure equity between urban and rural areas.

(b) Describe the process(es) used to transparently review the submissions received for possible integration into this proposal. *(If a different process was used for each disease, explain each process.)*

From 3 to 8 May 2008, the Burundi CCM received 8 sub-proposals from players on the ground, and in particular non-members of the CCM. These sub-proposals were analysed by the CCM Executive Secretariat and then sent to the various working groups to be incorporated into the national proposal.

The CCM Executive Secretariat sent correspondence and information on the outcome of these contributions by recorded delivery to the originators.

In-depth examination and integration of the proposals was carried out in the 5 thematic groups mentioned above, and the originators were added to the national proposal list of Sub-Recipients.

From 12 to 17 May, the proposal writing team completed the logical framework on the lines of the suggested format, comprising the aims, objectives, SDAs and the activities into which the various contributions were incorporated. It follows therefrom that this proposal is a mouthpiece for the players on the ground and its implementation will be their responsibility.

The work of the proposal writing committee involved harmonising the needs of the various players and beneficiaries and the priorities in relation to the National Strategic Plan to fight HIV/AIDS, the National health Development Plan and the National Reproductive Health Plan.

(c) Describe the process(es) used to ensure the input of people and stakeholders other than CCM (or Sub-CCM) members in the proposal development process. *(If a different process was used for each disease, explain each process.)*

The process for drawing up this proposal started with the Burundi CCM's decision taken at its meeting on 12 February 2008 to prepare an HIV component proposal for submission to Round 8.

Following this decision, the chairman of the Burundi CCM appointed an enlarged national proposal writing team on 21 February 2008. This team comprises over 100 people from the following sectors : CCM, Ministry of Public Health and AIDS, National solidarity USLS, Education USLS, Youth USLS, Work and Civil Service USLS, Agriculture USLS, INSS, PES/NAC (at both central and decentralised level), AIDS National Reference Centre, networks and associations, development partners, international NGOs, religious organizations and the private sector.

The members of the proposal writing team were chosen on the basis of their experience, their commitment to contribute and the multi-sector approach that characterises national interventions to combat AIDS in Burundi.

At the same time, the chairman of the Burundi CCM appointed the committee responsible for examining the TRP's comments on Round 7, the select proposal writing committee, the national proof-reading committee and the committee responsible for coordinating the the process for formulating the proposal.

The enlarged national team was increased as and when required and was used for brain-storming sessions. The select committee was divided into the following sub-groups: prevention, case management, RH/PMTCT, OVC and HSS/RSC. A smaller team of 16 people was selected from within the select committee to write the various parts of the proposal form. It should be

noted that 12 members of the proposal writing committee took part in workshops held in Cotonou and Brighton on guidelines regarding the preparation of Round 8.

At its meeting of 14 April 2008, the Burundi CCM decided that the proposal to Round 8 would be carried out by two Principal Recipients, one from the governmental sector and the other from the non-governmental.

On 13 May 2008, the national proposal writing team shared the proposal elements with the CCM. After discussion and examination, the members of the CCM approved the contents, reserving the right to look at it again when the detailed document was ready.

The proposal writing procedure may be summarised as follows :

Stage 1 : On 12 February 2008, **the CCM decided to submit an HIV proposal** to Round 8.

Stage 2: On 21 February 2008, the chairman of the CCM appointed **a national proposal writing team,** a coordinating team, a national proof-reading team and requested technical assistance from the various partners.

Stage 3: On 3 March 2008 a **request for contributions to the proposal** was made through the media and this request was repeated on the radio and in the press on 13 March 2008. The closing date for submission of sub-proposals was 8 May 2008 to allow for examination of the new initiatives and their incorporation into the national proposal.

Stage 4: On 15 March and 14 April, 2008, two **meetings were held to consider the Round 7 TRP's comments.** Discussion concluded with the decision to take account of these comments when writing the proposal for Round 8. The relevant chapter clarifies the concrete actions taken in this respect.

Stage 5: On 17 March 2008, a meeting took place to discuss the **incorporation of Reproductive Health (RH) and Health and community systems strengthening (HSS/RSC)** into the Round 8 proposal. Two people from the Friends of the Global Fund Africa were also present.

Stage 6: Two teams of 12 people went to either Cotonou or Brighton for a briefing on Round 8. A reporting back session on the workshops held in Cotonou and Brighton was held on 14 April 2008. This session was for CCM members and the enlarged national proposal writing team.

Stage 7: It was in the course of this 14 April 2008 meeting that the Burundi CCM decided to write a proposal with twin channel funding. It was suggested that civil society organizations should meet and decide on a PR candidate to be presented at the next CCM meeting.

At the end of the reporting back session, the select proposal writing team met to agree on the methodology for drawing up the proposal. 5 working groups were formed, supported by players on the ground. These working groups are as follows: *1) AIDS prevention, 2)RH/PMTCT), 3)PLWHA case management, 4) OVC case management, 5) Health System Strengthening / Community system Strengthening (HSS/RSC).*

Stage 8: Proposal writing proper began on 15 April 2008. From 15 to 28 April 2008, the various working groups carried out a gap analysis exercise and drew up the constituent elements of the logical framework for each group. On 29 April 2008, they reported back to the enlarged committee and additional elements were put forward for integration into the proposal. On 30 April 2008, a meeting was held to allocate the various sections of the proposal form and proposal writing was started for parts 1 and 2. From 5 to 8 May 2008, a logical framework validation workshop was held with the select proposal writing committee. The outcome of this workshop was the identification of the key elements of the proposal which were validated by the CCM on 13 May 2008.

Stage 9: Selection of the PRs. In parallel with the proposal writing, the CCM set up a procedure for selecting the PRs, resulting in the selection of two PRs, one governmental and one non-governmental, on 19 May 2008.

Stage 10: The final version of the proposal was presented to the CCM on 30 June 2008. The CCM examined the document and made some observations on form and substance to the select proposal writing committee which in turn incorporated them into the proposal. The Burindi CCM then approved the proposal.

The development partners who provided technical and financial support during the drafting process are in alphabetical order, International AIDS Alliance, CORDAID, CRS, World Bank, ESTHER Friends of the Global Fund Africa, FHI, GTZ,Health Net TPO, WHO, UNAIDS, UNICEF, UNFPA, USAID, PSI.

(d) **Attach** a signed and dated version of the minutes of the meeting(s) at which the members decided on the elements to be included in the proposal for all diseases applied for.	***Annex 10***

2.2.3. Processes to oversee program implementation

(a) Describe the process(es) used by the CCM (or Sub-CCM) to oversee program implementation.
The supervision and implementation of the activities and projects funded by the GFATM will be carried out in compliance with the new Round 8 GFATM guidelines and the Burundi CCM by-laws. Because the members of the Burundi CCM were party to this Round 8 proposal, which is the outcome of an examination of national priorities and the achievements of previous Rounds, the members are in a position to follow the actions, using a time chart provided for them by those managing the program and the PRs. Furthermore, the CCM action plan for 2008, adopted at the CCM meeting of 17 March 2008, provided for supervision of program implementation on the ground, with supervision reports being routinely provided to the supervision task forces. Through its Executive Committee, the Burundi CCM will set up thematic sub-committees, made up of members of the CCM and experts, whose job will primarily be to design and implement a plan for supervising the implementation of the Global Fund grant. In addition, the CCM will also have the possibility of calling on national and international technical expertise depending on the importance of the matters involved. Among other tasks, the CCM Executive committee will also have to prepare a detailed program of the supervision arrangements as well as the terms of reference to guarantee the expected results.
(b) Describe the process(es) used to ensure the input of stakeholders other than CCM (or Sub-CCM) members in the ongoing oversight of program implementation.
Over and above the reports that will be sent to the partners on a quarterly basis, joint and multidisciplinary supervisory reports, Ministry of Health and AIDS supervisory reports, supervisory reports from the Deputy Minister responsible for the fight against AIDS and from other organizations with a remit in the field being supervisied, will be organised on a regular basis. Members who are not part of the CCM will be able to participate in the process of monitoring the use of grants, and they will also be able to participate in the open reporting back meetings on the outcomes of the supervision. Civil society organizations that do or do not form part of the CCM and which are decentralised to communite level will also play a supervisory role in the implementation of the grant.

2.2.4. Processes to select Principal Recipients

The Global Fund recommends that applicants select both government and non-government sector Principal Recipients to manage program implementation. ➔ *Refer to the Round 8 Guidelines for further explanation of the principles.* .

Clarified Section 2.2.4(a): additional information on PR selection provided.

(a) Describe the process used to make a transparent and documented selection of each of the Principal Recipient(s) nominated in this proposal. *(If a different process was used for each disease, explain each process.)*
On 14 April 2008, the CCM decided to submit an HIV element proposal with two Principal Recipients. At the same meeting, the CCM asked civil society organizations to meet and choose a single beneficiary on the basis of the evaluation criteria indicated under heading 4.8 of the proposal guidelines. At its meeting on 13 May 2008, the CCM did not have in mind only one candidate, but rather two, from among civil society organizations, one proposed as a group candidate and the other as an independent. Therefore the selection of Principal Recipients was postponed until the meeting on 19 May 2008. Regarding civil society, the CCM set up an independent committee of 6 people, including 3 members of the CCM and 3 non members, to consider the applicants with the aim of pre-selecting one of the two candidates who best filled the relevant criteria. The Burundi CCM appointed the 2 Principal recipients for the Round 8 HIV proposal at its meeting on 19 May 2008. Before beginning deliberations on this matter, the chairman of the meeting was careful to ask members of the organizations who had put forward candidates to leave the room to avoid situations of conflict of interest. The candidate organizations were the

Burundi AIDS Alliance (ABS) and the Burundi network for Persons Living with HIV/AIDS (RBP+) for Principal recipient from the non governmental sector, and the Permanent Executive Secretariat of the National AIDS Council for the Principal Recipient from the governmental sector.

Selection of the non governmental PR

The CCM began with the selection of the non governmental PR. The chairman of the non governmental PR selection committee appointed by the CCM at its meeting of 13 May 2008 presented the report of the work of the said committee.

He reported that the committee scrutinized the self-evaluation documents of the two candidates in terms of the minimum capability criteria required by the Global Fund to exercise the role of Principal Recipient.

The report reviewed the Global Fund criteria for exercising the role of PR and the self-evaluations provided by each candidate in the light of each criterion, along with the analytical appraisal of the committee as to which candidate best met the criteria.

After consideration of all the criteria, the lobbying of the candidates and the appraisal of the committee in terms of each criterion, the committee concluded that the RBP+ best met the minimum capability criteria for the functions of Principal Recipient as defined by the Global Fund.

Concerning the weighting allocated to the various criteria, the committee explained that the capability for financial management was the most important when considering minimum criteria for Principal recipients.

As for having recourse to additional criteria to appraise the capabilities of candidates, the committee used the criteria defined by the Global Fund because there is no doubt as to their objectivity, and these are the criteria recognized by the Global Fund in such matters.

As to checking the information provided by the candidates in their documents, the committee decided that this would be carried out during the Local Fund Agent's (LFA) evaluation of the PR.

In the matter of which of the two candidate organizations is more representative of civil society, the committee explained that its mandate was limited to examining the capabilities of the two applicants in respect of the minimum capabilities required by the Global Fund for exercising the role of PR.

Lastly, regarding the problem of conflict of interest that arises from being both a Principal recipient and a Sub-Recipient, the committee noted that the two candidates were Sub-Recipients in the previous proposal and that, once chosen for the actual Round, it would then be up to them to relinquish one or other of their roles in order to avoid a conflict of interest in round 8.

At the conclusion of these discussions, the CCM agreed to appoint the RBP+ as the non governmental Principal Recipient for the HIV proposal to be submitted to the Global Fund Round 8.

It should be noted that in his capacity as observer on behalf of the Ministry of Public Health and AIDS (Chairman of the CCM), the Minister's principal secretary did not contribute to the CCM's discussions and decisions.

Selection of the governmental PR

After selecting the non governmental PR, the CCM proceeded to select the governmental PR.

By way of introduction to this matter, the Chairman of the meeting informed the audience that the CCM had received only one candidate for the role of governmental PR for the HIV proposal for the Global Fund Round 8, namely that of the Permanent Executive Secretariat of the National AIDS Council (PES/NAC). He then opened the meeting to the members of the CCM to express their evaluation of the candidate.

The CCM had no difficulty in reaching a consensus on this candidate given the proven capabilities of the applicant for the role of PR, since it currently held this role for the Round 5 HIV proposal, the Round 2 malaria proposal and the 1st 2007 RCC for malaria.

The applicant provided additional information on the process to select PRs. According to the applicant, a number of non-government sector consultative meetings were held in view of selecting PR leading up to a non-government sector vote on 05May. The applicant provided the minutes of the various meetings as supporting documentation.

15 NGOs were present during the vote and there were 2 candidates (ABS and RBP+, both CCM members). The participants first voted to present only one PR candidate to the CCM. They then proceeded to elect one of 2 candidates. ABS was elected by 11 votes to 1 but the whole process was contested by RBP+. The letter of protest submitted by RBP+ was submitted by the applicant as a supporting document.

Given lack of consensus within the CSO sector, a proposition was raised and approved during the CCM's 13May08 meeting to create a technical commission in order to decide

between ABS and RBP+ by applying the Global Fund's minimum criteria for PRs. Criteria used include: financial system, institutional and programmatic system, procurement and stock management, M&E system.

The technical commission found that RBP+ fills the Global Fund requirements better than ABS. The technical commission presented its report to the CCM on 19May08 for a final vote. Before the CCM voted, PR candidates left the room as per CoI policy. After deliberations, consensus was reached by CCM which ultimately agreed with technical commission's findings. RBP+ was named non-government PR.

As for the government PR, the applicant stated that SEP/CNLS was the only candidate and that given its track record in handling previous GF grants, the CCM easily reached consensus to elect it as the government PR for Round 8.

(b) **Attach** the signed and dated minutes of the meeting(s) at which the members decided on the Principal Recipient(s) for each disease. ***Annex 11***

2.2.5. Principal Recipient(s)

Clarified Table 2.2.5.

Name	Disease	Sector**
Permanent Executive Secretariat of the National AIDS Council (PES/NAC)	HIV	Government
Burundi Network for Persons living with HIV/AIDS (RBP+)	HIV	**PLWD**

[use "Tab" key to add extra rows if needed]

*** Choose a 'sector' from the possible options that are included in this Proposal Form at s.2.1.1.*

2.2.6. Non-implementation of dual track financing

Provide an explanation below if at least one government sector and one non-government sector Principal Recipient have not been nominated for each disease in this proposal.

Not applicable to Burundi

2.2.7. Managing conflicts of interest

(a) Are the Chair **and/or** Vice-Chair of the CCM (or Sub-CCM) from the same entity as any of the nominated Principal Recipient(s) for any of the diseases in this proposal?

☉ Yes ***provide details below***

☐ No
➔*go to s.2.2.8.*

(b) **If yes, attach** the plan for the management of actual and potential conflicts of interest.

☑ **Yes** ***ANNEX 2***

Since 14 December 2007, the Burundi CCM office has been managed by the Minister of Public Health and AIDS assisted by two vice-chairmen from the non governmental sector, the legal representative of the Burundi Network for People Living with

HIV/AIDS (RBP+), and the representative of the World Health Organization (WHO) in Burundi on behalf of the multilateral development partners.

Burundi is unique in that it involved representatives of PLWHAs at a very early stage, and it was in this spirit and as part of this process that the first vice-chairman of the Burundi CCM was the RBP+ representative.

The Principal recipients appointed by the Burundi CCM for this proposal are the PES/NAC and the RBP+ for the governmental and non governmental sectors respectively.

The plan to manage current and potential conflicts of interest was subject to articles 40 to 44 of the Burindi CCM by-laws.

By way of summary, the plan to manage conflicts of interest is based on the following rules:

1. Each CCM meeting will have an agenda drawn up in advance to enable any member concerned about a conflict of interest situation to explain the nature of the potential conflict of interest.
2. Tis explanation must be made during the 7 calendar days from the date of invitation to the meeting, and the member concerned must be careful to distance himself from all deliberations (including the vote). He may be asked to leave the room during deliberations on the conflict of interest.
3. The items in the non-exhaustive list below will be subject to particular scrutiny by the CCM in respect of potential conflict of interest:
   - ❖ Discussions relating to the selection of the Principal Recipient;
   - ❖ Renewal of phase 2 of a subsidy currently in place;
   - ❖ Substantial re-programming of subsidy funds;
   - ❖ Questions relating to the monitoring and control of the Principal recipient;
   - ❖ Questions having a financial impact on the Principal Recipient, such as contracts with other entities including Sub-Recipients.
4. Any CCM member may raise a possible question of conflict of interest before or during the CCM meeting or may submit it anonymously to the CCM Executive Secretariat if he so wishes, having in mind a concern not to stand in the way of the carrying out of activities and to ensure the harmonious functioning of the CCM.
5. CCM members not involved in the conflict of interest will have to decide by simple majority on the participation in all or part of the meeting of the members affected by the conflict of interest.
6. If the CCM Chairman is involved in a conflict of interest, one of the vice-chairmen must assume the chair for the period and assume all the responsibilities of the chairmanship of the CCM.

2.2.8. Proposal endorsement by members

Clarified Section 2.2.8: missing signatures and explanations provided.

Attachment C – Membership information and Signatures	**Has 'Attachment C'** been completed with the signatures of all members of the CCM (or Sub-CCM)?	☑ Yes

ROUND 8 – HIV

3. PROPOSAL SUMMARY

3.1. Duration of Proposal

	Planned Start Date	To
Month and year: *(up to 5 years)*	January 2009	December 2013

3.2. Consolidation of grants

(a) Does the CCM (or Sub-CCM) wish to consolidate any existing HIV Global Fund grant(s) with the Round 8 HIV proposal?

☐ Yes *(go first to (b) below)*

☒ No *(go to s.3.3. below)*

'Consolidation' *refers to the situation where multiple grants can be combined to form one grant. Under Global Fund policy, this is possible if the same Principal Recipient ('PR') is already managing at least one grant for the same disease. A proposal with more than one nominated PR may seek to consolidate part of the Round 8 proposal.*

➔ *More detailed information on grant consolidation (including analysis of some of the benefits and areas to consider is available at: http://www.theglobalfund.org/documents/rounds/8/R8GC_Factsheet_en.pdf*

(b) If yes, which grants are planned to be consolidated with the Round 8 proposal after Board approval?
(List the relevant grant number(s))

3.3. Alignment of planning and fiscal cycles

Describe how the start date:

(a) contributes to alignment with the national planning, budgeting and fiscal cycle; and/or

(b) in grant consolidation cases, increases alignment of planning, implementation and reporting efforts.

This Round 8 proposal will cover the 2009-2013 period. The start of implementation must take place at the same time as the first financial disbursement which must correspond to the start of a quarter of the national fiscal cycle from January to December. The disbursements will be aligned quarterly in order to facilitate output reporting especially as there are two main recipients which must be coordinated.

3.4. Program-based approach for HIV

3.4.1. Does planning and funding for the country's response to HIV occur through a program-based approach?

☐ Yes. Answer s.3.4.2

☒ No. ➔ *Go to s.3.5.*

3.4.2. If yes, does this proposal plan for some or all of the requested funding to be paid into a common-funding mechanism to support that approach?

☐ Yes ➔ ***Complete s.5.5 as an additional section to explain the financial operations of the common funding mechanism.***

☒ No. Do not complete s.5.5

3.5. Summary of Round 8 HIV Proposal

Provide a summary of the HIV proposal described in detail in section 4.

Prepare after completing s.4.

This proposal is the result of a national consultation process involving all the stakeholders in the fight against HIV in Burundi, which, under the auspices of CCM Burundi has analyzed the dynamics of the epidemic, additional and complementary financial and programmatic needs, outcomes of previous Rounds and comments from the Round 7 TRP, in order to prepare the proposal.

Burundi's Round 8 request to the GFATM is thereby based on a particularly important national stake for PLWHA, actors in the HIV Program, including those from civil society, the private sector and development partners. It is all the more important and decisive that it will enable efforts to be pursued in areas of prevention, case management and support for PLWHA, who are likely to encounter serious hardship without Round 8 support.

The Round 8 proposal is effectively based on the national STI/HIV/AIDS strategic plan 2007-2011 including towards Universal Access, initiated by WHO/UNAIDS, which has four aims:

Aim 1 Strengthen the STI/HIV program by integrating RH and improving direct prevention, care and support interventions among the general population and the key at-risk populations.

Aim 2: Strengthen therapeutic care of PLWHA qualitatively and quantitatively, and psychosocial and nutritional case management of PLWHA (adults and children including OVC)

Aim 3: Strengthen community capacity to protect the rights, support and reduce the economic impact of HIV/Aids on PLWHA and OVC

Aim 4: Strengthen management, coordination and monitoring-evaluation capacity of the Program

Aim 1 Strengthen the STI/HIV program by integrating RH and improving direct prevention, care and preventative support interventions among the general population and the key at-risk populations.

This aim will be implemented by the government PR and the civil society PR in partnership with civil society, faith-based and private sector organizations and health practitioners in Burundi's 17 provinces.

It is a question of strengthening outreach prevention activity in all vulnerable settings, particularly among high-risk populations, including young people, female sex workers (SW), men who have sex with men (MSM), drug users, soldiers and police, the disabled, prisoners and Batwa (a Burundi minority population).

The Round 8 proposal will enable greater epidemiological and behavioral knowledge to be obtained concerning these groups and also to develop outreach activity, counseling, addressing discrimination and stigma, particularly concerning MSM, IDU, and SW with their participation and involvement through peer education and health and social mediation.

7234 peer educators will be deployed across the whole country, operating among the groups they originated from: 160 for 14 public and private universities, 3200 for young people in schools divided between 972 secondary and vocational schools, 1935 recruited from young people not in education, which is equivalent to 15 young people per village out of a total of 129 villages, 470 soldiers, 270 police, 400 sex workers, 60 MSM, 450 prisoners, 80 disabled people in 16 centers for the disabled, 80 drug users out of an estimated 800 and 129 Batwa out of an estimated total 80,000.

Furthermore, 6650 community organizers covering all 2908 hills in the country will be supported to continue to provide community mobilization and sensibilization to combat AIDS and to pursue condom distribution and marketing at community-level in order to sustain these services especially in outlying and highly vulnerable areas.

In addition to peer education, there will also be multimedia campaigns in order to maintain informed awareness among highly vulnerable groups and the general population.

Promotion and access to testing will be strengthened not only as an individual approach but also through health care providers who will be trained to welcome vulnerable populations and counseling. PNC and community-based organizations will contribute towards mobilizing testing for pregnant women and the involvement of men in RH in general and PMTCT in particular.

RH activity will be generalized in PNC and PLWHA case management sites and capacity of care providers and

community actors will be strengthened to ensure global access to information, and Reproductive Health services.

Burundi has adopted the strategy of integrating PMTCT in the Sexual and Reproductive Health services. Interventions to prevent mother-to-child HIV transmission including the family unit, will be strengthened qualitatively in all 17 provinces in order to move towards standardization. PMTCT sites will provide a complete service for women and their partners, infants born to HIV-positive women and their brothers and sisters to prevent mother-to-child transmission according to the standards recommended by WHO and UNICEF. The main outcomes expected include increasing the acceptance rate and collection of test results among women, their partners and children. There are currently 51 PMTCT sites owing to World Bank, Round 1 and Round 5 contributions. The program will run in 255 PMTCT centers in 2013.

Aim 2: Strengthen therapeutic care of PLWHA qualitatively and quantitatively and psychosocial and nutritional case management of PLWHA (adults and children including OVC)

This aim will be implemented by the PR/Government in partnership with public and private case management facilities, and the PR/Civil society to which the organizations are affiliated. The Civil society PR, which is already highly involved with the whole country and has already built a basic partnership with community and public actors, can guarantee speedy implementation of community interventions in symbiosis and harmony with the provision of care from public, organizational and private facilities.

The Ministry of Public Health and AIDS has developed and implemented an accreditation system for ARV treatment centers and a plan to extend decentralization of ARV treatment sites to achieve Universal Access and ensure equality in the offer and accessibility of services. This plan which will run until 2013 aims to increase the number of accredited ARV treatment case management centers from 66 centers at the end of 2008 to 200 centers in 2013. Currently, there are 48 accredited ARV treatment centers in operation.

These centers have ensured case management of 10,928 PLWHA on ARV treatment in 2007 and clinical and biological monitoring. Decentralization of ARV treatment centers to health centers in health districts in rural areas and contract-based relationships with case management facilities to ensure free care for destitute PLWHA will increase both financial and geographical access to case management facilities.

Owing to this strategy, the number of PLWHA receiving comprehensive case management will increase gradually from 10,928 PLWHA in 2007 to 34,500 PLWHA in 2013 (17,500 in 2009; 21,000 in 2010; 25,500 in 2011; 30,000 in 2012; and 34,500 in 2013).

For the first two years (2009 and 2010), Round 8 financing will cover programmatic gaps in the National AIDS control program 2007-2011 for the procurement of first-line ARV drugs and immunovirological monitoring tests for 1,704 and 3,604 PLWHA respectively. The remainder will be provided by financing from the 2nd phase of Round 5 currently in progress and MAPII financing from the World Bank.

Aim 3: Strengthen community capacity to protect the rights, support and reduce the economic impact of HIV/Aids on PLWHA and OVC

This aim will be implemented by health and social professionals from the public and private sectors in partnership with civil society, the main networks and over 200 NGO/Organizations involved in different service delivery areas, half of whom will be sub-recipients and half sub-sub-recipients.

The aim is to strengthen capacity and community mechanisms to protect rights, care and reduce the economic impact of HIV/AIDS on PLWHA and OVC. In the context of Round 8, reducing impact will generally target PLWHA, their families and in particular OVC for whom activity in previous Rounds was quite limited. With regard to OVC, action will be taken in 9 provinces specifically targeting around 13% of households containing OVC, among households in the poverty categories as defined in the Poverty Reduction Strategy and located on each of the 3052 hills in 59 villages of the 9 provinces targeted (on average 64 households per hill, totaling 86,350 households). The choice of 9 provinces out of 17 is based on the complementary nature of an existing support project for OVC in the other 8 provinces supported by DFID through a consortium of local and international NGOs (Project Nzokira, Care-CRS and local partners).

In addition to pre-identified sub-recipients, the Civil society PR working with the government PR will identify other civil society sub-recipients able to implement activities in each of the 9 provinces, in addition to sub-sub-recipients practicing at baseline community level. AIDS Committees will be involved in this exercise at provincial and village-level.

Contractual relationships were adopted by Burundi as a strategy to stimulate quantitative and qualitative performance of health facilities and civil society organizations (NGO/Organization), also part of the financing within this proposal will be used to pay for the package of HIV services offered to PLWHA in the 400 care

facilities.

