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Document of
The World Bank

Report No: ICR00001957

IMPLEMENTATION COMPLETION AND RESULTS REPORT
(IDA-H3830)

ON A

GRANT

IN THE AMOUNT OF SDR 9.9MILLION
(US$ 15MILLION EQUIVALENT)

TO THE

REPUBLIC OF BURUNDI

FOR A

SECOND MULTISECTORAL HIV/AIDS PROJECT

December 22, 2011

Human Development Department
Country Department East Africa 1
Africa Regional Office

CURRENCY EQUIVALENTS

(Exchange Rate Effective 10/20/2011)

Currency Unit = BIF (Burundi Franc)
1.00 BIF= US$ 0.00080
US$ 1.00 = 1,213.41 BIF

FISCAL YEAR

2010 - 2011

ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASAP	AIDS Strategy and Action Plan Service
BCC	Behavioral Change Communication
BSS	Behavioral Surveillance Survey
CNLS	Conseil Nationale de Lutte Contre le SIDA (National HIV/AIDS Council)
CSO	Civil Society Organization
CSW	Commercial Sex Worker
DHS	Demographic and Health Survey
FA	Financial Agreement
GF	Global Fund for TB, Malaria & HIV/AIDS
HIV	Human Immune Deficiency Virus
HSDSP	Health Sector Development Support Project
ICR	Implementation Completion and Results Report
IDA	International Development Association
IGA	Income Generating Activities
KPI	Key Performance Indicators
MAP	Multi-sectoral HIV/AIDS Project
MARPs	Most-At-Risk Populations
MC	Male Circumcision
MDGs	Millennium Development Goals
M&E	Monitoring & Evaluation
MoH	Ministry of Health
MSM	Men having Sex with Men
MSPLS	Ministère de la Sante Publique et Lutte Contre le SIDA (Ministry of Health and HIV/AIDS)
MTCT	Mother-To-Child Transmission
NGO	Non-Governmental Organization
NHAS	National HIV/AIDS Strategy and Plan
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PAD	Project Appraisal Document
PMTCT	Prevention Mother-to-Child Transmission of HIV/AIDS
PLWHA	People Living With HIV/AIDS
PPF	Project Preparation Facility
PDO	Project Development Objective(s)
PRSP	Poverty Reduction Strategy Paper

QAG	Quality Assurance Group
QER	Quality Enhancement Review
RBF	Results-Based Financing
SEP/CNLS	*Secrétariat Exécutive du Conseil Nationale de Lutte contre le SIDA* (Executive Secretariat for the National HIV/AIDS Council)
STI	Sexually Transmitted Infections
USLS	Unité Sectorielle de Lutte Contre le SIDA (Sectoral Unit for HIV/AIDS Control)
VCT	Voluntary Counseling and Testing

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BURUNDI
BURUNDI SECOND MULTISECTORAL HIV/AIDS PROJECT

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A. Basic Information

Country:	Burundi	Project Name:	Second Multisectoral HIV/AIDS
Project ID:	P109964	L/C/TF Number(s):	IDA-H3830
ICR Date:	12/22/2011	ICR Type:	Core ICR
Lending Instrument:	SIL	Borrower:	THE REPUBLIC OF BURUNDI
Original Total Commitment:	XDR 9.40M	Disbursed Amount:	XDR 9.35M
Revised Amount:	XDR 9.40M		
Environmental Category: B			
Implementing Agencies: Secretariat Executif Permanent du Conseil National de lutte contre le SIDA			
Cofinanciers and Other External Partners:			

B. Key Dates

Process	Date	Process	Original Date	Revised / Actual Date(s)
Concept Review:	11/21/2007	Effectiveness:	10/10/2008	10/10/2008
Appraisal:	02/18/2008	Restructuring(s):		
Approval:	05/13/2008	Mid-term Review:	07/16/2010	06/18/2010
		Closing:	06/30/2011	06/30/2011

C. Ratings Summary

C.1 Performance Rating by ICR	
Outcomes:	Moderately Satisfactory
Risk to Development Outcome:	Moderate
Bank Performance:	Moderately Satisfactory
Borrower Performance:	Moderately Satisfactory

C.2 Detailed Ratings of Bank and Borrower Performance (by ICR)

Bank	Ratings	Borrower	Ratings
Quality at Entry:	Moderately Satisfactory	Government:	Moderately Satisfactory
Quality of Supervision:	Satisfactory	Implementing Agency/Agencies:	Moderately Satisfactory
Overall Bank Performance:	Moderately Satisfactory	**Overall Borrower Performance:**	Moderately Satisfactory

C.3 Quality at Entry and Implementation Performance Indicators			
Implementation Performance	**Indicators**	**QAG Assessments (if any)**	**Rating**
Potential Problem Project at any time (Yes/No):	No	Quality at Entry (QEA):	None
Problem Project at any time (Yes/No):	Yes	Quality of Supervision (QSA):	None
DO rating before Closing/Inactive status:	Moderately Satisfactory		

D. Sector and Theme Codes

	Original	Actual
Sector Code (as % of total Bank financing)		
Central government administration	21	
Health	50	72
Other social services	23	28
Sub-national government administration	6	
Theme Code (as % of total Bank financing)		
HIV/AIDS	67	85
Social safety nets	33	15

E. Bank Staff

Positions	At ICR	At Approval
Vice President:	Obiageli Katryn Ezekwesili	Obiageli Katryn Ezekwesili
Country Director:	Mercy Miyang Tembon	John McIntire
Sector Manager:	Jean J. De St Antoine	John A. Elder
Project Team Leader:	Pamphile Kantabaze	Pamphile Kantabaze
ICR Team Leader:	Enias Baganizi	
ICR Primary Author:	Enias Baganizi	

F. Results Framework Analysis

Project Development Objectives (from Project Appraisal Document)
The Project's objective is to increase the utilization of a selected set of preventive services, among groups highly vulnerable to, or affected by HIV/AIDS.

Revised Project Development Objectives (as approved by original approving authority)

(a) PDO Indicator(s)

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1 :	Percentage of female sex workers reporting the use of condom with their most recent client			
Value quantitative or Qualitative)	82%	30% increase (106.6%)		91.2%
Date achieved	12/15/2008	10/10/2008		06/30/2011
Comments (incl. % achievement)	Target not realized due to skewed target value. The change is nonetheless substantial, especially starting from an already very high base.			
Indicator 2 :	Percentage of women and men aged 15-49 who have had more than one sexual partner in the last 12 months reporting the use of a condom during their last sexual intercourse			
Value quantitative or Qualitative)	6% for men and 10.9% for women	30% increase for men (7.8%) and 30% increase for women (14.2%)		13.9% for men and 14.3% for women
Date achieved	10/10/2008	10/10/2008		06/30/2011
Comments (incl. % achievement)	Indicator achieved/surpassed for both men and women.			
Indicator 3 :	Percentage and number of HIV-infected pregnant women who receive a completed ARV treatment to reduce the risk of MTCT			
Value quantitative or Qualitative)	6% (old Spectrum data) and 15.1% (new Spectrum data)	30%		31.6%
Date achieved	10/10/2008	10/10/2008		06/30/2011
Comments (incl. % achievement)	Spectrum is a widely used model for estimating number of women needing PMTCT. Based on the new estimates the target was achieved as 2,617 of an expected 8,282 HIV positive pregnant women were put on ARV for PMTCT.			

(b) Intermediate Outcome Indicator(s)

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1 :	Percentage of people from at-risk- groups who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission			
Value (quantitative	5.3% for men and women	25% increase (6.6%)		CSW: 31.2%; MSM: 21.4%,

or Qualitative)				Prisoners: 28.5%, Seasonal workers: 31.3%, Uniformed personnel : 32.7%
Date achieved	10/10/2008	10/10/2008		06/30/2011
Comments (incl. % achievement)	Although the data from the 2007 and 2010 surveys are not strictly comparable it appears that the indicator was achieved for both men (MSM and uniformed personnel) and women (CSW).			
Indicator 2 :	Percentage of people most-at-risk population (IDU, MSM, SW) who receive an HIV test in the last 12 months and who came back for their test results			
Value (quantitative or Qualitative)	66.3% for SW	85%		65.2% for SW
Date achieved	10/10/2008	10/10/2008		06/30/2011
Comments (incl. % achievement)	This indicator was not achieved			
Indicator 3 :	Number of men 12-49 circumcised per year			
Value (quantitative or Qualitative)	Unavailable	6,000		8,278
Date achieved	10/10/2008	10/10/2008		06/30/2011
Comments (incl. % achievement)	Based on available data for 2011 and linear extrapolation, it appears that for the first 3 quarters of the year, 6,209 male circumcisions have been performed, for an annualized total of about 8,278, surpassing the target by 38%.			
Indicator 4 :	Percentage of health facilities that offer VCT to all pregnant women			
Value (quantitative or Qualitative)	27%	35%		84.5%
Date achieved	10/10/2008	10/10/2008		06/30/2011
Comments (incl. % achievement)	The target for this indicator was by far exceeded. A total of 524 health facilities out of 620 offer VCT services to the general population, including pregnant women.			
Indicator 5 :	Percentage and number of adults and children with advanced HIV infection receiving ARV therapy			
Value (quantitative or Qualitative)	46%	50%		90.8%
Date achieved	10/10/2008	10/10/2008		06/30/2011
Comments (incl. % achievement)	This indicator was achieved at 182% thanks mainly to the scaling up of the RBF scheme at country level.			
Indicator 6 :	Number of PLWHA reached through small grant activities			
Value (quantitative or Qualitative)	8,799	11,000		5,744
Date achieved	10/10/2008	10/10/2008		06/30/2011
Comments	Indicator not realized. This is partially due to refocusing efforts of the project			

(incl. % achievement)	towards the most-at-risk populations (CSW, MSM, etc...).			
Indicator 7 :	Number and value of sub-projects targeted to high risk and vulnerable populations			
Value (quantitative or Qualitative)	Number: 100 Value: $1,856,214	Number: 247 Value: $2,682,600		Number: 280 Value: $2,948,087
Date achieved	10/10/2008	10/10/2008		06/30/2011
Comments (incl. % achievement)	This indicator's targets were achieved both in terms of number and value of projects targeting most-at-risk populations			
Indicator 8 :	Number of public sector organizations that include in their annual action plans or sector strategies HIV/AIDS related targets			
Value (quantitative or Qualitative)	2 institutions	10 institutions		13 institutions
Date achieved	10/10/2008	10/10/2008		06/30/2011
Comments (incl. % achievement)	This indicator was achieved and surpassed.			
Indicator 9 :	Joint annual report of Multisectoral HIV/AIDS Program, disseminated during the annual meeting of CNLS			
Value (quantitative or Qualitative)	Done	Done		Done
Date achieved	10/10/2008	10/10/2008		06/30/2011
Comments (incl. % achievement)	This indicator was achieved. The CNLS met every year and disseminated the annual reports.			
Indicator 10 :	Percentage of executing agencies (public sector and civil society) that submit financial three-monthly reports completed and in time			
Value (quantitative or Qualitative)	70%	90%		90%
Date achieved	10/10/2008	10/10/2008		06/30/2011
Comments (incl. % achievement)	This indicator was achieved and surpassed.			

G. Ratings of Project Performance in ISRs

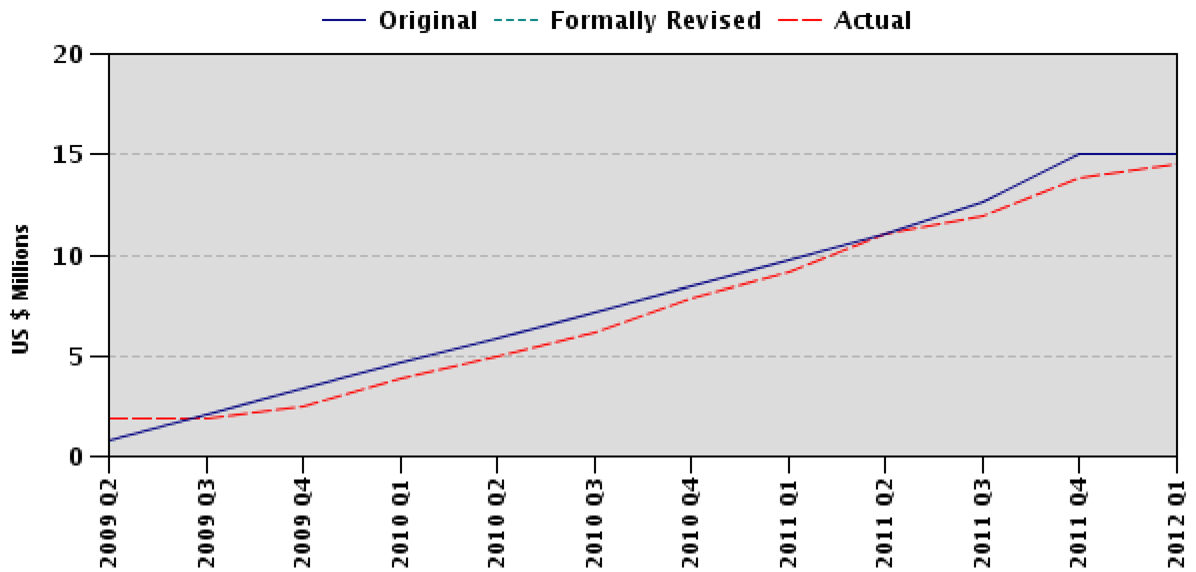
No.	Date ISR Archived	DO	IP	Actual Disbursements (USD millions)
1	06/20/2008	Satisfactory	Satisfactory	0.00
2	12/31/2008	Moderately Satisfactory	Satisfactory	1.93
3	06/22/2009	Moderately Satisfactory	Moderately Satisfactory	2.01

4	12/28/2009	Moderately Unsatisfactory	Moderately Unsatisfactory	4.98
5	06/29/2010	Moderately Unsatisfactory	Moderately Unsatisfactory	7.89
6	12/21/2010	Moderately Satisfactory	Satisfactory	10.20
7	06/28/2011	Moderately Satisfactory	Satisfactory	13.80

H. Restructuring (if any)

Not Applicable

I. Disbursement Profile



1. Project Context, Development Objectives and Design

1.1 Context at Appraisal

1. Burundi is one of the poorest countries in Africa and over the last two decades has suffered from considerable political and economic turbulence, negative economic growth, and stagnation, resulting in remarkably low socio economic and health indicators. With a gross income per capita of $380, Burundi has a total expenditure on health per capita of $49 but much of this is out of pocket and public expenditure remains low.

