

Burundi

Country Operational Plan

(COP) 2019

Strategic Direction Summary

29 April 2019



Table of Contents

1.0 Goal Statement

2.0 Epidemic, Response, and Program Context

- 2.1 Summary statistics, disease burden and country profile
- 2.2 Investment profile
- 2.3 National sustainability profile update
- 2.4 Alignment of PEPFAR investments geographically to disease burden
- 2.5 Stakeholder engagement

3.0 Geographic and population prioritization

4.0 Program Activities for Epidemic Control in Scale-up Locations and Populations

- 4.1 Finding the missing, getting them on treatment, and retaining them
- 4.2 Prevention, specifically detailing programs for priority programming
- 4.3 Additional country-specific priorities listed in the planning level letter
- 4.4 Commodities
- 4.5 Collaboration, Integration, and Monitoring
- 4.6 Targets for scale-up locations and populations

5.0 Program Activities for Epidemic Control in Attained and Sustained Locations and Populations

- 5.1 COP19 programmatic priorities
- 5.2 Targets for attained and sustained locations and populations
- 5.3 Establishing service packages to meet targets in sustained provinces

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

7.0 USG Management, Operations and Staffing Plan to Achieve Stated Goals

Appendix A - Prioritization

Appendix B - Budget Profile and Resource Projections

Appendix C - Tables and Systems Investments for Section 6.0

Appendix D - Minimum Program Requirements

Appendix E - Faith and Community Initiative (as applicable)

Acronym List

ABS	Alliance Burundaise contre le SIDA et pour la promotion de la Santé
AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
BNDF	Burundian National Defense Force
CAGs	Community ART Groups
CAMEBU	Centrale d'Achats de Médicaments du Burundi (National Drug Store)
CBO	Community-Based Organization
CCM	Country Coordinating Mechanism
CHW	Community Health Worker
CLHIV	Children Living with HIV
CNLS	National AIDS Council
COP	Country Operating Plan
CSO	Civil Society Organization
CTX	Cotrimoxazole
DBS	Dried Blood Spot
DHIS ₂	District Health Information System
DHT	District Health Team
DHS	Demographic and Health Survey
DOD	Department of Defense
DSD	Differentiated Service Delivery
EID	Early Infant Diagnosis
EMR	Electronic Medical Record System
EPOA	Enhanced Peer Outreach Approach
ER	Expenditure Reporting

FAST	Funding Allocation Strategic Tool
FBO	Faith-Based Organizations
FP	Family Planning
FSW	Female Sex Workers
FY	Fiscal Year
GBV	Gender-based Violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNI	Gross National Income
GOB	Government of Burundi
HEI	HIV Exposed Infant
HIV	Human Immunodeficiency Virus
HIVST	HIV Self-Testing
HQ	Headquarters
HR	Human Resources
HRH	Human Resources for Health
HSS	Health Systems Strengthening
HTC	HIV Testing and Counseling
HTS	HIV Testing Services
IBBSS	Integrated Biological and Behavioral Surveillance Survey
ICT	Information Communication Technology
IDP	Internally Displaced Person
IHME	Institute of Health Metrics and Evaluation
INH	Isoniazid
IP	Implementing Partner
IPT	Isoniazid Preventive Therapy
KANCO	Kenya AIDS NGOs Consortium
KP	Key Population
LGBTI	Lesbian, Gay, Bisexual, and Transgender Individuals
LMIS	Logistic Management Information System

LPV/r	Lopinavir/ritonavir
LTFU	Lost to Follow-Up
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MMP	Multi-Month Prescribing
MSM	Men Who Have Sex with Men
MSPLS	Ministry of Public Health and Fight against AIDS
NAC	National AIDS Council
NACP	National AIDS Control Program
NGO	Non-Governmental Organization
NHDP	National Health Development Plan
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PAAR	Prioritized Above Allocation Request
PBF	Performance-Based Financing
PEPFAR	President's Emergency Plan for AIDS Relief
PHIA	Population-Based HIV Impact Assessment
PITC	Provider-initiated Testing and Counseling
PLACE	Priorities for Local AIDS Control Efforts
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-To-Child Transmission
POART	PEPFAR Oversight and Accountability Response Team
POC	Point of Care
PLL	Planning Level Letter
PrEP	Pre-Exposure Prophylaxis
PWID	People Who use Injectable Drugs
QA/QI	Quality Assurance/Quality Improvement
RTK	Rapid Test Kit
SABERS	Seroprevalence and Behavioral Epidemiology Risk Surveys

SCMS	Supply Chain Management System
SDS	Strategic Direction Summary
S/GAC	U.S. Global AIDS Coordinator and Health Diplomacy, Department of State
SI	Strategic Information
SID	Sustainability Index and Dashboard
SIMS	Site Improvement through Monitoring System
SNU	Sub National Unit
STI	Sexually Transmitted Infections
SW	Sex Workers
TA	Technical Assistance
TAT	Turn Around Time
TB	Tuberculosis
TG	Transgender Individuals
TPT	TB Preventive Therapy
UNAIDS	United Nations Joint Program on HIV/AIDS
UNDP	United Nations Development Program
UNHCR	United Nations High Commissioner for Refugees
USAID	United States Agency for International Development
USG	United States Government
VL	Viral Load
WHO	World Health Organization

1.0 Goal Statement

Burundi has made remarkable progress in its HIV response over the past five years, and the country is poised to achieve sustained epidemic control in fiscal years 2020-2021. As a result, the President's Emergency Plan for AIDS Relief (PEPFAR) program and its key partner, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), must realign and harmonize investments to strengthen Burundi's HIV response by closing known gaps, maintaining achievements, and rapidly transferring best practices to the National AIDS Control Program (NACP) through a program model of targeted and tailored technical assistance to achieve and sustain epidemic control. The PEPFAR Burundi program will achieve its ambitious goal for COP19 by ensuring enhanced coordination with the GFATM throughout the implementation of the new geographic strategy, differentiated age, gender, and population approaches, and key above-site investments, comprehensively aimed at prioritizing epidemiologic impact with a cross-cutting focus on quality management and quality improvement (QM/QI) at all levels.