Aim 4: Strengthening management, coordination and monitoring-evaluation capacity of the Program

This aim will strengthen coordination and support activity concerning the national health information system. Results-based management in its component (SDA) program administration and management costs aim to provide technical, managerial and financial capacity for the main recipients. It provides the PR with the capacity to report to CCM Burundi and the Global Fund on the financial and programmatic performance for the duration of the Program.
Also, support for strengthening human resources qualitatively will be implemented in order to enable public and private sector partners and organizations to play a larger role and to offer strong proposals and partnership concerning strategic issues of this proposal
Sharing information on realizing interventions and developing indicators will be organized through 3 main instruments:

- organization of a national implementation workshop for the Round 8 proposal with all the stakeholders for 100 people over 5 days;
- annual production of an STI/HIV/AIDS report to be published in 1000 copies;
- organization of an annual information day on the epidemiological situation concerning HIV/AIDS for 60 participants for one day.

The main outcomes expected include: i) Quarterly reporting of activities and spending in accordance with monitoring indicators; ii) Gathering data and back information; iii) An annual program and financial review; iv) Strengthening knowledge and skills of professionals and associated actors; v) Implementing a database on care sites; vi) Capacity to respond and anticipate enlightened decisions for all actors in the HIV/AIDS field.

4. PROGRAM DESCRIPTION

4.1. National prevention, treatment, care, and support strategies

(a) Briefly summarize:

- the current HIV national prevention, treatment, and care and support strategies;
- how these strategies respond comprehensively to current epidemiological situation in the country; and
- the improved HIV outcomes expected from implementation of these strategies.

The main national HIV prevention, treatment, care and support strategies are defined in the reference documents drawn up with full participation of the key actors and the main partners in the health and HIV sector. It mainly concerns the following strategic documents: the national STI/HIV/AIDS strategic plan 2007-2011, the National Health Development Program 2006-2010, the National Reproductive Health Policy, Condom Policy, the Policy relating to Orphans and other Vulnerable Children and the national OVC national action plan 2007-2011.

1° National AIDS Strategic Plan 2007-2011

This national strategy is the specific reference for any HIV and AIDS intervention in any focus area. The National AIDS Strategic Plan 2007-2011 is an adapted response to the HIV epidemiological situation in Burundi and plays a major role in the continuity of the national AIDS action plan 2002-2006 for which the appraisal has been deemed satisfactory by national and international experts. The latter have correctly recognized that "the Burundian response to the HIV epidemic has been to subscribe to the best practices". The NSP 2007-2011 emphasizes the following main principles: undertaking protection at the highest level of the rights of infected and affected people and vulnerable groups, decentralized, multisectoral approach, outreach and social skills to face HIV. The outline of the strategic plan **comprises of 4 strategic axes and 12 Programs**.

Strategic axis n°1 aims to reduce STI/HIV transmission by strengthening and expanding prevention interventions deemed efficient with focus areas to reduce sexual transmission by promoting low-risk sexual behavior, reducing HIV transmission through blood and reducing mother-to-child HIV transmission.

Strategic axis n°2 aims to improve the well-being and quality of life of PLWHA by reducing the impact on health, prophylaxis, diagnosis and treatment of opportunistic infections, universal access to antiretrovirals for children and adults, psychological and nutritional case management of PLWHA in order to consolidate adherence and approaches to care. The antiretroviral treatment protocols currently in force were updated in June 08. In order to strengthen medical case management of people living with HIV, **antiretroviral treatment protocols and other algorithms for STI treatment are developed and updated regularly** in order to not only face the side effects caused by medication, but also to respond to any possible resistance to commonly used molecules.

Strategic axis n°3 aims to reduce poverty and other factors determining vulnerability in those facing HIV: Improving the socio-economic situation of PLWHA and people affected by AIDS, case management of orphans and vulnerable children owing to AIDS, promoting the rights of PLWHA and other vulnerable groups.

Strategic axis n°4 aims to improve management and coordination of the national AIDS response: increasing performance of the Information System to manage the national response, coordination of the multisectoral, decentralized response and support for implementing, mobilizing and managing financial resources. The four axes respond to the problems faced by a country with a general epidemic which is also concentrated around certain high-risk groups to whom particular attention is paid concerning prevention, care and psychosocial support.

This strategic plan will enable Burundi to head towards "Universal Access to prevention, treatment, care and support" which is the backbone of the HIV/AIDS policy developed by the Government of Burundi.

2 National Health Development Program

The National Health Development Program 2006-2010 is a materialization of the health policy 2005-2015, which itself arose from a participative process which started by organizing the National Institute for Health (Etats Généraux de la Santé) from 31 May to 4 June 2004. The process was participative and inclusive as it brought together executives from central and intermediary administration, different actors involved in implementation including the public sector, civil society and the private sector; and representatives of health and development partners in BURUNDI.

The challenges to be met by the National Health Development Program and which also express the concerns set out in the analysis of the situation which guided development of the AIDS control Strategic Plan 2007-2011 are the

following:

- reduction of the high levels of morbidity and mortality related to transmittable and non transmittable diseases;
- increasing geographical accessibility to health services;
- the problem of financing the health sector;
- increasing the availability of qualified human resources;
- Improving coordination between partners operating in the health sector.

Analysis of the health profile of Burundi places AIDS among the 5 main causes of morbidity and mortality and stigmatizes its negative impact on determining factors of social and economic development.

Strengthening performance of the national health system is an essential component of the National Health Development Program and includes implementing a policy to develop human resources, health infrastructure, rational drug use and financing.

3. National Reproductive Health Policy

Like the prevention and treatment strategies described above, the national reproductive health policy was inspired by Millennium Development Goals and integrates perfectly into Strategic Framework to Fight Poverty and the National Health Development Program. The various components of this policy are as follows:

- safer pregnancy and neonatal health;
- family planning;
- sterility and sexual dysfunction prevention and case management;
- abortion prevention and case management;
- STI/HIV/AIDS prevention and case management;
- promoting reproductive health among young people and teenage men;
- sexual abuse prevention and case management;
- breast, cervical and other gynecological cancer prevention and case management.

The challenge is obviously the capacity of the reproductive health program and the national health system to be able to integrate implementation of these strategic areas in the different health facilities according to the standards defined by system level, whether at health center level, 1st referral hospital, 2nd referral hospital or national referral hospital level. Therefore, the concept of safer pregnancy defines promotional, preventative and treatment care during pregnancy, birth and the immediate post-partum period to protect the mother and newborn, which obviously includes HIV prevention and appropriate case management in the event of infection.

Component 5 of the National Reproductive Health Policy tallies with the priority interventions in the National AIDS Control Strategic Plan and there is the opportunity to systemically integrate prevention of mother-to-child transmission in the prenatal consultation service.

Promoting certain methods of contraception such as condoms recommended in the reproductive health policy obviously contributes to preventing sexual transmission of HIV which is a priority focus area of the National Strategic AIDS Plan 2007-2011 to respond efficiently to sexual transmission of HIV which is the highest in Burundi's epidemiological context.

4. National Condom Policy

Participants attending workshops held in Bujumbura in May 2003 and May 2004 to develop national condom policy noted the lack of adequate planning and strategies to make condoms available, which are the only sure way of preventing HIV contamination in the event of high-risk sexual relations, and are accessible and useable by the sexually-active population.

It was this acknowledgement which lead to the situation being analyzed and obstacles were identified which must be tackled by implementing the policy defined in particular gaps in communication not sufficiently covering behavior change, inefficient management of condom stocks including controlling coordination of distribution networks.

The objectives of this policy have thus been defined and are as follows:

- Make male and female condoms available and accessible to vulnerable groups;
- Increase the rate of condom use to 100% among vulnerable groups.

Efforts made to define the national condom policy have finally resulted in increased use by the most vulnerable groups in order to reduce the appearance of new cases of sexually transmitted HIV infections, which is a substantial contribution to the national response to the epidemiological situation described in this proposal.

5. National Policy for Orphans and other Vulnerable children

The OVC Policy defines the concepts relating to the vulnerability of children, target groups and their problems and the constraints surrounding protection and care of OVC and proposes the main strategic axes of intervention.

This policy indicates that any OVC protection and case management initiative must include a minimum case management package which satisfies basic needs such as housing, food and health care, as well as registration of births, schooling and/or learning a trade, in order to ensure autonomy and social and economic insertion.

6. National Action Plan for Orphans and Vulnerable Children in Burundi

The OVC Plan is largely inspired by OVC policy and sets 7 strategic priority objectives:

- To protect the rights of OVC through lobbying, formulation, implementation and vulgarization of the appropriate policies and legal frameworks;
- Reduce vulnerability of children infected and/or affected by HIV/AIDS and high-risk children;
- Improve medical, nutritional and psychosocial case management of OVC;
- Improve access to schooling and professional training for OVC;
- Strengthen capacity of the most needy host families for improved case management of OVC;
- Mobilize and provide technical and financial resources for community initiatives to help OVC;
- Set up and strengthen coordination mechanisms, monitoring and evaluation and provide institutional support to facilitators focusing on OVC.

According to UNAIDS projections, there will be 700,000 OVC in 2006 which will increase to 720,000 between now and 2011.

All these strategies aim to reduce the risk of new HIV infections as well as the socio-economic impact of HIV/AIDS on the poorest populations by guaranteeing them access to basic social services, through a community systems strengthening approach, strengthening civil society organizations and improving the coordination, monitoring and evaluation system, with the aim among other things of accessing basic data and tools for measuring the impact of Programs.

In the National HIV/AIDS Strategic Plan 2007-2011, among some of the major obstacles to be overcome to achieve the expected outcomes from the Plan are the large number of orphans and vulnerable children and the fact that vulnerable or high-risk groups did not receive sufficient attention in implementing the previous National AIDS Control Action Plan (PANLS) 2002-2006

Implementation of these various policies and strategies will provide a good synergic response to the epidemiological situation described in this proposal and achieve the objectives set out in each axis of the Strategic AIDS plan 2007-2011.

(b) From the list below, attach* **only those documents that are directly relevant** to the focus of this proposal *(or, *identify the specific Annex number from a Round 7 proposal when the document was last submitted, and the Global Fund will obtain this document from our Round 7 files).*

Also identify the specific page(s) (in these documents) that support the descriptions in s.4.1. above.

Document	Proposal Annex Number	Page References
National Disease Specific Strategic Plan	Annex 17, Round 8	Page 3, pages 33 - 37
National Condom Policy	Annex 20, Round 8	Pages 7-8, 19-22
National Policy for Orphans and other Vulnerable Children	Annex 13, Round 8	Pages 7-11, 33, 42, 56-58
National Action Plan for Orphans and Vulnerable Children 2007-2011	Annex 14, Round 8	Pages 4-5, 18-23
National Reproductive Health Policy	Annex 15, Round 8	Pages 13-20
Burundi's proposal to support health system strengthening 2006-	Annex 16, Round 8	

2010 financed by GAVI		
Accreditation norms and standards for HIV voluntary counseling and testing centers, ARV case management and PMTCT	Annex 27, Round 7	
National list of essential drugs, May 2004	Annex 28, Round 7	
National Policy for the prevention of mother-to-child transmission of HIV in Burundi, February 2004.	Annex 29, Round 7	
Strategic Framework for growth and to fight Poverty, Poverty Reduction Strategy Paper, August 2006.	Annex 30, Round 7	
National Health Development Program 2006-2010, December 2005	Annex 31, Round 7	Page 7, pages 33 - 37
Plan to achieve the Millennium Development Goals. (Evaluation of needs in the health sector, February 2007)	Annex 33, Round 7	
National Consultation to develop an integrated mechanism for the nutritional case management of PLWHA and their beneficiaries	Annex 34, Round 7	
Plan to achieve the Millennium Development Goals. (General needs assessment report to achieve the MDG)	Annex 35, Round 7	
Joint support program to fight HIV/AIDS	Annex 36, Round 7	
Review of the ARV treatment plans in Burundi	Annex 37, Round 7	
Financing code of the civil society response, May 2005	Annex 38, Round 7	
Internal appointment at the Ministry of Public Health	Annex 39, Round 7	
Priority action plan to implement the CSLP 2007-2010	Annex 40, Round 7	
National plan for monitoring and evaluating activities to fight AIDS.	Annex 41, Round 7	

4.2. Epidemiological Background

4.2.1. Geographic reach of this proposal

(a) Do the activities target:

☉ Whole country ☐ Specific Region(s) ***If so, insert a map to show where* ☐ Specific population groups ***If so, insert a map to show where these groups are if they are in a specific area of the country*

***** Paste map here if relevant***

(b) **Size of population group(s) targeted in Round 8**

Population Groups	Population Size	Source of Data	Year of Estimate
Total country population (all ages)	8.275.177	Burundi Demographic Survey N°8	2007
Women > 25 years	1.599.819	Burundi Demographic Survey N°8	2007
Women 19 – 24 years	387.181	Burundi Demographic Survey N°8	2007
Women 15 – 18 years	447.491	Burundi Demographic Survey N°8	2007
Men > 25 years	1.441.643	Burundi Demographic Survey N°8	2007
Men 19 – 24 years	386.912	Burundi Demographic Survey N°8	2007

(b) Size of population group(s) targeted in Round 8			
Population Groups	**Population Size**	**Source of Data**	**Year of Estimate**
Men 15 – 18 years	447.345	Burundi Demographic Survey N°8	2007
Girls 0 – 14 years	1.770.172	Burundi Demographic Survey N°8	2007
Boys 0 – 14 years	1.794.614	Burundi Demographic Survey N°8	2007
Other **: ** *Refer to the Round 8 Guidelines for other possible groups*			
Other **:			
Other **:			[*use "Tab" key to add extra rows if needed*]

4.2.2. HIV epidemiology of target population(s)			
Population Groups	**Estimated Number**	**Source of Data**	**Year of Estimate**
Number of people living with HIV *(all ages)*	165.700	NSP 2007-2011	2006
Women living with HIV > 25 years	40.064	Estimation based on sentinel surveillance data of HIV in pregnant women	2007
Women living with HIV 19 – 24 years	Not available		
Women living with HIV 15 – 18 years	18.092	Pediatric AIDS care in Burundi Inventory and areas to reflect upon, GIP ESTHER	2007
Pregnant women living with HIV	Not available		
Men living with HIV > 25 years	Not available		
Men living with HIV 19 – 24 years	Not available		
Men living with HIV 15 – 18 years	18.200	Pediatric AIDS care in Burundi Inventory and areas to reflect upon, GIP ESTHER	2007
Girls (0 – 14 years) living with HIV	Not available		
Boys (0 – 14 years) living with HIV	Not available		
Other**: ** *Refer to the Round 8 Guidelines*			

4.2.2. HIV epidemiology of target population(s)			
Population Groups	**Estimated Number**	**Source of Data**	**Year of Estimate**
for other possible groups			
Other**:			
Other**:			[*use "Tab" key to add extra rows if needed*]

4.3. Major constraints and gaps

(For the questions below, consider government, non-government and community level weaknesses and gaps, and also any key affected populations[4] who may have disproportionately low access to HIV prevention, treatment, and care and support services, including women, girls, and sexual minorities.)

4.3.1. HIV program

Describe:

- the main weaknesses in the implementation of current HIV strategies;
- how these weaknesses affect achievement of planned national HIV outcomes; and
- existing gaps in the delivery of services to target populations.

Analysis of the main weaknesses can be structured around the axes of prevention, case management and reduction of socio-economic impact as well as coordination and Monitoring-Evaluation, which happen to constitute the main priorities in Round 8

1. Regarding prevention

- **Geographical accessibility to HIV counseling and testing services** remains relatively weak owing to unequal distribution of facilities providing such services and reduced and poorly trained staff numbers. Weak promotion of testing limits awareness of HIV-status for many people leading to late discovery of status with the accompanying advanced stage of the disease. Late testing is much more common in men than in women. This is the reason Round 8 will be able to provide increased voluntary testing services, professionals to be trained and promotion through social mobilization which will be provided by community outreach actors and testing on the initiative of health providers.
- **Some key populations are more exposed to the risk** of HIV infection, mainly sexual minorities and vulnerable populations who, through their socio-cultural situation, were not targeted by a specific Program. Despite the fact that epidemiological data concerning these populations remains very fragmented, the fact remains that outreach activity performed by organizations show increased risk factors. The Round 8 proposal will enable greater epidemiological knowledge to be obtained on these groups and also develop outreach activity, counseling, fight discrimination and stigma, in particular for MSM, IDU, and SW with the participation of stakeholders.
- **The capacity for social marketing of condoms** remains short of national need, including organization of the distribution network and the actual marketing of condoms. Round 8 aims to increase condom access and use and reverse the dropping trend observed in 2006.
- **The weak promotion of PMTCT in health facilities and at community level** is the reason for weak demand for PMTCT for HIV-positive women (testing, collecting results, recourse to prophylaxis, family planning).

The lack of financial resources, involvement of partners, nutritional support and the absence of early testing of newborns of HIV-positive mothers are the challenges facing the PMTCT program in Burundi. They are major axes

of the Round 8 proposal.

2. Weaknesses relating to medical, psychological/social and nutritional care.

Despite the tangible progress made in case management, which is characterized by an increase in open files on PLWHA undergoing treatment, there are still not enough case management centers and the existing ones are too far from populations in isolated parts of the country.

Furthermore, there is not enough competent, motivated staff in any of the facilities. The national case management strategy is only just starting to develop efficient interventions for infected children or members of marginalized groups.

The lack of social workers (for psychological follow-up), the capacity of community organizations and nutritional support compromises adherence to treatment and its efficiency. Effectively, a study performed in January 2007, has highlighted an overall malnutrition rate of 21% in PLWHA whose case management is covered by 4 organizations under the Town Hall of Bujumbura namely ANSS, ADRA, Nouvelle Espérance and SWAA.

Public facilities remain weak in psychosocial case management and deserve to be strengthened in order to offer these services in addition at the same time as decentralization is taking place. Owing to the fact that it is aiming for Universal Access, Round 8 will enable us to overcome these weaknesses and achieve this objective.

3. Reducing the socio-economic impact

This confronts the huge poverty facing the Burundian population in general and particularly the most vulnerable, namely women, orphans and other vulnerable children especially those who are infected or affected by HIV.

The first World Bank financing anticipated financial resources for income generating activities to reduce the impact of HIV and enable those infected or affected by HIV to be independent. Contributions from the second multisectoral World Bank project will certainly enable the poverty reduction effort to be pursued, but on a reduced scale owing to the drastic decrease in resources granted by the World Bank for this component.

Up until now the Global Fund has essentially supported medical case management. The main gaps identified in the area of support and care of orphans and vulnerable children show a lack of financial and human resources to respond holistically to the needs of OVC.

Even though they are very active, civil society organizations still need institutional strengthening as they suffer from gaps both on a technical and management level, and monitoring and evaluation of activities.

Also Round 8 will enable intervention through AGR systems, capacity strengthening mechanisms and socio-professional reintegration by giving independence to PLWHA, namely women, men and OCV.

4. Weakness in Coordination and the Monitoring and Evaluation system

Implementation of the first National Plan of Action 2002-2006 was mainly supported by the World Bank, UNICEF, UNDP and DFID (SIPAA project) both at national coordination and decentralized level.

The withdrawal of certain partners (UNDP and DFID (SIPAA project)), changes to intervention policies (UNICEF) and the drop in contributions (World Bank) has meant that pursuing decentralization efficiently cannot be considered, nor support for a community response.

There is a national monitoring and evaluation plan but the work associated with implementing this proposal would be an extra burden on the existing national M&E system given the amount of information to be collected and analyzed.

The permanent Executive Secretariat of the National AIDS Council has organized an assessment of the monitoring and evaluation system with the "Monitoring and Evaluation system strengthening tools from the AIDS program" and participants at the workshop described the main gaps and proposed a plan and budget intended to fill them.

Activities from this M&E plan have been identified in terms of gaps. The gaps identified relate to the standardization and command of data collection tools, the technical capacity of facilitators to analyze and use the information collected and delays in reporting on interventions. This affects public, private and community facilities in equal measure.

4.3.2. Health System

Describe the main weaknesses of and/or gaps in the health system that affect HIV outcomes.

The description can include discussion of:

- *issues that are common to HIV, tuberculosis and malaria programming and service delivery; and*
- *issues that are relevant to the health system and HIV outcomes (e.g.: PMTCT services), but perhaps not also malaria and tuberculosis programming and service delivery.*

The main weaknesses of the health system which can affect outcomes are summarized in the following points:

1. Weak integration of PMTCT in Reproductive health services;
2. Low availability of transport and the problem of maintaining biomedical equipment;
3. Intervention coordination health information system remains limited;
4. Poor planning and management of drugs and other pharmaceutical products;
5. Weak financing of the health sector;
6. Qualitatively weak community level.

1. Weak integration of PMTCT in Reproductive Health services;

Weak integration of AIDS services, mainly PMTCT into Reproductive Health services, and the highlighted delay in moving towards standardizing case management of people living with HIV are largely due to the weak performance of the national health system relating to:

- Limited human resources (poverty, unequal distribution of numbers, unmotivated and unsettled staff);
- Weak access to health services and low adherence to the prevention of mother-to-child transmission Program;
- The lack of sites which have implemented the PMTCT policy and distribution which remains patchy and does not allow geographical coverage of the whole country;
- The run-down condition of some health facilities which have not been renovated since the 1993 crisis. Due to a lack of resources, some facilities have a very rudimentary specialized platform if referring to the document outlining the norms and standards of the Ministry of Public Health and AIDS.

2. Low availability of means of transport and the problem of maintaining biomedical equipment;

- The referral system is not very efficient. Only 8 out of 49 districts have such a system (vehicles and means of communication). If the average distance to the 1st referral hospital is 14.5km, 62% of health centers are more than 10km from the referral hospital and for 60.6% of health centers, the time for a woman referred to arrive at hospital is at least two hours and more than two hours for the others (39.4%). Very few health centers have an ambulance, so few that the majority of pregnant women referred urgently to hospital are transported on a stretcher.
- Burundi does not have enough human resources specialized in maintaining medical equipment, which is a significant handicap The country relies on foreign experts each time there is a breakdown, which occurs frequently, incurring high costs and delays in the maintenance and repair of health equipment and supplies. The quality of immunovirological monitoring is also compromised by the lack of motivated maintenance technicians at national level.

3. Intervention coordination health information system remains limited;

- The weaknesses of the integrated information and monitoring & evaluation system have been described in various reviews of the Action plan 2002-2006 and during various supervision missions carried out by partners. Notification is often given at several levels and there are weaknesses in coordinating data collection between USLS/Health, EPISTAT and PES/NAC. Although it has been defined, the data network is not always followed by the participants. IT tools to monitor patients and manage pharmaceutical products have been developed and training sessions pertaining thereto have been realized for better use by the providers, which should bring short term improvements.

4. Planning and management of drugs and other pharmaceutical products still unsatisfactory;

The recurrent problem of being out of stock of drugs and other health consumables is often raised during the various supervision missions.

The main causes identified are related to:

- Estimates due to a lack of basic data for adequate quantification;
- Institutional weaknesses at CAMEBU which owing to its State Trustee status, cannot have greater financial autonomy and is not entitled to procure products without going through the public contract procedures. Such procedures are lengthy and restrictive and can increase the time taken to procure drugs and the likelihood of running out of stock. This is the reason why PES/NAC which is financially autonomous, and has technical skills and experience, performs this mission for CAMEBU in full compliance with the GFATM and LFA Secretariat.

5. Weak financing of the health sector;

Despite obvious political will, the health sector is under financed. Public spending on health has hardly risen above 3% during the last decade whereas the Summit of African Heads of State in Abuja recommended that the States allocate at least 15% of the national budget to health.

- This sector is also dependent on outside aid. For Burundi, public development aid intended for the health sector has decreased slightly since 1993 owing to the socio-political crisis and armed conflict.
- Solidarity and risk mutualization mechanisms are not sufficiently developed, notwithstanding the existence of the Public Service Mutual which covers only 10% of the population. There are no perennial financing mechanisms involving the informal sector, households, local authorities, the private sector and civil society.

6. Community level remains qualitatively weak

Despite real efforts to provide community cover, in particular by making 6650 community organizers available to cover the 2908 hills in Burundi, it must be admitted that the specific audiences targeted which need appropriate messages and services are not sufficiently covered.

Furthermore, they do not yet have normalized tools to efficiently provide the outcomes of their interventions and data quality in their reports must be assumed by the decentralized level of the conventional health system which was limited to health centers.

An operational link must be created between these two levels and motivation supported to enable them to perform their obligations better.

4.3.3. Efforts to resolve health system weaknesses and gaps

Describe what is being done, and by whom, to respond to health system weaknesses and gaps that affect HIV outcomes.

1. Regarding prevention

- **Geographical accessibility to counseling and testing services:** to resolve the disparity in the distribution of health facilities offering VCT, the Ministry of Public Health and AIDS started decentralization to all the health provinces and districts, observing the accreditation norms established. Round 5 financing has equipped these facilities, which were recently opened to the public. Financing from the World Bank also contributed towards organizing the network of community agents to promote testing among the general population and in particular key populations who are the most at-risk.
- **Some key populations who are more exposed to the risk** of HIV infection have received closer attention from our activities since 2007. Effectively, the Burundi AIDS Alliance, supported by the International Alliance and UNAIDS has specifically targeted MSM, Sex workers and OVC for sensibilization of the necessity of VCT, the implementation of income generating activities or professional training with the aim of socio-professional reinsertion. During Round 5 and with the support of the World Bank, action has been undertaken for other vulnerable groups such as: young mothers, drug users, prisoners, sex workers, war veterans, uniformed personnel and their spouses, displaced and repatriated individuals. Truck drivers were taken into account by the activity carried out by GLIA.
- Regarding **the absence of friendly services** for counseling certain key populations who are most exposed to the risk of infection but also for their medical and psychological case management, there are organizations that are already specialized in caring for victims of sexual abuse (SERUKA and NTURENGAHO centers). The latter takes care of young girls in particular.

- Regarding the **weak capacity for social marketing of condoms** and the **problems organizing the condom distribution networks:** joint assessment of the situation in 2007 by PES/NAC, the PNSR (National Reproductive Health Program and PSI issued recommendations including revising the national condom policy which will be implemented to strengthen social marketing and organization of the condom distribution network.
- **The weaknesses in the PMTCT program** are in the process of being progressively rectified. The Ministry of Public Health and AIDS has decentralized centers offering PMTCT and organized training for health practitioners on PMTCT, which shows the constant effort made by the latter. Organizing early testing of newborns born to HIV-positive mothers and nutritional support for HIV-positive pregnant women and the poorest HIV-positive mothers and their newborns are positive aspects which improve performance of this Program. Community involvement to promote testing among pregnant women and those of reproductive age is among the strategies to move towards standardization initiated by the national program and supported by FHI in three provinces in the north of the country.

2. Weaknesses relating to medical, psychological/social and nutritional case management.

- Constant improvement of medical, psychological and nutritional case management remains a constant worry for the National AIDS Program. The Ministry of Public Health and AIDS is pursuing its decentralization program in ARV treatment and biological monitoring centers. Strengthening capacity of health personnel is constantly ensured through continuous training or field supervision.
- This proposal was inspired by the contract-based approach adopted by the Ministry of Public Health and AIDS. This approach is already in force and performance of institutions who have applied it is already very encouraging and calls for support. This motivates providers and managers of various institutions to improve service quality. Organizations already involved in implementing this policy include CORDAID, HealthNet TPO and Coopération Suisse. Several other partners are in the process of aligning with this policy to support PNDS implementation (National Health Development Program) and establish a definitive performance culture among health practitioners and care facility managers.