2. The project appraisal was conducted just three months after a new Government was formed. This transition saw the abolition of the Ministry of State at the President Office in charge of HIV/AIDS and the creation of a Ministry of Health and HIV/AIDS with a Vice-Minister in charge of HIV/AIDS control activities.

3. Data from the 2007 National Sero-Prevalence and Socio Behavioral Surveillance (NSPSBS) show a slight decrease in HIV prevalence in the general population to 3.0% from an estimated 3.2% in 2002 (2002 BSS). The prevalence rate among commercial sex workers (CSWs) was found to be 38%. Results of this study only became available after the project appraisal. The survey suggested a significant variation in prevalence rates within the country and an apparent rapid increase in prevalence in rural areas. The main factors driving the HIV/AIDS epidemic appear to be commercial sex work, widespread presence of multiple concurrent partnerships, and low rates of male circumcision.

4. This Project is a successor to a Project financed through a US$36 million IDA Credit in the context of the second round of the Bank's Multi-country HIV/AIDS Program (MAP). Despite a constrained environment, the first project has been implemented successfully. Activities financed under this first IDA Credit were carried out with minimal delays and the Project achieved its development objectives with satisfactory ratings.

5. As encouraging as those results were, they remained insufficient to stop the transmission of HIV/AIDS or to reduce its impact on affected families. This is not surprising as only 30 percent of the activities under the Burundi's 2002-2006 National HIV/AIDS Strategy (NHAS) were financed, mainly through the IDA Credit. In addition, there were many institutional, technical, financial, and capacity-related issues that constrained the implementation of the NHAS. Lessons learned from the implementation of the first strategy were used to develop the second 2007-2011 NHAS. In order to leverage the country's limited financial and human resources, the 2007- 2011 NHAS introduced changes in the focus and scope of operations for HIV/AIDS prevention and treatment.

6. The rationale for the Bank's involvement in HIV/AIDS in Burundi has been reflected in the Bank's sector strategies. Strategic guidance and lesson learned reflected in the 2006 *"AIDS Program of Action"*, and the Health, Nutrition and Population Strategy published under the name of *"Healthy Development",* (2007), were central to the Project's design. Specifically, the Bank provided technical assistance to strengthen the 2007-2011 NHAS, and to ensure the synergy between health system strengthening and HIV/AIDS interventions. The Project's focus on results and accountability stemmed directly from the strategies referred to above. Consolidating and scaling-up effective interventions under the first project were essential to progress towards achieving the country's MDGs.

7. In national and international fora, the Government, communities and partner agencies have indicated that they consider IDA's continuing involvement in Burundi's National Program as critical, particularly regarding multisectoral capacity and in the areas of prevention and support to civil society through subprojects and capacity building activities.

1.2 Original Project Development Objectives (PDO) and Key Indicators

8. The Project's development objective (PDO) as presented in the PAD was "to increase the utilization of a selected set of preventive services, among groups highly vulnerable to, or affected by HIV/AIDS" and was to be tracked through a set of three PDO indicators and ten intermediate output indicators. However, the Financial Agreement adds the treatment dimension to the PDO. Indeed, component 2 specifically provides funding for performance-based curative services. Also, component 3 provides grants to vulnerable families to increase treatment compliance. Two of the seven PDO indicators monitor treatment services. The PDO, as stated in the signed Financing Agreement reads as follows: "The objective of the Project is to increase the coverage of a selected set of preventive and treatment services among groups highly vulnerable to, or affected by, HIV/ AIDS." The Government and the Bank project team were aware of the omission from the PAD of what was an important component of the PDO. Unfortunately, this discrepancy was not well handled during an earlier HNP sector wide exercise (undertaken in 2008) to harmonize PADs and respective FAs.

9. The key performance indicators included in the results framework were selected from indicators of the NHAS to measure the achievement of the project development objective. They include: (i) percentage of female sex workers who report using a condom with their most recent client, (ii) percentage of women and men aged 15-49 who report having sex with more than one partner in the last 12 months which report having used a condom in the last sexual act, (iii) number and value of subprojects targeting vulnerable populations and high risk groups (iv) percentage and number of adults and children with advanced HIV infection receiving antiretroviral combination therapy, (v) number of HIV+ pregnant women who received antiretroviral therapy to reduce the risk of mother-to-child transmission (MTCT) versus the expected number of HIH+ pregnant women, (vi) number of persons living with HIV/AIDS reached through small grant activities, and

(vii) number of public sector organizations that have HIV control-related activities in the annual plans or sector strategies.

1.3 Revised PDO (as approved by original approving authority) and Key Indicators, and reasons/justification:

10. NA

1.4 Main Beneficiaries

11. The primary beneficiaries of the Project were: (i) people belonging to vulnerable groups such as commercial sex workers, demobilized ex-combatant, internally displace persons (IDPs), youth, Batwa (an ethnic minority), transport bus touts, handicapped persons, domestic workers, uniformed personnel, fishermen, seasonal workers, drug users, prisoners, (ii) people living with HIV/AIDS and affected individuals and families, and (iii) pregnant women and their babies.

1.5 Original Components

12. *Component 1: Preventive Services Targeted to High Risk Groups (IDA financing: US$7 million)* financed (i) IEC and behavior change activities to be implemented by CSOs, NGOs, community groups, professional associations and line ministries (other than Ministry of Health (MoH), and(ii) direct transfers to the MoH to finance performance based contracts for public and private service providers to support PMTCT and male circumcision.

13. *Component 2: Performance-Based Curative Services (IDA financing: US$2 million)* supported the expansion of ARVs country wide, using performance based contracting arrangements to be managed by the MoH (where the SEP/CNLS had managed this in MAP I).

14. *Component 3: Decentralized Financing of Small Grants to Families Living with HIV/AIDS and High Risk Groups (IDA financing: US$ 3 million)* used mechanisms applied in the first project to finance subprojects managed by NGOS, community groups to provide small grants to vulnerable families.

15. *Component 4: Capacity Building for Local Authorities and Key Ministries to Implement HIV/AIDS Activities, and National Program Management (IDA financing: US$ 3 million)* supported HIV/AIDS activities in key ministries and local governments, improving the operations and management of SEP/CNLS.

1.6 Revised Components

16. The components were not revised. The MTR proposed changes to the PDO and components with a revised results framework but the project was not restructured.

Management rejected a request for additional financing as well as an extension of the project closing date.

1.7 Other significant changes

17. The results based financing (RBF) which started during the first MAP Project on a very limited scale was extended to the entire country during the second MAP.

2. Key Factors Affecting Implementation and Outcomes

a. Project Preparation, Design and Quality at Entry

Preparation

18. The Project preparation built on lessons learned and good practices from its predecessor which was rated satisfactory.

19. The preparation process was highly participatory and included members from the Ministry of Health and HIV/AIDS, other public institutions involved in HIV/AIDS prevention activities, UNAIDS, UNICEF, WHO, UNFPA, etc.

20. During the transition between the first MAP project and the second MAP there were many vacancies at the SEP/CNLS which took a long time to fill. This had a negative impact on the implementation of the project in the beginning.

Design

21. The project design, as laid out in the PAD, sought to focus more on the provision of preventive and treatment services to high risk groups, encouraging decentralization of decision making, and intensifying efforts to improve national monitoring and evaluation of the epidemic and response.

22. At the same time, the project was structured to finance a transverse slice of the underfinanced 2007-2011 NHAS, meaning that the components of the project were aligned to the four axes of the that strategy. The project components were designed to align with NHAS 'axes' to ease the reporting burden on the CNLS.

23. Therefore, the project design, though earnestly seeking to focus attention on MARPs, suffered from excessive breadth and complexity that comes from trying to align with the whole of the National HIV/AIDS Strategy.

24. The task team was on the cutting edge of HIV/AIDS prevention methods by including male circumcision as one important activity to be supported by the project. At the time of the project appraisal results from the randomized trials had only recently been published.

25. At the institutional level, the role of the SEP/CNLS, the HIV/AIDS Coordinating body, was clearly re-defined and more autonomy given to implementing entities, especially the Ministry of Health which is in charge of HIV activities in the health sector.

Quality at entry

26. The team that conducted the appraisal mission had members from the Bank's AIDS Strategy and Action Plan (ASAP) who supported the country in its efforts to improve the quality of the 2007-2011 National Strategic Plan, especially on how to focus on most-at-risk populations.

2.2 Implementation

27. At the beginning of the Project, the focus was on too many vulnerable groups and there was insufficient targeting of the groups that were driving the HIV epidemic, i.e. CSWs. Just before the MTR, a QER Panel suggested identifying a highly specific set of activities that could be usefully delivered to specific target groups, and proceeding to contract for these groups in specific areas where they were numerous, rather than attempting to engage all line ministries and all provincial governments in the effort. The MTR recommendations went in the same direction. It was one and a half years into implementation before the implementing agency really started focusing on the most-at-risk population driving the epidemic, namely the commercial sex workers (CSW).

28. The Project suffered major implementation lags in the beginning. Major factors for the lags included (i) significant turnover in leadership (the country had four Ministers of Health in three years) which hampered needed implementation of institutional changes at the implementing agency level, (ii) a long transition period at the managerial position at the SEP/CNLS after the departure of the former Manager, (iii) misunderstanding of certain procedures between the Bank and Borrower as to the need for pre-financing activities by the Borrower while awaiting funds to transfer from the Bank, (iv) delays in project selections at the provincial level due largely to ignorance of the existence of funding opportunities from the Project, (v) delays in approval of the 2009 annual work plan and in selecting keys staff positions at the SEP/CNLS, (vi) delays in understanding how to identify and target most-at-risk populations at the provincial level so that sub grants only started in September 2009, and (vii) the work to develop the mechanisms necessary to use performance contracting for curative services, a central element of component 2, was only completed and reviewed in October 2009. This created delays in contracting with CSOs.

29. For all the above reasons, following a June 2009 mission, the PDO and implementation performance ratings were downgraded from MS/MS to MU/MU. During that mission, specific benchmarks were agreed upon between the Bank and the Borrower. These benchmarks had to be achieved satisfactorily for the disbursement to continue. Starting February 2010, implementation performance had improved as evidenced by the

progress on intermediate indicators and disbursement rates. The PDO/IP ratings were upgraded to MS/S.

30. The transition toward scaling up the Results-Based Financing (RBF) strategy took place fairly late in the implementation stage, starting in April 2010. This reflected the fact that it was part of a larger, nation-wide roll-out of RBF. Seven HIV-related indicators were included in the service package covered by the RBF scheme, namely, (i) the number of persons benefiting from VCT services; (ii) the number of new ARV-treated cases; (iii) the number of pregnant women under PMCT protocol; (iv) the number of ARV-treated persons monitored during a six-month period; (v) the number of STI cases treated; (vi) the number of newborns from seropositive mothers under PMCT protocols; and (vii) the number of 15 to 49 year-old males who benefited from male circumcision.

2.3 Monitoring and Evaluation (M&E) Design, Implementation and Utilization

M&E Design

31. In an effort to support the Government and development partners' desire to harmonize monitoring and evaluation arrangements, the PDO and results framework for the project were designed to align with those for the NHAS. This is in line with the World Bank desire to support the strengthening of the entire health system for sustainability purposes and Government ownership. However, it undermines the ability to collect necessary data in a timely manner in order to inform the ISRs of the progress made toward the achievement of the project's objectives.

32. The 13 performance indicators in the PAD, which were selected from the larger list of indicators in the NHAS, were relevant to the project. However, some of the indicators could not be tracked with reasonable frequency. For some other indicators there were no baseline data.

33. There were additional design flaws in the PAD. The behavioral surveillance survey (BSS) as designed would have to generate data for monitoring the PDO once every two years, but this has de facto become once every three years in the ISRs with one BSS study at the beginning of the Project and another one towards the project closing date.

34. Determination of the number of HIV positive pregnant women in need of PMTCT services, an important denominator to some of the project outcome indicators was done using the Spectrum software. Use of this modeling program was problematic because it yielded different figures when new parameters (more accurate ones) used towards the end of the project were plugged into the program.

M&E Implementation

35. The capacity and number of M&E experts at the implementing agency (SEP/CNLS), the provincial and CSO level were reinforced by training sessions. This had

a positive impact on the timeliness and accuracy of information reported to the central level. However, data available at the Ministry of Health for health-related HIV activities were not always in synch with data available at SEP/CNLS in a database (SidaInfo).

36. The M&E system improved over time. The SidaInfo database was updated and completely decentralized. The functionality of this database with regard to data management for the ARV coverage module has been good. The assurance of data quality improved with increased supervision. In addition, collection of more elaborate data made it possible to organize more systematic supervision missions and audit the data. In turn, this led to a better information system regarding results framework indicators.

M&E Utilization

37. Project funds enabled a clear improvement of the knowledge of the epidemic in Burundi thanks to the availability of an analysis and epidemiologic synthesis report regarding HIV/AIDS in Burundi. In addition, the implementation of a bio-behavioral survey targeting most-at-risk populations which allowed the country to identify the populations that were really most-at-risk. However, that survey was brought to completion toward the end of the project.

2.4 Safeguard and Fiduciary Compliance

38. There are no legal covenants but one financial undertaking consisted in the provision of Government budget allocation to support the implementation of the national HIV/AIDS strategic plan in the amount of US $3.0 million through the national annual budget. This commitment has been partially fulfilled with an average allocation of US $2.0 million per year. There are no unresolved fiduciary, social or environment problems. There are no audit issues. The project procurement and financial management ratings are **satisfactory**.

39. The project as a whole had a single Category of Expenditure. The allocation amounts by component shown in the PAD were indicative of the relative importance of each component with regard to the implementation of the project. This may explain the difference between the effective expenditures and the level of IDA funding by component as shown in table 1 below. The 30% overrun of Component 4 expenditures was mainly due to the increased burden of operating costs incurred by the governing body (SEP/CNLS), particularly the salaries. The 10% increase of Component 1 expenditures was naturally due to a de facto reallocation between components in an attempt to follow the MTR recommendation to focus on CSWs targeted interventions.

