Country-specific information: BURUNDI

I. Status at a glance

Since gaining independence in 1962, Burundi has been characterised by cyclic conflicts of extreme violence, the most serious of which has been the civil war which started in 1993. Burundi has a total population of approximately 7,211,350 inhabitants and a surface area of 27,834 km^2 (UNFPA). The under-15 age bracket accounts for 48% of the population, while life expectancy at birth is 47.6 years. Per capita GDP stands at USD 90. Sixty-eight percent of the population lives below the poverty line.

Concerning HIV/AIDS, the key epidemiological facts for 2005 are the following:

Data	%	Source
Prevalence rates among adults (15-49 years)	4%	National seroprevalence survey (2002)
People living with HIV / Adults (15-49)	220,000	As above
Young people (15-24) / living with HIV	46,916	As above
Women (15-49) / living with HIV	130,000	As above
Number of male condoms distributed	10,399,064	2005 CNLS* Annual Report
Total number of people having had access to Voluntary Testing and Counselling (VTC) services	70,628	As above
Number of pregnant women having had access to PMTCT services	2007	As above
Number of patients waiting for treatment	25,000	National seroprevalence survey (2002)
Number of people receiving treatment	6416	2006 CNLS Report
Number of deaths (adults and children)	40,000	National seroprevalence survey

*National Council for the Fight against AIDS (CNLS)

This table shows that few patients are receiving ARV treatment and few women have access to PMTCT services.

Core indicators for the implementation of the 2005 Declaration of Commitment

Area	Indicator	Data source
1. Amount of national funds disbursed by the government to fight HIV/AIDS	$44,000,000	Mid-way review of the National Action Plan and the CNLS Report (2005)
2. Percentage of schools with teachers who have been trained in life-skills-based HIV/AIDS education and who taught it during the last academic year	78.87%	Ministry of Education report (2005)
3. Percentage of large enterprises/companies which have HIV/AIDS workplace policies and programmes	68.75%	Workplace survey (2005)
4. Percentage of women and men with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled	Unavailable	
5. Percentage of HIV-positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission	13.21%	CNLS Report (2005)

Area	Indicator	Data source
6. Percentage of women and men with advanced HIV infection receiving antiretroviral combination therapy	25.66%	CNLS Report (2005)
7. Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	3.61%	BSS (Behavioral Surveillance Surveys; 2004)
8. Percentage of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner	50.60%	BSS (Behavioral Surveillance Surveys; 2004)
9. Ratio of current school attendance among orphans to that among non-orphans, aged 10-14	Unavailable	
10. Percentage of young women and men aged 15-24 who are HIV infected	2.71%	National seroprevalence survey (2002)
11. Percentage of infants born to HIV infected mothers who are infected	1.86%	CNLS Report(2005)

Remarks on the table above

The private sector was initially hesitant to commit itself to the fight against AIDS. Today, however, through the Burundi Employers' Association (AEB), highly significant efforts are being planned and the National Business Committee Against HIV/AIDS (CIELS) has recently been set up.

It is regrettable that the prevalence of common STIs is still poorly documented in Burundi. Very few STI cases are reported by hospitals. It is important to note that very few health care centres are able to give a precise diagnosis of gonorrhoeal infection and symptomatic syphilis. The diagnosis is only presumptive. Furthermore, collecting this indicator according to the recommendations is not possible in Burundian health care facilities.
Likewise, orphans come under the OVC category (Orphans and vulnerable children) and therefore there is no specific indicator for this single category.

II. Overview of the AIDS epidemic

After the first cases of AIDS were observed in Burundi in 1983, the disease continued to spread. The situation was aggravated after the 1993 crisis due to the effects of armed conflict on the population, such as population displacement, the destruction of infrastructure and the breakdown of the economy and society.

Despite the appearance of new cases, the health authorities at the time did not take the necessary steps to contain the epidemic. The first reaction came later with the creation of a national department to fight against STD/AIDS at the Ministry of Public Health. This department would later become the National Programme for the Fight Against AIDS and Sexually Transmitted Diseases (PNLS/MST). Serological testing of blood donations began in 1987 as screening tests became available.