Geographically, PEPFAR Burundi will expand nationally, extending program support from the six PEPFAR-supported *Legacy* provinces to all 18 provinces. Intensity and level of support in each province will be tailored to current progress towards achievement of the three 95 goals for epidemic control: in provinces with substantial progress in finding and linking people living with HIV (PLHIV) to treatment- the *Sustain* provinces - PEPFAR programming will focus on closing antiretroviral treatment (ART) coverage gaps, strengthening retention on treatment, and accelerating viral load access and suppression; case-detection efforts will be highly targeted. In provinces where progress has been slower, with low case-finding and low ART coverage - the *Optimize* provinces - PEPFAR programming will focus on case-detection, accelerating ART coverage, strengthening retention, and accelerating viral load access and suppression. In each province, PEPFAR programming will prioritize technical assistance to districts with the highest burden and need, and support sites with highest case-finding rates and/or large ART cohorts, particularly district hospitals, sites associated with large key populations (KPs) hotspots, and tuberculosis (TB) reference facilities, with the aim of directly assisting sites that collectively serve 80 percent of all ART patients in each province, while the District Health Teams (DHTs) will receive targeted technical assistance to ensure that they are reaching the remainder of sites. Complementarity and harmonization of activities with the GFATM and deliberate, continuous coordination with both the GFATM and the NACP will be paramount to achieving national goals of high ART coverage.

Programmatically, PEPFAR Burundi will continue to develop and implement solutions that are population-, age-, and gender-specific with the goal of accelerating case-finding, strengthening retention nationally, and closing the viral load access and suppression gaps. In collaboration with the NACP and the GFATM, the team will develop and scale with fidelity approaches that are geographically tailored to optimize epidemic control achievements and to increase the national program's ownership of the response. Interventions will target the continuum of the HIV patient's journey, from community-level to the facility and back, to ensure high-quality services

throughout the patient's experience and to meet the needs of all populations, especially KPs, adolescent girls and young women (AGYW), and orphans and vulnerable children (OVC). The PEPFAR program will optimize the integration of TB/HIV services by improving TB screening of all ART clients and by expanding TB preventive therapy (TPT) for all TB-negative ART clients. In COP19, the Burundi program will also expand the successes of its gender-based violence (GBV) program, by establishing and implementing a framework for full integration of GBV prevention and treatment services across all PEPFAR-supported services and interventions. Above-site investments will be aligned with site-level objectives, focusing on strengthening supply chain systems, optimizing lab networks and functionality, and expanding health information systems to serve the needs of a sustained epidemic control program. In close complementarity with the GFATM, PEPFAR will continue to procure ARV drugs and other essential commodities (including test kits, viral load test reagents, TB screening commodities, etc.) to maintain the provision of high-quality HIV services and to meet expanding needs in COP19.

In COP19, further enhancement of evidence-based KP interventions targeting female sex workers (FSW), men who have sex with men (MSM), and transgender individuals (TG) will continue, seeking to find, enroll, and retain harder to reach KPs via enhanced case-finding methods, such as strategies to find more hidden and wealthier MSM via self-testing and outreach to private sector clinics. The program will also optimize patient navigation strategies for KPs, a core component of success to date for treatment enrollment and retention. The use of information communication technology will expand beyond demand creation to assist with retention strategies for viral suppression.

To accelerate achievement of the first 95 (percent of HIV-positive individuals who know their status), the PEPFAR Burundi program will optimize case-finding by implementing index testing and highly-targeted testing strategies, with differentiated approaches and interventions that address varying age, gender, and population barriers and needs. Index testing will be utilized to improve pediatric and adult male case-finding by leveraging the prevention of mother to child transmission (PMTCT) program platform. Additionally, programs will also leverage the OVC program to improve pediatric case-finding. PEPFAR will continue targeted provider-initiated testing and counseling (PITC) for all TB patients, sexually transmitted infections (STIs) patients, and KPs. HIV self-testing (HIVST) will be doubled.

To strengthen and sustain achievements in the second 95 (percent of HIV-positive individuals who know their status and are enrolled in ART), PEPFAR Burundi will accelerate the implementation of test-and-start, same-day treatment initiation, and differentiated service delivery (DSD) models, while strengthening community linkages and retention on treatment. Specifically, the program will implement a comprehensive strategy focused on access to DSD models and multi-month scripting (MMS) of ARVs for eligible and stable patients, community-level access to ARVs through intensive engagement of civil society organizations (CSOs), strong linkages between communities and facilities, and an enhanced patient monitoring system to ensure high-quality, accurate, and timely routine data for each site, with the ability to identify defaulting patients and bring them back into care. Linkage to treatment and retention strategies

will be tailored and differentiated to address age-, gender-, and population-specific barriers, especially for children, AGYW, and KPs.

To rapidly advance the achievement of the third 95 (percent of HIV-positive individuals on treatment who are virally suppressed), PEPFAR Burundi will focus on demand creation and results uptake, and strengthening viral load testing capacity at all levels of the system. In FY20, PEPFAR Burundi, in collaboration with the GFATM and the NACP, plans to expand access to viral load in all provinces, reaching at least 80 percent coverage in *Optimize* provinces and 90 percent coverage in *Sustain* provinces. Current viral load coverage and suppression gaps are particularly acute among KPs, children and OVC, and AGYW. PEPFAR Burundi will implement differentiated strategies that target age-, gender-, and population-specific barriers to viral load access, and site-level strategies to improve clinical patient monitoring and use of patient viral load data.

From a policy perspective, the PEPFAR Burundi program will continue to support the NACP in the dissemination of the new testing strategy and in training and supervising modules for providers, as well as the modification of performance-based financing indicators to focus on case-detection and lowering the age of testing consent to 12 years of age. The PEPFAR program will continue to work with the NACP and the World Health Organization (WHO) on policies supporting task-shifting and on updating national guidelines to ensure alignment and compliance with WHO guidance and PEPFAR standards. PEPFAR Burundi will continue to implement a comprehensive above-site strategy to optimize national- and district-level laboratory systems, by improving the laboratory-facility interface, and by enhancing patient tracking tools.

PEPFAR Burundi will continue to strengthen its partner management framework to ensure efficient implementation of quality interventions and adjustments in real-time, and to optimize using granular site and patient level data. Management of partners will be in line with the level of intensity and support tailored to the *Sustain* and *Optimize* provinces. Weekly monitoring of key testing indicators in a surge approach will be done to maximize yield and accelerate success in the index testing modality. The Burundi program will contribute to PEPFAR global goals of transitioning 70 percent of funding to local organizations by transitioning one-third of its implementing mechanisms to local partners by 2020 and two-thirds by 2021. The transition will leverage existing, high-performing CSOs in the GBV and OVC spaces, as well as available technical assistance from central mechanisms to mitigate fiduciary and programmatic risks.