Table 1: Level of Project's funds spending by component

Component	**Effective expenditure (in USD)**	**Indicative level of IDA funds allocation in the PAD (in USD)**
Compontent 1	7,711,233	7,000,000
Compontent 2	1,379,921	2,000,000

Compontent 3	1,980,798	3,000,000
Compontent 4	3,919,073	3,000,000
TOTAL	**14,991,025**	**15,000,000**

40. With regard to the environmental safeguards, Burundi acquired instruments to monitor medical waste management through a ministerial decree pertaining to classifying and managing biomedical wastes produced by care facilities in Burundi. This decree was signed jointly by the Public Health Minister and the Environment Minister on February 4, 2008. Based on this decree and with the financial support from the Project, the Health Minister led activities to strengthen the biomedical waste management, namely: (i) an analysis study of the biomedical waste management situation; (ii) the development of a biomedical waste management plan; (iii) the development of training modules for care providers; (iv) the availability of appropriate material in care facilities; and (v) the organization of a training series for health service providers regarding biomedical waste management. Physicians who are also health province directors, physicians who are also heading health districts, health promoting coordinators at the provincial level, paramedical school officers, heads of labs in provincial hospitals, and hygiene officers at provincial hospitals in 16 provinces were trained as trainers.

2.5 Post-completion Operation/Next Phase

41. At the Project mid-term review, it was planned that the RBF related HIV indicators would later be financed by other funds. Indeed the Government has been paying for these HIV related indicators since the closing of the Project, namely by those from the Health Sector Development Support Project (HSDSP), PRIDE, European Union, and the Belgian Cooperation.

42. The restructuring of the SEP/CNLS has been approved by the Minister of Health and focuses on re-organization and staffing. Only after the closing of the Project the Government began to take some serious steps to resolve this issue. These steps should have been taken at the beginning of the Project or just after the MTR in order to ensure a smooth transition after the Project closing date.

43. The announcement of the Project closing on June 30, 2011 has caused fear and distress, even frustration and discouragement, among the Burundian population through all kinds of media reports. However, this mixture of fear and discouragement was mostly due to the scarcity of reliable information. It quickly disappeared following a joint press conference organized jointly by the Borrower and Bank project teams. During this information session, both parties asked the press to explain to the general population that the project's end was not a financial freeze by the World Bank, as many people had come to believe, but rather a normal project closing occurring at the end of its term as foreseen in the Project Financing Agreement. Moreover, this agreement was signed by the Burundian government and the World Bank prior to implementation. The organizers of the press conference explained that, as for any other project, a specific timeframe had been given to this project from the onset. As a result, it was not surprising that this project would close on a date known to project staff and the Burundian government. No other expression of misunderstanding came about, and the situation returned to normal.

3. Assessment of Outcomes

3.1 Relevance of Objectives, Design and Implementation

Relevance of objectives

44. The project objective to provide HIV preventive and treatment services to MARPs is relevant according to current international recognized best practices. These best practices recommend concentrating efforts on the populations which are the drivers of the epidemic in a country. The PDO is fully aligned with the current Country Strategic Plan and the Burundi PRSP in which HIV control is a strategic priority. In the current international financial crisis, it is imperative for poor countries like Burundi to focus on recognized effective and efficient interventions.

45. The relevance of the project objective is therefore rated **substantial**.

Relevance of design

46. The MAP II project was structured to finance a transversal slice of the underfinanced 2007-2011 NHAS, meaning that the components of the project were aligned to the four axes of the that strategy. This transversal slice financing of the NHAS may have created confusion at the level of the implementing partner and may be one of the reasons why targeting activities towards most-at-risk populations took time to materialize.

47. The components of the project were well designed to achieve the project development objective because they were directed towards ensuring preventive and treatment services to MARPs with a community component. Focusing on MARPs rather than on traditional BCC messages directed to the general population made the project design relevant even at current scientific evidence which suggest adapting the HIV response to the actual epidemiological situation of a country. The focus on male circumcision also made compelling sense in the context of Burundi. The task team deserves a lot of credit for braving animosity and ridicule for promoting circumcision. The Bank was the only development partner to bring the issue up consistently.

48. The transfer of all health related activities under the responsibility of the Ministry of Health ensured both ownership by the Ministry and proper implementation. Since some treatment activities were conducted by the private sector, it reinforced public-private partnerships in the country thereby maximizing the project reach and ensuring sustainability of interventions.

49. The selected three performance indicators are judged to be relevant. Baseline data for two of them were not available at the time of the project appraisal. However the task

team was waiting for data collected for the 2007 BSS study to be made available by Government Officials to be used as baseline for these two indicators. The data became available in late 2008. Unfortunately, when the baseline data became available, necessary target re-setting for some of the indicators was not done accordingly

50. The relevance of the project design is therefore rated **substantial**.

Relevance of implementation

51. There have been unnecessary delays from the implementing agency, to focus the project efforts on fewer, most-at risk populations (e.g CSW) which are the drivers of the HIV epidemic in the country. In addition, the project was designed to scale up male circumcision services in order to mitigate the transmission of HIV in the general population. Although, the activity has now achieved very encouraging results, the implementation of MC took a long time to veritably take off.

52. The implementation of RBF was delayed (not due to any fault of the SEP/CNLS or the project), reflecting the challenge of scaling up such an innovative approach to an entire country (proper preparation of implementation and monitoring tools was necessary to ensure future success). Once implemented, the RBF scheme helped the project to catch up on several outputs indicators as shown below (Graph 1).

53. According the information presented above, the relevance of the project implementation is rated **modest**.

54. For all the facts described above, the relevance of the project objective, design and implementation is rated **substantial**.

3.2 Achievement of Project Development Objectives

55. The Project achieved two out of three outcome indicators as shown in table 2 below. For the first one, the project did not achieve the target set because it was impossible to achieve (above 100%). In fact, the target setting for the first outcome indicator on condom use among female commercial sex workers illustrates the problems of setting target without baseline data. With an 82% condom use at baseline (data became available after the project effectiveness date), a target of a 30% increase at the end of project meant achieving condom use levels at 106.6%, which is impossible. Nonetheless, condom use rate among female commercial sex workers increased from 82% from baseline to 91.2% at the end of the project which is quite satisfactory.

56. The project was the only major project engaging in behavior change communication (BCC) activities for sex workers in a concentrated way, so this result can be almost solely attributable to the project.

Table 2: Level of achievement of project development indicators

Project Outcome Indicators	Baseline (2008)	Mid – term (June 2010)		End of Project (June 2011)*	
PDO: *Increase the utilization of a selected set of preventive and treatment services among groups highly vulnerable to, or affected by HIV/AIDS*					
		Target	Achieved	Target	Achieved
Percentage of female sex workers reporting the use of a condom with their most recent client (disaggregated by age (<25, 25+>)	82% (2007 BSS Study)	20% increase (98.4%)	na	30% increase (106.6%)	91,2%
Percentage of women and men aged 15-49 who have had more than one sexual partner in the last 12 months reporting the use of a condom during their last sexual intercourse. Disaggregated by sex and age (15-19, 20-24, 25-49)	6.0% for men 10.9% for women (2007 BSS Study)	15% increase for men (6.9%) 15% increase for women (12.5%)	na	30% increase for men (7.8%) 30% increase for women (14.2%)	13.9% for men 14.3% for women (2010 DHS)
Percentage and number of HIV-infected pregnant women who received a completed antiretroviral treatment to reduce the risk of mother-to-child transmission.	6%	18%	17% (1,488/8,733)	30%	32% (2,617/8,282)

*Data available up to end of June 2011

57. Over the life of the project there was a large decline in HIV prevalence rates in the general population. (See table 3 below) which was out of keeping with the secular trend (in 2002 the HIV prevalence rate was 3.2%). With more than a doubling of the number of the number of people on ARV treatment, people infected with HIV are living longer with the disease. Thus the decline in prevalence combined with a longer duration of the disease indicates a significant decline in incidence. The significant (47%) decline in HIV prevalence among CSWs is also remarkable.

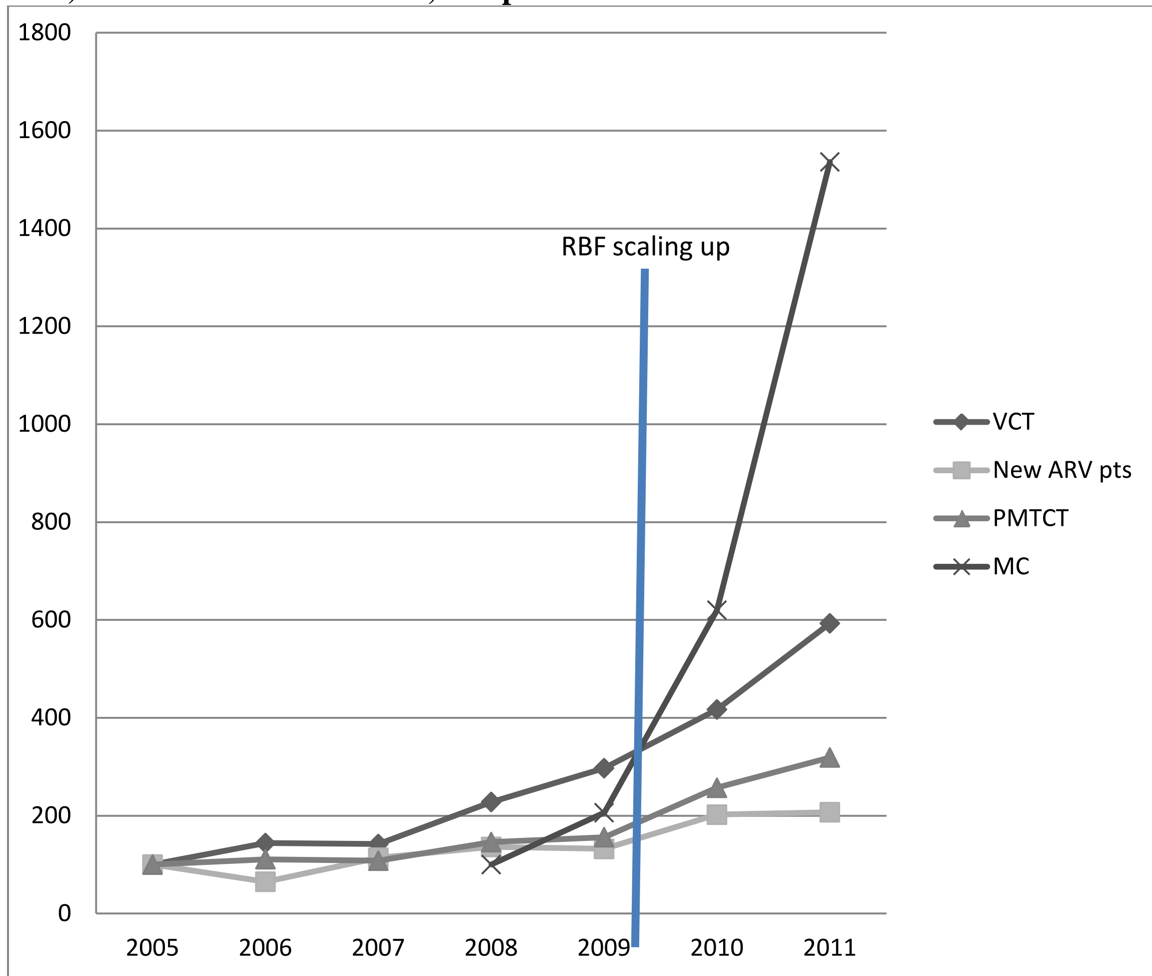
58. The project was the one that put male circumcision "on the roadmap" in Burundi. Without the project, the strong takeoff in male circumcisions would never have happened, and in this way the project has permanently changed the landscape of HIV prevention in Burundi.

Table 3: Trends in selected indicators between 2007 and 2011

Indicator	2007	2011
HIV prevalence nationwide	3.0%	1.4%
Total people on ARVs	10,928	25,117
HIV prevalence among CSWs	37.7%	19.8%

59. In terms of outputs indicators, the RBF scheme allowed the project to have significant achievements, as shown in the graph 1 below.

Graph 1: Changes in HIV prevention and treatment indicators in Burundi (2005 - 2011) – Baseline for 2005 = 100, except MC where 2008 = 100



60. Attribution: The project made the largest (and likely highest quality) investment in CSW programs, one of the reasons why the Government wanted continued Bank involvement after the closing of the project. The RBF scheme, with its impressive results in HIV indicators as shown above, was financed mostly by the Bank through this project. In addition, the project team courageously advocated for male circumcision with shows already very encouraging positive results.

61. With regard to intermediate indicators, the project achieved, and in many cases far exceeded, the targets for 8 out of 10 of them.

62. In terms of achievement of project development objectives the project is therefore rated **modest**.

3.3 Efficiency

63. As was the case for other MAP operations, no formal economic or financial efficiency analysis was conducted at appraisal. However, the Project achieved the outcome targets to satisfactory levels in a short period of time (less than three years of implementation, thereby maximizing the efficiency of the results achieved).

64. Targeting most-at-risk populations is currently recognized by the international community as a highly effective and efficient means of intervention. In addition, prevention of mother-to-child transmission has been recognized as a cost-effective approach. The project contributed to increasing the rate of PMTCT from 15% at the beginning of the project to 32% at the end of the project. The project also supported implementation of male circumcision after conducting a feasibility study in the country. Male circumcision is now recognized as a very important and efficient intervention in curbing the rate of new HIV infections among men.

65. The BSS survey of MARPs, conducted to look closely at the beneficiary groups, was another effort to sharpen efficiency and gain information on the size and nature of vulnerable groups.

66. These results from the economic and financial analysis (see Annex 3) show that the total economic benefits for two interventions (BCC for CSW and PMTCT) supported by the project are over $13 million. This almost equals the amount spent from project ($15 million) funds for all the interventions. Note that these interventions are all under Component 1, for which a total of $7.7 million was spent (for these two interventions as well as others). Even if all the other interventions under this project – including those under Components 2, 3 and 4 – impart total benefits of zero, the total benefit from the three interventions alone of over $13 million.

67. It should be stressed that these estimates are very much lower-bound estimates, even for the two interventions considered. This is because a very conservative figure has been used for the economic cost of each new HIV infection. If one takes into account the many costs imposed along different dimensions by every new HIV/AIDS infection, as described by Haaker (1994) chapter (as well as in many other sources), the total economic benefits for the two interventions due to the project would be much higher.

68. The efficiency of the project is rated **substantial**.

3.4 Justification of Overall Outcome Rating

69. Based on the above presented data on the relevance of the project's objectives, design, and implementation (**substantial**), achievement of PDOs (**modest**) and efficiency (**substantial**), the overall outcome rating of the project is **moderately satisfactory**.