3. Reducing the socio-economic impact

- The World Bank has made a significant contribution to income generating activities to reduce the impact of HIV and provide independence to people who are infected or affected. Community organizations have benefited from training in project preparation, management and follow-up for improved training or improved performance of revenue-raising activities. Equal access to financing is ensured by leaders of provincial AIDS committees which ARE divisions of the National AIDS Council. The latter are composed of administrative, political, religious and community leaders.
- In an effort to strengthen the intervention framework for OVC, the Government of Burundi developed the OVC policy (2005) and the National Plan for OVC (2007) which define a minimum case management package and recognize in particular free primary education, free healthcare for children under 5 and free secondary school for poor children. In order to strengthen implementation, monitoring and evaluation of the NAP, the Government is preparing to set up a technical committee to implement the OVC NAP, bringing together the main government and civil society actors working with OVC. Furthermore, PES/NAC has started an AIDS Info database, part of which is dedicated to OVC. Also, in order to strengthen CSO capacity, training modules have been developed through the "Nzokira" project and several CSO are now experienced in implementing, managing, and monitoring and evaluating OVC projects.

4. Weakness in Coordination and the Monitoring and Evaluation system

- Many facilitators have supported implementation of the coordination structure for the National AIDS program and the Monitoring and Evaluation System. These include the World Bank, the Global Fund, Unicef, DIFD, GTZ, UNDP and FHI for the National Action Plan 2002-2006 and some have partially supported implementation of the NSP 2007-2011. The Ministry of Public Health and AIDS set up the Partnership Framework for Health and Development to improve coordination of health interventions. All facilitators are stakeholders. This framework includes the Ministry of Public Health and AIDS, bi- and multilateral organizations involved in developing the Health sector, national and international non-governmental organizations and civil society organizations.
- The NAC Executive Secretariat organized analysis of the National Monitoring and Evaluation system for the National Program to Combat AIDS and has now developed a Strengthening Plan using the tool provided by the Global Fund. The PES/NAC has a database (AIDSinfo) to monitor the open files of patients on ARV treatment or not registered with case management facilities and mothers and children recruited through the PMTCT

- Program. Financing from Rounds 1 and 5 has equipped case management and PMTCT facilities with IT equipment to manage the database and stock levels of ARV drugs (using SAGE SAARI software). Training to use and operate these tools has been organized for agents in the aforementioned facilities. Availability of IT equipment and organization of training occurs as and when the new sites are accredited.

ROUND 8 – HIV

4.4. Round 8 Priorities

Complete the tables below on a program coverage basis (*and not financial data*) for **three to six areas** identified by the applicant as priority interventions for this proposal. Ensure that the choice of priorities is consistent with the current HIV epidemiology and identified weaknesses and gaps from s.4.3.

Note: All health systems strengthening needs that are most effectively responded to on an HIV disease program basis, and which are important areas of work in this proposal, should also be included here.

Priority No: 1	SDA: Counseling and testing	Historical		Current		Country targets			
Intervention	*Screening tests*	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
A: Country target *(from annual plans where these exist)*		120.000	150.000	180.000	194.000	354.352	394.109	435.238	477.796
B: Extent of need already planned to be met under other programs		150.092	147.575	180.000	194.000				
C: Expected annual gap in achieving plans						354.352	394.109	435.238	477.796
D: Round 8 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*				354.352	394.109	435.238	477.796

Priority No: 2	SDA: PMTCT	Historical		Current		Country targets			
Intervention	*Prophylactic treatment*	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
A: Country target *(from annual plans where these exist)*				2.457	3.629	5.049	6.318	8.318	10.318
B: Extent of need already planned to be met under other programs		1.129	2.026	3.172	4.468	772			
C: Expected annual gap in achieving plans					457	1.722	6.318	8.318	10.318
D: Round 8 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			457	1.722	5.546	8.318	10.318

ROUND 8 – HIV

Priority No: 3	SDA: ARV Treatment and monitoring	Historical		Current		Country targets			
Intervention	*Antiretroviral treatment*	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
A: Country target *(from annual plans where these exist)*			11.500	14.000	17.500	21.000	25.500	30.000	34.500
B: Extent of need already planned to be met under other programs		8.048	10.928	14.000	15.796	17.396			
C: Expected annual gap in achieving plans					1.704	3.604	25.000	30.000	34.500
D: Round 8 proposal contribution to total need		*(e.g., can be equal to or less than full gap)*			1.704	3.604	25.000	30.000	34.500

Priority No: 4	SDA: Counseling and Support for the chronically ill	Historical		Current		Country targets			
Intervention	*Delivering nutritional kits*	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
A: Country target *(from annual plans where these exist)*				21.256	23.789	25.091	26.440	27.861	29.359
B: Extent of need already planned to be met under other programs		12.991	12.769	13.256	1.580	820			
C: Expected annual gap in achieving plans				8.000	12.209	24.271	26.440	27.861	29.359
D: Round 8 proposal contribution to total need		*(i.e., can be equal to or less than full gap)*			3.500	4.200	5.100	6.000	6.900

Priority No: 5	SDA: Care and support for Orphans and other vulnerable children	Historical		Current		Country targets			
Intervention	*Provision of school kits*	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
A: Country target *(from annual plans where these exist)*			433.600	500.400	567.200	600.600	634.000		
B: Extent of need already planned to be met under other programs		323.077	492.401	492.401	425.000	410.000	400.000		
C: Expected annual gap in achieving plans					142.200	190.600	234.000		
D: Round 8 proposal contribution to total need		*(i.e., can be equal to or less than full gap)*			71.100	95.300	117.000	81.846	61.712

ROUND 8 – HIV

Priority No: 6	SDA: Strengthening the health system	Historical		Current		Country targets			
Intervention	*Contracts with the care facilities to improve access to services (prevention and care)*	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
A: Country target *(from annual plans where these exist)*				310	420	530	640	666	666
B: Extent of need already planned to be met under other programs		53	86	120	180	230	300	286	266
C: Expected annual gap in achieving plans				190	240	300	340	380	400
D: Round 8 proposal contribution to total need		*(i.e., can be equal to or less than full gap)*			240	300	340	380	400

➔ *If there are six priority areas, copy the table above once more.*

4.5. Implementation strategy

4.5.1. Round 8 interventions

Explain: (i) who will be undertaking each area of activity (which Principal Recipient, which Sub-Recipient or other implementer); and (ii) the targeted population(s). *Ensure that the explanation follows the order of each objective, service delivery area (SDA) and indicator in the 'Performance Framework' (Attachment A) and work plan, and budget.*

Where there are planned activities that benefit the health system that can easily be included in the HIV program description (because they predominantly contribute to HIV outcomes), include them in this section only of the Round 8 proposal.

***Note**: If there are other activities that benefit, together, HIV, tuberculosis and malaria outcomes (and health outcomes beyond the three diseases), and these are not easily included in a 'disease program' strategy, they can be included in s.4B **in one disease proposal** in Round 8. The applicant will need to decide which disease to include s.4B (but only once). ➔ Refer to the Round 8 Guidelines (s.4.5.1.) for information on this choice.*

The Round 8 proposal is based on the national HIV strategy and the programmatic and financial gap analysis which will enable us to achieve Universal Access. There are 4 aims based on 14 related objectives and SDA:

Aim 1 Strengthening the STI/HIV program by integrating RH and improving direct prevention, care and support interventions among the general population and the key at-risk populations.

Aim 2: Qualitative and quantitative strengthening of therapeutic case management of PLWHA, psychosocial and nutritional case management of PLWHA (adults and children including OVC)

Aim 3: Strengthening community capacity for the protection of rights, support and reducing the economic impact of HIV/Aids on PLWHA and OVC

Aim 4: Strengthening program management, coordination and monitoring-evaluation

Aim 1: Strengthening the STI/HIV program by integrating RH and improving direct prevention, care and support interventions among the general population and the key at-risk populations.

Objective 1.1: Strengthen prevention services for the key populations at risk of HIV

This objective will be implemented by the Government PR and the civil society PR in partnership with civil society organizations and private communications agencies, public and private media and the NGO PSI which has expertise in facilitating cine mobile sessions and other communication supports. This section has strengthened and spread the BCC activities started in Round 5 and through MAP 1 which ends in November 2008.

SDA 1: BCC - Mass media (Government and civil society PRs)

Referring to the national communication strategy, messages will be developed according to the requirements of target groups, namely: young people, female sex workers (SW), men who have sex with men (MSM), drug users, soldiers and police, disabled people, prisoners and Batwa (a minority in the Burundian population).

The Round 8 proposal will enable greater epidemiological knowledge to be obtained on these groups and also to develop outreach activity, counseling, fight discrimination and stigma, in particular for MSM, IDU, and SW with the participation of stakeholders.

The messages developed will be broadcast using different communication channels and tools. PSI will show documentary films to each target group. In order to broadcast quality information, 100 journalists will be trained and retrained on collecting and processing information relating to reproductive health taking into account the problem of HIV/AIDS. Two annual media campaigns will be organized to support the lobbying activities, HIV testing and case management of patients and their families.

SDA 2: BCC – School and community outreach (Government and civil society PRs)

BCC activities will be performed at community-level by peer educators identified among the key at-risk populations who will be trained and retrained in behavior change communication and monitored by supervisors from

NGOs/organizations and communal and provincial AIDS committees.

7234 peer educators will be rolled out across the whole country, working among the groups they originated from: 160 for 14 public and private universities, 3200 for young people in school divided between 972 secondary schools and vocational schools, 1935 recruited from young people not in education, equivalent to 15 young people per village out of a total of 129 villages, 470 soldiers, 270 police, 400 sex workers, 60 MSM, 450 prisoners, 80 disabled people in 16 centers for the disabled, 80 drug users out of an estimated 800 and 129 Batwa out of an estimated total 80,000.

SDA 3: condoms (Government PR)

For Round 8, male and female condoms and lubricating gel for high-risk populations will be acquired to prevent STIs and HIV as well as unwanted pregnancies. Therefore 67,000,000 male condoms and 940,000 female condoms will be acquired over 5 years and distributed in the community and through outreach activity by peer educators and through 6,650 community facilitators. The highly vulnerable areas will be taken into account as a priority. Furthermore, it is planned to support condom distribution with social marketing on the private commercial network, generating creation of 1000 points of sale which will be supervised by PSI.

Objective 1 2: Promote the HIV testing strategy initiated by providers in all the health services

This objective will be implemented by the government PR, the Ministry for Public Health and Voluntary Counseling and Testing centers (VCT) in partnership with the public, private and organizational sectors (NGO/organizational and faith-based). It will strengthen activities carried out in the context of the 5th Round financed by the Global Fund and MAP I and II financed by the World Bank.

SDA 1: HSS (health systems strengthening): Health practitioners (Government PR)

Despite the efforts made to extend provision of the VCT service (Burundi now has 182 VCT sites in 600 existing health centers), the number of people tested is increasing very slowly. This is why further to promoting the individual step of voluntary testing, the proposal will also promote the testing approach at the initiative of health providers as recommended by WHO and UNAIDS. As it is a question of introducing a new approach, training activities will be developed for providers to strengthen the skills of 800 providers on 400 sites (2 providers per site).

SDA 2: Counseling and testing (Government PR)

In order to perform voluntary testing, procuring the tests namely the Determine as first line treatment and the Genie II for the distinguishing test is planned from the 2nd year, the first year being covered by Round 5. The ELISA test will be chosen to confirm the result and the Inno-Lia HIV1/2 tests for the results where there is some doubt over HIV1 and 2. In order to improve their services, the VCT counselors will meet quarterly to exchange views within their network.

In order to increase geographical accessibility to HIV counseling and testing, 182 new VCT sites will be enlarged and accredited, and this will increase from 182 in 2008 to 400 in 2013, which will ensure good coverage insofar as 2 health facilities out of 3 will be able to offer this service which constitutes an open door to all the other HIV-related services.

Objective 1.3: Aim for improved STI diagnosis and treatment in all health facilities

This section will be performed by the government PR in collaboration with the National Reference Center, the National Institute of Public Health and the University of Kamenge Hospital Center Laboratory.

SDA 1: STI diagnosis and treatment (sexually transmitted infections) (government PR)

One method of HIV prevention is STI testing and treatment. For the treatment, the syndromic approach currently in force will be used and 15,000 treatment kits each year will be made available to health providers to welcome and manage high-risk populations.

SDA 2: HSS: Information system & Operational research (Government PR)

The protocol in force in Burundi for STI care consists of a syndromic approach in accordance with the WHO international standard. It is planned to carry out a study of the etiology of ulcerating and non-ulcerating STIs on a sample of 500 people with STIs on 4 different treatment sites (2 in Bujumbura, 2 in Ngozi and Bururi), which will be complemented by a second study on the sensitivity of STIs (gonococcus, Chlamydia…) to the usual antibiotics. Performance of the two studies will be entrusted to a collaborative research group composed by the National Reference Center, National Institute of Public Health and the University of Kamenge Hospital Center Laboratory.

SDA 3: HSS: Health practitioners (Government PR)

On a case-by-case basis, WHO generic algorithms will be adapted by a national consultant, taking into account the results of prevalence studies and STI sensitivity to antibiotics. The providers will be informed and introduced to the revised algorithms through training workshops involving 1600 providers over 40 sessions with 40 providers per

session lasting three days each. The algorithms will then be copied and 2000 copies will be distributed.

Objective 1.4: Improve prevention of HIV transmission through blood, case management of accidental exposure to blood and victims of sexual abuse

This objective will be implemented by the Government PR in collaboration with all the health providers in health centers and in partnership with the NGO/organizations operating in the community.

SDA 1: Blood safety and universal precaution (Government PR)

Development of the transfusion policy will be entrusted to an international consultant assisted by a national consultant who will work closely with blood transfusion managers, hospital facility managers, blood donor organizations and national decision makers.

Furthermore the staff in these facilities (NBTC & CRTS) will be trained at 5-day seminars involving 80 people in order to improve blood security and biological testing of target infections (HIV, VHB, VHC, and Syphilis).

In the context of Round 8, blood security will be decentralized through bringing the 4 regional centers up to standard. Procuring 30,000 VHB serology reagents, 30,000 VHC serology reagents, 30,000 syphilis serology kits per year for the NBTC will be provided in order to contribute to national efforts to improve blood safety.

Furthermore, the increase in the volume of activity will generate extra waste, which will require adequate infrastructure for its disposal which will be made possible by the renovation of 150 incinerators in peripheral, public, private and organizational health structures.

SDA 2: Post-exposure prophylaxis (PEP) (Government PR)

Implementation of this section consists of making 1000 kits per year available to facilities to ensure the case management of people exposed to HIV through blood and 1000 kits per year to ensure the case management of people after exposure following sexual abuse including emergency contraceptives.

SDA 3: HSS (health systems strengthening): Health practitioners (Government PR)

The government of Burundi has introduced a measure to provide free care for children aged 0 - 5 years and birth-related care, which has seen an increase of the number of births attended by a qualified person rise from 20% to 40% today. However, around 60% of births still take place at home with the assistance of a traditional birther. In this context, there is a need for these community participants to be equipped with the correct HIV prevention practices. Their knowledge will be improved through CSO training which will cover 3870 traditional birthers, which is around 30 per village.

The population, especially in rural areas continues to use traditional practitioners for certain areas of care which can be dangerous in general and comprise a risk of HIV transmission in particular. Uvulectomy, bleeding, tooth extraction and other operations are still performed in the community and in deplorable unhygienic conditions. Better practices will be adopted following organized training in the form of 3-day seminars aimed at 2580 traditional practitioners, at the rate of 20 per commune. The training will be facilitated jointly by outreach CSO (traditional practitioners associations) and decentralized level health practitioners.

Objective 1.5: Improve primary prevention of HIV infection in women of reproductive age and strengthen the quality of PMTCT cover by integrating it with RH

This objective will be implemented jointly by the Government PR and the PNSR (National Reproductive Health Program) in collaboration with the Civil Society PR as well as the civil society organizations and the provincial health office (PHO).

SDA1: Reproductive health (Government and civil society PRs)

Access by PLWHA to ARVs increases life expectancy and gives couples the legitimate right to experience father and motherhood under safe conditions and with social and psychological support.

In this context, strengthening and improving the quality of reproductive health interventions is necessary to take into account the specific needs of PLWHA and in particular in the case of HIV-positive couples or couples with differing HIV status to prevent unwanted pregnancy if applicable.

To strengthen the skills of health providers in this area, 600 providers from PLWHA case management centers will receive 12 days of training on family planning.

Training for trainers (6 trainers per province) community organizers/Peer Educators living with HIV (taking into account sex and age) will be organized.

Similarly, training in the sexual and reproductive health of young people and case management of people who are victims of sexual abuse will be provided for 60 providers.

Furthermore 425 members belonging to 85 civil society organizations identified in the provinces (at a rate of 5 per CSO) will enable community actors to play an intermediary role by playing an active part in family planning awareness for women of reproductive age and steering PLWHA towards facilities which offer this service.

SDA2: Prevention: PMTCT (Government and civil society PRs)

Burundi has adopted the strategy of integrating PMTCT in the Sexual and Reproductive Health services. Interventions to prevent mother-to-child transmission of HIV including the family unit will be strengthened qualitatively to move towards standardization. PMTCT sites will provide a complete service for the prevention of mother-to-child transmission to women and their partners, infants born to HIV-positive women and their brothers and sisters according to the standards recommended by WHO and UNICEF. The main outcomes expected include increasing the acceptance rate and collection of test results among women and their partners as well as children.

Extending PMTCT will exclusively target care facilities which already offer prenatal consultation services and newborn care in particular vaccination in the context of the wider vaccination Program. To be able to integrate recipients of RH services at any point of contact, 765 providers (3 per site) will be trained in PMTCT and DBS. Owing to contributions from Round 1 and Round 5 and from the World Bank, from the existing 51 PMTCT sites today the program will extend to 255 PMTCT centers in 2013; which means that 204 new sites will be accredited and operational involving provision of technical and mobile equipment including hemoglobinometers (1 unit per PMTCT site).

Round 8 financing will enable procurement of ARV drugs for prophylaxis for 26,361 HIV-positive pregnant and breastfeeding women, 22,491 newborns of HIV-positive women, Cotrimoxazole for OI prophylaxis in newborns of HIV-positive mothers, HIV-positive pregnant women from the 2nd trimester of pregnancy and for 26,361women, drugs for 12,546 STI cases for PNC in the context of PMTCT

The activities planned for this SDA also include the procurement of reagents and consumables for HIV testing in PNC. A real time PCR device and its accessories, for the viral load in children (and adults) will be provided and installed at Ngozi Hospital in addition to the one already available in the National reference laboratory at the National Institute of Public Health. The relevance of this second PCR device is as a possible substitute in the event of malfunction of the only other device and less importantly to reduce the distances to be covered to convey samples. A contractual relationship with the suppliers will be set up for training and maintenance services.

Finally to ensure better adherence of women and families to the PMTCT Program, the Civil Society PR and civil society organizations will provide psychosocial follow-up to 26,361 women, nutritional support to 9,261 poor HIV-positive pregnant or breastfeeding women and 7,871 children from six to twelve months.

SDA 3: HSS: Information system & Operational research (Government PR)

To improve knowledge, owing that there are no data in this area in Burundi and the need to increase efficiency of the PMTCT Program, a monitoring study of a population of children under PMTCT to analyze the morbidity and mortality and HIV transmission according to ARV regimes is planned. A second study is planned on the involvement of men in PMTCT Programs PMTCT which will be performed by a national consultant.
The two studies will be performed by a team from the Faculty of Medicine under the supervision of the National Reference Center.

Objective 1.6: Promote male circumcision from the point of view of preventing HIV infection

Male circumcision has been selected as a national strategy for reducing the risk of sexually transmitted HIV taking into account international recommendations. The Government PR in partnership with the Ministry of Health and the Civil Society PR will implement this SDA considered as a Round 8 innovation.

SDA 1: Male circumcision (Government PR)

In effect, 17 awareness campaigns will be organized in the 17 provinces in order to circulate information, understanding and adherence to the male circumcision strategy in a care setting with a view to preventing HIV infection. A technical reference committee will be set up to coordinate lobbying.

The care providers will be trained in the technique and to be able to perform it on a large scale. The training will use the “learning by doing” method and the learners will be supervised by a surgeon. Training will be on a results-based contract with the trainer at each facility in question. The circumcision service will also be contracted with 50 hospitals.

Aim 2: Qualitative and quantitative strengthening of therapeutic care of PLWHA, psychosocial and nutritional care of PLWHA (adults and children including OVC)

Burundi has opted for Universal Access to prevention care and support initiated by WHO and UNAIDS. This approach guarantees treatment that is free, with equal access and duration, for all PLWHA with therapeutic indications. This aim will be implemented by the PR/Government in partnership with public, private and organizational case management facilities.

Currently, 48 accredited ARV treatment centers are operational owing to the financial contribution made by the Global Fund during Rounds 1 and 5 and the World Bank through the MAP I Project.

Round 8 financing will allow decentralization to take place and extend comprehensive case management to reach the poorest levels of the population, from national level to peripheral and community level rising gradually from **10,928 PLWHA at the end of 2007 to 34, 500 PLWHA in 2013**.

Objective 2.1: Increase the coverage and quality of therapeutic case management and monitoring of PLWHA at national level

SDA1: HSS (health systems strengthening): Health practitioners (Government PR)

Currently, the providers do not have any tools for standardized case management of opportunistic infections at national level. Training to use algorithms to treat opportunistic infections will be provided for 1470 providers in the first year which is 30 providers per health district. IUD training on comprehensive case management will be pursued through contracts with the NRC.

Three teachers from the School of Cleaning and Laboratory Technicians (Ecole des Techniciens d'Assainissement et de Laboratoire) will be supported to participate in a retrovirology course in Dakar for one month to update their knowledge in the field and convey it adequately to learners

SDA2: HSS (health systems strengthening): Health practitioners (Government PR)

To improve the quality of biological and immunological monitoring of PLWHA, 46 district hospital laboratories will be equipped with spectrophotometers and hematology counters. . The number of ARV case management centers monitoring patients using the CD4 count will increase to 27 whereas currently this service was only available in 13 case management centers, 3 of which are in Bujumbura.

Burundi has a very low number of laboratory technicians. To increase skills laboratory operators will be trained each year and the Round 8 proposal will allow 4 classrooms and a laboratory to be renovated as well as the provision of their technical and mobile equipment. This intervention which will be performed under the supervision of the Ministry of Public Health and AIDS, managed by ETAL as the main contractor, aims to increase the number of graduates per year from 15 currently to 50 from 2012.

Redesigning work and equipping 13 new ambulatory Patient Case management centers will be performed, in addition to the 5 which are already operational to reach the level of at least one center per province.

The number of operational case management centers is 48 today; it is planned to bring this number to 200 at the end of the period in this proposal. For better drug management IT equipment and air conditioning units will be provided to operational centers (the rate of availability will be in accordance with progress of the accreditation of case management centers).

The Government PR will provide running costs for the NRC (telephone, water, electricity, fuel and office supplies) as well as paying the NRC staff. It will participate from June 2010 because it is currently provided in the context of round 5 and will concern 6 units in 2010, 7 in 2011 and 8 in 2012 and 2013

CAMEBU is the strategic pillar in drug management at central level and AIDS product management is the main priority for CAMEBU. The related amount is very large. Logically this increase in the volume of activity and anticipated stocks of drugs and other consumables will generate need in terms of storage and maintenance. CAMEBU's services will be remunerated on the basis of an annual contract and the budget is estimated based on an annual storage cost per m3, the storage area for the HIV and AIDS related products being 1280m^3.

The product quality control service will be entrusted to International Medical Solutions based in South Africa and it will be remunerated according to the number of samples sent to it which itself depends on the number of lots received by the Principal Recipient for each type of product (ARV, OI drugs, reagents, condoms and other health products).

SDA 3: Treatment: Prophylaxis and treatment for opportunistic infections (Government PR)

Activities which aim to improve comprehensive case management and provide in particular opportunistic infection

diagnosis and treatment will be performed by the case management facilities in the public, private and organizational sectors including religious organizations, under the coordination and supervision of the Sector-based unit for the fight against AIDS du Ministry of Public Health and AIDS (USLS/Health)

The Permanent Executive Secretariat of the National AIDS Council (PR: Government) will take care of ordering the drugs and laboratory equipment in view of the skills acquired in Rounds 1 and 5, as well as financing diagnostic and treatment services through contracts with the case management facilities, on the basis of requirements expressed by the Sector based unit for the Ministry of Public Health and AIDS.

The expected outcomes from these activities are the prevention of opportunistic infections by prescribing Cotrimoxazole to 53,103 PLWHA and correctly treating 233,062 cases of opportunistic infections.

SDA4: TB / HIV (Government and civil society PR)

Collaborative activities between the HIV and TB Programs were taken into account in the Tuberculosis proposal in Round 7. This proposal takes into account the specific collaborative activities which fall under the HIV Program. These are as follows:

Accredit all Tuberculosis testing centers (DTC) with VCT and vice versa; train the staff in these centers and provide them with HIV rapid tests; provide the DTC and treatment centers with Cotrimoxazole for prophylaxis of opportunistic infections; place comorbid HIV/TB patients on ARV treatment and provide clinical and biological monitoring; adapt monitoring-evaluation tools for TB/HIV activities and improve the collection, analysis and distribution of data on TB/HIV comorbidity.

A longitudinal and multicentric study on Tuberculosis testing will be carried out by the National Reference Center for case management, training and research into HIV/AIDS HIV/AIDS (NRC) in collaboration with the Executive Secretariat of the National AIDS Council and the National Program to Combat Tuberculosis.

Providers at the ARV treatment centers which are not at the same time Tuberculosis treatment centers will receive training on case management of HIV/TB comorbidity.

SDA 5: Treatment: Antiretroviral treatment (ARV) and monitoring PLWHA (Government and civil society PR)

The Ministry of Public Health and AIDS has developed and implemented an accreditation system for ARV treatment centers and **a plan to extend decentralization of ARV treatment** sites to achieve the Universal Access objective and ensure equality in the provision and accessibility of services. This plan which will run until 2013 aims to increase the number of accredited ARV case management centers from 66 centers at the end of 2008 to **200 centers in 2013**. Currently, there are 48 accredited ARV treatment centers in operation. These centers have provided care for **10,928 PLWHA on ARV treatment in 2007** and clinical and biological monitoring. Decentralization of ARV treatment centers to health centers **in health districts** in rural areas and contractual relationships with case management facilities to ensure **free care for destitute PLWHA** will increase accessibility to case management facilities, both financially and geographically.

Owing to this strategy, the number of PLWHA receiving comprehensive case management will increase gradually **from 10,928 PLWHA in 2007 to 34,500 PLWHA in 2013**, of which 7,097 are children (17500 in 2009; 21,000 in 2010; 25,500 in 2011; 30,000 in 2012; and 34,500 in 2013). To that end, emphasis will be placed on the availability of drugs and reagents for biological monitoring.