So as to measure how far the epidemic had spread, seroprevalence surveys were carried out in 1989-90 and 2002. However, in general, data concerning seroprevalence, in particular, are currently unsatisfactory. Another survey is scheduled for 2006/2007 and this explains the lack of recent data for this area.

The epidemiological situation of HIV/AIDS places Burundi among the most affected countries in the world (16th) with national seroprevalence of 6% for over 15 year olds at the start of 2004 (2004 report on the global AIDS epidemic, UNAIDS). The highest rates, which appear to have stabilised over past years, are noted in urban and semi-urban areas and stand at 9.5% and 10.5% respectively. In rural areas, where 90% of the population lives, the relatively low rate of 2.5% must not overshadow this rate's massive rise: it

has tripled over ten years. There are 250,000 people living with HIV/AIDS, of which 220,000 are adults (15-49 years of age). Among these infected adults, 130,000 are women.

The increase in rural areas can be explained by the effects of war, such as population displacement, the large number of widows and widowers, the breaking up of numerous families, the growing impoverishment of the population, increases in the number of cases of sexually transmitted diseases and the lack of access to information and communication.

The vulnerability of women to HIV is a fact in Burundi. Prevalence is far higher among women in all areas, although it is lower in rural areas: 13% of women infected compared to 5.5% of men in urban areas, 10.5% of women and 6.8% of men in semi-urban areas, 2.9% of women and 2.1% of men in rural areas.
The highly vulnerable nature of women is connected to the limited access they have to information due to their poor level of education. Women are financially dependent on and culturally submissive to their husbands. During times of conflict, women may or may not be exposed to domestic violence; those women living in camps for displaced people and regroupment camps are more likely to suffer from it.

According to UNAIDS, the number of deaths stood at 25,000 in 2004 while the number of AIDS orphans was estimated at 200,000.
Even if orphans are taken in by families, the poverty that affects the majority of households means that they are seen as an extra burden that adds to the community's impoverishment. These orphans therefore find themselves vulnerable in terms of food supplies, health care and education as the families tend to favour their own, and already numerous, children. These orphans do not inherit anything from their parents, who die in dire financial circumstances due to their physical incapacity and the prohibitive cost of health care.

Biological surveillance data from sentinel sites concerning pregnant women, though irregular, shows a progressive drop in HIV seroprevalence. This correlates with the data from the 2002 seroprevalence survey, which shows that the curve dips in urban and semi-urban areas. However, the progress noted in rural areas is only seen at sentinel sites.

HIV/AIDS seroprevalence among pregnant women according to sentinel site (15-24 years of age)

Site	1999	2000	2001	2002	2003	2004
CMC Buyenzi (urban)	15.95%	13.9%	16.0%	13.2%	13.2%	12.6%
Gitega (semi-urban)	13.1%	11.1%	8.7%	5.3%	3.4%	6.5%
Rumonge(semi-urban)	11.2%	5.0%	12.8%	7.4%	6.8%	3.9%
Kayanza(semi-urban)	5.5%	11.6%	5.6%	11.1%	5.4%	4.8%
Muramvya (rural)	7.4%	3.7%	3.5%	3.4%	4.8%	2.2%
Ijenda	2.6%	3.8%	1.1%	0.8%	2.1%	0.9%
Kiremba	0.9%	2.2%	1.6%	2.0%	2%	0.2%

Source: USLS/Santé, 2004 Epidemiological Bulletin

III. National response to the AIDS epidemic

The fight against AIDS really started in Burundi in 1987 with the launch of the National Programme for the Fight Against AIDS and Sexually Transmitted Disease (PNLS/MST). This programme particularly focused

on prevention and the improvement of knowledge about the epidemic on the basis of seroprevalence and behavioural research. The PNLS/MST programme suffered from a lack of human and financial resources.