3.5 Overarching Themes, Other Outcomes and Impacts

(a) Poverty Impacts, Gender Aspects, and Social Development

70. The Project made a very positive impact on the lives of women having multiple partners, most of which are widows living in rural areas. Many of these women confessed that they learned their HIV status as a result of this Project and have benefited from the income generating activities (IGA) financed by the Project. However, they lamented that the project came to a close too fast and could not reach the majority of women. Furthermore, the funding level of these IGA was insufficient to allow these women to live a descent life without depending on income from their multiple sexual partners.

(b) Institutional Change/Strengthening

71. The Project strengthened the CNLS body in charge of the overall coordination mandate for HIV/AIDS activities in Burundi. The CNLS (after necessary restructuring) will be able to carry out this role in the future for all Government and partner (GF, PEPFAR, etc…) funded HIV/AIDS activities in the country.

(c) Other Unintended Outcomes and Impacts (positive or negative)

3.6 Summary of Findings of Beneficiary Survey and/or Stakeholder Workshops

72. A beneficiary survey was not conducted.

4. Assessment of Risk to Development Outcome

73. HIV indicators are now part of the national RBF program and will continue to be financed under the RBF scheme along with other indicators as long as the national program remains. RBF indicators, including the HIV indicators, are now being financed not only by the IDA supported HSDSP project, but also by the Government and partners such as the European Union and the Belgian Cooperation.

74. The tariffs for HIV indicators may have to be reduced from their current levels in the future if partners, particularly the Global Fund project PRIDE, do not start to provide payments for RBF indicators. At the moment, the tariffs for RBF indicators that have been set do not take into account the additional parallel financing that the PRIDE project is providing on an "input" rather than "output" basis for bills for HIV health services. This creates a situation where there is double payment to health facilities for HIV indicators – one payment on the RBF basis as part of the national RBF scheme and one payment on the input basis by the PRIDE project.

75. One important area which is not being funded under the remaining mechanisms is BCC activities for most-at-risk populations like the CSW, which was not part of the RBF- paid activities under the project.

76. For the above reasons, the risk to the development outcome is rated **moderate.**

5. Assessment of Bank and Borrower Performance

5.1 Bank Performance

(a) Bank Performance in Ensuring Quality at Entry

77. Drawing on experience gained from the MAP 1 Project, the Bank built on lessons learned to design a project that maximizes the PDO achievement. However, the lack of baseline data makes it difficult to fully appraise any contribution of the Project to the achievement of the PDO indicators as agreed upon in the PAD.

78. The participation of a highly qualified team from the ASAP program also increased the quality of the project design at onset.

79. Therefore the Bank performance in ensuring quality at entry rating is **moderately satisfactory**.

(b) Quality of Supervision

80. The Bank's pro-activity in providing expert advice to the country during supervision visits, helping the project to remain focused on its main objective (providing prevention and treatment services to most-at-risk populations), was lauded by the QAG in their evaluation just before the mid-term review.

81. The presence of the Project TTL in the country throughout its implementation assured continuity of the Bank's support to the Borrower. In total seven official supervision visits, with accompanying Aide Memoires, were produced over the three-year lifespan of the Project. The supervision teams always were composed of qualified persons in their respective area of expertise.

82. The Bank's quality of supervision rating is therefore rated **satisfactory.**

(c) Justification of Rating for Overall Bank Performance

83. Given the two ratings above with regard to the Bank's performance in ensuring quality at entry (**moderately satisfactory**) and the quality of supervision (**satisfactory**), the overall Bank performance rating is **moderately satisfactory** because the overall outcome rating is moderately satisfactory**.**

5.2 Borrower Performance

(a) Government Performance

84. The Government commitment to provide a budget allocation to support the implementation of the national HIV/AIDS strategic plan in the amount of US $3.0 million equivalent through the national annual budget did not fully materialize. This commitment has been partially fulfilled with an average allocation of US $2.0 million equivalent per year.

85. The country's total expenditure on health as a percentage of GDP of 13.1% is among the highest in Africa and close to the 15% advocated by WHO. This testifies to the Government's commitment to improving the overall health status of its population.

86. Despite being a post-conflict country, there has not been any reported misappropriation of project funds. Likewise, a Global Fund General Inspector's investigative team found no mismanagement of GF money.

87. Although there was delay in replacing the outgoing Manager of the SEP/CNLS at the beginning of the project, once replaced, the new Manager remained for the entire project implementation period. This stability in leadership contributed to high quality performance of the implementing agency.

88. There have been too many changes in leadership, however, at the Ministry of Health level with four Ministers in total during the short period of the project. This situation hindered the project's goal of allowing the Ministry of Health to take on more direct responsibilities in implementing health related activities.

89. Rating for the Government performance is **moderately satisfactory**.

(b) Implementing Agency or Agencies Performance

90. The SEP/CNLS, the implementing agency of the project, was strengthened in its capacity and ability to become a true coordinating body. Although, some personnel restructuring was necessary to make it an efficient and effective HIV/AIDS coordinating structure.

91. Unfortunately, the SEP/CNLS took a long time to understand the focus of the Project on most-at-risk populations and may have contributed to the project not fully achieving its objectives. In addition, major studies (i.e. BSS among MARPs) were not conducted as planned in the PAD. Only two BSS studies instead of the planned three studies (one at the beginning and another one towards the end of the Project) were conducted.

92. Rating for the implementing agency is **moderately** s**atisfactory**

(c) Justification of Rating for Overall Borrower Performance

93. Given the incomplete disbursement of the Government committed budget contribution to the Project and the delays from the Implementing Agency in focusing more on the MARPs, the overall Borrower rating is **moderately satisfactory**.

6. Lessons Learned

94. ***The RBF scheme is a suitable tool to accelerate and/or maintain the achievement of results even within weak health systems like the one in a post-conflict country***. The scaling up of the RBF scheme at country level can contribute significantly to achieving significant results in a relatively short period of time.

95. ***Close coordination and collaboration between partners is necessary to ensure sustainability of achieved results***. A lack of harmonization of RBF policies supported by the Bank and the Client on one side and the financing of "inputs" on the side of the Global Fund created problems of double payment for the same services, thereby decreasing the efficiency of the overall HIV program in the country.

96. ***Project task team need to correct any discrepancy between the PAD and the Financing Agreement to harmonize the language between the two important reference documents.*** In this particular project, the development objective in the PAD mentions only preventive services to MARPs while the FA adds treatment to prevention. This creates confusion at the time of preparing the ICR because it's not clear which document should be the basis for the evaluation of PDO achievement.

7. Comments on Issues Raised by Borrower/Implementing Agencies/Partners

(a) Borrower/implementing agencies

97. Comments raised by the Borrower on the draft ICR (see Annex 7) have been taken into account in this final report.

(b) Cofinanciers

98. N/A

(c) Other partners and stakeholders

(e.g. NGOs/private sector/civil society)

Annex 1. Project Costs and Financing

Table 4: Project Cost by Component (in USD Million equivalent)

Components	Appraisal Estimate (USD millions)	Actual/Latest Estimate (USD millions)	Percentage of Appraisal
Component 1	7.0	7.7	110%
Component 2	2.0	1.4	70%
Component 3	3.0	2.0	66.7%
Component 4	3.0	3.9	130%
Total Baseline Cost	15.0	15.0	100%
Physical Contingencies	0.00	0.00	0.00
Price Contingencies	0.00	0.00	0.00
Total Project Costs	15.0	15.0	100%
Front-end fee PPF	0.3	0.3	.00
Front-end fee IBRD	0.00	0.00	.00
Total Financing Required	15.3	15.3	

Table 5: Project Financing

Source of Funds	Type of Cofinancing	Appraisal Estimate (USD millions)	Actual/Latest Estimate (USD millions)	Percentage of Appraisal
Borrower		0.00	0.00	.00
IDA Grant		15.00	0.00	100%

Annex 2. Outputs by Component

I. Project outcome indicators

Component 1: Preventive services targeting most-at-risk populations (MARPs)

99. This component was to finance: (i) sub-projects for the promotion of behavior change communication strategies for the MARPS and communications campaigns for male circumcision (MC), (ii) counseling and testing (VCT) of MARPS; (iii) training of health personnel and supply of medical equipment for the accreditation of providers of services to prevent mother to child transmission (PMTCT) and male circumcision, and (iv) contracts based on performance in the provision of PMTCT services and CM.

Table 6: Level of achievement of intermediate outcome indicators for component 1

Intermediate Outcome Indicators	**Baseline (2008)**	**Mid – term (2009)**		**End (2011)**	
Component 1: ***Prevention services targeted to high risk groups (IEC/BCC, promotion of male circumcision, PMTCT, VCT)***					
		Target	Achieved	Target	Achieved
Percentage of people from at-risk groups who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission. Disaggregated by sex and age (15-19, 20-24).	Men: 5.3% Female: 5.3%	15% increase (6.1%)	na	25% increase (6.6%)	CSW : 31.2% MSM : 21.4% Prisoners : 28.5% Seasonal workers : 31.3% Uniformed personnel : 32.7% (2010 BSS Study)
Percentage of people most-at-risk (IDU, MSM, SW) who received an HIV test in the last 12 months and who came back for their test results. Disaggregated by sex and age (<25, 25+).	CSW: 66.3% (2007 BSS Study)	70%	na	85%	CSW : 65.2% MSM:23.2% Seasonal workers : 4.5% Prisoners : 66.7% Uniformed personnel : 87.2% (2010 BSS study)
Number of men 12-49 circumcised per year.	Na	3000	1,109	6000	8,268
Percentage of health facilities that offer VCT to all pregnant women.	27%	30%	64.3% (399/620)	35%	84.53% (524/620)

100. The Project exceeded the targets for two intermediate outcome indicators (for HIV/AIDS comprehensive knowledge and the percentage of health facilities that offer VCT to pregnant women) but fell short of achieving the targets for the remaining two others (HIV testing among MARPs and number of circumcised men).

101. With regard to output indicators, the Project achieved a lot in terms of clinical services, behavioral change communication and VCT for MARPs, geographical coverage of services and training of health professionals in ARV provision, PMTCT, VCT, and medical waste management.

Table 7: Evolution of selected HIV indicators: 2005 – 2011

Indicator	YEAR						
	2005	**2006**	**2007**	**2008**	**2009**	**2010**	**2011***
# persons tested for HIV	103,952	150,092	147,575	236,988	308,827	433,711	616,596
# new cases put on ARVs	2,516	1,632	2,880	3,415	3,318	5,074	5,217
# of pregnant women put on PMTCT treatment	1,017	1,129	1,102	1,488	1,582	2,617	3,248
# of people on ARVs followed for a period of 6 months	6,416	8,048	10,928	14,343	17,661	22,735	50,354
# of STI cases treated	21,878	21,036	31,790	33,781	38,358	43,453	9,7024
# of males 15-49 years old who had circumcision	na	Na	na	539	1,109	3,343	8,278

*Annualized figures

102. The data above confirm the fact that the Project helped maintain the momentum gained from its predecessor (MAP 1). Without this Project (MAP 2), it is not clear that the previous successes would have continued in order to achieve the results observed at the closure of the Project, even with funding from the Global Fund.

103. It took time and persistent technical support from the Bank for the Implementing Agency to start activities focused on the vulnerable groups most responsible for driving the HIV epidemic in Burundi, namely the commercial sex workers. In the beginning, efforts were directed towards too many defined vulnerable groups (see Table 7 below), which would not allow the Project to achieve its PDO.

Table 8: Number and funding level of CSO projects by target

Target group	# reached	# of projects funded	Funding level (USD)
Batwa (ethnic minority)	330	5	18,729
Demobilized	5034	9	98,464
Internally Displaced Persons	10336	19	168,841
Women with multiple partners (rural CSW)	14177	57	1, 765,948
Unmarried young mothers	135	3	19,685
Handicapped	367	5	35,741
Uniformed personnel	880	4	35,799
MSM	100	1	2,034
Youth	27612	22	341,731
OVC	10836	50	1, 178,107
Fishermen	1711	3	47,815
Prisoners	400	1	1,603
PLWHA	5745	51	733,753
Returnees	8220	21	107,752
Bus transportation touts	1500	1	24,037
Domestic workers	1700	1	2,809
Seasonal workers	1350	5	30,651
Drug users	4330	4	104,871
PMTCT target (pregnant women and babies)	26 645	17	359,076
TOTAL	**94,763**	**247***	5, 077,445

*Some projects touched more than one group, that's why the total doesn't add up to 280.

a) Behavioral change communication (BCC) for the MARPs

104. Several activities regarding prevention and/or support to behavioral changes of vulnerable groups were financed under this Project. Since the MTR recommendations in February 2010, the coverage of activities regarding prevention and/or support to behavioral changes of vulnerable groups has largely been extended to the groups facing the highest risks, particularly sex workers. As a result, 1,061 awareness group sessions were organized that reached 14,177 sex workers. In addition, awareness tools were developed for sex workers and their partners, notably: (i) 4,392 reference flyers were distributed to sex workers, 1,000 flyers (for clients) were distributed to Lake Tanganyika fishermen and truck drivers; (ii) a film was developed, which raised the awareness of 4,866 sex workers and 188 partners of sex workers by way of a mobile movie theater; and (iii) 20,621 prevention kits were distributed to sex workers. Among the general population, sex workers in particular, benefited from the distribution of 4,426,322 male condoms and 28,573 female condoms to prevent HIV infection. In addition, 5,292 sex workers tested seropositive and retrieved their test results. See table 9 below.

Table 9: Achieved results by IEC/BCC activities targeting commercial sex workers

ACTIVITIES	RESULTS ACHIEVED
Preventing STI / HIV / AIDS through IEC / BCC activities to improve knowledge of CSW and the reduction of their high-risk behaviors for HIV / STIs	
Development, validation and multiplication of a training module for CSW peer educators	Module developed and validated
CSW peer educators training on STI / HIV, reproductive health, youth and adolescents, sexual violence, the main signs of STIs	- 180 CSW peer educators trained on the prevention of STI / HIV, SR youth and adolescents, sexual violence, the main signs of STI - 272 CSW peer educators trained on the prevention of STI / HIV
Design and production of a guide to educational talks for TS / PE	153 copies of the Guide distributed
Organization of group discussion sessions led by CSW/PE under the supervision of social workers	1,061 sessions organized
	14, 177 CSW reached
Design and production of a reference flyer with messages	4,392 copies of the flyer distributed
Adaptation and reproduction of an educational pamphlet for CSW clients	1,000 Brochures for CSW clients (truckers and fishermen) distributed
Design and production of a film on IEC/BCC, STI/HI /AIDS, and reproductive health for CSW	The film is available
Organization of group discussion sessions IEC / BCC by using the mobile cinema to educate CSW and their clients	64 group sessions held
	4,866 CSW reached
	188 CSW clients reached
Free distribution of male condoms	4,426,322 male condoms distribute
Social marketing of condoms in "hot spots" of Bujumbura and Rumonge cities and their peripheries	An outlet at the bus station in Bujumbura was created
Free distribution of female condoms	28,573 female condoms distributed
Distribution of awareness kits to CSW peer educators	368 awareness kits distributed
Distribution of prevention kits to CSWs	20,621 kits distributed
Organization of 4-day information on the rights of CSWs for CSWs	169 CSW reached
Organization of 5-day information on the rights of CSWs for security officers	189 security officers reached
Number of CSW who underwent HIV testing and who know their results	5, 292

105. The transition toward scaling up the Results-Based Financing (RBF) strategy took place starting in April 2010, and six HIV-related indicators were included in the service package covered by Results-Based Financing. During the 13-month period until the closure of the Project, these indicators reached quite noticeable levels. 633,459 persons tested seropositive while 6,294 new cases of infected and gravely ill persons were monitored over a six-month period. Regarding PMCT, 3,407 seropositive pregnant women benefited from the prophylactic ARV treatment, and 2,097 newborns from seropositive mothers were treated. In the context of HIV prevention, 93,856 STI cases were treated.