For the first two years (2009 and 2010), Round 8 financing will cover the programmatic gaps in the National AIDS control program 2007-2011 for the procurement of first-line ARV drugs and immunovirological monitoring tests for **1,704 and 3,604 PLWHA** respectively. The remainder will be provided by financing from the 2nd phase of Round 5 taking place and MAPII financing from the World Bank.

Particular emphasis will be placed on adherence to antiretroviral treatment by following up support to PLWHA from prescription centers to maintain adherence to care and treatment. Standardized educational tools adapted to Burundi for therapeutic education and promoting adherence to ARV treatment will be developed with technical assistance from an international consultant, and made available to providers to bring this activity to fruition.

SDA6: Care and support: Care and support for the chronically ill (Government and civil society PRs)

Home based care and palliative care is necessary for PLWHA. This will be provided by home based facilitators who will strive to maintain the best quality of life possible for PLWHA and offer support to their loved ones. These actors will have kits to ensure quality home based care (514 kits). In the interest of harmonizing interventions, in the context of this proposal, a regulatory provision for home based care and palliative care will be implemented. Direct support will be provided to PLWHA on ARV requiring home based care and palliative care. They will receive travel costs as

well as home based care kits for the patients requiring palliative care (1,285 kits)

SDA 8: HSS (health systems strengthening): Strengthening community systems (civil society PR)

The role of health mediators who work in PLWHA case management centers in an interfacing role between care providers and patients, is highly appreciable especially concerning adherence to ARV treatment and continuity of care. Their numbers should rise from 191 at the end of Round 5 to 400 in 2012 following recruitment of 160 new recruits who will be trained at a 12 day training workshop. A monthly contract based salary will be granted to 160 new health mediators from January 2009, not forgetting the 191 paid by the 5th round from June 2010.

Objective 2.2: Implement an operational strategy for the medical case management of pediatric HIV/AIDS

Burundi has opted for Universal Access including children. However pediatric case management of HIV infection is still not very developed. Organizing care for pediatric case management will also constitute an innovation from Round 8 and a significant amount of effort.

The pediatric case management activity will be connected to the PMTCT activity in particular promoting early HIV testing in children through parental or guardian awareness and the use of real time PCR, integrating prevention of opportunistic infections using Cotrimoxazole as well as access to ARVs in pediatric care. The Government PR is responsible for this objective in collaboration with public, private and organizational care facilities.

SDA 1: Treatment: Prophylaxis and treatment for opportunistic infections (Government PR)

Activities aiming to improve pediatric case management of HIV (as for the adult PLWHA) will be performed by case management facilities in the organizational sector, faith-based organizations, the government and the private sector under the coordination and supervision of the Sector-based unit for the fight against AIDS of the Ministry of Public Health and AIDS (USLS/Health). The algorithms for treating opportunistic infections set out in objective 2.1 will take into account the specific nature of opportunistic infections in children.

The expected outcomes of such activities are the prevention of opportunistic infections in 8307 children and the treatment of 41, 360 cases of opportunistic infections in children.

SDA 2: HSS (health systems strengthening): Health practitioners (Government PR)

It is planned to develop a national strategy for the pediatric case management of HIV. To accelerate implementation of this strategy, USLS/health will give priority to the training of trainers at decentralized level (health districts) and training in succession of providers who provide case management of opportunistic infections, ARV prescription and clinical and biological monitoring of children living with HIV on ARV treatment. .

Provider training will be centered around the specific clinical, biological, therapeutic and progressive needs of babies and young people. Four-day training workshops will be organized for 670 providers.

SDA 3: Antiretroval treatment (ARV) and monitoring infected children (Government PR)

Pediatric case management was started in Round 5 and will be considerably developed qualitatively and quantitatively in Round 8. To date 1,600 children or 20% of children with therapeutic indications receive ARV treatment and monitoring.

Owing to the implementation of a national HIV infection case management strategy in children, the number of children benefiting from comprehensive case management services will increase gradually from **1,600 in 2008 to 7,097 in 2013, (2,413 in 2009; 3,563 in 2010; 4,291 in 2011; 5,633 in 2012; and 7,097 in 2013).** To this end, emphasis will be placed on the availability of pediatric forms of ARV drugs and reagents for biological monitoring.

Round 8 financing will cover the requirements of the National AIDS Control Strategic Plan for 2011, 2012, and 2013. The requirement for ARV drugs for children for the first two years, 2009 and 2010, will be provided by UNITAID/Clinton Foundation financing.

SDA 4: HSS (health systems strengthening): infrastructure (Government PR)

In order to enable adequate case management of newborns under the PMTCT Program, it is planned to equip the pediatric departments of 5 regional or national referral hospitals (Kamenge UHC, Prince Regent Charles Hospital, Gitega Hospital, Ngozi Hospital and Bururi Hospital) with neonatology kits (bells, incubators, masks, neonatology equipment).

Objective 2.3: Develop psychological and social case management of people infected with and affected by HIV/AIDS (adults and children including OVC)

Faced with this multi-faceted disease, it is essential to offer comprehensive case management of people infected with

and affected by HIV/AIDS. Interventions will be implemented by the PR/Civil society in partnership with the organizations and the PR/Government.

SDA 1: HSS (health systems strengthening): Health practitioners (Government and civil society PRs)

In the context of Round 8, a national psychological and social case management strategy will be developed and set out in an intervention guide for people infected with and affected by HIV. Two types of training (training trainers and training facilitators) will be placed under the direct responsibility of USLS/Health in collaboration with the NRC.

Stress management sessions (4 sessions per year per case management facility for 50% of existing facilities) will be organized for providers in order to help them deal with the stress and exhaustion related to the complex role of medical, psychological and social case management.

Quarterly case management team coordination meetings lasting one day will be organized at provincial level by the PHO.

SDA 2**: HSS (health systems strengthening): Service delivery (Civil society PR)**

In the context of Project APRODIS financed by Round 5, professionals (social psychologists and social workers) were recruited and made available to some public and organizational case management facilities. Their remuneration will be pursued during Round 8 through pursuing delivery contracts.

Case management facilities for PLWHA will organize 4416 discussion group sessions with one session per month for 50% of PLWHA case management facilities (Yr 1: 516, Yr 2: 696, Yr 3: 936, Yr 4: 1068, Yr 5: 1200)

SDA 3: Stigma reduction in all settings (Government and civil society PRs)

During Round 5, a study on the social acceptance of PLWHA in their living environment and workplace was performed. As a result, it was deemed necessary to have a booklet on social rights for facilitators to use as a practical tool giving information on the social rights, legal assistance, action to be taken and any possible actors for ease of reference. 1,000 copies will be printed and distributed in the various facilities affected by the problem.

Objective 2.4: Develop nutritional case management of PLWHA and their beneficiaries

Nutritional support is one area of support which is essential for PLWHA, OVC and poor pregnant and breastfeeding HIV-positive women. The various nutritional interventions will be strengthened upstream and downstream and will be based on the Integrated nutritional care measure (DIPECN) implemented through project APRODIS (5th Round GF). Such interventions will be carried out by the various public, private and organizational care facilities.

SDA 1: Care and support: care and support for the chronically ill (civil society PR)

Nutritional support is essential for PLWHA, OVC and poor pregnant and breastfeeding HIV-positive women. The various nutritional interventions will be strengthened upstream and downstream and will be based on the Integrated nutritional care measure (DIPECN) developed with the support of funding from round 5, phase 1

The case management facilities will distribute 67,883 food kits containing locally available produce to the poorest infected and affected OVC. Over 5 years, the case management facilities will distribute 308,400 nutritional supplement kits covering 20% of known PLWHA who are very poor and living below the poverty line.

Distribution of the 308,400 kits will be performed monthly by the case management facilities. The number of PLWHA covered by the end of the project is estimated at 3500 in 2009 and will increase gradually to reach 6900 PLWHA at the end of 2013 which is 20% of those in need.

PERIOD	2009	2010	2011	2012	2013	
Estimate of the number of PLWHA	174.920	184.490	194.410	204.863	215.878	
Estimate of PLWHA aware of their HIV status	34.984	36.898	38.882	40.973	43.176	20%
Estimate of PLWHA aware of their HIV status below the poverty line	**23.789**	**25.091**	**26.440**	**27.861**	**29.359**	**68%**
Annual number of nutrition kits	42.000	50.400	61.200	72.000	82.800	
Mean recipients to be covered each month	3.500	4.200	5.100	6.000	6.900	
Annual % of PLWHA covered	**15%**	**17%**	**19%**	**22%**	**24%**	

Given the high cost of food and the ever-increasing demand, the contribution of this proposal will only cover part of the requirement, namely 15% in 2009, 17% in 2010, 19% in 2011, 22% in 2012 and 24% in 2013

The content is set out in the Budget Annex containing the budget assumptions and specifies the composition and the quantity of provisions per food kit**.**

Implementation of such interventions from the nutritional support program will be carried out by the various public and organizational case management facilities for PLWHA **under the responsibility of the civil society PR** which is already experienced in financed nutritional support projects in the provinces supported by FHI.

The calculation of the food ration was in accordance with the WFP guideline and the Integrated nutritional care measure (DIPECN) mentioned above.

Calculation of the number of recipients has taken into account a) the estimated number of PLWHA, b) the estimated number of PLWHA aware of their HIV status and using case management services (20% of the estimated number of PLWHA), c) the level of the poverty line in the Burundian population (68%).

For malnourished PLWHA with therapeutic indications, 29,267 renutrition kits will be distributed during the nutritional recovery phase.

5299 culinary demonstration workshops will be organized by case management facilities with the aim of improving nutritional education sessions and providing social interaction for PLWHA

Implementation of the DIPECN requires publication of a booklet to facilitate its use by providers on various delivery levels. 1200 copies of the booklet will be printed and distributed to all the case management facilities.

An Integrated nutritional care measure for PLWHA was developed in Round 5. Recommendations were drawn up in order to improve previous activities and will be taken into account by this proposal, in particular: increase staff in charge of nutritional case management in the facilities, nutritional support for the supplementation and renutrition of poor PLWHA on ARV, monitoring and evaluation of nutritional case management protocols, strengthening capacity and skills of providers through training and production of educational tools.

Aim 3: Strengthening community capacity for the protection of rights, support and reducing the economic impact of HIV/Aids on PLWHA and OVC

The aim is to strengthen community capacity to protect rights, support and reduce the economic impact of HIV/AIDS on PLWHA and OVC. In Round 8, reducing impact will generally target PLWHA and their families and in particular OVC for whom activity in previous Rounds was quite limited. With regard to OVC action will be taken in 9 provinces in particular targeting around 13% of households containing OVC, among households in poverty categories as defined in the Poverty Reduction Strategy and in each of the 1339 hills located in 59 villages of the 9 provinces targeted (on average 64 households per hill, totaling 86,350 households). The choice of 9 provinces out of 17 is based on the complementary nature of an existing support project for OVC in the other 8 provinces supported by DFID through a consortium of local and international NGOs (Nzokira Project, Care-CRS and local partners). The civil society PR in collaboration with the government PR will identify sub-recipients in civil society who are able to implement the activities in each of the 9 provinces.

Objective 3.1: Extend access of the most vulnerable OVC and their households, including the households of PLWHA to a set of basic social services by strengthening the basic community mechanisms.

SDA 1: Care and support: support for orphans and vulnerable children (Civil society and Government PRs)

In order to make the interventions efficient, the eligibility criteria of recipients and the tools used by the committees to protect children's rights will be harmonized in collaboration with the main partners working in this field. In particular, these include partners in the "Nzokira" project, the sub-beneficiaries of civil society who will be trained in the approaches and tools and work in close collaboration with the community through the protection committees working at hill-level, with the Ministry managing the OVC, through the Family Development Centers at village-level and with the provincial authorities in particular the Provincial AIDS Committees. Owing to this community-based partnership network, OVC from 86,350 households targeted will have facilitated access to basic social services:

- 7,500 households containing OVC will receive support with income generating activity;
- From the first year, 71,100 OVC will be supported through school and at the end of 5 years, 398,618 school kits will be handed out to OVC at primary school while 28,340 school kits will be distributed to OVC at secondary school;
- 1,750 OVC taken out of school will have access to professional training and support with starting out, depending on the trade learnt;

- ❖ 25,905 OVC will have access to health care: their medical costs will be paid through contracts with medical case management facilities;
- ❖ 8,634 cases of violations of rights will be resolved, through child rights protection committees.

SDA 2: Care and support for the chronically ill (civil society PR)

In order to reduce the impact caused by HIV/AIDS on PLWHA and their families, it is planned to enhance the medical and psychosocial case management of such people through socio-economic support (6,450 support kits to start AGR will be available through this proposal, please see the details regarding the budget assumptions). 2550 PLWHA will receive socio-professional training for successful reintegration. The details of RGA content for each recipient will be discussed further on a case by case basis with the recipients identified. For this, 1,290 PLWHA leaders will be trained to train the other RGA recipients at a rate of 5 PLWHA per leader. Legal assistance will be provided to PLWHA who require it in order to ensure better protection of their rights and those of their children.

SDA 3: Stigma reduction in all settings (Government and civil society PRs)

Awareness, lobbying and training workshops with the main actors playing a role in anti-discrimination against OVC and PLWHA and resource mobilization for such target populations will be organized.

Objective 3.2: Strengthen capacity of service providers (CSO and government facilities) in the implementation, coordination and monitoring and evaluation of activities for OVC and PLWHA

The organizational and community facilities have played a large role since Rounds 1 and 5 in psychological and socio-economic case management of PLWHA and OVC. They have developed experience and skills in this field and contribute to comprehensive case management of PLWHA by offering complementary services to the treatment offered in public care facilities. They contribute remarkably to decentralizing services and community supervision. In this proposal, five organizational facilities per province will be selected on the basis of performance criteria to be agreed and subsidized to implement support provision either to PLWHA, or OVC within communities

SDA 1: Strengthening of civil society and institutional capacity building (Government PR)

In order to achieve a referral situation in the 9 provinces, a basic study will be performed during the first year. This will measure the impact of the project on OVC. The existing PES/NAC OVC database will be made more efficient and will provide up to date data sorted by age, sex and access to the minimum care package for OVC in the 9 provinces.

SDA 2: HSS (health systems strengthening): strengthening community systems (PR civil society)

The CSOs involved in implementation will receive a performance-based grant to complete the field activities successfully and provide the minimum service package.

Regarding testing, PMTCT, ARV treatment, nutrition and psychological support services, the households will be referred on a case by case basis, mainly through health centers and civil society organizations operating in these fields taking into account the fact that this proposal includes strengthening health systems and decentralizing these services.

Aim 4: Strengthening program management, coordination and monitoring-evaluation

The Round 8 proposal will be implemented by health and social professionals from the public and private sectors in partnership with civil society, the main networks and the NGO or organizations involved in the various service delivery areas.

Objective 4.1: Strengthen national and decentralized planning and coordination of intervention implementation

SDA 1 HSS (health systems strengthening): Service delivery (Government PR)

Contractual relationships were adopted by Burundi as a strategy to stimulate quantitative and qualitative performance of health facilities, also part of the financing within this proposal will be used to pay for the package of HIV services offered to PLWHA in the 400 care facilities selected. To do this, technical assistance from an international consultant and two national consultants will be contracted to perform a study of the cost of service packages to be contracted and develop the related tools. Therefore, provision will be remunerated by quarterly contracts signed between the PR1 and the facilities involved and based on the service packages for: VCT, PMTCT, medical (clinical, paraclinical, hospitalization) and psychological case management.

Decentralized intermediate-level (Provincial Health Office) and peripheral-level health coordination bodies (Health District Office) will play their role in regulating provision in care facilities through training supervision, monitoring and evaluation.

SDA 2: HSS (health systems strengthening): strengthening community systems (Civil society PR)

Civil society organizations to combat AIDS are organized in Networks or Collectives for internal coordination, mutual exchange and strengthening, to carry out joint lobbying and for more representativity. Themed networks of women, young people and PLWHA and faith-based organizations will participate fully in the implementation of the proposal through outreach supervision and training supervision of member CSOs. The networks will involve community-based organizations according to the appropriate mechanisms in order to decentralize towards the activities in the Round 8 proposal down to commune and community level.

Objective 4.2: strengthen the monitoring-evaluation system for outcome-based management

SDA 1: HSS (HIV sentinel surveillance): information system (Government PR)

To better define the gaps and requirements of the national monitoring-evaluation system and connect to other systems, situational analysis of the systems will be performed by a national consultant for 30 days under the technical supervision of PES/NAC (Government PR).

Further to such analysis and the resulting recommendations, 1000 copies of a monitoring-evaluation operating manual will be developed and circulated and users will be trained to use the manual during workshops (5 days) for 300 people.

The Ministry of Public Health and AIDS (MSPLS) is reorganizing its health information system. This will comprise of sub-systems including HIV/AIDS. Once implemented, this new system needs to be expert support and the rollout will be based on the transfer of skills approach.

In the context of strengthening the monitoring evaluation system, a distance network connection will be implemented between the Sub-Recipients and the PR to enable to access the data relating to patient case management such as the numbers on file as well as drug stocks. This will involve renting 50 ADSL lines for the sites connected to the ONATEL network, and procurement of a batch of equipment required for the installation of 50 ADSL lines and the effective installation thereof.

During the 4th year of the Program, technical assistance from an international study office will be hired by the Government PR to lead a national survey combined with behavior and biological monitoring among the general population in order to update the HIV epidemiological situation.

At the same time two other behavior monitoring surveys will be led specifically within key populations at-risk of HIV infection namely female sex workers, men who have sex with men, migrant workers and uniformed personnel. Performance of these studies will be supported by technical assistance from an international research consultancy supervised by PES/NAC (Government PR)

The 8 operational sentinel sites will be provided with consumables kits annually.

In order to assess ARV resistance and adjust treatment plans as required, 5 PMTCT facilities will be contracted for sentinel surveillance of the transmission of resistant strains (2 in Bujumbura, 1 in Gitega, 1 in Ngozi and 1 in Bururi)

SDA 2: Program administration and management costs (Government and civil society PRs)

Strengthening the monitoring-evaluation system for outcome-based management in its component (SDA) administration and management cost of the Program, is intended to provide the main recipients with technical, managerial and financial capacity. Objective I1 provides the PR with the capacity to report to CM Burundi and the Global Fund on financial and program performance for the duration of the Program. It describes the supervision requirements and service provision at the time required by the implementing partners, in the context of the grant awarded by the Global Fund.

Sharing information on interventions and indicator development will be organized through 3 main instruments:

- organization of a national implementation workshop for the Round 8 proposal with all the stakeholders for 100 people over 5 days;
- Annual publication of 1000 copies of an STI/HIV/AIDS epidemiological newsletter;
- Organization of an annual information day on the epidemiological situation concerning HIV/AIDS for 60 participants.

The main elements regarding payment of salaries to human resources including strengthening their capacity in various areas of expertise (15 for the civil society and 20 for the Government PR, procurement of mobile equipment

for supervision and IT equipment including 5 vehicles for the new civil society PR, 4 vehicles for the Government PR (renewing the cartage acquired in Round 1 and 5), 20 computers for the civil society PR (procurement and renewal), procurement of management tools (Tompro) for the new PR, and reconfiguration for the government PR, rental of offices and mobile equipment for the civil society PR.

At the end of each year, each Principal Recipient (government PR and civil society PR) will start an annual programmatic evaluation of interventions which will be realized by an International Consultant and 2 National Consultants, as well as an annual financial audit performed by an audit office specialized in the field.

For efficiency reasons the civil society PR will strengthen its financial service by recruiting a national audit office to monitor Sub-Recipients regularly.

4.5.2. Re-submission of Round 7 (or Round 6) proposal not recommended by the TRP

If relevant, describe adjustments made to the implementation plans and activities to take into account each of the 'weaknesses' identified in the 'TRP Review Form' in Round 7 (or, Round 6, if that was the last application applied for and not recommended for funding).

1. Weak financial gap analysis, which does not provide a clear picture of what resources are already available for each area of the proposal

With regard to gap analysis, the national editorial team and CM members firstly decided to analyze the national priority programmatic requirements using the NSP 2007-2011, the PNDS to strengthen the health system, the PNSR (National Reproductive Health Program) to integrate PMTCT in reproductive health services, and the need to strengthen civil society organizations through their reports and action plans.

During this first stage, thought was put into perspective in order to better identify the Funds available to date, the differential constituting the financial gap which will not enable national objectives to be reached in the various preventative, health and social service delivery areas. Based on these requirements, the amounts to be requested in Round 8 of the Global Fund were identified taking into account the complementarity, sums granted by the World Bank, sums available from phase 2 of Round 5 and sums not yet mobilized owing to the intervention of development partners.

2 Additionality and complementarity are of serious concern, especially with the activities being currently implemented in Round 5. No explanation is provided as to how overlapping is to be avoided.

Owing to in-depth analysis of Programs financed by various development partners, and gaining a perspective of the financial requirements and the gaps identified, the CM national editorial team is taking care to take into account only some of the financial gaps for Round 8 representing approximately **77**% of requirements which are not covered. **The CCM editorial team has systematically researched the complementarity and the additionality between Round 5 phase 2 and Round 8.** The Round 8 proposal will focus on priority requirements which will strengthen what has been started in the context of previous Rounds (Round 1 and Round 5); which are not covered by other partners. There is no overlapping between the activity financed, the previous Rounds, MAP1, MAPII or GLIA; but extension, decentralization and qualitative and quantitative strengthening of some activities which are indispensable to implementing the SDA defined in this proposal. The editorial team has tried to increase clarification of this aspect in the chapters regarding the programmatic and financial gaps and also in the chapters relating to complementarity and additionality with the previous rounds and the other support.

3. Absorptive capacity is of concern in the light of serious delays with disbursement and implementation in Round 5

In the first months of implementing Round 5, the PR has effectively encountered some delay owing to the implementation of management mechanisms, market transfer procedures, agreements with participants from the public sector and civil society . Furthermore large budgetary allowances for drug supplies were not disbursed quickly owing to delays in assessing the drug supplies which were still available to CAMEBU, required by GFATM before any orders.

However the lessons learnt from this experience have shaken up the implementation and absorption capacity shown by accelerating implementation, especially for case management activity. Upon observing this acceleration, CM Burundi asked for GF permission to change the round 5 proposal to 4 years, which initially covered a 5 year period. Therefore phase 2 of Round 5 was signed for 2 years instead of 3 years as previously planned PR absorption capacity was also proven by the satisfactory implementation of MAPI and other previous support by other donor funders.

Current developments in accelerating round 5 show a sharp improvement in implementation and management capacity for improved use of financing, also involving implementation of activities beyond what has been planned.

Furthermore for this Round 8 proposal, strengthening planned capacity for Sub-Recipients, strengthening the health and community system, the CM's financing option performed by two PR with a civil society PR and a public sector PR (dual track), will further increase implementation performance and absorption capacity.

4. There are numerous costly lump sum items in the budget without explanation of their content and reference to expected results. For example: 1.01.43 Specific prevention program $ 850,000; 3.08.02 Specific program for orphans and vulnerable children $ 500,000; 4.12.04 Procurement of materials and equipment for coordination $ 761,000, etc.

In this Round 8 submission, all costs have been broken down in the budget template in the Excel calculation sheet named "Detailed Budget assumptions"). Each cost in the "unit cost" column is explained each time as required in the document. Lump sum costs have been avoided.

5. High, unjustified unit costs (e.g. up to $ 10 for a leaflet or poster, etc).

As clarified in question 4 above, all unit costs will be realized according to living costs and the assumptions set out in the budget document. Budgeting has been developed taking unit costs in Rounds 1 and 5 into account consolidated by taking the increase in living costs into account and global consequences of petrol price increases which have a direct impact on the price of products and service goods, particularly in Burundi which is a landlocked country. The costs reflect the local market. *For example: The market cost of a leaflet is $3 whereas the cost of an average poster is $10*

6 Lack of clarity about the content and output of service delivery contracts with hospitals ($10.5 million) and their connection to ARV supply, lab equipment, and HR costs also requested in the proposal.

The principle of contracts with different implementation partners is part of a service purchasing policy for the recipients from providers. These contracts follow providers' performance in terms of quantity and quality: the number of recipients covered and their satisfaction. Several models exist and are being piloted in our country, managed by the MSPLS and in collaboration with the partners. The content of the services package to be purchased varies according to facility capacity and the type of services offered. An assessment of facility capacity is made before signing the contract.

The experience gained in Round 5 and MAP I showed that contracting with a facility depends on its specialty and capacity. the services package which will be contracted such as: VCT, PMTCT, male circumcision, medical case management (clinical, paraclinical, hospitalization), psychological and biological monitoring services do not take account of the ARV procured at central level, nor procurement of durable equipment, or staff remuneration. However, contracts take into account the expected services, increased workload and the overall performance of interventions.

Intervention quality must take account of the national norms and standards and the time taken to implement interventions. This method is based on the principle of performance-based financing and included in a contract of agreed objectives. Four main points present an added value to this approach:

a) the provision of services according to needs identified within the affected populations (prevention, care and support) ;
b) Making partner stakeholders who have contracts with the PR aware of their responsibilities to achieve objectives;
c) Better traceability of outgoings, in particular for drugs provided to hospitals and health centers;
d) Better financial accessibility of recipients.

A study of the contracted services package costs will be performed, related tools to facilitate management and monitoring-evaluation will be developed, to improve the current experiences with the NGO CORDAID and HEALTH-NET TPO.

7. Lack of clarity about the content and planned implementation of income generation activities

Regarding the content and implementation of income generating activities: Identification of the type of activity will be performed in collaboration with the recipients through a skills assessment. Implementation of RGA and socioprofessional reintegration will be provided by experienced civil society organizations with a coordination and an inter-organizational monitoring evaluation system through the Burundi AIDS Alliance. Such interventions will be for PLWHA, OVC and other vulnerable groups (sex workers, young mothers, women in difficult situations and MSM) as a matter of urgency.

The calculation of the estimated number to be covered comes from the poverty index of the Burundian population. Therefore RGA and/or socioprofessional reintegration will cover around 20% of the open files on PLWHA, OVC and certain categories of vulnerable people.

8. Lack of clarity about the content and planned implementation of the nutrition support program

Nutritional support is one area of support essential for PLWHA, OVC and poor pregnant and breastfeeding HIV-positive women. The various nutritional interventions will be strengthened upstream and downstream and will be based on the Integrated nutritional care measure (DIPECN) developed with the support of Round 5 phase 1 funding. **The content** is set out in the Annex for budget assumptions and specifies the quantity of foodstuffs **per food kit.**

Implementation of such interventions from the nutritional support program will be carried out by the various public and organizational case management facilities for PLWHA **under the responsibility of the civil society PR** which is already experienced in financed nutritional support projects in the provinces supported by FHI.

The calculation of the food ration was in accordance with the PAM guideline and the Integrated nutritional care measure (DIPECN) mentioned above.