In addition to regular consultations with the NACP and the GFATM, the COP19 development process included the participation of CSOs and multilateral stakeholders with multiple fora for discussion, joint planning, and integration of inputs into the final COP19 proposal. Stakeholder and CSO engagement touched on the appropriateness of overarching program objectives, program priorities and targets, and technical solutions. Specifically, multilateral engagement centered on HIV national policies (transition to new ARV regimens, testing strategies, DSD models, TB screening and TPT protocols), while CSO engagement was particularly focused on priorities and direction of community-level programming and the health needs of vulnerable populations. Discussions were rich and valuable, and, wherever feasible, inputs were integrated

into the COP19 plan, which guarantees stakeholder commitment to its successful implementation.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden, and country profile

The Republic of Burundi is a small, landlocked country in the African Great Lakes region bordering Lake Tanganyika. The country shares borders with Rwanda, Tanzania, and the Democratic Republic of the Congo. Burundi is a very densely populated country, with an estimated population of 11.2 million in 2018¹. It is the second most densely populated country in Africa, with about 423.06 inhabitants per square kilometer, as of 2017². With one of the highest fertility rates in the world (total fertility rate per woman: 5.5³), Burundi faces a large youth bulge. Almost half of the population is below the age of 15.

According to the International Office for Migration (IOM) and the United Nations High Commissioner for Refugees (UNHCR), Burundi has witnessed substantial civil conflicts that have resulted in internal mass displacements and large migration flows. Internally displaced persons (IDPs) were settled in sites established for them, while other people fled to neighboring countries and were mainly settled in refugee camps. While Tanzania hosted the majority, Rwanda and the Democratic Republic of the Congo were also the destinations of Burundians seeking international protection. As of January 2019, UNHCR estimates that there are 346,983 refugees that have fled Burundi for neighboring countries since 2015⁴. Natural hazards, limited access to land, and food insecurity are three critical issues faced by Burundi's displaced population. In general, job seeking behavior results in the movement of people around the country, as individuals seek income from different occupational activities. The migratory patterns are attributable to agricultural migration, labor migration, or rural-urban migration, and are at times intensified by the political climate.

Burundi is a low-income country with Gross National Income (GNI) of \$702 per capita⁵ and remains one of the poorest countries in the world: 71.7 percent of Burundi's population lives with less than \$1.90 a day. Burundi is in the bottom five of the low-income categories of countries (185 of 189 countries) on the 2017 United Nations Development Programme (UNDP) Human Development Index. The economy is predominantly agricultural, with a 91.5 employment rate (share of total employment that is employed in agriculture) in 2017⁶. Burundi remains a

¹ <https://www.unfpa.org/data/world-population/BI>

² <https://data.worldbank.org/indicator/en.pop.dnst>

³ Idem

⁴ UNHCR Regional Update. Burundi Situation January 2019. Published 7 March 2019.

⁵ Idem

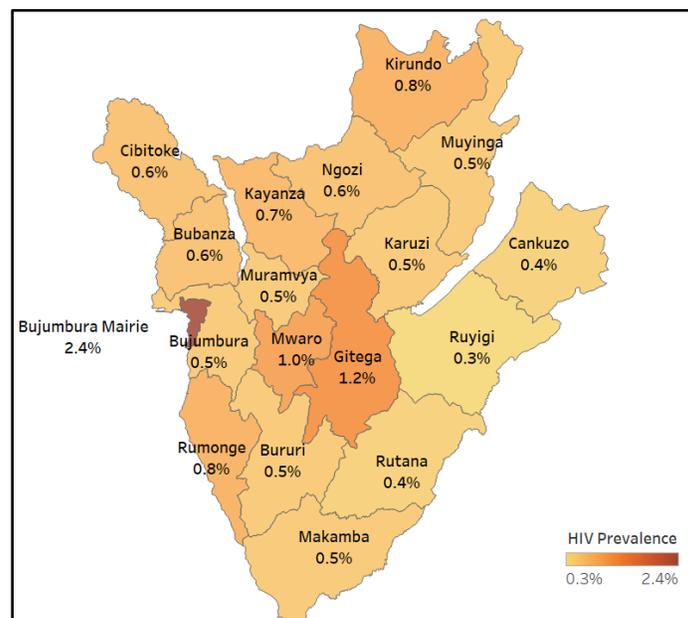
⁶ Idem

challenging operating environment for implementation of U.S. government (USG)-funded programs due to its fragility, its low local capacity, and security and travel restrictions for USG personnel and implementing partners (IPs).

According to 2019 Spectrum modeling, the HIV prevalence rate is 0.7 percent. Among adults over age 15, this figure is 1.2 percent. The prevalence rate varies according to the age group. The most affected age groups are 40-49 years old among both males and females; these age groups have a prevalence rate of 3.1 percent. Comparatively, those between 30 and 39 years have a prevalence of 1.3 percent, and 20-29 year olds a prevalence of 0.6 percent. Overall, there is a trend towards urbanization (2.4 percent in Bujumbura Mairie versus 0.5 percent in Bujumbura Rural) and feminization of the epidemic (0.9 percent in women versus 0.6 percent in men).

The prevalence also differs from one province to another: 2.4 percent, 1.2 percent, 0.8 percent, and 0.3 percent, respectively in Bujumbura Mairie, Gitega, Kirundo, and Ruyigi (Figure 2.1.1. HIV Prevalence by province, all ages). Geographic analysis of Spectrum data shows a higher prevalence in provinces traversed by major international transport routes and with large KP hotspots. This suggests a KP-driven epidemic and the need to target KPs, their social and sexual networks, and other vulnerable and hard-to-reach populations, including men with mobile professions, clients of KPs, children of KPs, and vulnerable adolescents and children. Migratory patterns across different regions of the country have an effect on both short- and long-term retention rates as well as prevalence data. Anecdotal reports suggest that as many as 3,000 HIV clients have been displaced, and could be a major factor contributing to the lower under-24 months retention rates.