The crisis hindered the fight against HIV/AIDS considerably in Burundi despite medium term plans which were implemented regularly up until 2003. The truly historic change in the fight against AIDS was prepared in 2002 in anticipation of its implementation at the start of 2003.

As of 2001, the highest national authorities made a political commitment to fight against HIV/AIDS by setting up a national body in charge of fighting this disease. The National Council for the Fight against AIDS (CNLS) was established by Presidential decree Nº 100/077 on July 18 2001. Decree Nº 100/032 of March 1 2002 amending Decree Nº 100/015 of February 4 2002 defines the organisation, operation and composition of the CNLS. So as to ensure the greater visibility and authority needed to guarantee multi-sectorial coordination, the CNLS was linked to the Presidency of the Republic and a ministry with the task of fighting against AIDS was created in the President's Office. This political will was recently reaffirmed when the new government appointed by democratic election decided to maintain this ministry. Its technical body, the Permanent Executive Secretariat, which was granted greater resources and freedom of management, has become more operational in its role as technical coordinator.

So as to ensure a wide coverage of HIV services, a process aimed at decentralising administration was implemented. Currently, the national response to the HIV/AIDS epidemic is organised according to the country's administrative and community structure and it goes as far as the 'colline' level, the lowest level of organisation before individual households. AIDS committees have been set up at various levels (provincial, communal, 'zonal', 'collinaire'). They form a dense community network which has allowed a greater number of people to be targeted by measures against AIDS.

Furthermore, Burundi has adopted the three essential principles, or the "Three Ones": one action framework against HIV/AIDS, one national coordinating body for all partners' activities, and one common monitoring and evaluation system, as is strongly encouraged by the United Nations joint programme on HIV/AIDS, "UNAIDS".

The National Action Plan to fight against AIDS was drawn up in 2002 and covers 2002-2006. In line with the mid-way review proposals, it now includes 5 areas and 16 priority programmes (guidelines):

- Area A: Prevention:

P1 Reduction of high risk behaviour through IEC measures
P2 Promotion of condom use
P3 HIV/AIDS voluntary and anonymous screening
P4 Early STD diagnosis and treatment
P5 Reduction of risks of blood-borne transmission
P6 Reduction of risks of mother-to-child transmission

- Area B: Medical and psycho-social care

P7 Psycho-social care for people living with HIV/AIDS
P8 Capacity to diagnose and treat opportunistic diseases
P9 Improvement of access to antiretroviral treatment

- **Area C: Socio-economic care**

P10 Promotion of the rights and the protection of people living with HIV/AIDS and other vulnerable groups

P11 Care of AIDS orphans and other vulnerable children
P12 Revenue-generating activities in favour of people living with HIV/AIDS and those economically affected by HIV/AIDS.

- Area D: Strengthening of institutional capacity:

P13 Strengthening of the capacity of civil society organisations:
13 a) National, regional and local NGOs and NfP associations
13 b) Private sector organisations

P14 Strengthening of capacities to design, coordinate and monitor/evaluate sectorial action plans and decentralised action plans.

- Area E: Response Management and Coordination

P15 Information system for Action Plan Management
P16 Strengthening of national coordination

IV. Major challenges faced and actions needed to achieve the UNGASS goals/targets

Coverage of essential services is missing in some places more than in others. According to priority programme analysis in the 2002-2006 National Action Plan, there are few programmes aimed at covering health care costs for the sick and preventing mother-to-child HIV transmission.

Access to ARV remains limited when needs and available resources are compared. The Global Fund to fight AIDS, Tuberculosis and Malaria was the only partner funding access to ARV. It has now been joined by the World Bank. Few large development partners have accepted to bear social care costs (particularly, food support).

We also note that the optimal management of opportunistic infections does not pass through health care structures. In fact, the staff (doctors, psychologists, nurses, advisers, laboratory technicians and chemists) suffer from a shortfall both in terms of quality and quantity.

The decentralised structures of Burundi's National Council for the Fight against AIDS (CNLS) must be consolidated and sustained so as to ensure not only coordination, supervision, monitoring and evaluation but also the quality of the services.