Calculation of the number of recipients has taken into account a) the estimated number of PLWHA, b) the estimated number of PLWHA aware of their HIV status and using case management services (20% of the estimated number of PLWHA), c) the level of the poverty line in the Burundian population (68%).

9. Selection of wide variety of ARVs and other drugs is not justified and has no references to the drugs procured in Round 5.

In Burundi the treatment protocols are standardized and correspond to the WHO international recommendations. However, several factors must be taken into account: firstly the majority of patients are treated with first line combinations, which is 85% of the open files, and 15% of patients with second line combinations considering the fact that some patients formerly treated or in therapeutic failure have moved on to second line therapeutic combinations.

The therapeutic regimes which will be acquired in Round 8 take into account not only WHO international recommendations but also pursue regimes approved by the Global fund in April 2008 in Round 5, phase 2. These treatment protocols have just been updated and adopted by the MSPLS in June 2008.

10. While in Round 5 there are considerable savings, including those arising from giving up the plans of buying excessive number of vehicles, more vehicles are requested in this proposal

The financial sums provided for the procurement of vehicles in Round 5 have been reallocated to case management activity in an attempt to cover the priority needs which were not sufficiently taken into account in Round 5.

The vehicles acquired in 2003 with support from Round 1 and the World Bank are now almost completely amortized and require renewal.

The vehicles to be purchased in Round 8 partially take into account the extension of activities in the provinces and also the availability of means in order to improve supervision, the volume of which increases proportionally to the increase in activities.

Furthermore, the fact that the CM opts for two PR with one from civil society and associative networks requires new means of transport.

11. Inconsistency in described weakness of national health system in procurement (4.3.4.), compared to procurement and supply management analysis showing strong existing capacity (4.10.2-4.10.5).

The national editorial committee implemented by CCM Burundi estimates that despite the noteworthy capacity of the supply system, this also presents supply, distribution and dispensation gaps which must be notified and resolved satisfactorily.

In fact, most capacity weaknesses notified concern CAMEBU which owing to the fact that it has State Trustee (Administration Personnalisée de l'Etat) status, cannot have greater financial independence and does not have the right to procure products without going through the public contract procedures, but in particular the methods of drug storage and distribution are insufficient.

This is the reason why PES/NAC which are financially autonomous, experienced and technically competent, performs this mission for CAMEBU in full accordance with the Secretariat of the GFATM and the LFA. Strengthening the health system will involve CAMEBU among others in order to allow it to play its role in the medium term.

12 Data in table 4.3.2. is not consistent with what is written in the text

The national editorial committee implemented by CM Burundi has taken this observation into account to avoid any interpretation and contradiction between the data to be presented in Round 8 and the explanatory text to follow.

13. Numerous inconsistencies and omissions in Attachment A (For example, number of people living with HIV treated for opportunistic infections at 6 months is higher than at the end of year 5, etc).

The national editorial committee implemented by CM Burundi noted that the impact of therapeutic case management thanks to ARV will gradually allow a constant decrease in the occurrence of opportunistic infections. Epidemiologically, reducing the annual occurrence of cases of opportunistic infections is the result of therapeutic benefits from ARV treatment, which is why the amount for such treatment is in decline for the 5th year.

14. Equity issues between different ethnic groups and feasibility of implementation given persistent insecurity are not sufficiently addressed in the proposal.

The very principle of equality in prevention and care provision in the area of public health in Burundi implies that there is no discrimination between the populations nor between sexes, religions or social and cultural points of view. This principle is the basis of the national policy for public health in Burundi (cf. PNDS)

Round 8 in Burundi will develop outreach and involvement with populations themselves to avoid exclusion of any kind.

Decentralization of services down to community level and free care will reduce social exclusion and the constraints related to distance and increase Universal Access.

Extending services by adopting bolder strategies in the area of testing (advanced strategy), integration of testing services, PMTCT, reproductive health in therapeutic case management care facilities and adherence to treatment, psychosocial support, improving the network of patient case management and dispensation of treatment will improve geographical cover in terms of prevention, care and treatment.

Despite problems of insecurity in Burundi's past, there has been no doubt about the strategy to access prevention and care. Huge efforts have been made to bring action to insecure areas through the outreach community interventions but also to the health facilities which have continued to operate. Finally, please note that today, insecurity has decreased considerably owing to the fact that the government of Burundi has just signed an agreement with the last armed rebel group.

4.5.3. Lessons learned from implementation experience

How do the implementation plans and activities described in 4.5.1 above draw on lessons learned from program implementation (whether Global Fund grants or otherwise)?

Mid-track evaluations, supervision reports and technical and financial audits of the implementation of projects to fight AIDS financed by the Global Fund to fight AIDS, Tuberculosis and Malaria (Round 1 and Round 5) and the World Bank, have underlined positive performance of implementation management and the lessons learned by the various participants. The main lessons drawn from implementation of previously financed Programs are taken into account and will be used to the benefit of the Round 8 proposal.

Importance of planning interventions regarding the epidemiological profile

The epidemiological profile of HIV in Burundi is a generalized epidemic which is concentrated on groups who are highly exposed to the risk of HIV. The 8th round interventions are adapted to this specificity. Experience has shown that in the context of an intense epidemic, the interventions targeting high-risk areas and groups are the most effective method of reducing transmission. This aspect was used to develop prevention activities which are essentially adapted to the needs of the most at-risk groups: uniformed personnel, sex workers, young people, MSM, women of reproductive age, prisoners, repatriates, etc.

Decentralization and extension of prevention and case management services

Implementation in previous rounds (1 & 5) proved that it was possible to increase access to services by accrediting decentralized facilities in semi-urban and rural areas. Interventions relating to case management fall into this category with the accreditation of new VCT, ARV treatment and PMTCT sites at health district level, as well as innovative follow-up measures and requests from communities to accelerate Universal Access.

Motivation of staff who work to fight disease

The various audit reports revealed the reticence of some demotivated service providers, in particular those in the public sector who consider service delivery to PLWHA as extra work.

Accounting for the contractual approach in this proposal with case management facilities from both the private sector

and civil society and faith-based organizations will contribute towards improving staff motivation and the quality of case management.

Innovative community approaches

The community interface approach and care facilities through interventions from health mediators, community facilitators and peer educators started in the 1st Round and was followed up in the 5th round and through MAP I, improved the quality of psychosocial case management services and adherence to ARV treatment . This approach will be strengthened and extended during the implementation of this proposal by recruiting new health mediators in the areas covered by case management facilities which will be accredited for ARV treatment during round 8.

Enthusiasm of civil society

The involvement of civil society which has many community organizations, PLWHA organizations, the private sector and the faith-based sector has been an asset for implementing interventions to combat AIDS. These organizations will be strengthened and provided with the required resources to make the most of the skills acquired performing activities for this proposal. Bringing together the various actors in civil society in themed networks strengthens collaboration and coordination of community interventions.

4.5.4. Enhancing social and gender equality

Explain how the overall strategy of this proposal will contribute to achieving equality in your country in respect of the provision of access to high quality, affordable and locally available HIV prevention, treatment and/or care and support services.

(If certain population groups face barriers to access, ***such as women and girls, adolescents, sexual minorities and other key affected populations****, ensure that your explanation disaggregates the response between these key population groups).*

The overall strategy of Burundi's Round 8 proposal takes social equality and equality between the sexes into account across the 4 aims, objectives and the SDA:

- Firstly CM Burundi's national editing team decided to identify the vulnerable populations and the factors determining vulnerability in order to become familiar with the specific needs and respond to their requirements. These groups have already been targeted through the work undertaken by the organizations in Round 5 in particular with women, young girls, adolescents, sexual minorities and drug users. The approach selected for the Round 8 proposal will consist of developing activities in all areas in an innovative way which involves the groups in order to bring them closer to prevention and care provision.
- Strengthening intervention capacity of Civil society organizations through supporting their operation, strengthening partnerships between these CSO and private and public socio-health practitioners to better take into account the specific needs of socially vulnerable populations and at-risk populations is a reality.
- Decentralization of services to community level, improving the ARV dispensation network and OI treatment, improving biological monitoring and free HIV/AIDS related care constitutes a major change of direction to reduce social exclusion and distance-related constraints. Much more importantly, free medical care for children under 5 years including pediatric ARV and OI drugs demonstrates the commitment to expanding Universal Access.
- Extending services by adopting more offensive strategies in the area of testing (PTIC), integration of testing services, PMTCT, reproductive health in therapeutic case management facilities and adherence to treatment, psychosocial support, improving the network of patient case management and dispensation of treatment will increase geographical cover in terms of prevention, care and treatment.
- Implementing specific action for women and young girls, in particular organizing case management services for girls and women who are victims of sexual abuse, taking account of MSM through the appropriate services which will be strengthened , action taken to help sex workers, inclusion of physically or mentally handicapped people, prisoners and other socially vulnerable groups targeted to increase their accessibility to services such as IEC/BCC, PNC, PMTCT, RH, therapeutic and psychosocial case management, voluntary testing, pre- and post- test counseling services provided free of charge for everyone will contribute to improving their living conditions and consequently reduce social inequality. Involving women as actors in the response (peer educators, mediators, NGO/organizations) is one such example.
- Including the Batwa ethnic minority, the only one which is marginalized by the community, for access to all the

HIV/AIDS services is an innovative measure in the proposal. The latter has also planned interventions for PLWHA and adults and children who are affected. Safeguarding the rights of PLWHA and OVC features highly in this proposal. Training trainers, providers and health mediators concerns both sexes indiscriminately and extends to all sectors of the population.

The proposal plans care facility renovation activities, procurement of equipment and supplies, OI drugs and reagents to improve the quality of interventions to combat AIDS.

4.5.5 Strategy to mitigate initial unintended consequences

If this proposal (in s.4.5.1.) includes activities that provide a disease-specific response to health system weaknesses that have an impact on outcomes for the disease, explain:

- the factors considered when deciding to proceed with the request on a disease specific basis; and
- the country's proposed strategy for mitigating any potentially disruptive consequences from a disease-specific approach.

- Burundi has adopted a multisectoral strategy to combat AIDS and interventions in this proposal are directly related to the Strategic Framework to Fight Poverty (CSLP), and fit into the framework of current reforms developed by the PNDS.
- The selected priorities take account of the weaknesses identified by the Ministry of Public Health and AIDS and its partners (creditors and actors in the field).
- The request for a grant in Round 8 aims to improve performance of the contractual approach adopted by the Ministry of Public Health and AIDS. This approach aims to acquire services and motivate the providers involved in the realization of objectives agreed between the two parties. This could demotivate providers from the same institution who were not involved in implementing objectives or who belonged to neighboring structures who do not implement the contractual approach. This approach could have unintended consequences. Motivation concerning all the providers in the facility will therefore be preferable to individual motivation.
- The key populations most exposed to risk of HIV infection for whom the proposal will develop interventions, risk facing stigma from the general population. To avoid this, prevention, case management and impact reduction interventions for the general population will be pursued by permanently promoting a strategy to combat stigma in vulnerable people.
- Cultural aspects risk halting promotion of PMTCT. Women attending PMTCT services can also be subject to stigma and discrimination from their family and social environment. Involving partners and community leaders, community awareness and involving and health mediators of both sexes will ease such obstacles considerably.
- Accreditation of many ARV treatment centers could generate inadequate use of molecules resulting in resistant strains of HIV appearing. The Government of Burundi implemented the National Reference Center to supervise use of the national plans by the case management centers. It also oversees resistance monitoring to eventually propose more efficient treatment plans. A National Drug Management Committee (Comité National de gestion des médicaments) has also been set up to decide on the nature and quantity of drugs (in particular ARV) to be ordered to ensure strict adherence to the national protocols recommended by WHO.

4.6. Links to other interventions and programs

4.6.1. Other Global Fund grant(s)

Describe any link between the focus of this proposal and the activities under any existing Global Fund grant. *(e.g., this proposal requests support for a scale up of ARV treatment and an existing grant provides support for service delivery initiatives to ensure that the treatment can be delivered).*

Proposals should clearly explain if this proposal requests support for the same interventions that are already planned under an existing grant or approved Round 7 proposal, and how there is no duplication. Also, it is important to comment on the reason for implementation delays in existing Global Fund grants, and what is being done to resolve these issues so that they do not also affect implementation of this proposal.

This proposal effectively aims to extend and strengthen interventions undertaken since the 1st Round and for which financing continued with the 5th Round in the context of the continuity of activities taking in to account the triple aspects of prevention of HIV transmission, therapeutic case management of PLWHA and reducing the impact through psychosocial case management and socio-professional reintegration. The service delivery areas indicated as well as other delivery areas deemed important in this proposal will benefit from 5th Round financing of which the 2nd phase which is currently running will end on 31 May 2010.

There is no overlapping insofar as the financing requested for the first two years of this proposal has been calculated exactly to cover the program gaps with regard to the needs identified in the National AIDS Control Strategic Plan 2007-2011 and not covered financially by any partner, nor financing from the 5th Round. .

1. Relating to prevention

The Round 8 proposal aims to extend and diversify outreach prevention activity and through innovative approaches to reduce sexual transmission. . There is also an objective to promote risk reduction approaches among others by reducing sexual transmission by promoting low-risk sexual behavior, reducing transmission of HIV through blood and reducing mother-to-child transmission of HIV. This is the reason why Round 8 will extend voluntary testing services, and testing at the initiative of health providers, training for professionals and promotion through social mobilization which will be provided by community outreach actors. Finally to increase the work on behalf of populations at high risk of STIs and HIV, the Round 8 proposal will increase epidemiological knowledge on these groups and develop outreach activities, counseling and fighting discrimination and stigma in particular for MSM and SW with the participation of stakeholders.

2. Relating to case management

Round 8 financing will enable decentralization to go ahead and services to be extended to reach targets from the National AIDS Control Strategic Plan 2007-2011 as well as projections for 2012 and 2013.

Medical case management

- **For the priority SDA "ARV treatment and monitoring",** while national targets for the first two years of the 8th Round are 17,500 and 21,000 PLWHA adults and children on ARV treatment respectively, the budget requested from the Global Fund for the 8th Round corresponds to the budget required to cover the programmatic gaps for this period. This budget corresponds to the procurement of first line ARV drugs for 1704 PLWHA in the first year and 3604 adult PLWHA in the second year of Round 8 and financing immunovirological monitoring services for them. Antiretroviral treatment and monitoring have always been one of the strategic priorities for 1st and 5th Round interventions. To maintain what has been achieved and increase service access to all PLWHA who need it, financing is requested from the Global Fund to extend and decentralize the case management services in order to treat and provide biological follow up for **34,500** patients at the end of the proposal period in 2013. To achieve this objective, the total financing required for the last three years of the proposal is requested from the Global Fund owing to the fact that there is no objective information on the other sources of financing to date.
- **For the SDA "Diagnosis and treatment of opportunistic infections",** this service delivery area is only very partially covered by Round 5 financing. In effect, only serious opportunistic infections were taken into account only for PLWHA on ARV treatment. The World Bank which largely financed the procurement of prophylaxis and treating opportunistic infections has reduced its contribution in this area as shown by the MAP II budget action plan . The budget requested in this proposal will cover prevention and opportunistic infection diagnosis and treatment for all patients infected with HIV. This strategy is recommended by WHO in the international case management standards of PLWHA.

Psychological and social case management

- **Care and support for the chronically ill:** this service delivery area takes psychological and social case management into account, started in the 1st Round and followed up in the 5th Round. The 8th Round will establish this strategy by implementing measures to perpetuate this provision. With regard to nutritional support of patients infected with HIV according to medical and social criteria, the program was cofinanced with WFP. This program ends in 2008 and no information on the size or extent of a new program is available.
- At a time when public institutions and the organizations have just implemented the integrated nutritional care measure, Round 8 interventions are mainly intended to cover nutritional case management of the poorest PLWHA on ARV treatment. This is a large intervention which is part of long term supervision of PLWHA to improve adherence to ARV treatment.
- For the first two years, the financing requested will cover the programmatic gaps during this period but as need is high and availability is not significant, that amounts to almost all the required budget to achieve the objectives planned for the period covered by this proposal.

For the non-observance of deadlines for sending financial reports

- Delays in sending financial reports do not have a direct effect on the performance of activities, given that case management facilities do not stop such vital patient services at any time. However such delays will have an effect on the level of budgetary performance as the funds in the following sections cannot be disbursed during the period anticipated. This can sometimes lead to a delay in the request for disbursement of funds to the Global Fund with repercussions for the performance calendar of other activities.
- The new contract approach with case management facilities is a response to this problem. The contracts are effectively results-based with regard to the service performance indicators agreed on a monthly basis. Letters of credit will be sent monthly with activity reports. These contracts include staff motivation which is an inciting factor for sending reports and declaring credit at the agreed time.

For the delay in performing operational research activities: Two solutions have been identified and are part of this proposal.

These are as follows:

- obtaining technical assistance from international consultants for some intellectual design and research activities with the participation of National Consultants to facilitate transfer of knowledge.
- Strengthening the National Reference Center for case management, training and research into HIV/AIDS by providing it with the equipment, recruitment and training experts to enable it to play its role.

4.6.2. Links to non-Global Fund sourced support

Describe any link between this proposal and the activities that are supported through non-Global Fund sources (*summarizing the main achievements planned from that funding over the same term as this proposal*).

Proposals should clearly explain if this proposal requests support for interventions that are new and/or complement existing interventions already planned through other funding sources.

This section is developed by referring to various service delivery areas in Round 8 for which CM Burundi recognizes the existing interventions and financing which will take place or be announced by partners in the combat against HIV/AIDS and the health sector.

The service delivery areas are indicated with regard to the NSP strategic axes, which is the reference framework for all stakeholders fighting HIV/AIDS in Burundi.

Axis: Prevention:

SDA: Counseling and testing

The World Bank will provide HIV tests.
The NGO FHI will also provide tests for VCT in its intervention area.

SDA: PMTCT

In the prevention of mother-to-child transmission of HIV through the MAP II project, the World Bank will provide financing for the following activities:

- Prophylactic ARV treatment for 1320 HIV-positive women and 1320 newborns;
- Procurement of equipment for 50 new PMTCT centers;
- Organizing a national annual social awareness and mobilization campaign to promote PMTCT among women of reproductive age;
- Development of a reference and counter reference document between maternity units and case management services;
- Production and distribution of educational support to raise awareness among women of reproductive age;
- The assessment study of interventions to prevent mother-to-child transmission of HIV.

FHI will lend its support through providing doctors in hospitals, training providers in VCT, PMTCT and ARV prescription in the 3 provinces constituting its intervention area.

SDA: Circumcision:

MAP II financing will support a feasibility and acceptability study on circumcision as a supplementary strategy in the measures to prevent HIV transmission.

Axis: Medical, psychological and nutritional case management

SDA: diagnosis and treatment of opportunistic infections:

- World Bank financing for MAP II will be used for the development and implementation of algorithms to treat opportunistic infections

SDA: ARV treatment and monitoring

- MAP II will contribute to the services package for 1000 PLWHA on ARV treatment
- As has been stated earlier, the NGO FHI will continue to support case management facilities in its area of intervention in the fields of case management through allocating doctors to hospitals and training health practitioners on different aspects of case management.

SDA: care and support for OVC

MAP II will cover the period from 2009-2010 with its component 3 and support 20,000 OVC with schooling, 12,000 OVC with medical costs and 34 groups for AGR.

DFID finances the "Nzokira" project to the tune of $9,000,000 USD until 2009 and for a period of 3 years. This Project, implemented by a consortium of NGO comprising of CARE, CRS and 8 local NGOs covers 8 provinces and 30,000 OVC will benefit from the interventions carried out by this consortium in the various fields following the "service package" approach. UNICEF supports around 350,000 to 400,000 children, including OVC each year.

SDA: care and support for the chronically ill

FHI provides nutritional support to poor PLWHA in 3 out of the country's 17 provinces and will expand its interventions to a fourth province in 2009.

At the same time as supporting facilities offering VCT, PMTCT services and prescribing ARVs, it will continue to support community prevention and case management interventions.

Each year, FHI allocates $3,000,000 USD to activities combating AIDS in Burundi and plans to increase this amount.

There is no bilateral cooperation intervention to seriously consider as support.

SDA: Health Systems Strengthening and SDA: community Systems strengthening

Partners involved in this area include CORDAID, HEALTH NET TPO, GIP ESTHER, the European Union through the Santé Plus Project and the GAVI HSS Project. The Government of Burundi is bringing its competition through the IHIPC fund.

FHI supports human resources, layout and renovation of infrastructure, provision with equipment, provider training, procurement of services and drugs, procurement and maintenance of laboratory equipment and office rental for non-government players.

These different contributions finance procurement of performances (contracting) and the current proposal will be integrated into this approach, which has already produced very encouraging results in decentralization and the availability and quality of services and provisions by health practitioners.

Negotiations are underway for a collaboration contract between CORDAID and the Santé Plus Project by the European Union to implement the contractual approach in Ruyigi, Cankuzo, Rutana and Karusi provinces for 2,120,000 Euros covering the period from June 2008 to December 2010.

Formulation of this proposal occurs at a time when the program cycles of the various development partners in the health sector in general and in the fight against AIDS have not yet determined the interventions and budgets to be allocated for the period starting with 2009 (first year of Round 8). This is why their interventions do not appear in this section.

4.6.3. Partnerships with the private sector

(a) The private sector may be co-investing in the activities in this proposal, or participating in a way that contributes to outcomes (even if not a specific activity), if so, summarize the main contributions anticipated over the proposal term, and how these contributions are important to the achievement of the planned outcomes and outputs.

*(Refer to the Round 8 Guidelines for a **definition of Private Sector** and some examples of the types of financial and non-financial contributions from the Private Sector in the framework of a co-investment partnership.)*

The population group is specific: workers in the private or informal sector.

To date, no cofinancing is planned from the private sector part of the Program. There is participation from private companies in certain program activities in areas of work that will certainly be pursued on a much larger scale.

Some private companies have taken the initiative to lead prevention, testing and HIV/AIDS treatment activities in-house for their employees and their dependents and even outside the companies. The Ministry of Public Health and AIDS has provided reagents and ARV to some private companies through Burundi Central Drug Procurement or public care facilities. This corresponds to the Public-Private Partnership (PPP) logic even if this partnership is not yet formal.

These affirmations are based on the cases of private companies which are pioneering PLWHA case management in the working environment. They are also based on the activities of the Burundi Employers' Association (AEB) which has set up an Inter-Company Committee to Fight AIDS (CIELS) which included 55 private companies (in 2006) out of 2,800 with 142,000 employees who will receive greater support during this Program. In fact, CIELS is aware that many large, medium and small companies need to organize ways to improve the fight against HIV/AIDS.
There are currently 205 companies or institutions employing 50 people or more affiliated with the INSS with a total of 95,000 workers including the army and police. Among these, 160 are private with 38,736 workers; 45 are public with 56,644 employees including the army and police.

AEB is in contact with ADRA which has already carried out mobile testing activity in some companies. Demand for the testing service has not been satisfied as it is greater than supply. With the support of ILO, the organization has already led, in collaboration with the Ministry of Employment and the workers' organizations, three-way activities to combat HIV/AIDS within companies. There have been contributions from private companies in the wider community, not merely covering employees from BRARUDI and the National Social Security Institute (INSS) to name but two. Burundi Breweries and soft drinks manufacturers (BRARUDI) has started activities for the public:

- Awareness sessions have been led in the private secondary school, Saint Luc;
- Awareness sessions are planned for the International Lycée and the Lycée du Lac Tanganyika on 25 June 2008;
- Voluntary testing was performed at the Lycée Saint Luc and Lycée du Lac Tanganyika;
- The company has a Facscount device for CD4 counts available to BRARUDI staff and agents from other companies and organizations;
- BRARUDI receives free ARVs from CAMEBU
- BRARUDI receives free reagents from CAMEBU;
- Employees living with HIV who have left the company continue to be case-managed by BRARUDI;
- OI treatment is provided by the company and supplies come from CAMEBU;
- CAMEBU is supplied monthly with ARVs, reagents and OI drugs;

Furthermore, the INSS workers' union has encouraged blood donation and voluntary testing on national and international AIDS days and has actively campaigned to unionize casual workers. This gave rise to the National Federation of Transport, Social and Casual Workers (FNTSI);
Moreover, ILO has recommended that the AEB (Burundi Employers' Association) integrates the casual sector (mechanics, hairdressers, dressmakers etc.…) in its activities;

- Casual workers organized by INSS employees (unionized) in the fight against HIV/AIDS include: bicycle rickshaw drivers, motorbike taxis and domestic workers;
- The INSS medical team organizes listening services to give appropriate advice on HIV/AIDS thanks to a new telephone line which has opened.

The private sector participates in a way which contributes indirectly to program outcomes. In effect, HIV/AIDS has a real impact on economic output. Fighting HIV/AIDS within a company lessens the impact of AIDS on human resources and stabilizes both production and the market. The private sector should develop at the same rate as the public sector and civil society organizations and be similarly well structured. The AEB would like to benefit from support to strengthen its technical and institutional capacity to better coordinate the activities to combat AIDS in the private sector through a national coalition of private companies.

(b) Identify in the table below the annual amount of the anticipated contribution from this private sector partnership. *(For non-financial contributions, please attempt to provide a monetary value if possible, and at a minimum, a description of that contribution.)*

Population relevant to Private Sector co-investment (*All or part, and which part, of proposal's targeted population group(s)?)*	The contribution in question here, whether from the public or private sector, is non-financial. It has not been assessed one way or the other in terms of cost. Private sector population in question: • Employees and employers in private companies Employees in the casual sector

Contribution Value (in USD or EURO)

Refer to the Round 8 Guidelines for examples

Organization Name	Contribution Description (*in words*)	Year 1	Year 2	Year 3	Year 4	Year 5	Total
[use "Tab" key to add extra rows if needed]							

4.7. Program Sustainability

4.7.1. Strengthening capacity and processes to achieve improved HIV outcomes

The Global Fund recognizes that the relative capacity of government and non-government sector organizations (including community-based organizations), can be a significant constraint on the ability to reach and provide services to people (e.g., home-based care, outreach prevention, orphan care, etc.).

Describe how this proposal contributes to overall strengthening and/or further development of public, private and community institutions and systems to ensure improved HIV service delivery and outcomes. ➔ *Refer to country evaluation reviews, if available*.

This proposal was developed participatively by the stakeholders in the combat against Aids in Burundi both from government sectors as well as civil society and community-type organizations. This proposal is therefore a consensual response to the main challenges limiting the population of Burundi in general, and vulnerable groups in particular to universal access to preventative care, treatment and support as defined in the National AIDS Control Strategic Plan and the National Health Development Program.

This proposal aims to intensify prevention activities with more emphasis on preventing mother-to-child transmission and improving medical and psychological case management in the context of universal access. It also aims to give PLWHA, orphans and other vulnerable groups defined in the NSP 2007-2011 the means and the capacity to access income generating activities through organizational supervision facilities; in an adequate context of social and economic reintegration.