Figure 2.1.1: HIV Prevalence by province, all ages



Source: Spectrum 2019

There are no recent data on FSW, MSM, and TG. The Integrated Biological and Behavioral Surveillance Survey planned to take place during FY2017 is still on hold due to political resistance to collect data on key populations. The 2013 PLACE Study estimated that there are 51,482 FSW in Burundi, with a prevalence rate of 21.3 percent. There is geographic variation in FSWs' numbers with 13,385 in the Bujumbura-Mairie area (26 percent), 12,356 in other urban areas (24 percent), and 12,741 in rural areas (25 percent). The study estimated a 3.8 percent prevalence rate among their clients and 5.2 percent for their partners. The same study estimated 9,346 MSM with an HIV prevalence rate of 4.8 percent. MSMs are mainly concentrated at Bujumbura-Mairie, with a population estimated at 6,916, or 74 percent of the total population size, in other urban areas 1,215 (or 13 percent), and in rural 1,215 (or 13 percent). Transgender individuals were not specifically included in the study. A 2017 study⁷ funded by the GFATM through the Kenya AIDS NGOs Consortium (KANCO) on injection drug users (IDUs) in Bujumbura Mairie shows a prevalence of 10.2 percent, in a population of 127 drug users survey participants, 9.4 percent of these IDUs were infected with hepatitis B virus, and 5.5 percent with hepatitis C.

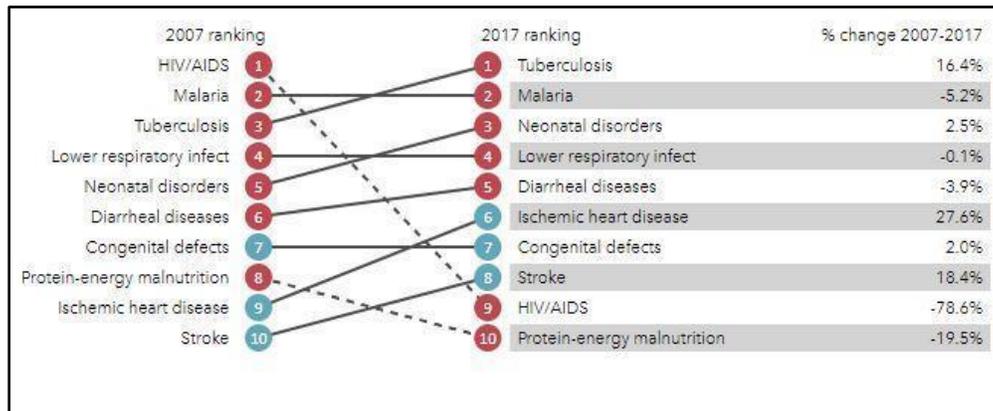
The Burundian National Defense Force (BNDF) is also a priority population due to known high-risk behavior among military personnel. Results from the SABERS study conducted in 2017 estimated a 1.8 percent HIV prevalence rate among military personnel, twice the national prevalence rate. The behavioral survey highlighted several areas that need further attention, including condom use and HIV testing services. Other programs that would benefit the BNDF are alcohol prevention programs and GBV awareness.

In Burundi, there is little data on the epidemiology of hepatitis. Some studies with limited scope and power show that the prevalence of hepatitis B is between 5 and 10 percent and that hepatitis C is closer to 10 percent and increases with age. The National Viral Hepatitis Strategic Plan 2018 - 2022 has identified PLHIV and KPs (MSMs and IDUs) as priority populations.

According to the Institute of Health Metrics and Evaluation (IHME), TB is the first cause of death in the country (Figure 2.1.2: Top causes of deaths in Burundi).

⁷ Nkurunziza M. HIV and harm reduction for drug users. ABS, NACP, Kenya AIDS NGOs consortium. June 2017

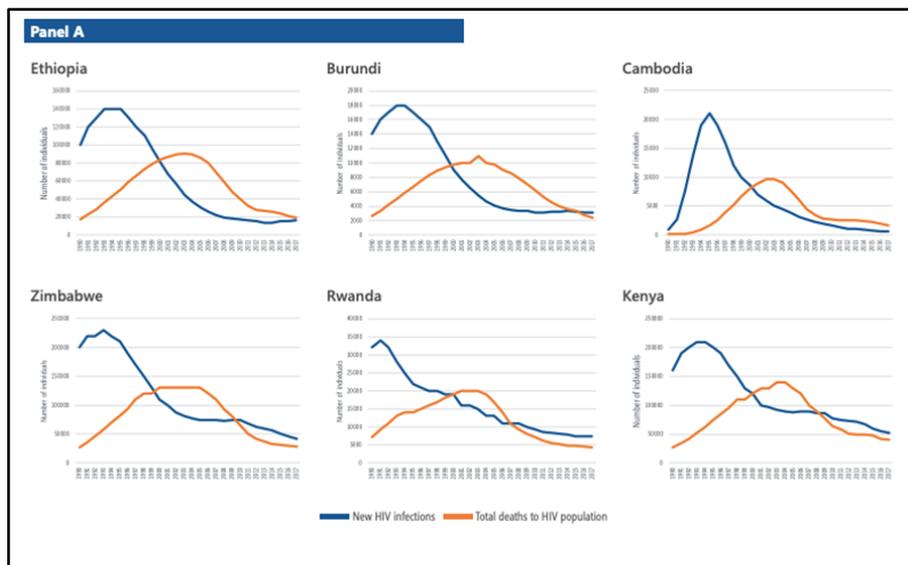
Figure 2.1.2: Top Causes of Death in Burundi (2017)



Source: <http://www.healthdata.org/Burundi>

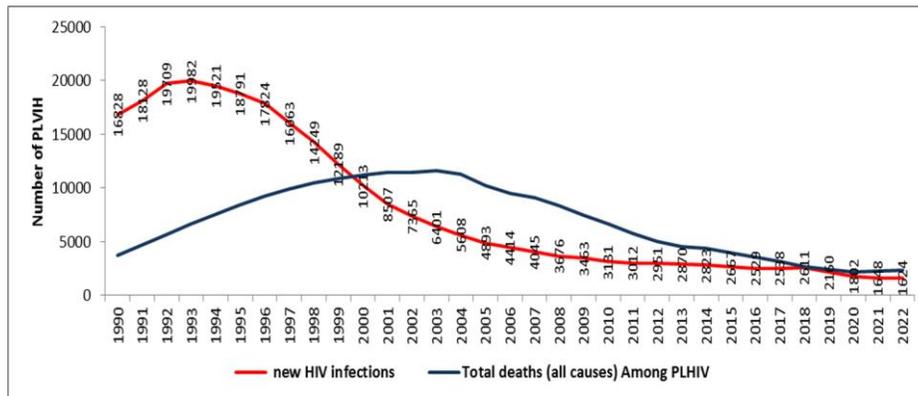
HIV/AIDS remains one of the leading causes of death in Burundi. However, Burundi has accelerated progress towards HIV epidemic control and is now considered in the Panel A list of countries that have shown dramatic declines in both new HIV infections and HIV-related mortality (Figure 2.1.3: Panel A. Changes in mortality and new HIV infections in select PEPFAR supported countries; Figure 2.1.4 Trend of new infections and all-cause mortality among PLHIV). PEPFAR defines national HIV epidemic control as “the point at which the total number of new infections falls below the total number of deaths from all causes among HIV-infected individuals, with both declining.” Emphasis is placed on optimizing programs and systems investments to support, achieve, and sustain epidemic control.