Despite progress seen in some sectors (defence, employment, social affairs), the response from the public sector remains lacklustre. The lack of human resources in the health sector must be highlighted in particular.

Except for a few companies, such as Brarudi (Burundian brewery), the response from the private sector is also quite poor.

The decentralisation of medical-psycho-social care is still unsatisfactory.

The monitoring-evaluation plan is still in its early stages and has been undermined by the complexity of indicator terms and data collection tools.

The measures foreseen to overcome these problems are the following:

- Strengthen at a technical and sectorial level the public sector units; specific attention must be given to the health sector.

- Continuously advocate the plan to the country's new authorities so that they truly adopt the National Action Plan and ensure national resources are allocated to the fight against AIDS.
- Allocate greater manpower to the civil society support unit at the Permanent Secretariat level so that the civil society organisations receive the necessary technical support and follow-up (in terms of designing projects and organising partnership forums).
- Implement a project review scheme subject to the permanent secretariat for funding under MAP. This scheme should be both competent and swift, and enable resorting to an independent scheme;
- Ensure sustained advocacy to stimulate response from the private sector.
- Review the CNLS' founding texts so as to extend the general assembly's composition to other key ministries, the private sector and international partner representatives (UNS, Bilaterals, etc.).
- Strengthen and accelerate the decentralisation process, which should also concern power over financial resources.
- Give technical support to the monitoring-evaluation unit and mobilise appropriate resources for this purpose.
- Allocate more manpower to the monitoring-evaluation unit, particularly at decentralised levels.
- Diversify the means by which information is presented in accordance with the desired target audience.
- Set up a working group, which includes key partners, to help simplify the current monitoring-evaluation system and pilot its implementation.
- So that the database can become operational as soon as possible, continue with the plan to put the various levels of the monitoring-evaluation system on-line. It is therefore important to improve the skills of both the monitoring-evaluation teams and the users, so that the teams can collect, analyse and present reliable information and the users can use this information effectively for decision-making.

V. Support required from country's development partners

To achieve UNGASS targets, Burundi requires financial commitment from partners to facilitate implementation of the National Action Plan. The United Nations coordinating body as well as bilateral cooperation bodies are called upon, in particular, to work closely with the Burundian government and non-governmental and private sector organisations to improve allocation and distribution of the necessary and available resources to fight AIDS. This is ensured through the UNAIDS Technical Working Group, the expanded UNAIDS Theme Group, the UNAIDS Focal Point Coordination Group, the restricted Technical Working Group and the Technical Working Group.

VI. Monitoring and evaluation environment

Burundi has a joint monitoring and evaluation plan: the National monitoring-evaluation plan for activities that fight against AIDS in Burundi. It is in line with and forms part of the National Action Plan. It was designed according to a process incorporating contributions from coordination officials, officials implementing the National Action Plan and development partners. It meets international-level requirements regarding monitoring-evaluation requirements for the indicators related to the United Nations' declaration on HIV/AIDS and other basic items concerning operation and accountability obligations. This plan includes a series of 51 additional (resources), process, product, result and impact indicators. It also indicates the data collection tools, collection method, data sources and frequency.

A monitoring-evaluation unit was implemented at the SEP/CNLS level. It is made up of three sub-units: (i) planning, monitoring-evaluation; (ii) distribution of information; (iii) national database and IT support.

The national monitoring-evaluation plan is now up and running but the relatively large number of indicators and data collection tools it contains makes it complex. This is one of this device's weaknesses. SEP CNLS officials are aware of this and are prepared to make the necessary changes. The partners, particularly the United Nations System, are responsible for contributing the necessary technical support to this young system.

APPENDICES

APPENDIX 1: Consultation/preparation process for the national report on monitoring the follow-up to the *Declaration of Commitment on HIV/AIDS.*

APPENDIX 2: National Composite Policy Index Questionnaire (through CRIS)

APPENDIX 3: National Return Forms for programme, knowledge, behaviour and impact indicators (through CRIS)