This proposal is integrated in the operational strategies which aim to improve access to preventative services, treatment and support while strengthening and innovating them, in particular:

- Decentralization in progress through progressive implementation of health districts which aim for more outreach and connection to improve the populations' access to services. Support will consist of integrating HIV response planning in the health districts' and Provincial Health Offices' annual plans while taking account in this exercise of both public sector and civil society actors;
- The proposal will also grant funds to the services provided by care facilities in the context of performance-based financing taking into account the remuneration of performances based on quarterly contracts with 400 care facilities including a VCT, PMTCT and psychological and medical case management service package. Through this proposal, the national health system will be supported in the effective implementation of human resource stabilization mechanisms in the health sector, which will improve the quality of services;
- Pursuit of the strategy to access prevention and treatment services owing to health mediators playing an interfacing role between the community and health actors. This approach has proved to increase access, reduce stigma, improve adherence to treatment and must therefore be pursued;
- Pursuing network interventions and implementing a reference and cross-reference system to improve the quality of comprehensive case management;
- The proposal will also grant funds to provisions by community and organizational support facilities to the most vulnerable groups, in particular PLWHA, orphans and other vulnerable children.

Finally the proposal will pursue implementation of a results-based monitoring and evaluation system which will be a reference to all the actors in the fight against HIV/AIDS with strict observance of the three one's.

4.7.2. Alignment with broader developmental frameworks

Describe how this proposal's strategy integrates within broader developmental frameworks such as Poverty Reduction Strategies, the Highly-Indebted Poor Country (IHIPC) initiative, the Millennium Development Goals, an existing national health sector development plan, and other important initiatives, such as the 'Global Plan to Stop Tuberculosis 2006-2015' for HIV/TB collaborative activities.

1. ALIGNMENT WITH THE NATIONAL HEALTH DEVELOPMENT PROGRAM (PNDS).

The National Health Policy aims to restructure the sector organizationally and strategically, run interventions in the sector, and will pursue the responsibility and resource decentralization policy and strengthen management capacity at all levels.

This proposal aims to strengthen the National Health Development Program (PNDS) in its various components and

specifically those concerning the 3rd and 4th objective.

a) With regard to the fight against HIV infection and AIDS, the 3rd objective of the PNDS aims to reverse the epidemiological trend of HIV/AIDS by intensifying prevention activity taking into account sexual transmission, blood and mother to child transmission, improve medical and psychosocial case management and improve epidemiological monitoring by strengthening sentinel sites and performing surveys on HIV prevalence and socio-behavioral issues. Regarding the fight against HIV/AIDS , the priorities described in the PNDS correspond to the contribution from the Ministry of Health in realizing the national strategic plan 2007-2011 of the National Aids Council.

b) With regard to strengthening the national health system in the 4th objective, the proposal will contribute to supporting the strategic approach taken by the Ministry of health of implementing stabilizing and motivational mechanisms for health practitioners. This will involve a new remuneration policy, implementing a motivation system based on performance and distance and improving working conditions. The proposal will contribute to renovating and equipping basic health infrastructures and as a matter of urgency those carrying out PMTCT activity and their upkeep and maintenance.

In order to make prevention and case management services accessible, the number of PMTCT sites will be increased to 255 and ARV sites to 200, the proposal will contribute to strengthening them in terms of the specialized platform and human resources.

The community-level contribution will be based on mobilizing behavioral change, promoting effective use of condoms and early prenatal consultations, testing and adherence to the PMTCT protocol for HIV positive women, monitoring mothers and children on the PMTCT program and continuity of care. Particular emphasis will be placed on the involvement of men in reproductive health and PMTCT Programs.

In its health dimension, the HIV component offered integrates fully in the national strategy relating to transmittable diseases, referring to what has been described in the previous section relating to PNDS content. In the objective concerning the fight against transmittable diseases, the PNDS emphasizes the activities relating to three specific diseases in the following order: Malaria, HIV infection and TB. Regarding HIV, the recommended strategic approaches are part of the NSP 2007-2011, which has been developed in close association with the health sector. However the measures recommended by the PNDS to improve the national health system will create a good environment for implementing the component.

All infection prevention services relating to the health sector (VCT, PMTCT, STI treatment, blood security, male circumcision) and all the medical case management activity for PLWHA (ARV prescription, OI treatment) are integrated in the health system. To integrate HIV/reproductive health, the prenatal consultation services will offer VCT services.

In keeping with the fight against TB, it is envisaged to carry out HIV testing in all the TB case management centers and TB testing in the medical case management centers for PLWHA.

All the Health Mediators and Community agents working with PLWHA will be trained in managing HIV/TB comorbidity. Regarding malaria, the two components have the same Principal recipient. There is a real link between the Malaria and HIV components at community intervention level as the HIV case management sites will distribute mosquito nets and antimalarials to PLWHA in particular pregnant women and children under 5.

Microscopes distributed by the malaria component will also be used to diagnose opportunistic infections on PLWHA case management sites. This synergy will reach more recipients and provide them with a minimum service package in terms of fighting HIV, TB and Malaria at the lowest cost.

2. ALIGNMENT WITH INTERNATIONAL INITIATIVES

Burundi has adhered to all the international initiatives concerning HIV/AIDS: the Declaration of Commitment on HIV/AIDS (UNGASS, June 2001), accelerating prevention, the 3x5 initiative and universal access to prevention, treatment, care and support. The New Partnership for African Development (NEPAD) offers a framework and new opportunities to realize African Union objectives on HIV. Burundi is also working in line with Millennium Development Goals (MDG).

On the subject of MDG, Burundi has just drawn up its final needs assessment report in collaboration with its development partners in order to achieve its objectives. In this document, needs are assessed for the period 2007-2015 to achieve the following health MDG: i) Reduce maternal mortality by 2/3 by 2015; ii) Reduce the infant mortality rate by 75% by 2015; iii) Reduce the mortality and morbidity rate of transmittable and deficiency-related diseases by emphasizing Malaria, HIV/AIDS and TB; iv) strengthen health sector performance by improving access to services and the quality of care.

The cost of necessary direct interventions to achieve the health MDG in Burundi between 2007 and 2015 totals $2,820,879,137 USD representing 23% of all sectoral costs totaling $12,483,163,144 USD, or $34.6 USD per head per year on health. The fight against HIV/AIDS, with an amount of $454,297,701USD represents 16% of the amount of the health MDG, followed by the fight against malaria which represents 14%; whereas the budget to cover TB interventions is 1%.

At sub-regional level, Burundi is a member of the Africa's Great Lakes Initiative on AIDS (GLIA).

Burundi has also highlighted financing for the fight against HIV in the context of IHIPC in its priorities. These funds will also contribute to subsidizing care related to childbirth and children under 5 years of age.

4.8. Measuring impact

4.8.1. Impact Measurement Systems

Describe the strengths and weaknesses of in-country systems used to track or monitor achievements towards national HIV outcomes and measuring impact.

Where one exists, refer to a recent national or external evaluation of the IMS in your description.

In 2006, Burundi acquired a National AIDS Control Strategic Plan for the period 2007-2011 (NSP 2007-2011) to face the HIV/AIDS pandemic. This NSP was transformed into a Operational Budget Plan which shows the indispensable key interventions to achieve the expected objectives in 2011. It was in order to be able to report on the progress of implementing the plan that PES/NAC started the participative process of developing a national monitoring-evaluation plan of activities to combat AIDS in the context of the "Three One's".

In view of the importance of Monitoring-evaluation in results-based management, it has proven indispensable to review the strengths and weaknesses of the current monitoring-evaluation system, in a participative process, in order to develop an action plan to strengthen it which will be integrated in the activity to be financed by the resources currently being mobilized. A series of workshops have therefore been organized at national level and in two pilot provinces to improve decentralization of the monitoring-evaluation system.

Capacity strengthening workshops for the monitoring-evaluation system have been organized at central and decentralized level with the "monitoring-evaluation system strengthening tool". The activities proposed to remedy the weaknesses and others to improve the strengths of the monitoring-evaluation system are integrated into this proposal.

The major advantage of the monitoring-evaluation system for activities to combat HIV/AIDS in Burundi lies in its National M&E plan. The latter provides a good description of all the relevant monitoring-evaluation indicators in the National Strategic Program action plan 2007-2011, the frequency of data production, the managers and the data circuit through a clear organizational chart. Data collection tools have been developed (software and registers) for data management and information. Training has been organized for the people who will be using these tools.

Information collected is distributed by means of quarterly, six-monthly and annual reports which are sent to the main participants in the HIV/AIDS field (creditors, Provincial AIDS committees - CPLS, national and international NGOs) and are also available at the PR Documentation Center. The PES/NAC database which contains information on the whole country is also a means of distributing data. The content of these reports will also be distributed on the website: www.cnlsburundi.org and the PES/NAC server for complementary information to that appearing in the aforementioned reports. Information can also be distributed by holding regular meetings. Proven experience in collecting and analyzing data and drawing up reports and the existence of a permanent M&E unit at central and provincial level constitutes the main backbone of the monitoring-evaluation system in Burundi.

However a few weaknesses have been revealed during these monitoring-evaluation system strengthening workshops. Most data are not collected at sub-system level owing to insufficient skills and a lack of motivation whereas the data available are blocked upstream and do not go up to central level and are not always good quality. At PHO-level, not all the health data relating to HIV are centralized nor links with the other reporting institutions. Not all the staff working for the Principal Beneficiaries are trained to use the tools and data management processes. It has also been noted that there are not enough data collection tools (registers and IT equipment).

Analysis of the "monitoring-evaluation system strengthening tool" has enabled weaknesses to be exposed and corrective action has been included in this proposal.

Activities to strengthen the monitoring-evaluation system will start with by analyzing the situation followed by a review/adaptation of the tools and their availability, training on how to use the tools, in particular IT software and computers and on data quality control and finally supervision. Monitoring-evaluation agents will be motivated to

improve their performance. Regular supervision missions will be organized.

To ensure efficient interventions in the proposal, central and decentralized coordination must be strengthened in the spirit of the "three ones" so that the national monitoring-evaluation plan can effectively be a tool which generates the data required for decision making. Studies and surveys will also be organized to measure the effect and impact of all the interventions to combat HIV/AIDS. Genotyping tests to identify ARV resistance started in Round 5 will be pursued with this proposal. Still in the context of impact studies, a second national survey combined with behavioral and biological monitoring (second generation survey) of the general population will be organized after the one organized in 2007 with Round 5 cofinancing and the Multisectoral HIV/AIDS Control and Orphans Project (PMLSAO) financed by the World Bank. Annual programmatic and financial reviews will be organized to improved results-based management.

Coordination and monitoring-evaluation of interventions will be carried out by the two PR.

4.8.2. Avoiding parallel reporting

To what extent do the monitoring and evaluation ('M&E') arrangements in this proposal *(at the PR, Sub-Recipient, and community implementation levels)* use existing reporting frameworks and systems (including reporting channels and cycles, and/or indicator selection)?

In order to avoid parallel reporting, monitoring-evaluation of implementation of this proposal will appear in the context of the national monitoring-evaluation plan of activities to combat HIV/AIDS in the country. The latter describes all the relevant monitoring-evaluation indicators, the frequency of data production, the managers and the data circuit through a clear organizational chart. Strengthening the health information system started with financing from Round 5 and the Project financed by the World Bank will be accelerated with this proposal through training in monitoring-evaluation, IT and telecommunication equipment for data management in real time. The activities proposed during the monitoring-evaluation system strengthening workshops will contribute to harmonizing the data collection circuit and the tools used. For data other than health-related data, the decentralized PES/NAC facilities will contribute to data collection as they have already proved their efficiency. Other harmonization workshops for data collection tools (AIDSinfo for data management, SAGE SAARI for drug management, registers) will be organized to take account of the changes which have occurred with action plan reviews to be realized.

Further to these activities, the quarterly coordination meetings to be organized at central and provincial level will also help avoid parallel reporting.

4.8.3. Strengthening monitoring and evaluation systems

What improvements to the M&E systems in the country (including those of the Principal Recipients and Sub-Recipients) are included in this proposal to overcome gaps and/or strengthen reporting into the national impact measurement systems framework?

➔ *The Global Fund recommends that 5% to 10% of a proposal's total budget is allocated to M&E activities, in order to strengthen existing M&E systems.*

Improvements to the monitoring-evaluation system are shown in the proposal both at PR level and Sub-Recipient level given that weaknesses have been noted at all levels of the system.

Previously, owing to insufficient financial means, the PR was unable to make all the necessary tools available to the partners to meet all the challenges posed by the monitoring-evaluation system in particular the availability of sufficient personnel to collect data, data collection registers, procurement of IT equipment, real time data management and supervision missions.

To make up for various difficulties, this proposal will contribute to the remuneration of personnel responsible for data collection, procuring data collection tools (manuals and software) and training those responsible for data at Sub-Recipient level which will be organized on the monitoring-evaluation system. Equipment and IT networks will be installed to manage data in real time. Training supervision missions will be organized with regard to Sub-Recipients and Sub-Sub-Recipients.

The following activities feature in this proposal to improve the monitoring-evaluation system for activities to combat HIV/AIDS:

- Organize a national implementation workshop for the Round 8 proposal with all the stakeholders;
- Organize an information day on the HIV/AIDS epidemiological situation;
  - ⇨ Perform situational analysis on the monitoring-evaluation system;
  - ⇨ Increase the data collection registers and reporting;
- Train users on manual and electronic data collection tools;

- Obtain validation of data and information produced during implementation by actors at all levels of the pyramid before distribution (improve data quality);
- Improve and update the OVC database;
- Organize quarterly meetings for monitoring and evaluating interventions implemented by the OVC protection committees;
- Organize joint supervision missions by the PR and partners;
- Hold quarterly meetings (the two PR) at central level with the Sub-Recipients to ensure technical and financial follow-up of the grant;
- Produce and distribute reports regarding the "Three One's";
- Publish the HIV/AIDS /STI epidemiological newsletter;
- Acquire biostatistical analysis software for the NRC;
- Procure IT equipment;
- Provide sentinel surveillance of the transmission of ARV-resistant strains;
- Acquire consumables for HIV-prevalence sentinel surveillance sites;
- Train care providers on standardized collection tools (electronic and manual);
- Lead a behavior monitoring survey among the key-populations the most at risk of HIV infection;
- Contribute to performing a national survey combined with behavioral and biological monitoring among the general population;
- Realize an annual programmatic and financial assessment of interventions led by the civil society PR;
- Rent ADSL lines to operate the network in facilities for real time data management;
- Organize trainers' training on data analysis and verifying data quality;
- Provide quarterly training supervision for Provincial Health Offices and Health District Offices.

This proposal will also support implementation of studies/surveys for the Program's initial and final assessments, implementation of combined Monitoring to measure the impact of interventions.

4.9. Implementation capacity

4.9.1 Principal Recipient(s)

Describe the respective technical, managerial and financial capacities of each Principal Recipient to manage and oversee implementation of the program (or their proportion, as relevant).

*In the description, discuss any anticipated barriers to strong performance, referring to any pre-existing assessments of the Principal Recipient(s) **other than 'Global Fund Grant Performance Reports'**. Plans to address capacity needs should be described in s.4.9.6 below, and included (as relevant) in the work plan and budget.*

PR 1	The Permanent Executive Secrétariat of NAC (PES/NAC)
Address	Chaussée Prince Louis Rwagasore, Immeuble banque de la ZEP, BP: 836, Bujumbura BURUNDI

PES/NAC was set up in the context of concrete application of the "three ones", directing principles for concretization of an adequate framework to implement a coherent policy to combat HIV which takes into account efficient coordination of all actors in the field and partners involved in the response to HIV in Burundi.

Over the past six years, PES/NAC has provided proof of its financial, technical and managerial capacities to develop a strategic vision and implement it through relevant, efficient Programs which have allowed it to achieve good results which are visible through an increased number of people receiving medical, nutritional and psychological case management and enjoying preventative services; as well as activities to reduce the social and economic impact of HIV on the recipients of Programs in the Strategic plan.

Since 2002, PES/NAC has developed leadership on the technical and management front enabling it to be the national reference, particularly for promoting and providing efficient technical support to civil society and public institution interventions; while orientating all its activities in a coherent bundle of various services offered to the population in different drop-in, basic and referral socio-health facilities.

PES/NAC has also developed administrative and financial capacities by recruiting and training, at national and provincial level, executives who are skilled in administrative and financial management, which has allowed it to manage different financial resources mobilized with partners in Burundi to combat HIV, in particular GFATM, the World Bank and other United Nations System and bilateral cooperation partners in the fight against HIV. PES/NAC has also developed instruments which enable it to provide financial support for different stakeholders in the fight against HIV, in particular signing agreements with the latter, giving it the possibility of objectively ensuring the observance of various commitments on both sides, awarding contracts observing all the transparency, equity and cost efficiency procedures.

A management team has been set up to strengthen PES/NAC capacity to implement this proposal as in round 5, currently in progress.

PES/NAC therefore justifies its technical, managerial and financial capacity with the panel of professionals it brings into its teams both at central and decentralized level. To implement the National AIDS Program, since June 2002 PES/NAC has effectively recruited experts in different technical fields coming from different backgrounds and experienced in fighting HIV/AIDS . This expertise is in many different guises (doctors, pharmacists, psychologists, sociologists, economists, statisticians, IT experts, administrators, accountants, etc..) and the experts have a strong background with regard to the technical, managerial and financial aspects.

The technical, managerial and financial capacity of PES/NAC is also firmly established by different planning, management and monitoring and evaluation instruments in projects developed since 2002 to date, and which have enabled correct management of the different financing agreements to fight HIV/AIDS in collaboration with the various partners in the field working in Burundi, in particular the Global Fund, World Bank and other United Nations System partners.

Such capacity is also recognized through evaluating different LFA missions on behalf of GFATM, and also through audits and assessments made during different phases of Global Fund financing. This capacity is also appreciated through various World Bank supervision missions.

Furthermore, in this proposal it is planned to strengthen SEP /NAC to enable it to continue to provide better program coordination, decentralization and M&E.

PR 2	The Burundi Network of People Living with HIV (RBP+)
Address	Quartier Kigobe Opposite the United Nations Roundabout B.P. 6881 Bujumbura Tel:(257)22248493 Fax:(257)22248494

The Burundi Network of People Living with HIV/AIDS "RBP+", is a national organization bringing together people living with HIV/AIDS (PLWHA) approved by Ministerial Order n° 530/174 and Act n°1/011 of 18 April 1992 as a non-profit organization in Burundi.

The aim of RBP+ is to make PLWHA and other affected people heard and promote an efficient response to the pandemic.

The main objectives and challenges are:

- to promote visibility and opportunities for people living with HIV/AIDS;
- create awareness and involvement of PLWHA to combat the disease;
- facilitate access to outreach care services for PLWHA in rural areas;
- place people living with HIV at the heart of the community response in all the provinces and villages in the country;
- ensure successful social and professional integration for PLWHA and OVC and change the image of the disease and the people living with HIV/AIDS;
- contribute to mobilizing funds for prevention and case management;
- strengthen partnerships with different actors in view of improving comprehensive case management and prevention services;
- strengthen capacity of PLWHA and OVC to manage their own cases;
- obtain a political response piloted by leadership at the highest summit;
- promote and strengthen lobbying to improve policies and practices, taking account of human rights and similar aspects with regard to HIV/AIDS.

RBP+ continues to expand its range of partners and the latter develop according to its increasing areas of intervention.

At national level, the institutional partners include, among others, the Ministry of Public Health and AIDS, the Vice Ministry of AIDS, the National AIDS Council of which it is a member of the General Meeting and the CM for which it is Vice President.

Other international partners include: GIP-ESTHER, ACTION AID, WOI, Family Health International, UNAIDS, UNDP, OXFAM NOVIB, GLIA and the TIDES Foundation.

At organizational level, the decision-making and management bodies are operational and rational. These bodies are: the General Meeting, the National Committee and the management committee.

This management dynamic is strengthened by the existence of a coordinated mechanism and experienced technical services (Coordinated Mechanism, Programs Department, Administration and Finance Department, planning and M&E department, case management service, prevention service, lobbying and communication service and many others).

RBP+ however intends to acquire complementary staff for some key areas, such as a contract-awarding unit, an IT expert, a complementary M&E unit and a coordination assistant.

The existing personnel must also be strengthened in different areas of expertise in relation to implementation of the proposal.

At decentralized level, RBP+ has four regional offices to supervise field activity throughout the whole country, which are managed in turn by provincial office managers in the country's 17 provinces.

Implementation facilities are also composed of community organizations for PLWHA, RBP+ offices and local branches at decentralized level, public, private and organizational Health centers and hospitals, public, private and organizational technical training establishments etc.…with whom the RBP+ has signed partnership agreements to access outreach services in all the provinces of the country and in different areas of intervention.

The presence of RBP+ across the whole country, knowledge of challenges and opportunities at all levels, partnerships with all the public, organizational, private and faith-based actors and knowledge of management difficulties in agreed partner organizations present an opportunity to take on a future role as a PR.

The existence of recipients who are also service actors at national-level will provide good monitoring and better implementation of interventions.

With regard to managerial capacity, RBP+ has a management system which follows regular procedures in particular the procedure manual. It also has data processing software for different services "RBP DATA BASE", as well as accounting software, SAGE SAARI which is being adapted to the management and accounting activity of the organization.

With regard to evaluation, RBP+ has already undergone international audits (DELOITTE) and project audits financed by various creditors (ACTION AID, FHI, World Bank, Global Fund).

In order to respond efficiently to its new role as PR, RBP+ plans to strengthen its modernization plan in terms of financial management, alignment with different intervention tools as well as strengthening staff capacity which is already underway owing to the support of GLIA, OXFAM NOVIB and the International AIDS Alliance.

External assessment of financial, technical and institutional capacity is underway and a plan to strengthen capacity which various partners are prepared to finance will be proposed.

Please note that RBP+ has a strategic plan 2004-2008 and is preparing to develop a new strategic plan for 2009-2013.

RBP+ has an alert system for monitoring services and service availability at all levels, which allows time to react to any possible malfunction.

The RBP+ alert network will also play the same role for the Government PR to ensure better implementation, coordination and monitoring of interventions relating to the Program.

PR 3	[Name]
Address	[street address]
[Description]	

➔ ***Copy and paste tables above if more than three Principal Recipients***

4.9.2 Sub-Recipients

(a) Will sub-recipients be involved in program implementation?

☒ Yes

☐ No

(b) **If no**, why not?

(c) **If yes**, how many sub-recipients will be involved?

☐ 1 – 6

☐ 7 – 20

☐ 21 – 50

☒ more than 50

(d) Are the sub-recipients already identified?
(If yes, attach a list of sub-recipients, including details of the 'sector' they represent, and the primary area(s) of their work over the proposal term.)

☒ Yes
[Insert Annex Number for list]

☐ No
Answer s.4.9.4. to explain

(e) **If yes**, comment on the relative proportion of work to be undertaken by the various sub-recipients. If the private sector and/or civil society are not involved, or substantially involved, in program delivery at the sub-recipient level, please explain why.

Sub-recipients from the public sector, private sector and civil society will be heavily involved in implementing this proposal. Burundi's experience in fighting AIDS has always promoted participation of all actors, whether public, private or organizational from the first round.

The same applies for other financing. The public and private sectors have always worked together to implement national action plans.

With regard to the public sector, the Ministry of Public Health, the provincial health offices, health district offices, CAMEBU, INSP, NRC, PNSR, public health centers and sectoral units from other ministries and provincial AIDS committees will play an active role in implementing this Program. We are expecting much greater involvement from the health system as demonstrated by the current dynamic through accreditation of several VCT, PMTCT and ARV sites and these facilities receive support for strengthening in terms of capacity, equipment and human resources from different partners.

With regard to civil society, the organizational and private case management facilities, international NGOs, AIDS organizations, AIDS networks, religious organizations and groups of vulnerable people will take part in implementing this program in a much more decentralized way.

Pre-identified Sub-Recipients are largely those who have participated in implementing other projects, either financed by the Global Fund or other creditors and which have proven successful and given a satisfactory performance. We pay particular attention to integrating civil society in general and especially people living with HIV.

We also aim to decentralize in order to cover rural areas. The Sub-Recipients who will receive a large proportion of the funding are as follows: civil society organizations (CSO) involved in case management, hospitals with case management sites, the Burundi AIDS alliance (ABS). These various organizations all have solid experience of partnership with creditors in general and specifically with the Global Fund. Financing will be granted to civil

society organizations responsible for orphans and vulnerable children, HIV prevention in young people and other key populations at high risk of HIV infection. All funds will be released on the agreement of outcomes to be achieved and a technical sheet duly approved by the authorized departments.

Some Sub-Recipients will be able to grant funds to sub-sub recipients, particularly regarding Income Generating Activity (ABS, SWAA, ANSS, Nouvelle Espérance, RBP+, ….). This process will also be implemented with the Ministry of Public Health for financing case management health facilities in the context of performance-based contracts.

The major concern will be to ensure complementarity between public sector and civil society interventions to increase comprehensive access to services, including for marginalized and high-risk groups and to ensure that the needy have access to services in a given area.

The description by SDA of the proportion of related work managed by the different Sub-Recipients appears in the table in Annex N°: 21

4.9.3. Pre-identified sub-recipients

Describe the past **implementation experience** of key sub-recipients. Also identify any challenges for sub-recipients that could affect performance, and what is planned to mitigate these challenges.

The main sub-recipients of this proposal are public, private, faith-based and organizational actors who are already involved in implementing the National AIDS Action plan.

In the public sector, the Ministry of Public Health and AIDS, public hospitals and district health centers involved in the case management of PLWHA as well as various USLS of ministries and institutions (Education, Agriculture, Youth, Defense and former soldiers, National solidarity, National reconstruction, Repatriation, Human Rights and others.

These various facilities have solid experience in fighting AIDS other than participating in implementing various national Programs and projects to fight AIDS (MAPI, Round 1, Round 5,……) and traditional missions for health facilities.

The majority of Sub-Recipients in the public sector are first referral hospitals, provincial hospitals and district hospitals which already have minimal capacity in human resources and which continue to benefit from different support for functionality.

For the civil society sector: NGOs, pre-identified organizational, faith-based and private sector facilities are those already involved in the implementation of the National AIDS strategic plan. For example the organizational and private facilities contribute to the case management of more than 69% of patients on antiretroviral treatment.

Basically, most of these civil society Sub-Recipients have proven experience in implementing sub-projects and/or agreements. They have already worked with other partners such as the World Bank in the context of the decentralized implementation of PMLSAO throughout the implementation of the national action plan (NAP 2002-2006), with the bilaterals and multilaterals such as technical cooperations and United Nations agencies. Also, most have already been audited in the context of supporting the World Bank or the Global Fund through implementing Round 1 and Round 5

As well as the pre-identified facilities, the national NGO collective against AIDS called the “Burundi AIDS Alliance” or ABS was identified as the main sub-recipient responsible for interventions to be implemented by emerging community CSO which are not pre-identified, to increase the community response.

ABS is effectively a network of 236 CSO and 5 collectives and themed networks spread out across the 17 provinces of the country. The network includes experienced, developing and new CSOs including organizations for vulnerable and/or marginalized groups. ABS has a solid background of over 8 years experience in supervising, strengthening capacity, lobbying and coordinating community organizations. ABS already plays an intermediary role in terms of quality of the sub recipients in implementing current Round 5 proposals in progress. It signs sub agreements with the sub/sub-recipients and therefore participates in redistributing resources and decentralizing communities.