Figure 2.1.3: Panel A. Changes in mortality and new HIV infections in select PEPFAR supported countries



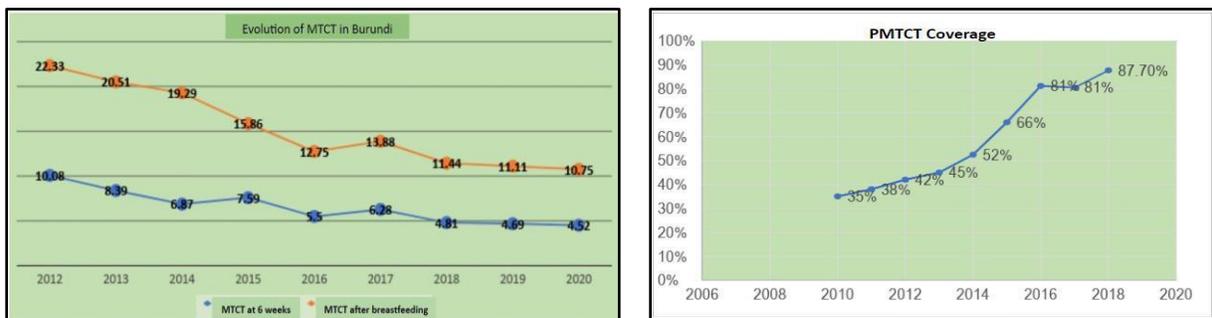
Source: PEPFAR Country Operational Plan Guidance

Figure 2.1.4: Trend of New Infections and All-Cause Mortality Among PLHIV



The GOB's leadership has resulted in achieving high HIV prevention of mother-to-child transmission (PMTCT) coverage levels (Figure 2.1.5: Mother-to-Child Transmission in Burundi).

Figure 2.1.5: Mother to Child Transmission in Burundi

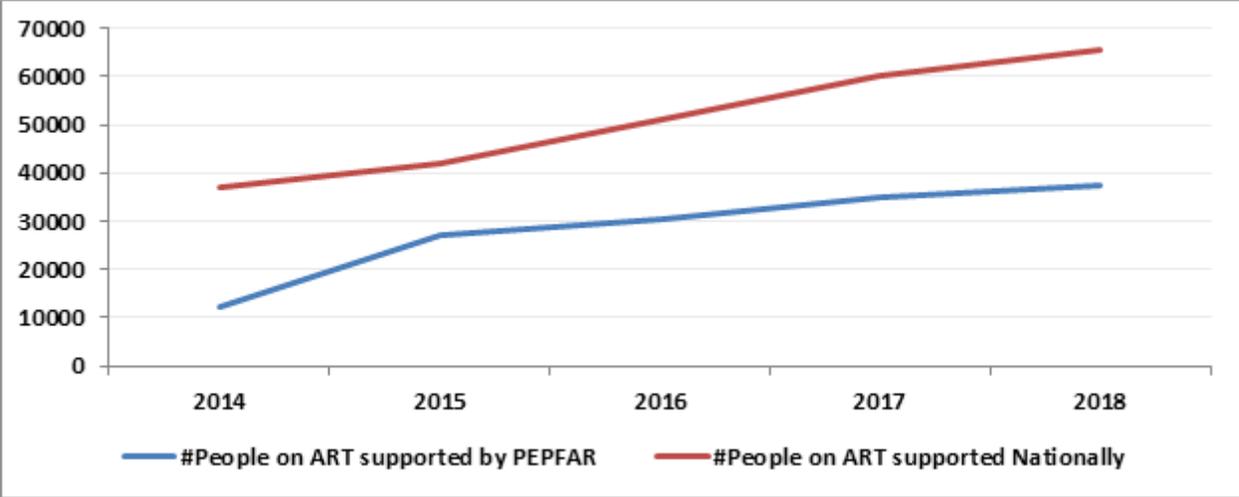


Source: The NACP, 2019

The Government of Burundi (GOB) has been supportive of PEPFAR efforts overall. It has adopted new international guidelines and best practices, including updates to the National Testing Strategy to optimize case-finding and prioritize index testing and self-testing, reducing the overall number of tests performed nationally. Performance-based financing (PBF) indicators have also been aligned with the new testing strategies. Burundi has already made significant progress in scaling up targeted case-finding strategies.

The country has also made substantial progress in enrolling patients on ART (Figure 2.1.6: National and PEPFAR Trend for Individuals currently on Treatment).

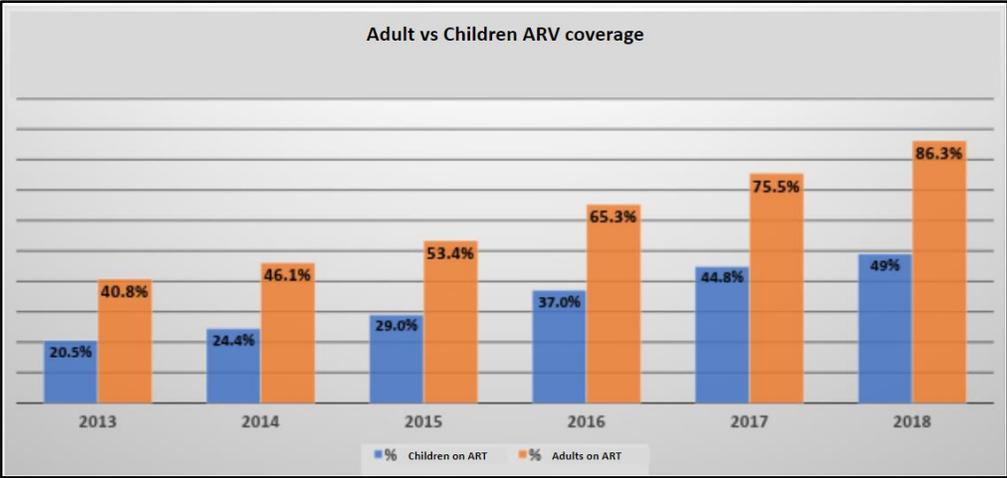
Figure 2.1.6: National and PEPFAR Trend for Individuals currently on Treatment



Source: NACP and FHI360 Reports

At the end of 2018, according to the NACP, 81 percent of the estimated 64,795 PLHIV in Burundi were on ART. However, despite the GOB’s continued effort, the overall ART coverage rate remains low and there is a Pediatric ART coverage gap (Figure 2.1.7: Adult vs Children ARV coverage).