106. Prevention activities and/or support for BCC have been funded through 138 sub-projects which reached the following vulnerable groups (see Table 8 above): From

January 2009 to June 2011, 14,177 female commercial sex workers (CSW), 5034 demobilized, 10,336 IDPs, 27,612 young people of which 18,205 youth from community colleges, 330 Batwa (ethnic minority), 8220 returnees, 1500 touts for transportation buses, 1700 household workers, 880 members of uniformed personnel (military and police), 1,711 fishermen, 1,350 seasonal workers, 4330 drug users, 400 prisoners, 100 MSM, 367 disabled, and 135 unmarried young mothers, from all the 17 provinces countries. The provincial Sectoral Public Units have conducted BCC activities for 3450 workers, 3000 fishermen working on fishing ports along Lake Tanganyika, and 1700 workers in construction sites.

107. After the February 2010 supervision mission, the approach of involving civil society organizations (CSOs) has been improved. It now puts more focus on a smaller number of MARPs and interventions, and uses a result based financing approach for selected projects.

Table 10: Achieved results in improving socio-economic status of commercial sex workers

Activity	Results
Improving the socio-economic status of CSW through solidarity actions and IGAs	
Identification/organization of associations of CSW and economic opportunities	3,175 CSW benefited from IGAs
	25 organizations identified and organized to receive economic opportunities
Training of CSW leaders of associations on management of small businesses and IGA	75 CSW leaders trained
Job training for CSW	45 CSW trained
Situational analysis, monitoring and evaluation of interventions towards CSW	
Mapping study to identify and confirm the sites of concentration of CSW, hot spots and services available to CSW in the cities of Bujumbura and Rumonge	Study realized
A KAP study among CSW	Study realized

108. All 17 provinces of Burundi included project activities supporting CSOs with an average of 14 sub-projects per province. Sixteen of the 17 provinces had at least one sub-project for sex workers approved for funding.

Table 11: Geographic coverage of funded projects by type of intervention

	Prevention	Curative activities	IGA	OVC	Legal assistance	Total
Ruyigi	3			3	0	6
Rutana	9		4	3	0	16
Ngozi	13	1	1	0	0	15
Mwaro	6		4	6	0	16
Muyinga	9		2	0	0	11
Muramvya	8	1	1	5	0	15
Makamba	8	1	1	9	0	19
Kirundo	7		3	1	0	11
Kayanza	8		4	3	0	15
Karuzi	4			2	0	6
Gitega	6	1	2	0	1	10
Cibitoke	8			2	0	10
Cankuzo	1		3	2	0	6
Bururi	6			5	0	11
Buja R	14	1	2	6	0	23
Buja M	9	1	16	1	0	27
Bubanza	11			2	0	13
Many provinces	8	2	5	0	2	17
Total	**138**	**8**	**48**	**50**	**3**	**247**

b) Promotion of male circumcision

109. With support from the Project, activities for the promotion and provision of male circumcision services were conducted: (i) Funding for a study on the feasibility and acceptability of male circumcision among the sexually active population in Burundi, (ii) the collection of data on male circumcision, (iii) signature of performance based contracts with hospitals to provide MC services, (iv) integration of an indicator on male circumcision in the national RBF scheme, (v) national training of health care providers on MC, (vi) procurement and distribution of medical kits for MC.

110. Retrospective data collected show that only 539 CM were conducted in 2008, 1109 CM in 2009, and 3343 CM in 2010.

c) Voluntary counseling and testing of high-risk groups

111. The number of testing centers (VCT) accredited increased from 266 in 2008 to 524 in June 2011. The number of people screened increased from 236,988 in 2008 to 334,409. In 2010, the expected number was 340,000 and 275,692 during the first half of 2011. By the end of the Project, testing kits for 45 VCT and 40 PMTCT sites were distributed.

d) Training of health professionals and provision of medical equipment for the accreditation of providers of PMTCT services and MC

112. In total, 520 caregivers were trained in PMTCT and 46 new PMTCT sites have been accredited. At the end of the Project on June 30, 2011, there were 130 PMTCT sites, from the public and private sector organizations (Civil Society Organizations and religious inspiration).

e) RBF contracts for the provision of PMTCT services and MC

113. The Ministry of Health has signed contracts with 563 health facilities involved in the PMTCT before April 2010 and a campaign of mobilization for PMTCT among women of childbearing age was conducted in all the communes of the country. A total of 130 health care facilities are accredited as PMTCT sites and 17 sub-projects aimed at mobilizing and increasing demand for PMTCT were funded. It should be noted, however, that experience has shown that many structures accredited spend months or years without providing the services expected because of lack of material and adequate human resources. Accreditation does not necessarily guarantee the availability and accessibility of PMTCT services.

114. Approximately 7,217 women received ARV prophylaxis during the project life (including 1,530 under RBF in the first half of 2011). As for PMTCT activities, the MOH is considering scaling up CM services in the entire country, as this is a now well proven strategy for HIV prevention.

Component 2: Curative services based on performance

115. This component aimed to contribute to (i) the provision of clinical services to AIDS patients through RBF contracts, (ii) the training of health facilities identified for the provision of such services, and (iii) funding of sub -projects to promote home based care in communities identified as priority.

Table 12: Table showing level of achievement of intermediate outcome indicators for component 2

Intermediate Outcome Indicators	**Baseline (2008)**	**Mid – term (2009)**		**End (2011)**	
Component 2: ***Performance-based curative services***					
		Target	Achieved	Target	Achieved
Percentage and number of adults and children with advanced HIV infection receiving antiretroviral therapy. Disaggregated by sex and age (<15, 15+).	46% (10,900/23532) (857 children <15 years)	48% (12,900/26,920)	65.6% (17,661/26,920) >15ans: 16,072 <15ans: 1,589	50% (14,000/27,674)	90.8% (25,117/27,674) >15: 23,202 <15 : 1,915

116. The achieved level for this indicator exceeded the targets set for both the mid-term and end of the project (65.6% realized versus the 48% target for mid-term and 90.8% realized versus the 50% target for end of project).

117. The number of sites of antiretroviral therapy (ART) accredited rose from 75 in December 2009 to 95 June 2011. The MOH Sectoral AIDS Unit (USLS) has conducted supervisory training in all ART sites while 210 providers were trained on the comprehensive care of HIV/AIDS including ART provision. The 95 ART sites were able to secure their own supply of medicines, reagents and consumables without documented stock out thanks to training received in the management of supply chains and the roll out of the RBF strategy.

118. The new approach of contracting services for clinical management of AIDS has proven to be effective in the MOH decentralization efforts and effective integration of such services in the minimum package of activities at health center level. With the scaling up of the RBF approach in all health facilities in the country, the number of health centers under contract jumped from 112 in March 2009 to 563 in 2010. This resulted in putting 5,074 new patients on ARV in 2010 alone, and the cumulative number of new people on ART as of June 30, 2011 was 25,117.

Component 3: Poverty reduction and other vulnerabilities

119. The implementation of this component was realized through the funding of selected income-generating activities (IGA) for people living with HIV (PLWHA) and orphans and vulnerable children (OVC).

Table 13: Table showing level of achievement of intermediate outcome indicators for component 3

Intermediate Outcome Indicators	**Baseline (2008)**	**Mid – term (2009)**		**End (2011)**	
Component 3: ***Decentralized financing of small grants to families living with HIV/AIDS and high risk groups***					
		Target	Achieved	Target	Achieved
Number of PLWHA reached through small grant activities.	8,799 (2007 CNLS Report)	10,000	3,909	11,000	5,744
Number and value of subprojects targeted to high risk and vulnerable population.	100 $1,856,214	142 ($1,521,800)	125 $1, 094,266	246 $2,682,600	247 $2,948,087

120. The number of PLWHA reached through small grants activities fell short of the targets set for both mid-term and end of the Project. This may be explained by the ultimate focus of the project on groups most-at-risk like commercial sex workers towards the end of the Project. However, the number and value of subprojects targeting MARPs exceeded the projections.

a) Activities benefiting people living with HIV (PLWHA)

121. In total, 48 sub-projects for PLWHA IGAs have been funded to reach 3,909 people infected with AIDS. In order to improve the socio-economic development of infected CSW, the following results were achieved: (i) 3,175 CSWs received project funding to undertake income generating activities (AGR); and (ii) 25 CSW associations were created. From these associations, 75 representatives were trained in organization and association management and 45 were trained in business management for the IGAs.

122. In terms of promoting the rights of PLWHA, the following results were achieved through the funding of three sub-projects:

- ✓ 1836 people received legal support in the 17 provinces of the country, this activity was conducted in partnership with the RBP +;
- ✓ 160 monitors and observers were trained and retrained on the law protecting people with HIV and their dependents, the tool index stigma, and techniques for monitoring human rights violations of PLWHA;
- ✓ 360 cases of violations of rights of PLWHA were reported as part of the establishment of an early warning system;
- ✓ 60 members of the network of parliamentarians committed to the fight against HIV / AIDS attended the meetings for exchange and dialogue on the fight against violations of rights of PLWHA and implementation of policies and legislation favorable to the protection of these groups.

b) Activities benefiting infected and affected OVCs

123. The number of sub-projects towards OVCs that were funded by the project was 50. The Project covered 14 provinces at the beginning of the project and ten provinces since 2010, the remaining provinces being covered by funding from other donors. The number of OVC affected cared for in the entire project life is 10,836.

Component 4: Capacity building of local authorities and key ministries for the implementation of activities against HIV / AIDS and Program Management

124. This component was to finance: (i) operating expenses of the CNLS Permanent Executive Secretariat (SEP-CNLS) in relation to the overall program management including the management of the Project; (ii) support activities to the national monitoring and evaluation in connection with (a) impact assessments and other epidemiological studies, (b) the effective targeting of interventions based on vulnerability mapping and triangulation of data periodically to identify high risk factors, and (c) monitoring of epidemiological and socio-behavioral and analysis and use of strategic information for decision-making programs; (iii) support activities to local authorities for the decentralization of collection and information management; and (iv) capacity building activities, implementation, coordination and supervision of action plans against HIV / AIDS by government departments and institutions involved in sectors other than health.

Table 14: Table showing level of achievement of intermediate outcome indicators for component 4

Intermediate Outcome Indicators	Baseline (2008)	Mid – term (2009)		End (2011)	
Component 4: ***Capacity building for local authorities and key Ministries to implement HIV/AIDS activities and national program management***					
		Target	Achieved	Target	Achieved
Number of public sector organizations that include in their annual action plans or sector strategies HIV/AIDS.	2 Institutions	4 Institutions	13	10 Institutions	13
Joint annual report of the Multisectoral HIV/AIDS Program, disseminated during the annual Meeting of the CNLS.	Done	Done	Done	Done	Done
Percentage of executing agencies (public sector and civil society) that submit financial three-monthly reports completed in time.	70%	80%		90%	90%

a) Monitoring and Evaluation

125. Regarding the system of routine monitoring, the performance reliable data management (SidaInfo) to generate information in real time has greatly improved. Supervision missions were conducted in 17 Provinces. The SidaInfo database is up to date and it is now completely decentralized. The tracking system would benefit greatly if the database incorporated all other modules that also support components (sub-project monitoring, prevention strategies, PMTCT, VCT) other than ARVs.

126. Project funds have helped to get a better understanding of the epidemic in Burundi through the availability of a report on the epidemiological analysis and synthesis of HIV/AIDS in Burundi and the implementation of a bio-behavioral survey targeting high-risk groups. The epidemiological report summary analysis has been very useful in that it paints a clear picture showing a certain level of knowledge of the situation of HIV/AIDS in the country, the state of data quality, needs and gaps in coverage as well as future prospects. The availability of the report provided a better understanding of the determinants of the HIV epidemiological situation in Burundi.

127. Available epidemiological data from 2007 to 2010 show that HIV is a real public health problem in Burundi. Indeed, the 2007 survey reveals an overall seroprevalence of 2.97% in the general population among the adult population. Furthermore, it was found that among sex workers, the overall seroprevalence was 38% with higher rates in the cities of the interior in Bujumbura capital city (46% against 29%). During the past three years, several activities aimed at strengthening the knowledge and behavior change were carried out as part of the operationalization of the strategic plan 2007-2011. The results of the 2010 BSS survey among MARPs, show encouraging results with regard to the impact of the national response. The prevalence of HIV among sex workers dropped from 37.7% in 2007 to 19.8% in 2011.

Annex 3. Economic and Financial Analysis

128. This annex presents estimates of economic analysis done for the project. The analysis focuses on the economic benefits on two categories of preventative activities supported by the project: (a) behavior change communication (BCC) for commercial sex workers and (b) prevention of mother-to-child transmission of HIV (PMTCT). These are all activities of Component 1 of the project which focuses on preventative activities. The analysis below provides estimates of the total economic benefits of these three categories of activities financed by the project.

129. The total expenditure under this component was $7.7 million. The focus on preventative activities more than treatment is appropriate in the project since key preventative activities are much more cost-effective than treatment (Canning, 2006).

130. Note that the analysis below focuses on just two categories of preventative activities, but these are only a subset of the preventative activities of the project. Other critical preventative activities such as male circumcision, behavior change communication for high-risk groups other than commercial sex workers and treatment of sexually transmitted diseases are not included in the analysis. If these – all with proven high benefits compared to costs in several studies in other countries – were included in the analysis, the total economic benefits would be even larger.