The difficulties likely to affect performance include in particular:

- lack of motivation among staff;
- weaknesses in terms of professional competence owing to staff instability;

- weaknesses in the management system and adapted tools;
- weaknesses in terms of planning and M&E;
- lack of coherence, complementarity and synergy of interventions from various Sub-Recipients;
- delays sending reports to the PR which will then delay payments for the following sections;
- late transmission of data required to measure performance.

The solutions planned in the proposal include:

With regard to weaknesses related to unmotivated staff, late reports and transmission of data and staff instability, the contractual approach adopted to implement the proposal will provide an adequate response in this context. Effectively buying performance will motivate staff facilitating implementation with results-based performance for which reports and real time data transmission are performance indicators. This approach will also contribute to stabilizing staff who have already acquired the required professional skills.

With regard to weaknesses related to the management system and adapted tools and M&E planning, this proposal plans to strengthen capacity by training staff and Sub-Recipients and a monitoring and regular training mechanism for Sub-Recipients and sub-Sub-Recipients using a private firm.

Following the lack of efficient participants in the organizational and faith-based sectors in certain provinces, the proposal plans to support emerging actors through efficient networks and organizations in order to cover all the provinces and at the end of the program it is planned to have at least 5 organizational, private and faith-based actors in each province, covering all localities and services.

We are aiming for decentralization here to enable coverage of rural areas and all sectors of the population. A sub-sub recipient system will be used, particularly in rural areas.

To ensure coherence, complementarity and synergy of interventions from various Sub-Recipients, an intervention-launching workshop has been planned to support the development of joint annual plans on provincial level, taking into account actors in the public sector and civil society. Joint reviews and supervision missions have also been planned.

4.9.4. Sub-recipients to be identified

Explain why some or all of the sub-recipients are not already identified. Also explain the transparent, time-bound process that the Principal Recipient(s) will use to select sub-recipients so as not to delay program performance.

Most sub-recipients have been identified. However for some key interventions, geographical coverage is incomplete and to ensure good coverage, it was necessary to use efficient organizations based a long way from the intervention site.

In implementing this Program, it is planned to mobilize at least 85 private sector, organizational and faith-based organizations for implementation in order to ensure maximum coverage of areas a long way from urban centers with regard to the provinces.

Identification will always be based on the intervention and organization capacity, technical and financial management, geographical coverage and intervention in an area with even less coverage, which is defined in the finance code.

Burundi's proposal for Round 8 aims to strengthen intensification and decentralization of AIDS services to move towards standardization through universal access to prevention, treatment, care and support services. Furthermore, it takes into account strengthening of the health system including the community system to improve intervention capacity.

However, some sub-recipients with the potential and likelihood of participating in implementation of some interventions at decentralized and community level have not all been identified yet. It would be difficult to list all the participants who are able to take part in implementation in the proposal.

To select sub-recipients who are not pre-identified, provincial workshops are planned in this program to bring together public, private, organizational and faith-based participants with combined planning. Through this exercise, potential new sub-recipients or sub/Sub-Recipients will be identified and validated with regard to intervention areas,

minimal management and implementation capacity.

With regard to Sub-Recipients in the public sector, all district hospitals which are not yet so, will be registered with the state health system. Efficient district health centers will be identified as sub Sub-Recipients through district hospitals taking into account accessibility of services.

Please note that this program intends to put 200 ARV sites into operation for medical case management, including 49 district hospitals and 9 referral hospitals, with the remainder being made up of public, private and organizational district health centers.

With regard to the schedule of repayments to be followed so as not to delay program performance, it is important to highlight that identification of various key actors has already been completed, and it will be necessary to perform identification each year to enroll new ones.

4.9.5. Coordination between implementers

Describe how coordination will occur between multiple Principal Recipients, and then between the Principal Recipient(s) and key sub-recipients to ensure timely and transparent program performance.

Comment on factors such as:

- **How Principal Recipients will interact where their work is linked** *(e.g., a government Principal Recipient is responsible for procurement of pharmaceutical and/or health products, and a non-government Principal Recipient is responsible for service delivery to, for example, hard to reach groups through non-public systems)*; and
- **The extent to which partners will support program implementation** *(e.g., by providing management or technical assistance in addition to any assistance requested to be funded through this proposal, if relevant)*.

In the context of this Program, traceability of responsibility of the two PR is based on already proven expertise and performance.

The Government PR will pursue prevention and case management interventions led by government facilities (Ministry of Public Health, USLS, Provincial AIDS committees - CPLS, Hospitals and public district health centers - CDS) and medical case management interventions led by private, faith-based and organizational facilities.

The Civil society PR will take responsibility for prevention and psychosocial case management interventions led by the organizational, community, faith-based and private sector facilities for communities, marginalized and high risk groups, PLWHA and OVC and the general population.

The civil society PR will also take care of strengthening the community system to increase and professionalize its interventions through capacity strengthening, operational support and supervision and training activities as well as grants for interventions in the civil society sector.

This traceability of responsibility enables follow-up collaboration to be considered, in evaluating Sub-Recipients' needs, joint assessment of service packages to be offered, identification of indicators to be followed for each principal recipient, joint follow-up of performance and coordinating preparation of agreements, which must be complementary in a given area of action.

Also, PLWHA and OVC case-managed medically by care facilities through the Government PR can be referred to civil society organizations working in the catchment area of the case management site to receive psychosocial follow-up (AGR, legal assistance, various support ….) and capacity strengthening for self management (training on HIV modules, socioprofessional reintegration, organizational management, AGR management etc. …)

Here coordination between the 2 PR and between Contractors under PRs must be set up to determine the services from one another, the reference and counter-reference mechanisms, as well as mechanisms to check the availability of services on all sides.

With regard to Sub-Recipients, traceability of interventions by activity area for prevention and case management interventions will be considered, in order to avoid duplications, follow indicators better, ensure better decentralization and equal access for all areas and all sectors of the population.

Analysis will be performed and consulted upon and service packages defined for types of intervention to ensure cofinancing of typically medical requirements by the Government PR and social services and support services to the facility implemented by the civil society PR. Joint agreements specifying cofinancing could be a solution, with indicators to be followed for each PR.

The two PR already have other means of technical support, supplies, financial support and human resources who will take part in program implementation.

The 2 Government and civil society PR will be supported by the development partners involved in implementing the national action plan. Their contributions will include in particular joint planning implementation and M&E.

The Sub-Recipients also receive technical and financial support from several partners.

4.9.6. Strengthening implementation capacity

The Global Fund encourages in-country efforts to strengthen government, non-government and community-based implementation capacity.

If this proposal is requesting funding for management and/ or technical assistance to ensure strong

program performance, summarize:

(a) the assistance that is planned;**

(b) the process used to identify needs within the various sectors;

(c) how the assistance will be obtained on competitive, transparent terms; and

(d) the process that will be used to evaluate the effectiveness of that assistance, and make adjustments to maintain a high standard of support.

*** (e.g., where the applicant has nominated a second Principal Recipient which requires capacity development to fulfill its role; or where community systems strengthening is identified as a "gap" in achieving national targets, and organizational/management assistance is required to support increased service delivery.)*

In order to ensure a favorable environment to implement the proposal, studies, assessments, maintenance work on biomedical equipment, technical training, audits and the procurement of management tools will occur throughout implementation in order to ensure the quality of services and alignment with principles and the UNGASS declaration and the Millennium Development Goals.

During the development of this proposal, technical assistance needs were raised with regard to the Strategic plan 2007- 2011 not covered by other partners. The various sectors in particular the health sector and the community sector also expressed technical assistance needs, which were discussed and validated by the national team. The other indispensable management or technical support is related to aspects of PR implementation and monitoring, as well as strengthening sub PR

A system for recruiting national and international consultants is already in place and sets out the conditions for competition which ensure transparency and competition.

The same applies for the procurement of services, equipment and management tools.

4.10. Management of pharmaceutical and health products

4.10.1. Scope of Round 8 proposal

Does this proposal seek funding for any pharmaceutical and/or health products?

☐ **No**
➔ ***Go to s.4B if relevant, or direct to s.5.***

☒ **Yes**
➔ ***Continue on to answer s.4.10.2.***

4.10.2. Table of roles and responsibilities

Provide as complete details as possible. *(e.g., the Ministry of Health may be the organization responsible for the 'Coordination' activity, and their 'role' is Principal Recipient in this proposal). If a function will be outsourced, identify this in the second column and provide the name of the planned outsourced provider.*

Activity	Which organizations and/or departments are responsible for this function? *(Identify if Ministry of Health, or Department of Disease Control, or Ministry of Finance, or non-governmental partner, or technical partner.)*	In this proposal what is the role of the organization responsible for this function? *(Identify if Principal Recipient, sub-recipient, Procurement Agent, Storage Agent, Supply Management Agent, etc.)*	Does this proposal request funding for additional staff or technical assistance
Procurement policies & systems	PES/NAC	Principal recipient	☐ Yes ☒ No
Intellectual property rights	Ministry of Commerce and Industry	Other	☒ Yes ☐ No
Quality assurance and quality control	Ministry of Public Health and AIDS (MSPLS) PES/NAC	Sub-recipient and Principal recipient	☐ Yes ☒ No
Management and coordination *More details required in s.4.10.3.*	PES/NAC	Principal recipient	☐ Yes ☒ No
Product selection	MSPLS	Sub-recipient	☐ Yes ☒ No
Management Information Systems (MIS)	MSPLS and PES/NAC	Sub-recipient and Principal Recipient	☐ Yes ☒ No
Forecasting	MSPLS and PES/NAC	Sub-recipient and Principal Recipient	☐ Yes ☒ No
Procurement and planning	PES/NAC and MSPLS	Principal Recipient and sub-recipient	☐ Yes ☒ No

Storage and inventory management *More details required in s.4.10.4*	CAMEBU and PES/NAC	Sub-recipient and Principal Recipient	☐ ☒	Yes No
Distribution to other stores and end-users *More details required in s.4.10.4*	CAMEBU	Sub-recipient	☒ ☐	Yes No
Ensuring rational use and patient safety (pharmacovigilance)	MSPLS and PES/NAC	Sub-recipient and.Principal Recipient	☐ ☒	Yes No

4.10.3. Past management experience

What is the past experience of each organization that will manage the process of procuring, storing and overseeing distribution of pharmaceutical and health products?

Organization Name	PR, sub-recipient, or agent?	Total value procured during last financial year *(Same currency as on cover of proposal)*
PES/NAC	PR	**3 374 433**
CAMEBU (Burundi Central Drug Procurement Unit)	S/B	**20 000 000**

[use the "Tab" key to add extra rows if more than four organizations will be involved in the management of this work]

4.10.4. Alignment with existing systems

Describe the extent to which this proposal uses existing country systems for the management of the additional pharmaceutical and health product activities that are planned, including pharmacovigilance systems. If existing systems are not used, explain why.

To manage supplementary activities relating to pharmaceutical and medical products, this proposal will be based on the existing national systems, including the drug-monitoring systems. All activities relating to selecting, quantifying, procurement, quality assurance, storage, stock management, distribution up to dispensation to patients will be performed in strict accordance with the laws and regulations surrounding Pharmaceutical practice.

The choice of drugs, tests and other health products intended for diagnosis, treatment and/or monitoring patients is made in strict accordance with the national standard algorithms and plans.

All legislative and regulatory aspects will be managed by the Ministry of Public Health and AIDS, through Pharmacy, Drug and Laboratory Management. This particularly concerns registering drugs and other regulated products, issuing import authorizations, inspecting pharmaceutical establishments and also aspects relating to drug quality assurance.

Procurement of pharmaceutical and health products will be carried out by the Executive Secretariat of NAC (PES/NAC) which has just been reappointed as one of the two main recipients of this proposal. The latter has already acquired solid experience in awarding contracts for pharmaceutical and health products and has a highly diverse team of experts including specialists in awarding contracts and Pharmacists with extensive experience in PSM systems.

In fact, PES/NAC has been procuring pharmaceutical and health products since 2002 with World Bank financing, and since 2003 with Global Fund financing to fight HIV, TB and Malaria.

Procurement of pharmaceutical and health products will occur according to procedures stated in the procedure manual specific to HIV Programs financed by the Global Fund which harmonizes it completely with the Global

Fund directives in terms of procurement and stock management of drugs and health products.

Procurement will be performed according to a competitive bidding procedure among suppliers whose products and manufacturing sites meet the standards set out in the Global Fund to fight AIDS, Tuberculosis and Malaria policy in terms of quality assurance. The Pharmacy expert in the APRODIS Project will ensure that Global Fund policy is strictly observed at all times.

CAMEBU, which is the national referral institute for storing and distributing pharmaceutical and health products will be involved to take responsibility for the products as soon as they are delivered and received, as it has always done with products purchased with previous grants. CAMEBU will store, manage and distribute the products, in collaboration with the Sector-based Unit for the fight against AIDS of the Ministry of Public Health and AIDS (USLS/Health).

They will be received by a reception committee nominated by PES/NAC, in which CAMEBU, USLS/Health and other key case management partners will be strongly represented.

USLS/Health will monitor distribution of pharmaceutical and health products. It will check and stamp requests before these are used by CAMEBU. USLS/Health will also perform supervision visits to treatment centers to ensure observance of product management standards and to train the managers.

Diagnosis, prescription and dispensation of pharmaceutical and medical products, as well as biological monitoring of patients is based on the facilities currently dedicated to these activities. This includes voluntary counseling and testing centers (VCT), case management sites and biomedical analysis laboratories.

These facilities are in both the public and private sectors, and include, among others, hospitals, health centers, clinics and organizational sites totally dedicated to fighting the pandemic, etc.

In terms of diagnosing HIV and biological monitoring of patients, it is useful to remember that this is led by the National Institute of Public Health (INSP) which is the national benchmark in this field. Next is the University of Kamenge Hospital Center Laboratory for its specific skills and research activities and the National Blood Transfusion Center (NBTC) for the role it plays in blood security. Other laboratories at all levels of the health pyramid are also involved.

Drug-monitoring activities are conducted in the hospital centers, under the coordination of the National Reference Center (NRC) with regard to HIV, created 2 years ago and whose activities and operations are partially financed by the PR.

The Ministry of Commerce and Industry will take care of aspects relating to international business laws, in particular intellectual property rights and patents, in close collaboration with the Ministry of Public Health and AIDS.

All activity relating to pharmaceutical and health products will be performed under the supervision of the National Management Committee for antiretroviral drugs and other health products intended for the case management of people living with HIV, which is constantly updated on each activity and issues directives.

4.10.5. Storage and distribution systems

(a) Which organization(s) have primary responsibility to provide storage and distribution services under this proposal?

- [x] National medical stores or equivalent
- [ ] Sub-contracted national organization(s) *(specify)*
- [ ] Sub-contracted international organization(s) *(specify)*
- [ ] Other: *(specify)*

(b) For storage partners, what is each organization's current **storage capacity** for pharmaceutical and health products? If this proposal represents a significant change in the volume of products to be stored, estimate the relative change in percent, and explain what plans are in place to ensure increased capacity.

All the drugs and health products procured in the context of Global Fund financing are still stored and distributed by CAMEBU which is the national referral facility for storage and distribution of drugs and medical products.

CAMEBU is staffed by highly qualified personnel, comprising of 3 Pharmacists, 7 university-level managers and 10 intermediate-level managers. It also has an efficient IT tool which provides it with a large capacity for stock and distribution management. It also receives various forms of technical support from different partners. For example a Technical Assistant, recruited by WHO, is already at work and supports CAMEBU to help it to undertake the reforms needed to increase management performance.

CAMEBU also has a very large storage capacity, composed of 7 large warehouses, with an area of 3,000m², two air-conditioned rooms with an area of 500m², 2 cold rooms with a total area of 30m² and premises to isolate dangerous or inflammable products. CAMEBU also has maintenance equipment comprising of 3 pallet trucks and 5 elevators. CAMEBU's storage capacity is currently not being used to its full capacity, and can thus meet growing needs for drugs and health products from this proposal. However, the wooden shelving, currently installed in the various warehouses, is old and is not conducive to good handling. It is for this reason that, taking into account the foreseeable increase in need arising from this proposal, part of the funds from this proposal will be used to strengthen CAMEBU's storage capacity further. In particular it is planned to replace the old shelves with a new storage system on pallets and to procure an electric stacker (to improve maintenance), a binding machine for boxes, a stretch wrapper for palettes, a 40ft cold room and 2 large freezers (one at -20°C and another at -80°C). Using pallets for storage in the place of shelving will meet a foreseeable increase of 20% more products to store.

Management costs will also be granted to CAMEBU in the form of a contract, in particular, to meet the foreseeable increase in terms of storage space required and staff in charge of management and maintenance.

The case management facilities which dispense drugs to patients are also sufficiently equipped to ensure optimal storage conditions for drugs and other health products. However, some of them must acknowledge the rise in need further to this grant and must therefore be strengthened. It will be necessary to provide them with shelves and management tools such as computers, stock management software, stock sheets, etc. It is also planned to provide air conditioning units in all the case management facilities located in very hot areas (temperatures above 25°C), in order to avoid any risk of the ARV medication and the other heat-sensitive provisions deteriorating.

Out of the total volume of antiretroviral medication and health products procured, 69% will be distributed to organizations and other civil society or private sector partners involved in case management of PLWHA (NGO and faith-based organizations) which treat 69% of patients.

CAMEBU which provides the storage and distribution of drugs and health products is equipped with a security system with optimum storage conditions, to avoid theft or deterioration. Moreover the Ministry of Health must ensure that the pharmacies on case management sites meet the same storage conditions before accrediting them.

The Principal Recipient has also installed a computer-based stock management system for CAMEBU and various case management facilities which gives access to data on drug management and health products at any time, as well as the number of patients in receipt of the same. To maintain an acceptable level of performance, the PR will provide support such as training on the use of various management tools, maintaining IT equipment and supervision visits etc.

(c) For distribution partners, what is each organization's **current distribution capacity** for pharmaceutical and health products? If this proposal represents a significant change in the volume of products to be distributed or the area(s) where distribution will occur, estimate the relative change in percent, and explain what plans are in place to ensure increased capacity.

CAMEBU which is the national referral facility for storage, management and distribution of pharmaceutical and health products has already acquired a wealth of experience in distribution. It distributes drugs and health products to all the health facilities in the country, both public and private.

Regarding ARV drugs, opportunistic infection drugs, reagents and other health products intended for the case management of PLWHA, case management centers come to CAMEBU for supplies, having sent a request sheet and then dispense these products to patients themselves. The average distribution pattern of drugs to case management sites is on a monthly basis.

USLS/Health is also highly involved in the distribution system. It verifies requests and stamps them before they are sent to CAMEBU to be issued. Equal funds will be allowed in the context of this proposal to strengthen supervision and distribution capacity.

With regard to logistics, CAMEBU already has enough means for distribution and ensure the rational use of drugs and health products at all levels. In the context of implementing this proposal, and taking into account the volume of products to be distributed, and consequently the workload, a large part of this fund will be allocated to strengthening capacity of CAMEBU.

All the case management sites also have their own logistical solutions adapted to receiving supplies from CAMEBU. The roads leading from the capital, Bujumbura, towards the provinces are passable and the security situation is good.

The small size of the country is an undeniable advantage. The distances between Bujumbura and the provinces are such that each case management facility can receive products requested the same day.

The volume of products to be distributed will be increased gradually over the 5 years covered by the proposal, so that the distribution capacity will not be considerably affected. Nevertheless, it must be noted that with regard to contracts, health facilities involved in the case management of PLWHA will use part of the allocated funds to cover management and administrative costs, including those related to distribution.

4.10.6. Pharmaceutical and health products for initial two years

Complete 'Attachment B-HIV' to this Proposal Form, to list all of the pharmaceutical and health products that are requested to be funded through this proposal.

Also include the expected costs per unit, and information on the existing 'Standard Treatment Guidelines ('STGs'). **However**, if the pharmaceutical products included in 'Attachment B-HIV' are not included in the current national, institutional or World Health Organization STGs, or Essential Medicines Lists ('EMLs'), describe below the STGs that are planned to be utilized, and the rationale for their use.

For the duration of this proposal, the PR will apply national Standard Treatment Guidelines (STG) which are in line with WHO Directives 2006.

This proposal coincides with the recent review of the national Standard Treatment Guidelines (STG) resulting in a significant reduction in choice offered to prescribers. This effort to reduce the number of possible options is part of a public health approach recommended by WHO to make treatment easier to manage, more efficient and less exposed to the emergence of ARV-resistant strains.

Contrary to the Round 7 proposal where there were a lot of ARV outside STG, in particular for the long-standing patients who started ARV treatment before the first national STG were developed, there is now only a single ARV outside STG, Fosamprenavir.

With the agreement of the prescribers, the National Management Committee for ARV drugs and other provisions intended for the case management of HIV, has agreed that all patients on ARV treatment be channeled towards protocols featuring in national STG, except for a dozen of them who have already used the only combination proposed as 2nd line (ABC+DDI+LPV/r) and who must find alternative treatment on account of this. The proposal selected as the only alternative is to replace Lopinavir (LPV) with Fosamprenavir.

The ARV drugs listed in Annex B-HIV regard only first line adult treatment because second line treatments and pediatric treatments (first and second line) will be procured by UNITAID and the Clinton Foundation until 2010.

Please note that ARV drugs, opportunistic infection drugs, reagents and other health products in this proposal are registered in Burundi and appear on the list of Essential Drugs and Medical Consumables in Burundi. If one of the aforementioned products was not registered, the PR would take steps to accelerate its registration with the Ministry of Public Health and AIDS.

With regard to health equipment, the PR will procure the equipment required by technical specifications by the recipient technical services (Hospitals, health centers and medical analysis laboratories) in the private, public and organizational sectors involved in the case management of PLWHA.

4.10.7. Multi-drug-resistant tuberculosis

Is the provision of treatment of multi-drug-resistant tuberculosis included in this HIV proposal as part of HIV/TB collaborative activities?	☐ Yes *In the budget, include USD 50,000 per year over the full proposal term to contribute to the costs of Green Light Committee Secretariat support services.* ☐ No *Do not include these costs*

4B. PROGRAM DESCRIPTION – HSS CROSS-CUTTING INTERVENTIONS

Optional section for applicants

SECTION 4B CAN ONLY BE INCLUDED IN ONE DISEASE IN ROUND 8 and only if:

- *The applicant has identified gaps and constraints in the health system that have an impact on HIV, tuberculosis and malaria outcomes;*
- *The interventions required to respond to these gaps and constraints are 'cross-cutting' and benefit more than one of the three diseases (and perhaps also benefit other health outcomes); and*
- *Section 4B is not also included in the tuberculosis or malaria proposal*

Read the Round 8 Guidelines to consider including HSS cross-cutting interventions.

'Section 4B' can be downloaded from the Global Fund's website here if the applicant intends to apply for 'Health systems strengthening cross-cutting interventions' ('HSS cross-cutting interventions').

ROUND 8 – HIV

5. FUNDING REQUEST

5.1. Financial gap analysis - HIV

➔ *Summary Information provided in the table below should be explained further in sections 5.1.1 – 5.1.3 below.*

Clarified Table 5.1.

Financial gap analysis *(same currency as identified on proposal coversheet)* **Note ➔ Adjust headings** (as necessary) **in tables from calendar years to financial years (e.g., FY ending 2007; etc) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
HIV program funding needs to deliver comprehensive prevention, treatment and care and support services to target populations								
Line A ➔ Provide annual amounts	**21.265.829**	**38.018.080**	**41.947.030**	**46.077.808**	**50.188.964**	**54.104.488**	**57.660.761**	**59.445.236**
Line A.1 ➔ Total need over length of Round 8 Funding Request				*(combined total need over Round 8 proposal term)*				**267.477.257**
Current and future resources to meet financial need								
Domestic source **B1**: Loans and debt relief (*provide name of source*)	539.030	2.285.714	2.348.000	3.000.000	3.000.000	3.000.000	3.000.000	3.000.000
Domestic source **B2** National funding resources	60 705	62.608	63.740	66.927	70.273	73.787	77.476	78.100
Domestic source **B3** Private Sector contributions (national)								
Total of Line B entries ➔ Total current & planned DOMESTIC (including debt relief) resources:	599735	2.348.322	2.411.740	3.066.927	3.070.273	3.073.787	3.077.476	3.078.100
External source **C 1** WORLD BANK	8.578.572	10.760.354	5.000.000	8.199.440	6.986.218			

ROUND 8 – HIV

Financial gap analysis *(same currency as identified on proposal coversheet)* **Note ➔ Adjust headings** (as necessary) **in tables from calendar years to financial years (e.g., FY ending 2007; etc) to align with national planning and fiscal periods**								
	Actual		**Planned**		**Estimated**			
	2006	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**
External source **C2** (United Nations Agency, Bilateral cooperatrion, international NGOs)	4.990.995	2.499.000	3.762.267	3.762.267	3.762.267	3.762.267	3.762.267	3.762.267
External source **C3** Private Sector contributions (International)								
Total of Line C entries ➔ Total current & planned EXTERNAL (non-Global Fund grant) resources:	13.569.567	13.259.354	8.762.267	11.961.707	10.748.485	3.762.267	3.762.267	3.762.267
Line D: Annual value of all existing Global Fund grants for same disease: Include unsigned 'Phase 2' amounts as "planned" amounts in relevant years	**5.285.938**	**6.367.928**	**8.154.800**	**8.040.000**	**4.750.000**			
Line E ➔ Total current and planned resources (i.e. Line E = Line B total + Line C total + Lind D Total)	19.455.240	**21.975.604**	**19.328.807**	**23.068.634**	**18.568.758**	**6.836.054**	**6.839.743**	**6.840.367**
Calculation of gap in financial resources and summary of total funding requested in Round 8 *(to be supported by detailed budget)*								
Line F ➔ Total funding gap (i.e. Line F = Line A – Line E)	1.810.589	**16.042.476**	**22.618.223**	**23.009.174**	**31.620.206**	**47.268.434**	**50.821.018**	**52.604.869**
Line G = Round 8 HIV funding request *(same amount as requested in table 5.3 for this disease)*				**18.572.938**	**22.742.207**	**35.981.258**	**39.626.538**	**42.182.146**

ROUND 8 – HIV

Financial gap analysis *(same currency as identified on proposal coversheet)*

Note ➔ Adjust headings (as necessary) **in tables from calendar years to financial years (e.g., FY ending 2007; etc) to align with national planning and fiscal periods**

	Actual		Planned		Estimated			
	2006	2007	2008	2009	2010	2011	2012	2013

Part H – 'Cost Sharing' calculation for Lower-middle income and Upper-middle income applicants

In Round 8, the total maximum funding request for HIV in Line G is:

*(a) For **Lower-Middle income countries**, an amount that results in the Global Fund's overall contribution (all grants) to the national program reaching not more than 65% of the national disease program funding needs over the proposal term; and*

*(b) For **Upper-Middle income countries**, an amount that results in the Global Fund overall contribution (all grants) to the national program reaching not more than 35% of the national disease program funding needs over the proposal term.*

Line H ➔ Cost Sharing calculation as a percentage (%) of overall funding from Global Fund

$$\text{Cost sharing} = \frac{(\text{Total of Line D entries over 2009-2013 period} + \text{Line G Total}) \times 100}{\text{Line A.1}}$$

%

5.1.1. Explanation of financial needs – LINE A in table 5.1

Explain how the annual amounts were:

- developed *(e.g., through costed national strategies, a Medium Term Expenditure Framework [MTEF], or other basis);* and
- budgeted in a way that ensues that government, non-government and community needs were included to ensure fully implementation of country's HIV program strategies.