Figure 2.1.7: Adult vs Children ARV coverage



Source: The NACP, 2019

Viral load testing is still not widely available in-country. With the COP19 geographic expansion nationally, measuring viral suppression will become increasingly important to Burundi’s efforts to control the epidemic closing the gap in viral load access will be paramount.

During FY19, key policy changes will be made to address COP19 minimum program requirements: updated national ART guidelines to take into account the optimized ARV regimens, as well as lessons learned and new guidance for the scale-up and optimization of DSD models and better consideration of co-infections. The task-shifting policy will also be updated to improve the HIV pediatric treatment component of the national program. Standard Operating Procedures (SOPs) and job aids based on these policies and guidelines will be developed and disseminated in all 18 provinces during FY20.

Finally, several systemic and programmatic challenges pose significant barriers to achieving sustainable epidemic control. HIV commodities and supply chain systems, and the health information and surveillance system, particularly recent infection surveillance, are health system components that require strengthening as the PEPFAR Burundi program shifts to a sustained epidemic control model.

Standard Table 2.1.1

Table 2.1.1 Host Country Government Results															
	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	11772322	100	2496470	21.2	2503654	21.3	1148631	9.8	111782	9.4	2311813	19.6	2199972	18.7	ISTEEBU, PROJECTIONS DÉMOGRAPHIQUES 2010-2050 NIVEAU NATIONAL ET PROVINCIAL, 2017
HIV Prevalence (%)		1%		0.2		0.2		0.6		0.4		1.7		1.1	
AIDS Deaths (per year)	1582		219		227		92		105		457		482		SPECTRUM 2019
# PLHIV	83 729		4797		4823		6349		4191		39998		23571		SPECTRUM 2019
Incidence Rate (Yr)		0.19		0.12		0.12		0.39		0.15		0.25		0.23	SPECTRUM 2019
New Infections (Yr)	2160														SPECTRUM 2019
Annual births	473197	4.2													SPECTRUM 2019

% of Pregnant Women with at least one ANC visit	455 172	96.2	210	0.05			190682	41.9			264281	58.1			SNIS_DHIS2 2018
Pregnant women needing ARVs	4925														SPECTRUM 2019
Orphans (maternal, paternal, double)	634885														SPECTRUM 2019
Notified TB cases (Yr)	7202														PNILT
% of TB cases that are HIV infected		10.6%													PNILT
% of Males Circumcised	Not available														
Estimated Population Size of MSM*	9,346														PLACE Study, 2013
MSM HIV Prevalence		4.8%													PLACE Study, 2013
Estimated Population Size of FSW	51,482														PLACE Study, 2013
FSW HIV Prevalence		21.3%													PLACE Study, 2013
Estimated Population Size of PWID	Not available														
PWID HIV Prevalence		10.2%													Ref. 7
Estimated Size of Priority Populations (Military)	100,000														
Priority Population Prevalence (Military)	1.8%														
*If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.															

Standard Table 2.1.2

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*										
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	11772322	1.0	83729	65800	65560	78.3	88.3	1787727	13476	13499
Population <15 years	5000124	0.2	9620	3466	3379	35.1	70.1	83068	682	912
Men 15-24 years	111782	0.4	4191	1974	1965	46.9	77.4	188168	770	599
Men 25+ years	2199972	1.1	23571	19052	19012	80.7	88.8	358656	3617	3892
Women 15-24 years	1148631	0.6	6349	5124	5103	80.4	81.6	511243	3001	2503
Women 25+ years	2311813	1.7	39998	36184	36101	90.3	91.3	646592	5406	5593
MSM**	9,346	4.8%	448	214	197	92	91.1	3885	94	90
FSW**	51,482	21.3%	10,965	2925	2808	96	89.3	14658	852	840
PWID	Not available									
Priority Pop (Military)***	100,000	1.8%	1,884	1790	1701	90%	92%	24,007	573	556

*National data

**Program data, LINKAGES

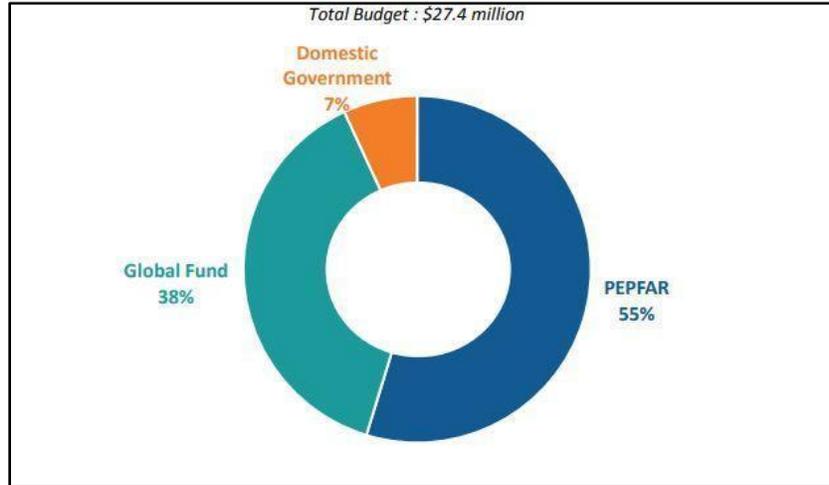
***Data include military personnel and their family members

Sources: SABERS 2017, APR 2018, Spectrum 2019, ISTEERU Projection

2.2 Investment Profile

The GFATM and PEPFAR remain the major contributors to Burundi’s HIV response covering 93 percent of the country’s HIV program costs in 2019 (Figure 2.2.1, budget by stakeholder).