131. The annex discusses the key assumptions underlying the analysis before presenting the results of the analysis.

Key Assumptions of the Analysis

Economic Cost of Each New Case of HIV/AIDS

132. This is critical for the analysis since it factors into estimates of the benefits of each new infection averted due to preventative interventions against HIV/AIDS. However, there is considerable variation in the methodologies used to estimate the economic cost of HIV/AIDS, and in results found using different methodologies. A key problem here is that by all accounts, the impact of HIV on society is multi-faceted and works along several different dimensions.

133. An excellent and thorough description of the economic costs of HIV/AIDS on society is provided in Haaker (2004). This is a chapter from an IMF book on the macroeconomic impact of HIV/AIDS. It describes in detail – and with evidence provided from various studies – how HIV/AIDS has a serious impact on traditional economic measures such as economic growth, income per capita, and investment, but it does so by affecting very diverse areas of public, social, and economic life. Aside from the direct mortality and morbidity costs imposed, as well as the cost of treatment, HIV/AIDS imposes economic costs in various other ways, including via: (i) changes in dependency ratios; (ii) effects on the economic situation of households (e.g. through a sick breadwinner or time needed to take care of a sick family member, as well as out-of-

pocket health expenditures; (iii) adverse effects on productivity and hence on the economy; (iv) an increase in the number of orphans; (v) adverse effects on social capital; and (vi) adverse effects on economic growth (including via changes in the composition of the workforce and on productivity).

134. In the present analysis, only the cost of care for an HIV/AIDS patient (over the lifetime of the patient, discounted appropriately) is taken into account to determine the economic cost of each new infection averted (which, in turn, is used to estimate the economic benefits of preventative interventions that reduce the number of new infections averted). A detailed study in Burundi found that the cost of care per year was $590, on average (Basenya and Renaud, 2008). To be conservative, about half of this estimate - $300 – was used in the present analysis for the estimated cost of care per year, for each new infection averted.

135. It is important to note that this approach substantially underestimates the benefits of preventative interventions against HIV, because: (i) only about half of the full cost of care as estimated in the Burundi context is taken into account; and (ii) the many other costs to the economy and to society as described briefly above (and in detail in the chapter by Haaker, 2004) are not taken into account in the calculations.

Other Assumptions

136. Key parameters for the analysis are provided in the table below. They are based on the results of the BSS surveys (mainly the 2007 BSS survey which took place before the start of the project), as well as data from UNAIDS and the Center for Diseases Control as wels as various meta-analyses and studies in other similar countries. A list of the latter is provided below, at the end of this annex.

137. For BCC for commercial sex workers, the number of sex workers reached is taken from project data. For PMTCT, figures are available in aggregate and it has been financed by the MAP 2 project as well as the PRIDE project. Thus, a proportion of the total (e.g. total number of mothers treated with PMTCT) was "attributed" to the MAP 2 project based on the expenditures made by the MAP 2 project relative to those of the PRIDE project for each intervention.

Methodology

138. The benefits were calculated for each of the two interventions (BCC for commercial sex workers and PMTCT) as follows. First, the number of lives saved was estimated in each year, using the below parameters. For example, in the case of PMTCT, the risk of an infected mother passing on the infection to the child is reduced from 33% to 5% if PMTCT is provided – a risk reduction of 25%. This means that the number of children saved from a new infection (the number of infections averted) is 25% x the total number of mothers provided with PMTCT. As mentioned in the preceding paragraph, not all of these were attributed to the MAP 2 project; the proportion of the total "attributed" to the MAP 2 project was based on the expenditures made by the MAP 2 project relative

to those of the PRIDE project for PMTCT. A similar approach was used for the other two interventions – the aim in each case being to determine the total number of new infections averted (and attributed to the MAP 2 project) in each year.

139. Next, a monetary value was ascribed to each new infection averted, equal to the present discounted value of the cost of care each year ($300 per year, every year until death, for every person with full HIV/AIDS). As mentioned in the table below, the discount rate used was 3%.

Table 14: Key Parameters Used in the Analysis

Assumptions for All Two Categories of Interventions	
Discount Rate	3%
Assumptions for BCC for Commercial Sex Workers	
HIV prevalence of rural commercial sex workers (based on BSS survey data)	46%
HIV prevalence of urban commercial sex workers (based on BSS survey data)	29%
Number of sexual episodes per year, on average per sex worker (based on BSS survey data)	281
Risk that an infected sex worker infects a client, per sexual episode, without condom use	1 in 2000
Reduction in the above risk when using a condom	89%
Total number of sex workers reached by project (lower-case estimate – includes BCC by peer educators, mobile cinema, others – see Table 8)	18,000
Percentage of all sexual episodes where condom is used, due to BCC activities – without which it would not be used (based on data on condom use from BSS survey data as well as studies on other countries, e.g. see Weller S.C., 1993)	12%
Probability that a client, once infected, will infect his regular partner as well	18%
Assumptions for PMTCT	
Risk of transmission of infected mother to child without PMTCT	33%
Risk of transmission of infected mother to child with PMTCT	<5%

Results of the Analysis

140. The total economic benefits for each of the three interventions are provided in the below table.

Table 15: Total Economic Benefits of Each Intervention Included in the Analysis, Due to MAP 2 project

BCC for Commercial Sex Workers	$6,756,813
PMTCT	$6,955,996
Total of the Above Three Interventions	$13,712,809

141. These results show that the total economic benefits for the two interventions considered, due to the project, are more than $13 million. This is almost equal to the total amount spent from project funds for all the interventions. Note that these interventions are all under Component 1, for which a total of $7.7 million was spent (for these two interventions as well as others). Even if all the other interventions under this project – including those under Components 2, 3 and 4 – impart total benefits of zero, the total benefit from the three interventions alone of over $13 million.

142. It should be stressed that these estimates are very much lower-bound estimates, even for the two interventions considered. This is because, as mentioned above, a very conservative figure has been used for the economic cost of each new HIV infection. If one takes into account the many costs imposed along different dimensions by every new HIV/AIDS infection, as described above and in the Haaker (1994) chapter (as well as in many other sources), the total economic benefits for the two interventions due to the project would be much higher than presented in the above table.

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Annex 4. Bank Lending and Implementation Support/Supervision Processes

(a) Task Team members

Names	Title	Unit	Responsibility/ Specialty
Lending			
Otieno Ayany	Financial Management Specialist	AFTFM	Financial Management Specialist
Serigne Omar Fye	Consultant	AFTED	Consultant
Astania Kamau	Language Program Assistant	AFTSP	Program assistant
Pamphile Kantabaze	Senior Operations Officer	AFTHE	Operations officer
Montserrat Meiro-Lorenzo	Sr Public Health Spec.	HDNHE	Former TTL
Prosper Nindorera	Senior Procurement Specialist	AFTPC	Procurement specialist
Dominique Puthod	Operations Officer	LCSHE	Operations officer
Supervision/ICR			
Otieno Ayany	Financial Management Specialist	AFTFM	Financial management specialist
Aurelien Serge Beko	Economist	AFTP2	Economist
Paul-Jean Feno	Environmental Spec.	AFTEN	Environment specialist
Edouard B. Houssou	Consultant	AFTHE	Consultant
Astania Kamau	Language Program Assistant	AFTSP	Program assistant
Pamphile Kantabaze	Senior Operations Officer	AFTHE	TTL
Alain-Desire Karibwami	E T Consultant	AFTHE	Consultant
Benjamin P. Loevinsohn	Lead Public Health Specialist	AFTHE	Cluster Leader
Cyprien Mbonigaba	Consultant	WBIGV	Consultant
Montserrat Meiro-Lorenzo	Sr Public Health Spec.	HDNHE	Former TTL
Nadeem Mohammad	Senior Operations Officer	OPCRX	Operations officer
Adjaratou Diakhou Ndiaye	Consultant	AFTHE	Consultant
Melance Ndikumasabo	Procurement Specialist	AFTPC	Procurement specialist
Prosper Nindorera	Senior Procurement Specialist	AFTPC	Procurement specialist
Marie-Claire Nzeyimana	Communications Associate	AFRSC	Communication associate
Adenike Sherifat Oyeyiola	Sr Financial Management Spec	AFTFM	Financial management specialist
Dominique Puthod	Operations Officer	LCSHE	Operations officer
Clarette Rwagatore	Team Assistant	AFMBI	Team assistant
Cheikh A. T. Sagna	Senior Social Development Spec	AFTCS	Social development specialist
Emmanuel Sinzohagera	Consultant	AFMBI	Consultant
Karen Cecilie Sjetnan	Senior Country Officer	AFCCM	Country officer

(b) Staff Time and Cost

Stage of Project Cycle	Staff Time and Cost (Bank Budget Only)	
	No. of staff weeks	USD Thousands (including travel and consultant costs)
Lending		
FY08	22.57	82.33
Subtotal - Lending	**22.57**	**82.33**
Supervision/ICR		
FY09	22.48	79.23
FY10	23.11	68.44
FY11	28.69	135.25
Subtotal – Supervision/ICR	**74.28**	**282.92**
Total	**96.85**	**365.25**

Annex 5. Beneficiary Survey Results

143. Not conducted

Annex 6. Stakeholder Workshop Report and Results

144. No stakeholder’s workshop conducted

Annex 7. Borrower's Comments on Draft ICR

Observations du SEP sur le RAPPORT DE FIN D'EXÉCUTION ET DES RÉSULTATS

(IDA-H03830)

1. Faire une revue de la partie « abréviations », car il y a quelques abréviations qui sont dans le texte et qui ne sont pas retrouvés dans la liste (exemple : **Au paragraphe 89, « FC » : on ne trouve pas la signification de cette abréviation dans la partie y relative).**

2. Contexte au moment de l'évaluation : Cette qualification « particulièrement médiocres » en ce qui concerne les indicateurs sanitaires me semble excessive, si l'on se réfère aux progrès en terme d'indicateurs de couverture et même d'accès. Ainsi donc, il ne faut pas ignorer l'accès gratuit aux soins maternels et infantiles depuis 2006 et qui en moins de 4 ans a fait doubler la proportion des accouchements médicalement assistés. C'est aussi en contadiction avec les résultats appréciés de la 1ère intervention de IDA dans la lutte contre le VIH (2002-2008).

3. Au chapitre du contexte au moment de l'évaluation : Ministère à la Présidence chargé de la Lutte contre le Sida (il n'était nulle part indiqué dans la structure gouvernementale qu'il s'agissait d'un ministère d'Etat)

4. **Au chapitre 3.1 : Pertinence des objectifs, de la conception et de l'exécution**

Au paragraphe 8 : l'objectif de développement du projet tel qu'indiqué dans le PAD « **Accroître l'utilisation d'un ensemble bien déterminé de services de prévention chez les groupes hautement vulnérables au VIH/SIDA ou affectés par cette épidémie »**

A la fin du paragraphe 34, il est suggéré d'ajouter : « L'une des explications de cette discordance était le fait que les structures n'étaient pas toutes intégrées dans SIDA INFO ou n'enregistraient pas leurs données en temps réel,ce qui générait un décalage. (mise en œuvre du suivi&évaluation paragraphe 34) »

Après le **paragraphe 51**, il est suggéré d'insérer un paragraphe pour rester en harmonie avec le paragraphe 27 de la page 11 sur las causes de retard,dont la responsabilité est entièrement partagée entre l'EMprunteur et l'IDA. Il faut également signaler que la mise en œuvre ne s'est jamais écartée du plan d'action approuvé par l'IDA . (Pertinence de l'exécution).

Il faut aussi signaler que le cadre des résultats a régulièrement fait l'objet de modifications de la part des différentes missions de supervision et que la version définitive n'a été adopté que longtemps après la revue à mi parcours.

5. **Au chapitre 3.2 : « Réalisations des objectifs du développement de développement du projet »**

Au paragraphe 59 : le rapport ne devrait pas minimiser la contribution du Fonds Mondial avec tout ce que ces interventions apportent pour améliorer la qualité de l'offre, notamment l'achat des intrants et le renforcement du système de santé. Il ne faut pas perdre de vue que c'est grâce aux apports du Fonds Mondial que le traitement ARV et le traitement des infections opportunistes sont plus accessibles, ce qui a bien contribué aussi à l'atteinte des bons résultats indiqués ci-dessus.

Enfin le taux de prévalence indiqué pour l'EDS 2010 de 1,4% est encore provisoire et n'est pas encore validé définitivement.

6. **Au chapitre 3.3 : Efficience**

Au paragraphe 61, il s'agit d'une étude d'acceptabilité et de faisabilité (et pas seulement une étude de faisabilité)

Au paragraphe 63, le SEP ne maîtrise pas bien l'échelle d'évaluation, mais la conclusion n'est pas en phase avec le corps contenu du 3.3qu'elle est censée conclure. (en rapport avec l'efficience du projet)

7. **Au chapitre 4 :** Évaluation du risque lié aux résultats en matière de développement

Au paragraphe 69 : Il est clair que le paiement FAR a stimulé la demande car elle est incitative pour le personnel de santé. Cependant, le paiement FAR n'est pas suffisant pour couvrir les intrants nécessaires pour les prestations VIH. Pensez- vous vraiment qu'avec l'achat des indicateurs, les établissements de soins pourraient acheter eux même les équipements nécessaires tels que les appareils de suivi biologique, la charge virale et autres, les réactifs et les médicaments. Il me semble nécessaire de continuer à financer l'offre si l'on veut améliorer la qualité des prestations VIH.

Par ailleurs avec le financement du Fonds Mondial les conventions établies avec les structures de soins permettent à celles-ci d'offrir des soins gratuits aux PVVIH, ce qu'ils ne feraient pas uniquement avec les paiements des indicateurs par le PBF car ceux-ci ne couvrent pas toutes les dépenses encourues par les établissements de soins. Est-ce que vous pouvez prouver que les coûts des indicateurs se sont réferés aux coûts réels des actes ? Si ce n'est pas le cas, ce qui est fort plausible, quelqu'un doit payer la différence. Le projet PRIDE appuie en remboursant des frais que l'établissement de soins ferait payer au malade en l'absence de la convention, et ce n'est donc pas un double paiement.