Burundi has just developed and validated its National AIDS Control Strategic Plan 2007-2011. Based on this national strategy, Burundi has also developed its national reference plan (operational budget plan 2007-2011) and the budget for the whole period, namely until 2011.

Also, owing to the fact that the strategic plan contains 12 programs, the budget was designed around these programs so that the estimated needs regard the large focus areas, namely primary prevention, testing (voluntary and suggested by providers), care and treatment, psychosocial support and follow-up.

Detailed assessment was performed over the 2007-2011 period based on the input required for realizing the strategy.

Regarding the 2012-2013 period, we have worked on a budgetary extrapolation model in accordance with national requirements taking into account the dynamics of the epidemic.

These large focus areas will be implemented by several partners, namely civil society, government partners, communities and the private sector for which budgetary needs have also been estimated in order to enable them to participate in implementing the planned interventions.

5.1.2. Domestic funding – 'LINE B' entries in table 5.1

Explain the processes used in country to:

- prioritize domestic financial contributions to the national HIV program *(including IHIPC [Heavily Indebted Poor Country] and other debt relief, and grant or loan funds that are contributed through the national budget)*; and
- ensure that domestic resources are utilized efficiently, transparently and equitably, to help implement treatment, prevention, care and support strategies at the national, sub-national and community levels.

In Burundi, the Government's financial involvement translates into its political commitment towards fighting HIV/AIDS. This is demonstrated by a process which places the epidemic highly among public health priorities and is demonstrated by a financial contribution shown by the budgetary allocation both in the context of the annual national budget and the allocation of IHIPC funds of which the level of HIV/AIDS resources is around 10% of the overall package.

This relatively low percentage nonetheless shows the importance of the financial commitment from the Burundian authorities to the epidemic, compared to the size of other needs for the socio-economic development of the country.

5.1.3. External funding *excluding Global Fund* – 'LINE C' entries in table 5.1

Explain any changes in contributions anticipated over the proposal term (*and the reason for any identified reductions in external resources over time).* Any current delays in accessing the external funding identified in table 5.1 should be explained (including the reason for the delay, and plans to resolve the issue(s)).

The current partners involved in the fight against AIDS in Burundi fall into 3 categories:

- Multilaterals (World Bank through MAP, UNICEF, UNFPA, UNESCO, WFP, WHO, GAVI and the

EUROPEAN UNION)

- Bilaterals (Esther, GTZ/KFW, USAID)
- International NGOs (INTERNATIONAL ALLIANCE, ACCORD, CRS, AIDSACTION, AEDES)

The reduced amount of external resources observed from 2011 is due to a foreseeable cessation of financing from the World Bank corresponding to the end of the MAPII project.

5.2. Detailed Budget

Suggested steps in budget completion:

1. **Submit a detailed proposal budget *in Microsoft Excel format as a clearly numbered annex*.** Wherever possible, use the same numbering for budget line items as the program description.

   - **FOR GUIDANCE ON THE LEVEL OF DETAIL REQUIRED** *(or to use a template if there is no existing in-country detailed budgeting framework)* **refer to the budget information available at the following link:** http://www.theglobalfund.org/en/apply/call8/single/#budget

2. Ensure the detailed budget is consistent with the detailed workplan of program activities.

3. From that detailed budget, **prepare a '*Summary by Objective and Service Delivery Area*'** (s.5.3.)

4. From the same detailed budget, **prepare a '*Summary by Cost Category*'** (s.5.4.)

5. Do not include any CCM or Sub-CCM operating costs in Round 8. This support is now available through a separate application for funding made direct to the Global Fund (and not funded through grant funds). The application is available at: http://www.theglobalfund.org/en/apply/mechanisms/guidelines/

5.3. Summary of detailed budget by objective and service delivery area

Objective Number	Service delivery area *(Use the same numbering as in program description in s.4.5.1.)*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
1.1	BCC - mass media	215.558	230.235	141.411	215.847	218.759	**1.021.811**
1.1	BCC—Community outreach	827.479	713.737	437.070	658.847	634.587	**3.271.719**
1.1	Condoms	937.500	993.000	1.413.000	1.463.000	1.513.000	**6.319.500**
1.2	Counseling and Testing	259.257	1.335.640	1.225.126	1.323.482	1.291.667	**5.435.172**
1.5	PMTCT	522.369	1.006.911	1.664.767	2.337.084	2.807.301	**8.338.432**
1.4	Post-exposure prophylaxis (PEP)	116.500	116.500	116.500	116.500	116.500	**582.500**
1.3	Diagnosis and treatment of STIs (sexually transmitted infections)	75.000	75.000	75.000	75.000	75.000	**375.000**
1.4	Blood safety and universal precaution	330.600	330.600	330.600	437.400	437.400	**1.866.600**
2.1, 2.2	Antiretroviral (ARV) treatment and monitoring	749.803	1.369.552	11.867.768	13.896.023	15.911.038	**43.794.185**
2.1, 2.2	Prophylaxis and treatment for opportunistic infections	1.460.163	1.849.165	1.939.169	2.018.555	2.080.735	**9.347.787**
2.1, 2.4	Care and support for the chronically ill	2.153.302	2.260.244	2.667.041	2.951.625	3.298.430	**13.330.641**
3.1	Support for orphans and vulnerable children	2.206.167	3.509.799	3.530.375	2.812.377	2.159.799	**14.218.517**
2.1	TB / HIV	37.114	3.238	4.318	5.397	5.397	**55.464**
3.2	Strengthening of civil society and institutional capacity building	116.576	0	56.576	0	106.576	**279.728**
2.3, 3.1	Stigma reduction in all settings	84.734	29.921	8.655	8.655	8.655	**140.620**

ROUND 8 – HIV

Objective Number	Service delivery area *(Use the same numbering as in program description in s.4.5.1.)*	Year 1	Year 2	Year 3	Year 4	Year 5	Total
1.4, 2.1, 2.2, 2.3, 4.1	HSS (health systems strengthening): Service delivery	3.283.649	1.983.946	3.465.390	4.003.597	4.465.650	**17.202.232**
1.2, 1.4, 2.1, 2.2, 2.3	HSS (health systems strengthening): Health practitioners	874.330	992.240	625.671	448.860	330.382	**3.271.483**
1.3, 1.5	HSS (health systems strengthening): Information system & Operational research	1.267.245	958.244	741.555	906.367	545.601	**4.419.013**
4.2	Coût de gestion et d'administration du Program	2.071.635	2.298.652	2.610.655	2.815.804	2.997.696	**12.794.443**
1.6	Male circumcision	73.867	1.183.060	1.673.969	1.675.675	1.675.675	**6.282.247**
2.1	Community Systems strengthening	450.256	884.624	1.328.062	1.456.440	1.502.298	**5.621.681**
1.5	Reproductive Health (RH)	459.833	617.899	58.580	0	0	**1.136.311**
Round 8 HIV funding request:		**18.572.938**	**22.742.207**	**35.981.258**	**39.626.538**	**42.182.146**	**159.105.086**

ROUND 8 – HIV

5.4. Summary of detailed budget by cost category *(Summary information in this table should be further explained in sections 5.4.1 – 5.4.3 below.)*

Avoid using the "other" category unless necessary – read the Round 8 Guidelines.	*(same currency as on cover sheet of Proposal Form)*					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Human resources	1.182.059	2.045.539	2.953.756	3.282.415	3.541.059	**13.004.827**
Technical and Management Assistance	316.354	107.900	130.694	121.120	130.320	**806.389**
Training	2.847.452	3.035.163	1.326.462	1.149.639	712.507	**9.071.224**
Health products and health equipment	2.371.443	2.710.382	4.785.258	5.561.043	6.233.133	**21.661.259**
Pharmaceutical products (medicines)	2.172.515	3.181.884	12.229.578	14.132.304	15.955.379	**47.671.661**
Procurement and supply management costs	1.020.140	747.052	723.620	723.620	723.620	**3.938.052**
Infrastructure and other equipment	2.058.165	1.560.590	715.430	615.430	383.240	**5.332.855**
Communication Materials	342.584	252.292	140.046	233.347	238.417	**1.206.685**
Monitoring & Evaluation	825.609	781.868	734.643	1.009.120	865.696	**4.216.936**
Living Support to Clients/Target Populations	4.185.288	7.050.196	10.904.509	11.404.317	11.951.480	**45.495.791**
Planning and administration	466.782	467.943	499.157	515.697	524.390	**2.473.969**
Overheads	784.546	801.396	838.105	878.486	922.904	**4.225.437**
Other: *(Use to meet national budget planning categories, if required)*						
Round 8 HIV funding request (*Should be the same annual totals as table 5.2*)	**18.572.938**	**22.742.207**	**35.981.258**	**39.626.538**	**42.182.146**	**159.105.086**

5.4.1. Overall budget context

Briefly explain any significant variations in cost categories by year, or significant five year totals for those categories.

In the budget table summarized by cost categories, the annual budget variations are not significant but follow the logic of increasing activity in the various areas of the proposal. On the five year plan, the variations in the budget are much more significant owing to the fact that they correspond to an accumulation of needs over 5 years. The latter are high for two reasons: (i) antiretroviral treatments correspond to a considerable increase in the open files owing to the national option for Universal Access, (ii) support for people living with HIV and the people targeted who are close to the former. In fact, the more people who need treatment, the more people who need follow-up. (iii) the overall financial means for health equipment corresponds to the overall improvement in the quality of interventions through early diagnosis and immunovirological monitoring of PLWHA, (iv) the amount of human resources is relatively important compared to setting up a contract-based system which enables improved program performance.

5.4.2. Human resources

In cases where '*human resources*' represents an important share of the budget, summarize: (i) the basis for the budget calculation over the initial two years; (ii) the method of calculating the anticipated costs over years three to five; and (iii) to what extent human resources spending will strengthen service delivery.

(Useful information to support the assumptions to be set out in the detailed budget includes: a list of the proposed positions that is consistent with assumptions on hours, salary etc included in the detailed budget; and the proportion (in percentage terms) of time that will be allocated to the work under this proposal.

➔ *Attach supporting information as a clearly named and numbered annex*

Human resources are the 4th largest budget expense in the summary by cost category. However they constitute an important part of implementing the proposal. The basis of calculations for the budget in the first 2 years takes into account the national salary scales and the need for strengthening human resources which will enable interventions in the proposal to be carried out.

The method of calculating anticipated costs in the 3rd year is performed on the same financial basis with a slight increase in human resources proportional to the increase in activities.

These human resources are very important with regard to the ambitions stated in the proposal which appears in the national option for Universal Access. On the one hand, financing acquired in the context of this proposal will enable a significant increase in the numbers of health practitioners generally and health mediators more specifically, whose usefulness is currently proven in terms of ensuring continuity of care to PLWHA. However the contract-based approach adopted will improve performance and the quality of services offered, as pilot schemes in Burundi have shown, (the 2 criteria constitute the basis for defining the indicators included in the contract) and encourage redeployment of care personnel to rural, hard-to-reach areas. The two factors combined will contribute to increasing accessibility of care for populations who were previously not covered, or hardly covered.

5.4.3. Other large expenditure items

If other 'cost categories' represent important amounts in the summary in table 5.4, (i) explain the basis for the budget calculation of those amounts. Also explain how this contribution is important to implementation of the national HIV program.

➔ *Attach supporting information as a clearly named and numbered annex*

- Antiretroviral treatment constitutes the highest budget expense in the proposal, the costs have been estimated on the basis of generic treatments owing to the UNITAID Bill Clinton Foundation agreement.
- Care and support also forms a large budget expense regarding support to PLWHA and OVC by emphasizing aspects regarding improvement of the quality of life, especially RGA and nutrition. Calculations have been performed based on several factors: estimation of a percentage of people requiring direct support (calculation based on open files), estimation of additional needs for other financing (OVC for

example), estimation of limited needs in time (for example RGA) to enable independence.

Health equipment also represents a large budget expense given the necessity of equipping new facilities for decentralization (real time PCR, 2nd national equipment) as well as renewing equipment procured in Round 1. With regard to unit costs, the current practices in force are those in invitations to tender.

5.5. Funding requests in the context of a common funding mechanism

In this section, **common funding mechanism** refers to situations where all funding is contributed into a common fund for distribution to implementing partners.

Do not complete this section if the country pools, for example, procurement efforts, but all other funding is managed separately.

5.5.1. Operational status of common funding mechanism

Briefly summarize the main features of the common funding mechanism, including the fund's name, objectives, governance structure and key partners.

➔ *Attach, as clearly named and numbered annexes to your proposal, the memorandum of understanding, joint Monitoring and Evaluation procedures, the latest annual review, accountability procedures, list of key partners, etc.*

Not applicable

5.5.2. Measuring performance

How often is program performance measured by the common funding mechanism? Explain whether program performance influences financial contributions to the common fund.

Not applicable

5.5.3 Additionality of Global Fund request

Explain how the funding requested in this proposal (*if approved*) will contribute to the achievement of outputs and outcomes that would not otherwise have been supported by resources currently or planned to be available to the common funding mechanism.

If the focus of the common fund is broader than the HIV program, applicants must explain the process by which they will ensure that funds requested will contribute towards achieving impact on HIV outcomes during the proposal term.

Not applicable

5B. FUNDING REQUEST – HSS CROSS-CUTTING INTERVENTIONS (NOT APPLICABLE)

Applying for funding for HSS cross-cutting interventions is optional in Round 8

SECTION 5B CAN ONLY BE INCLUDED IN ***ONE DISEASE*** *IN ROUND 8 and only if this disease includes the applicant's programmatic description of HSS cross-cutting interventions in s.4B.*

Read the Round 8 Guidelines to consider including HSS cross-cutting interventions

Download 'Section 5B' from the Global Fund website here if the applicant intends to apply for 'Health systems strengthening cross-cutting interventions' ('HSS cross-cutting interventions') ***in Round 8 and has completed section 4B and included that section in the HIV proposal sections.***

Proposal checklist

Clarified proposal checklist.

Section	Document description	Annex Number
2.2 c	Minutes of the CM meeting of 12 February 2008 during which the members decided to submit an HIV proposal to the 8th round	Annex 1, Round 8
2.2.7 b	Internal regulations of CM BURUNDI	Annex 2, Round 8
2.2 a ; 2.2.c	Communiqué of call for proposals from potential participants to formulate the HIV proposal for Round 8 of the Global Fund	Annex 3, Round 8
2.2 b	Letter acknowledging receipt of the sub proposals received by the CM following a call for proposals	Annex 4, Round 8
2.2 b	Letter stating the sub proposals to managers of the thematic groups on the editing committee of the proposal to analyze and integrate into the national proposal.	Annex 5, Round 8
2.2 c	Letter appointing preparatory commissions of the HIV proposal to be submitted to GFATM For Round 8	Annex 6, Round 8
2.2 c	Report from the CM and the extended editorial committee for editing the HIV proposal for the 8th round of the Global Fund dated 14 April 2008	Annex 7, Round 8
2.2 c	Report from the extended editorial committee for editing the HIV proposal for the 8th round of the Global Fund dated 24 April 2008	Annex 8, Round 8
2.2 c	Report from the extended editorial committee meeting for editing the HIV proposal for the 8th round of the Global Fund dated 29 April 2008	Annex 9, Round 8
2.2.2 d	Minutes of the CM meeting dated 13 May 08 decided which elements to include in the 8th Round HIV proposal.	Annex 10, Round 8
2.2.4 b	Minutes of the CM meeting dated 19 May 2008 during which the embers appointed the Principal recipients of the 8th Round HIV oposal	Annex 11, Round 8
2.2.2 c	Minutes of the CM meeting dated 30 June 2008 during which the members approved the HIV proposal to be submitted in the 8th Round	Annex 12, Round 8
	Verbal note 05/RE-GEN/2008	Annex 13, Round 8
4.1 a ; 4.3.1	National Policy for Orphans and other Vulnerable children	Annex 14, Round 8
4.1 a ; 4.3.1	National Action Plan for Orphans and Vulnerable Children 2007-2011	Annex 15, Round 8
4.1 a ; 4.3.3	National Reproductive Health Policy	Annex 16, Round 8
4.6.2 ; 5.1.3	Burundi's proposal to support health system strengthening 2006-2010 financed by GAVI	Annex 17, Round 8
2.1.3 c ; 2.2.2 a ; 2.2.2 b ; 3.5 ; 4.1 a ; 4.5.1 ; 4.6.1 ; 4.7.1 ; 4.7.2 ; 4.8.1 ; 4.9.1 ; 4.9.3 ; 4.9.6 ; 5.1.1	National AIDS Control Strategic Plan 2007-2011	Annex 18, Round 8
4.1 a	ARV treatment plans in Burundi, May 2008	Annex 19, Round 8
4.1 a	National Condom Policy	Annex 20, Round 8

Proposal checklist

2.2.2 b	List of Sub-Recipients represented by sector and service delivery areas	**Annex 21, Round 8**
4.3.2	Accreditation norms and standards for HIV voluntary counseling and testing centers, ARV case management and PMTCT	**Annex 27, Round 7**
4.10.6	National list of essential drugs, May 2004	**Annex 28, Round 7**
4.3.2 ; 4.3.3 ; 4.7.2	National Policy for the prevention of mother-to-child transmission of HIV in Burundi, February 2004.	**Annex 29, Round 7**
3.5 ; 4.1 a ; 4.5.5	Strategic Framework for growth and to fight Poverty, Poverty Reduction Strategy Paper, August 2006.	**Annex 30, Round 7**
2.2.2 a ; 4.1 a ; 4.7.1 ; 4.7.2	National Health Development Program 2006-2010, December 2005	**Annex 31, Round 7**
4.1 a ; 4.7.2 ; 4.9.6	Plan to achieve the Millennium Development Goals. (General needs assessment report to achieve the MDG	**Annex 33, Round 7**
4.7.2	Plan to achieve the Millennium Development Goals. (Evaluation of needs in the health sector, February 2007)	**Annex 34, Round 7**
3.5 ; 4.5.1	Joint support program to fight HIV/AIDS	**Annex 35, Round 7**
4.10.6	Review of the ARV treatment plans in Burundi	**Annex 36,Round 7**
4.9.4	Financing code of the civil society response, May 2005	**Annex 37, Round 7**
3.5 ; 4.5.1 ; 4.9.2 e ; 5.4.1 ; 5.4.2	Internal appointment at the Ministry of Public Health	**Annex 38, Round 7**
3.5 ; 4.1 a ; 4.5.5	Priority action plan to implement the CSLP 2006-2010	**Annex 39, Round 7**
Annexe A	National monitoring-evaluation plan of activities to combat AIDS	**Annex 40, Round 7**
	[Use the Tab button to add lines if necessary]	

Attachment A - HIV Performance Framework

Program Details

Country:	BURUNDI
Disease:	HIV
Proposal ID:	PRIDE

Program Goal, impact and outcome indicators

	Goals
1	Strengthening the STI/HIV program by integrating RH and improving direct prevention, preventive care and support in the general population and the most at-risk key populations
2	Qualitative and quantitative strengthening of treatment and management of managed care of PLWHA, and psychological, social and nutritional care of PLWHA (adults and children including OVC)
3	Strengthening community capacities for the protection of rights, support, and reduction of the economic impact of HIV/AIDS on PLWHA and OVC
4	Strengthening the Program's management, coordination and monitoring-evaluation capabilities
5	

Impact and outcome Indicators	Indicator	Baseline			Targets					Comments*
		value	Year	Source	Year 1	Year 2	Year 3	Year 4	Year 5	
impact	% of young women and men aged 15-24 who are HIV infected	4.80%	2005	2005 epidemiological bulletin	3%		2%		2%	
impact	Percentage of PLWHA undergoing ARV who are still alive after 12 months of treatment	80.00%	2007	SIDAINFO database	92%	93%	93%	93%	93%	
impact	% of infants born to HIV infected mothers who are infected	5.00%	2007	SIDAINFO database	4.20%	3.60%	3.60%	3.60%	3.60%	
outcome	Percentage of youth aged 15-24 (girls and boys) who have had more than one sex partner over the last 12 months and who state they used a condom the last time they had sex	F: 42,1% M: 47,6%	2004	BSS (Behavioral Surveillance Survey)		F: 65% M:70%			F: 75% M: 80%	
outcome	% of female and male sex workers reporting the use of a condom with their most recent client	74,20%	2004	BSS (Behavioral Surveillance Survey)		80%			95,0%	
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* please specify source of measurement for indicator in case different to baseline source

Program Objectives, Service Delivery Areas and Indicators

Objective Number	Objective description	Comments
1	Strengthen outreach prevention services to key populations most at risk of HIV	
2	Promote HIV screening strategy initiated by provider in all health services	
3	Continue to improve STI diagnosis and treatment in all health structures	
4	Improve prevention of blood transmission of HIV, care of blood-exposure accidents and care of rape victims	
5	Improve primary prevention of HIV infection in women of reproductive age, and improve quality of PMTCT coverage by incorporating it into reproductive healthcare	
6	Promote the practice of male circumcision in the interest of preventing HIV infection	
7	Increase coverage and quality of managed care and monitoring of PLWHA on a national scale	
8	Implement an operating strategy for medical care of pediatric HIV/AIDS	
9	Develop psychological and social care of people infected and affected by HIV/AIDS (adults and children, including OVC)	
10	Develop nutritional care of PLWHA and their dependents	
11	Extend access of the most vulnerable OVC and their households (including PLWHA households) to a range of basic social services, building on community-based mechanisms	
12	Improve service providers' capabilities (CSO and government facilities) in implementing, coordinating, monitoring and evaluating activities for OVC and their households	
13	Improve national and decentralized planning and coordination of intervention deployment	
14	Improve monitoring-evaluation system for results-based management	
15		

Attachment A - HIV Performance Framework

Program Details

Country:	BURUNDI
Disease:	HIV
Proposal ID:	PRIDE

Objective / Indicator Number (e.g.: 1.1, 1.2)	Service Delivery Area	Indicator	Baseline (if applicable)			Targets for year 1 and year 2				Annual targets for years 3, 4, and 5			Directly tied (Y/N)	Baselines included in targets (Y/N)	Targets cumulative (Y-over program term/Y-cumulative annually/N-not cumulative)	DTF: Name of PR responsible for implementation of the corresponding activity	Comments, methods and frequency of data collection
			Value	Year	Source	6 months	12 months	18 months	24 months	Year 3	Year 4	Year 5					
1.1	Condom	Number of male condoms distributed	14,350,707		February 2008 APRODIS Report		7,500,000	11,500,000	16,000,000	33,000,000	50,000,000	67,000,000	Y	N	Y - over program term	PR1 + PR2	Quarterly
1.2	Condom	Number of female condoms distributed	87,500		February 2008 APRODIS Report	35,000	70,000	130,000	190,000	390,000	640,000	940,000	Y	N	Y - over program term	PR1 + PR2	Quarterly
1.3	BCC - community outreach and schools	Number of students who benefited from BCC activities	3,139		February 2008 APRODIS Report	45,000	68,400	77,400	77,400	216,000	216,000	216,000	Y	N	N - not cumulative	PR1 + PR2	Quarterly
1.4	BCC - Mass media	Number of out-of-school youth who benefited from BCC activities	3,667		February 2008 APRODIS Report	194,400	472,500	658,800	696,600	2,786,400	2,786,400	2,786,400	Y	N	N - not cumulative	Government PR	Quarterly
1.5	BCC - community outreach and schools	Number of sex workers who benefited from BCC activities	66.9% (2341/3500)		February 2008 APRODIS Report	500	1,000	1,500	2,000	3,000	4,000	4,000	Y	N	Y - over program term	Civil Partnership PR	1000 Sex Workers made aware each year
1.6	BCC - community outreach and schools	Number of men who have sex with men who are aware	ND				100	100	200	300	300	300	Y	N	Y - over program term	Civil Partnership PR	Quarterly, number estimated based on NGO outreach activities
2.1	Testing and Counselling	Number of people screened	147,575		2007 NAC Report	158,000	158,000	177,176	177,176	394,109	435,238	477,796	N	N	N - not cumulative	PR1 + PR2	There are 216, 000 tests for Year 1 which are performed by Round 5 and 100,000 by MAPII
2.2	Testing and Counselling	Percentage of pregnant women who complete the voluntary screening cycle	92.97%		February 2008 APRODIS Report	93%	93%		94%	95.00%	95.00%	95.00%	N	N	Y - over program term	PR1 + PR2	Number of women tested who came back for their result, divided by the total number of women tested
5.1	PMTCT	Number of women who have received PMTCT	3,714		February 2008 APRODIS Report	1,815	1,815	2,525	2,525	5,546	8,318	10,318	Y	N	N - not cumulative	PR1 + PR2	
5.2	PMTCT	Number of HIV+ pregnant women who have received nutritional support under PMTCT	544		February 2008 APRODIS Report	635	635	875	884	1,941	2,911	3,611	Y	N	N - not cumulative	PR1 + PR2	
5.3	PMTCT	Number of newborns with HIV+ mothers who have received nutritional support	414		February 2008 APRODIS Report	1,179	1,179	1,642	1,642	4,109	5,411	6,712	Y	N	N - not cumulative	PR1 + PR2	
6.1	Male circumcision	Number of people who have had male circumcision	ND				1,920	13,920	35,520	83,520	131,520	179,520	Y	N	N - not cumulative	PR1 + PR2	
7.1	Antiretroviral treatment (ARV) and monitoring	Number of PLWHA who have received ARV treatment	10,928		2007 NAC Report	14,196	17,500	19,250	21,000	25,500	30,000	34,500	N	Y	Y - over program term	PR1 + PR2	Additional funding by UNITAID/ CLINTON FOUNDATION. Treatment for adults and children.
10.1	Care and support for the chronically ill	Number of neediest PLWHA who have received nutritional supplements from	1,228		February 2008 APRODIS Report	2,839	3,500	3,850	4,200	5,100	6,000	6,900	Y	N	N - not cumulative	PR1 + PR2	
11.1	Support for orphans and vulnerable children	Number of OVC in school	11,139		February 2008 APRODIS Report	71,100		95,300	117,000	117,000	81,846	61,712	Y	N	N - not cumulative	PR1 + PR2	
13.1	HSS: Service delivery	Number of health facilities that have contracted for improving access to services	120		CORDAID/HNTPO/ Coopération Suisse Reports	120	120	150	150	340	380	400	Y	N	N - not cumulative	PR1 + PR2	