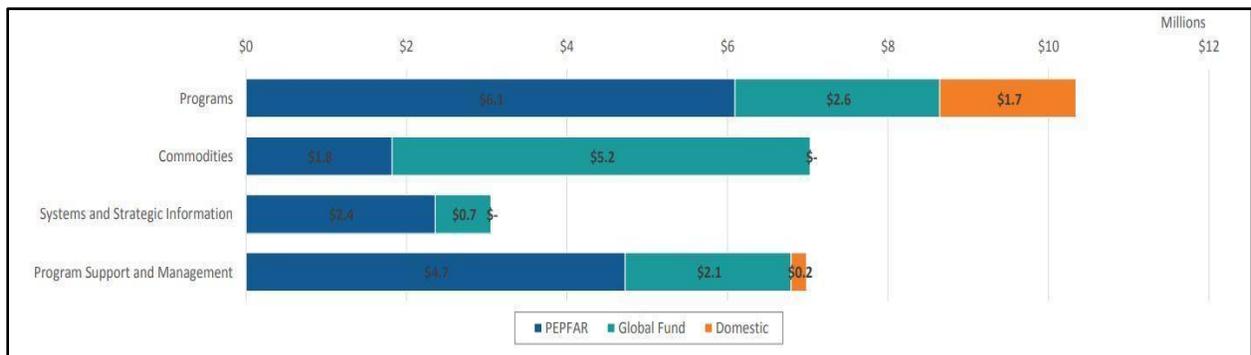
Figure 2.2.1: Budget by Stakeholder



Source: HIV Resource Alignment: Burundi Country Profile

The GFATM continues to be the largest procurer of HIV-related commodities (including ARVs and non-ARV drugs, condoms, rapid test kits, reagents, and supplies). The PEPFAR program will complement the procurement of commodities (including ARV drugs, GeneXpert cartridges, HIV self-test kits) and will continue to provide technical assistance to high-volume sites (Figure 2.2.2: Budget by Program Areas and Stakeholder) in supply chain management. Technical support will be directed to the DHTs during FY2020.

Figure 2.2.2: Budget by Program Areas and Stakeholder



Source: HIV Resource Alignment: Burundi Country Profile

Technical priorities for the GFATM grant period include four key areas:

1. Development of a national viral load strategy, including implementation of viral load scale-up;
2. Improved access to and coverage of virological testing for infants born to HIV-positive mothers (early infant diagnosis);
3. Better quality of interventions for KPs; and
4. A comprehensive supply chain management plan for the country, including warehousing and distribution until the last mile.

The GFATM and PEPFAR remain the primary providers of outreach prevention, and support for key and priority populations.

Close alignment of technical priorities between PEPFAR and the GFATM necessitate continuous collaborative planning and debriefing between the GFATM, the GOB, and PEPFAR to ensure coordination on key program areas: commodity quantification and procurement of optimized ARV regimens, lab strengthening, improved national information systems, and community engagement.

The GOB contribution has increased modestly during the last years (from \$1.8 million to \$2 million). The GOB's funding structure has nevertheless not changed significantly over the last three years. Its budget covers only ARVs and the NACP's operating costs. However, the GOB increasing domestic investment by engaging the private sector, Burundian citizens, and expatriates to contribute to the National AIDS Fund and by leveraging existing resources at provincial and national levels (from, for example, national health accounts, health centers management committees, and other health donors). The National AIDS Council, in partnership with UNAIDS, is developing a resource mobilization plan. Also, available HIV expenditure data by program area and by major donors in Burundi will come from the UNAIDS-supported National AIDS Spending Assessment that will be conducted during FY19. Key high-level priorities for the GFATM and PEPFAR team during FY20 include the prioritization and mobilization of domestic resources for health by the GOB, with a particular focus on increasing the GOB contribution to procurement of HIV/TB drugs.

Standard Table 2.2.1

Table 2.2.1 Annual Investment Profile by Program Area⁸					
Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
Clinical care, treatment and support	\$18,261,427	34	55	8	3%
Community-based care, treatment, and support	\$1,119,373	40	50	10%	0%
PMTCT	\$2,464,911	65	30	5%	0%
HTS	\$6,295,664	43	57	0%	0%
VMMC	NA	NA	NA	NA	NA
Priority population prevention	\$3,568,614	33%	50%	1%	16%
AGYW Prevention	\$800,000	100%	0%	0%	0%
Key population prevention	\$2,347,890	38%	62%	0%	0%
OVC	\$1,214,517	66%	44%	0%	0%
Laboratory	\$2,000,000	75%	25%	0%	0%
SI, Surveys and Surveillance	\$2,756,160	70%	30%	0%	0%
HSS	\$3,082,614	50%	50%	0%	0%
Total	\$43,911,170	41%	52%	4%	3%

Source: GRP, National AIDS Spending Assessment, 2012 (most recent complete assessment available, all amounts in USD)

⁸ (GRP, National AIDS Spending Assessment, 2012), all amounts in USD.

Standard Table 2.2.2

Table 2.2.2 Annual Procurement Profile for Key Commodities					
Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	\$6,180,402	12.47	67.58	18.64	1.31
Rapid test kits	\$514,149	19.09	80.91	0	0
Other drugs	\$336,579	81.42	18.58	0	0
Lab reagents	\$337,947	48.51	51.49	0	0
Condoms	\$1,149,780	NA	100	0	0
Viral Load commodities	\$1,642,823	74.17	25.83	0	0
Other commodities	\$20,874	100	0	0	0
Total	\$10,182,554	25.43	62.55	11.23	0.79

Source: Burundi VIH PAAR.

Standard Table 2.2.3

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration					
Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	\$3,000,000	NA	NA	NA	NA
USAID TB	NA	NA	NA	NA	NA
USAID Malaria	\$9,000,000	\$4,984,719	2	\$2,844,612	Supply chain systems and data/reporting enhancements
Family Planning	\$3,000,000	\$500,000	2	\$3,464,612	Access to Family Planning
Total	\$15,000,000	\$5,484,719	4	\$6,309,224	

Source: USAID/Burundi Operating Plan - Health Program Fy 2018

2.3 National Sustainability Profile Update

The Sustainability Index and Dashboard (SID 3.0), completed two years ago in collaboration with UNAIDS, the National AIDS Council, the NACO, UN agencies, the GFATM grants recipients, CSO organizations, the National Network of PLHIV, and public sector representatives, remains mostly the same.