8. **Au chapitre 6 : Leçons tirées du projet**

Après le paragraphe 91, insérer parmi les leçons tirées ce paragraphe : L'importance de créer un environnement propice pour le démarrage et la mise en œuvre du projet. Dans le cas du PMLS II, on peut remarquer que les conditions d'un bon départ n'étaient pas totalement réunies : nécessité de renouveler les contrats de certains personnels, retard dans la mise en place de l'équipe de direction, préalables comme la signature de conventions avec le Ministère, la formalisation de la contractualisation, le processus du ciblage, le recrutement des agences d'exécution, ainsi que la lenteur dans l'appropriation de l'approche PBF par les acteurs de mise en œuvre du Projet, etc.

Au paragraphe 92 : Les politiques FAR dans leur conception actuelle ne peuvent pas couvrir les prestations VIH car ce programme a encore besoin d'investissements importants pour une offre de service de qualité qui puisse susciter une augmentation de la demande. Quand il ya des problèmes de décaissements et de disponibilité de fonds pour signer les conventions avec les structures de soins avec le financement de GF, les PVVIH souffrent énormément car malgré le FAR, les établissements de soins leur exigent des paiements qu'ils n'arrivent pas à couvrir. Les coûts des indicateurs ne sont pas basés sur les coûts réels des actes, quelqu'un doit donc payer la différence. Il faut mieux harmoniser certes, mais il ne me semble pas approprié de parler de double paiement. Le FAR n'est pas une assurance-maladie, loin de là.

Autres observations (voir fichier joint)

1. Voir le commentaire fait au tableau n°7 (nombre et niveau des financements des projets des OSC par cible)
2. Compléter le tableau n°8 (Résultats obtenus par les activités d'IEC/BCC visant les travailleuses du sexe) indiquant le nombre de TS dépistés qui ont récupéré les résultats
3. Voir quelques corrections en mode « track changes » pages 13 et 23 (modifications des données spectrum après paramétrage des résultats du recensement général de la population ; puis de la page 32 à la page 34

Annex 8. Comments of Cofinanciers and Other Partners/Stakeholders

145. Not applicable

Annex 9. List of Supporting Documents

- ✓ Burundi MAP Project Appraisal Document (March 2004)
- ✓ Burundi MAP Development Grant Agreement – H080 (April 2004)
- ✓ Report of the Quality Enhancement Review (QER) (February 2010)
- ✓ Mid-term review Aide Memoire (June 2010)
- ✓ Burundi HIV epidemiology synthesis report (June 2010)
- ✓ Last ISR report (June 2011)
- ✓ Rapport final BSS study among MARPS (June 2011)

Annex 10: Summary of Borrower's prepared ICR

Second Projet Multisectoriel pour la Lutte contre le VIH/SIDA (PMLS II)

Don IDA H383-BI

Rapport d'Achèvement

Résumé exécutif

Objectifs : **« Accroître l'utilisation d'un ensemble bien déterminé de services de prévention chez les groupes hautement vulnérables au VIH/SIDA ou affectés par cette épidémie »** 9.400.000 DTS (15.000.000 USD)

Le projet est subdivisé en quatre composantes :

Composante 1 : Services préventifs ciblant les groupes à haut risque (allocation initiale : 7 millions USD)

Composante 2 : Financement basé sur les performances de services cliniques et

de services communautaires pour les malades du Sida (allocation initiale : 2 millions USD)

Composante 3 : Financement décentralisé des petits dons aux familles vivant

avec le VIH et aux autres groupes à haut risque (allocation initiale : 3 millions USD).

Composante 4 : Renforcement des capacités des autorités locales et des ministères

clé pour la mise en œuvre des activités de lutte contre le VIH/ SIDA et la gestion du programme national (allocation initiale : 3 millions USD).

CONTEXTE ET DE LA JUSTIFICATION DU PROJET

Au niveau national, le PMLSII a été conçu et négocié dans un contexte national caractérisé par des enjeux importants, parmi lesquels on peut citer:

a) Une situation de pauvreté généralisée, résultant d'une longue période de guerre et de ses effets divers,

b) Une situation sociopolitique et macroéconomique fragile, caractérisée par des insuffisances dans le domaine de la gouvernance et dans l'allocation des ressources

d) Des indicateurs sociaux de base parmi les plus faibles d'Afrique : taux de mortalité maternelle et infantile, situés à environ 900/100 000 et 179/1000 ,taux de malnutrition chronique touchant deux enfants burundais de moins de 5 ans sur trois

e) L'adoption par le pays d'une stratégie pour la réduction de la pauvreté (DSRP) dont les axes stratégiques principaux du DSRP à 4 axes dont celui du VIH et sida

f) Une prévalence globale du VIH de 2,97% avec une tendance à la stabilisation globale de l'épidémie en milieu urbaine et une flambée persistante en milieu rural

La principale innovation du projet par rapport au précédent est le focus de la prévention au sein des groupes à plus haut ainsi que par le fait de mettre en avant des stratégies avérées de prévention d'une part ,l'introduction du financement des soins à travers la nouvelle stratégie du Ministère de la santé Publique de Financement basé sur la performance et une plus grande responsabilisation de ce secteur dans la gestion des ressources du projet. .

Démarrage du projet

L'Accord de don pour le PMLSII a été signé le 16 juillet 2008 et le projet est entré en vigueur de fait le 16 octobre 2008. L'atelier de démarrage du projeta été organisé au cours du mois de février 2009.

Le démarrage effectif du projet a connu un retard d'environ six (6) mois[1], qui a été dû à plusieurs facteurs, dont les changements politiques intervenus au cours du démarrage du projet et ayant affecté le montage institutionnel du projet, une transition au niveau du management caractérisé par la vacance prolongée des postes de direction et d'une partie du personnel, une insuffisance de compréhension commune de certaines procédures entre les parties, le retard dans la soumission et l'approbation du premier PTA et budget 2009 ,le retard dans la signature de la convention entre le MSP et le SEP/CNLS et le contrat entre le MSP et les prestataires de services ,la lenteur dans l'appropriation de la nouvelle approche du financement basé sur les performances…

LES REALISATIONS DU PROJET PAR COMPOSANTE

Composante 1 : Services de prévention ciblant les groupes à haut risque.

Le projet a financé 138 sous projets qui ont été exécutés par les OSC et des activités réalisées par des ministères sectoriels dans l'optique de promouvoir un changement de comportement. Ces actions ont consisté , notamment, en sensibilisation la prévention du VIH et du sida, en dépistage volontaire du VIH, en distribution du préservatif (masculin et féminin), en production d'outils et de modules de formation, en formation des pairs éducateurs , des prestataires , du personnel de santé, en fourniture de services PTME, et ceci à travers la signature de conventions de financement.

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[1] L'accord de don a été signé en juillet 2008, mais le projet n'a été lancé qu'en février 2009

Les résultats enregistrés dans la composante 1 sont les suivants :

Les activités de prévention ciblées (IEC/CCC) dans les groupes à haut risque ont touché:

- 12034 travailleuses de sexe,
- 850 travailleurs saisonniers dont les pêcheurs,
- 10224 jeunes scolarisés des collèges communaux,
- 3840 déplacés,
- 140 membres des corps en uniforme, et
- 1275 usagers de drogues,
- 26545 femmes en âge de procréer ont bénéficié des séances de promotion de la PTME,
- PSI a produit et distribué des guides de causeries éducatives, des dépliants éducatifs à l'endroit des travailleuses de sexe, un film et des séances de ciné mobile,
- Des journées d'information sur les droits des TS ont été organisées en faveur des TS et des administratifs et des corps de sécurité
- Les activités de prise en charge des Infections opportunistes et des IST, de mise à disposition du préservatif, masculin et féminins, de dépistage du VIH, de planification familiale, de référence pour soins spécifique mais aussi de formation en métier ont été développées dans le cadre d'un paquet complet de services aux travailleuses de sexe, Une étude de la disponibilité et de l'utilisation des services par les TS ainsi que leur niveau de connaissance et comportements a été menée .

En matière de distribution et marketing social du préservatif et d'autres outils de prévention (trousses et kit de prévention):

- 5 376 408 préservatifs masculins sur 8 043 906 prévus ont été distribués, avec l'aide des pairs éducateurs sous encadrement des animateurs sociaux ; 2 600 préservatifs féminins ont été gratuitement distribués
  - En partenariat avec PSI, un point de vente de préservatifs a été créé à la gare routière, sur 10 Points de vente prévus
  - 31173 préservatifs féminins (sur 97 060 prévus) ont été distribués gratuitement;
  - 368 kits de sensibilisation sur 452 prévus ont été distribués aux paires éducateurs ;
  - Sur 30687 trousses de prévention prévues, 20 621 ont été distribuées aux TS ;

En matière de dépistage volontaire :

- 109 989 personnes sur 11 309 prévues ont été dépistées alors que le nombre de CDV n'a cessé de croître

En matière de PTME chez les femmes enceintes, les femmes en âge de procréer et les hommes:

- 332 campagnes (sur 465 prévues) de mobilisation en amont pour les activités PTME impliquant les hommes ont été organisés. Elles on touché 26 545 personnes sur 37 190 personnes prévues (femmes enceintes et en âge de procréer et les hommes) ;
- le nombre de couples mères enfants pris en charge a été progressivement rehaussé.

Les forces et les faiblesses

a) Principales Forces au niveau de la composante 1

- La stratégie de confier l'offre d'un paquet complet de services de prévention à une organisation d'expertise solide s'attachant elle-même les services spécifiques d' autres acteurs spécialisés a montré ses forces. C'est le cas de l'ABUBEF et PSI-Burundi ou de APJB- Service Yezu Mwiza et RAM (une association qui travaille avec les usagers de drogue)
- Les activités de prévention sont intégrées au sein des structures sanitaires (structures offrant CDV, PTME-ARV)
- Les documents d'opérationnalisation de la circoncision masculine sont disponibles pour mettre à l'échelle la stratégie de circoncision qui est avérée préventive
- L'indicateur « circoncision masculine » est intégrée dans les indicateurs du Manuel des procédures du PBF
- La collaboration entre les structures publiques et les structures privées est très dynamique et donne de bons résultats.
- L'adoption d'un code de financement clair se focalisant sur l'atteinte des résultat a été une valeur ajoutée.

b) Faiblesses principales au niveau de la composante 1

- L'instabilité du personnel du niveau décentralisé a eu des répercussions sur l'analyse des dossiers des associations financées, sur la supervision, sur le suivi des sous-projets et par conséquent sur le rythme de transfert des fonds et donc sur la performance d'ensemble.

- Dans certains CPLS, en l'absence des OSC expérimentées, ce sont des OSC non expérimentées qui ont soumis des offres de services. Il leur a été difficile de s'adapter au rythme, aux approches et à tout le système de travail de la composante. Il a fallu un accompagnement de proximité ayant un impact négatif sur l'acquisition des résultats des autres activités

Composante 2 : financement base sur les Services clinques et communautaires pour les malades du sida.

Le projet a financé des contrats de fourniture des services et des soins sur base d'achat d'indicateurs.

Le SEP/CNLS a d'abord acheté 12 indicateurs dans 6 provinces. **A** partir de janvier 2010, les indicateurs ont été réduits de douze à six auxquels s'est ajouté après l'indicateur sur la circoncision masculine et ils sont les suivants :

1) Dépistage volontaire du VIH
2) Femmes enceintes séropositives mises sous protocole ARV prophylactique
3) Prise en charge du nouveau-né d'une femme VIH+
4) Nombre de nouveaux cas sous ARV

5) Nombre de clients ARV suivis pendant 6 mois
6) Cas d'IST traités
7) Circoncision masculine

Les résultats de la Composante 2

Selon la base de données en ligne du PBF du Burundi, les données quantitatives compilées des formations sanitaires pour les indicateurs ci-dessus sont les suivantes, pour l'année 2010.

- 1180 femmes séropositives ont été mises sous protocole ARV prophylactique ;
- 511 nouveaux- nés de femmes VIH+ ont été pris en charge ;
- 334 409 personnes ont subi le test de dépistage et ont eu le résultat;
- 981 nouveaux cas ont été mis sous traitement ARV ;
- 1 322 clients ARV ont été suivis pendant 6 mois ;
- 58 223 cas d'Infections Sexuellement Transmissibles (IST) ont été traités

Pour la circoncision masculine (CM), il faut noter qu'elle a été intégrée dans le programme Financement Basé sur les Résultats (FBR) depuis seulement le début de l'année 2011. Cependant, on dispose actuellement des documents de référence suivants:

- Un rapport de l'étude d'acceptabilité et de faisabilité de la circoncision masculine
- un protocole pour l'opérationnalisation de la circoncision,
- une stratégie de communication.

Notons aussi que les données de base pour les années 2008 à 2011 ont été collectées et sont disponibles.

Les Forces et les Faiblesses

a) Forces

- L'utilisation des services de santé a augmenté ;
- La qualité des soins et des prestations s'est améliorée ;
- Le personnel des structures de santé a été motivé ;
- Le Système d'Information de Santé a été renforcé

b) Faiblesses

- Absence d'appui nutritionnel aux PVVIH qui ne sont pas sous ARV et des PVVIH sous ARV qui ne sont pas enregistrées comme bénéficiaires des vivres PAM
- La non adhésion des structures de soins associatifs à la stratégie PBF.

Composante 3 : Financement décentralisé de subvention aux familles vivant avec le VIH/SIDA et aux groupes à haut risque.

→ En matière d'amélioration de la situation socio-économique des TS à travers les actions de solidarité et AGR, les résultats suivants ont été atteints :

- 3 175 TS des 4 152 TS prévues ont bénéficié d'un financement du projet pour entreprendre des activités génératrices de revenus (AGR) ;
- 25 associations de TS ont été créées Parmi ces TS, 75 responsables ont été formées en organisation d'association et en gestion des AGR, dont 66 TS de Bujumbura et 9 de Rumonge ;
- 45 TS ont été formées en métiers, dont 40 à Bujumbura et 5 à Rumonge

→ En vue d'Améliorer la situation socio-économique - actions de solidarité et AGR en faveur des PVVIH :

- 3 909 personnes ont bénéficié des AGR diverses à travers 48 sous projets (exploitation de moulins, petit commerce, élevage, activités agricoles) pour améliorer leurs conditions de vie.
- En matière Services sociaux de base et de protection des droits des OEV : 10.500 OEV sur 10.000 prévus ont bénéficié des kits scolaires, 1625 OEV VIH+ et 10.836 OEV affectés ont reçu des soins, 1.149 comités collinaires de protection ont été mis en place/renforcés, 1.500 OEV ont bénéficié de consultations juridiques, 2.139 ménages dirigés par des OEV ou des veuves sur **1.100** ménages prévus ont bénéficié d'AGR/petits dons.

→ En matière de promotion des droits des PVVIH :

- 1836 personnes ont bénéficié d'un appui juridique ,160 moniteurs et observateurs ont été formés ,360 cas de violations des droits des PVVIH ont été dénoncés, 2130 membres des comités relais ODPIA+ et 60 membres du réseau des parlementaires engagés dans la lutte contre le VIH/SIDA ont été sensibilisés.

Les Forces et les faiblesses

a) Forces

- Un mouvement associatif fort présent ;
- Une forte implication et visibilité des PVVIH dans les projets d'AGR

- Il existe une base de données de référence permettant une analyse de la vulnérabilité des OEV et une meilleure planification ;
- Il existe un cadre légal pour la promotion et la protection des droits des PVVIH (Loi n° 8 du 12 mai 2005)

b) Faiblesses

- Le nombre important d'OEV nécessiteux par rapport aux ressources permettant de les appuyer
- Le manque de soutien nutritionnel pour les OEV et les PVVIH.

Composante 4 : Renforcement des capacités des collectivités locales et des ministères clés pour la mise en œuvre des activités de lutte contre le VIH et le sida et la gestion du programme national.

Le projet a financé le fonctionnement du SEP/CNLS pour lui permettre d'assurer la gestion et la coordination du projet et du programme national

Le Système de S&E a été renforcé par la réalisation de certaines études :

- La Synthèse épidémiologique du VIH/Sida au Burundi;
- L'Enquête bio-comportementale (BSS) 2011, dont une synthèse des indicateurs clé est donnée en annexe.

Dans le cadre de la consolidation du système d'information, des équipements informatiques avec l'installation de la base des données SIDA-INFO ont été distribués aux sites de prise en charge, tandis que les prestataires ont été formés à l'utilisation de cet outil.

Dans le cadre de la coordination de la réponse et du renforcement des capacités :

- Des missions de supervision formatives dans tout le pays.
- Le cadre de résultats a été actualisé et régulièrement complété.
- Les outils standardisés de collecte des données ont été commandés.
- La formation des formateurs sur le SIG a été organisée. La formation sur l'utilisation de la Base de données SIDA INFO est organisée en continu.
- L'appui à l'amélioration des données sanitaires a été assuré
- La capacité de recherche du CNR a été renforcée
- Le projet a appuyé une réflexion sur les ministères clés et l'élaboration de 13 nouveaux plans d'actions sectoriels de lutte contre le VIH et le sida.

- Un nouveau code de financement des OSC a été élaboré et des sessions de coordination des OSC ont été tenues
- La rédaction et la diffusion d'une note techniques sur la gestion des données

Les forces et les faiblesses

a) Forces

- Le SEP/CNLS dispose d'une équipe technique compétente et expérimentée
- Il existe des outils de gestion, de suivi évaluation et de collecte des données
- Il existe un cadre de résultats du PMLS2
- La Base SIDA INFO est fonctionnelle

b) Faiblesses

- La faiblesse de prédictibilité des financements des programmes /projets de lutte contre le Sida,
- La pérennité de la structure du SEP/CNLS qui n'est pas assurée après la clôture du PMLS2, et la précarité d'emploi de son personnel.
- Les structures décentralisées, notamment le COCOLS ne sont pas encore fonctionnels de manière satisfaisante.

Gestion financière du projet

Contribution du Gouvernement :

BUDGET	ANNEE		
	2009	2010	2011
Budget de l'Etat (BIF)	848 552 527 967	863 059 645 685	1 026 173 387 752
Budget du MSPLS (BIF)	2 229 702 751	2 573 404 718	2 786 371 299
Engagement financier de l'Etat par rapport au Programme (dollars)	3 000 000	3 000 000	3 000 000
Budget alloué au programme national (BIF) Equivalent à (dollars)	2 170 500 000 1 784 464	2 400 000 000 1 976 717	2 645 000 000 2 177 445
% Budget Activités VIH vs Budget de l'Etat	0,2%	0,3%	0,2%
% par rapport aux engagements	59%	69%	72,5%

Ressources du projet :

Composante	Prévisions PAD (dollars)	Restructuration	Décaissements au 31/12/2009	Décaissements au 31/12/2010	Décaissements au 31/03/2011	Décaissements au 30/06/2011
1	7.000.000	7.385.038	1.418.240	4.724.951	5.759.181	7.476.933
2	2.000.000	1.517.220	440.978	857.330	997.198	1.499.840
3	3.000.000	1.980.798	1.246.398	1.680.620	1.709.827	1.985.294
4	3.000.000	4.116.944	1.615.011	2.978.865	3.184.858	3.804.717
Total	15.000.000	15.000.000	4.720.627	10.241.766	11.651.064	14.766.784

Au regard du suivi et du contrôle de la gestion financière du projet, on peut remarquer que : (i) les rapports trimestriels de suivi financiers (RSF) ont été régulièrement produits, (ii) le projet a fait l'objet de 2 audits financiers.

Le système de gestion financière est également allé en s'améliorant, puisqu'il était côté « modérément satisfaisant » depuis le début jusqu'à mi-parcours du projet (juin 2010), à « satisfaisante » au 31/12/2010 et à « très satisfaisante » au 31 mars 2011

Passation des marchés

Tous les marchés prévus ont été passés et exécutés. Néanmoins, les procédures de passation de deux marchés et contrats importants ont accusé un retard: l'enquête socio-comportementale (BSS) et le recrutement de l'agence d'exécution pour la provision d'un paquet intégré de services VIH/SIDA aux professionnels du sexe. Une des explications est que le processus a pris beaucoup de temps (adoption des TDR, sélection des firmes ...); la responsabilité du retard étant partagée entre l'IDA et le SEP/CNLS du fait notamment des nombreux échanges de documents entre les institutions avec souvent une lenteur de réaction préjudiciable..

En dépit de ces petites faiblesses, le système de passation des marchés a également, de façon progressive, amélioré sa performance, passant de la note « modérément satisfaisant » depuis le début jusqu'à mi-parcours du projet (juin 2010), à « satisfaisante » au 31/12/2010 et à « très satisfaisante » au 31 mars 201.

Les leçons apprises

Les faiblesses constatées, les problèmes rencontrés les expériences acquises avant, au cours et à la clôture du projet permettent de tirer un certain nombre de leçons, qui seraient utiles pour les projets similaires à initier dans le futur. Ces leçons ont trait aux aspects qui suivent.

1. **La nécessité de créer un environnement propice pour le démarrage et la mise en œuvre du projet.** Dans le cas du PMLS II, on peut remarquer que les conditions d'un bon départ n'étaient pas totalement réunies : nécessité de renouveler les contrats de certains personnels, retard dans la mise en place de l'équipe de direction, préalables comme la signature de conventions avec le Ministère, la formalisation de la contractualisation, le processus du ciblage, le recrutement des agences d'exécution, ainsi que la lenteur dans l'appropriation de l'approche PBF par les acteurs de mise en œuvre du Projet, etc.

8. **Importance d'une bonne connaissance de la situation et d'un meilleur ciblage des interventions**. Pour s'assurer que les objectifs sont réalistes et que leur atteinte sera facilement mesurée, il est important d'avoir une bonne connaissance de la situation de départ. Dans le cas du présent projet, la mise à jour des données de base et l'actualisation des résultats cibles se sont avérées être un préalable, et elles n'ont été possible que grâce aux résultats de l'enquête BSS de 2007, qui n'ont été disponibles qu'en décembre 2008. De plus, cela a coûté du temps à un projet dont le démarrage effectif accusait déjà un retard de 6 à 8 mois.

9. **La nécessité et l'intérêt d'expérimenter d'autres approches innovantes dans le financement des interventions.** La nouvelle approche de contractualisation des services de prise en charge clinique des malades du sida , PTME et CM s'est avérée efficace pour la décentralisation et l'intégration effectives desdits services dans le paquet minimum/complémentaire d'activités des structures de soins. De la même façon, la nouvelle approche de financement des OSCs impliquées dans les activités de prévention en faveur des GPHR renferme des atouts aussi bien dans le choix des interventions que dans l'octroi du financement : (i) le champ d'action de l'intervention est bien cadré sous forme de paquet de services ; et (ii) le financement est conditionné par la définition claire des résultats à atteindre (pour la première tranche) et l'atteinte effective de ceux-ci (pour les tranches ultérieures). Cela étant, le temps d'apprentissage de ces nouvelles approches a eu un effet négatif sur la performance au début.

4. **La possibilité de faire beaucoup avec peu de moyens**. Les ressources que le projet a utilisées (15 millions de dollars) étaient modestes et des résultats appréciables et réplicables ont été cependant atteints.

5. **L'importance de l'appui à la mise en œuvre**. Le présent projet a été exécuté dans des conditions assez difficiles. Cependant, toutes les activités ont pu se réaliser, malgré un calendrier très serré, et ce grâce à l'appui de la Banque, à travers les nombreuses missions d'appui à la mise en œuvre, effectués à un rythme régulier et soutenu de 3 missions par an en moyenne.

6. **La capacité d'adaptation du SEP/CNLS**. Bien que le personnel ait travaillé sous pression à cause (i) du retard pris dans le démarrage du projet suite à des facteurs qui n'étaient pas souvent sous sa maîtrise et (ii) de nouvelles approches dans la gestion et le financement de projet, (notamment l'approche de financement basé sur la performance, etc.) le personnel du SEP/CNLS a su s'adapter rapidement, se mobiliser et mobiliser ses partenaires de mise en œuvre pour la bonne exécution du projet.

CONCLUSION.
Les stratégies promues par le projet étaient novatrices et sont prometteuses. Elles méritent d'être promues et passées à échelle.

Les études réalisées, notamment sur les besoins de la gestion des déchets biomédicaux, la circoncision masculine, la synthèse épidémiologique 2010, la BSS 2011,…ont permis ont une meilleure connaissance de l'état des lieux et une meilleure compréhension des facteurs qui favorisent la propagation du VIH.

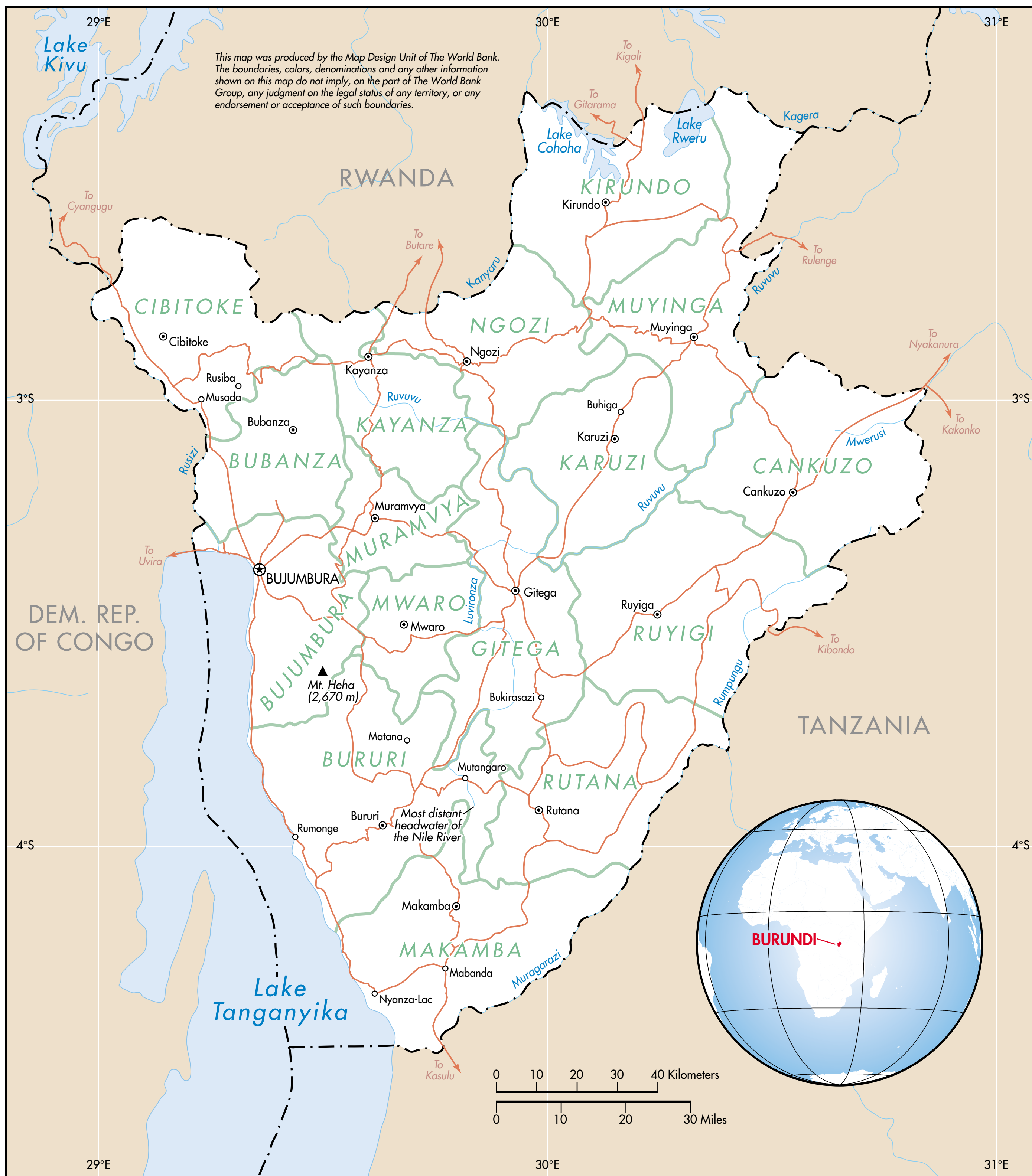
Ainsi, pour pérenniser les acquis du projet, les ressources doivent être mobilisées pour :

i. Mettre systématiquement et progressivement à l'échelle les approches de travail avec les groupes à plus haut risque (GPHR), en particulier les travailleuses du sexe (TS) ;
ii. Promouvoir la circoncision masculine à travers les mécanismes de financement basé sur les résultats (FBR), étant entendu que chacune de ces 2 stratégies est susceptible d'influer positivement sur l'autre.
iii. Renforcer les systèmes de S&E par l'introduction de système de gestion de l'information.
iv. Renforcer l'équipe de coordination du SEP pour assurer la pérennité à sa mission.

IBRD 33380

BURUNDI

- SELECTED CITIES AND TOWNS
- PROVINCE CAPITALS
- NATIONAL CAPITAL
- RIVERS
- MAIN ROADS
- PROVINCE BOUNDARIES
- INTERNATIONAL BOUNDARIES



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