Results from the SID 3.0 identified three main areas of strength – planning and coordination (9.0, dark green), performance data (7.52, light green), and public access to information (7.00, light green). Domestic resource mobilization (6.94, light green) and civil society engagement (6.96, yellow) were also identified as strengths.

Despite these strengths, the tool identified a number of challenges that remain unattended. Laboratory was identified as the main weakness with a score of 4.75, despite the support received from the GFATM and the PEPFAR program. Likewise, epidemiological and health data, security and supply chain of critical products at the subnational level, and the lack of a quality management system for health services were identified as weaknesses.

2.3.1 Updates on the COP17 SID

Sustainability Strengths

- **Planning and coordination:** The GOB has made significant strides in its capacity to develop, plan, budget, and coordinate HIV/AIDS response activities. With the support of donors, the GOB has developed an updated five-year National Strategic Plan (NSP 2018-2022) that details principles, priorities, and actions to guide the national response to the HIV epidemic. This NSP is aligned with the new National Health Development Plan 2019-2023 (NHDP III), which was developed based on a collaborative Health Sector Assessment. The GFATM Country Coordination Mechanism (CCM) has been reconfigured. The new team is receiving technical assistance from the community of donors to reinforce its performance and to be restored to its central place of national coordination body. The Health and Development Partner Framework (Cadre de Concertation des Partenaires pour la Santé et le Développement – CPSD) is now functional under the leadership of the new Minister of Health and the Fight against AIDS.
- **Performance data:** The GOB routinely collects, analyzes, and makes available HIV/AIDS service delivery data to track program performance. It also leads routine data review meetings at national and sub-national levels to review data quality gaps and outline improvement plans. A Health Management Information Systems (HMIS) Plan 2018-2022 has been developed. There have been improvements in the GOB ownership of HIV/AIDS data in the last year, especially with regard to the District Health Information (DHIS2). Collection, validation, reporting, and utilization of data for HIV/AIDS management has improved significantly at both the facility and district levels, although there remains a

need to focus the attention of service providers and managers on data utilization for epidemic control.

- **Public access to information:** The GOB disseminates on regular basis reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress, and challenges towards achieving HIV/AIDS targets. However, promptness and accuracy of data, as well as the insufficient analysis of the available data and the lack of financial information related to the national HIV response open to public scrutiny are areas in need of improvement.
- **Domestic resource mobilization:** Even though the GOB increased its commitment to contribute to the national response, the country should make further efforts to improve resource mobilization, efficiency, and transparency.
- **Civil society engagement:** In Burundi, there is active civil society engagement in HIV/AIDS advocacy, decision-making processes, and service delivery in the national HIV/AIDS response. However, there is a need to continue supporting CSOs for capacity - building in program management and to improve the linkage between community and facilities services. Improving community engagement throughout the clinical cascade is a key focus of the COP19 general strategy.

Sustainability Vulnerabilities

- **Epidemiological and health data:** Additional capacity is still required for ongoing epidemiologic activities. Supplementary support is needed for improving capacities at the national level for analysis of data and evidence-based decision making. Data on supply chain stock information is weak and in need of PEPFAR support. PEPFAR will continue to support the improvement and robustness of SIDAInfo and the use of unique identifiers to track individuals through the clinical cascade.
- **Service delivery:** HIV/AIDS services are accessible to poor and vulnerable populations at risk of infection. However, performance is weak in the areas of targeted HIV testing and counseling (HTC) services and finding those lost to follow-up (LTFU). PEPFAR will continue to support the implementation of these strategies. Service delivery is the responsibility of Burundi's decentralized district health system. DHTs need to play a more central role in providing technical oversight for HIV services. PEPFAR will improve DHT performance in its supervisory and support functions to health facilities and increase DHTs' capacity for systemic functions essential to supporting sites in delivering quality HIV services and helping "boost" the scale-up of new HIV strategies.
- **Quality management:** The GOB does not have an adequate quality management (QM)/QI system with dedicated leadership, nor a current QM/QI plan for HIV care and treatment. QI/QM will be a key element of PEPFAR's support during the current and next fiscal years. PEPFAR will foster and scale up innovations throughout the clinical cascade,

including improving HIV testing services, linkage and retention, rolling out a national HIV HMIS that collects data on HIV program indicators and allows analysis at different levels of the system.

- **Laboratory:** The main challenges remain: weak national ownership of the viral load strategy, maintenance issues, a limited number of qualified lab technicians, and a weak sample transportation system. PEPFAR Burundi, with critical support and coordination leadership from the GFATM and WHO, will continue to support the implementation of the National Viral Load Scale-up plan under the umbrella leadership of the Ministry of Health and the Fight Against AIDS (MSPLS).

2.3.2 Non-service delivery activities for the sustainability of the national AIDS response

During FY20, special attention will be given to health system strengthening at the national and district levels, with more tangible and better-tracked interventions to ensure impact. Non-service delivery activities (detailed in Table 6) and assistance from PEPFAR Burundi will support the GOB in the development of a framework for quality control approaches, as well as their adoption and systematization. This will improve the delivery and the quality of laboratory services. PEPFAR Burundi will also continue to strengthen supply chain management, in coordination with the GFATM, to assure adequate planning, ordering systems, distribution, and reporting, including communications, between central and peripheral levels to eliminate stock-outs in health facilities.

2.3.3 Transitioning to local partners

During COP19, PEPFAR Burundi will select two local partners to implement a GBV and an OVC activity with different modalities of operation.

The GBV mechanism will ensure the integration of GBV services (prevention, mitigation, and post-violence care) into existing PEPFAR-supported HIV services for national-level impact. It will act as a technical assistance provider and resource to other USAID partners in the HIV clinical cascade, OVC, and KPs program areas to support integration and mainstreaming of GBV services and programmatic considerations into programs. The local partner will provide the social and cultural competencies and may tap into a global technical expert to provide state of the art advice, guidance, design, evaluation, and standards. The new mechanism will also support the DHTs in six provinces with the highest rates of GBV (Bujumbura Mairie, Bujumbura Rural, Gitega, Kirundo, Kayanza, Rumonge, and Makamba) to increase the coverage and quality of the GBV component addressing the HIV response in Burundi. The local partner will work at non-service delivery level with the GOB, as well as with other GBV stakeholders such as the United Nations Population Fund (UNFPA) to advocate for GBV prevention, mitigation, and post-violence care.

The OVC mechanism will focus on direct service delivery in six provinces, covering 8,867 AGYW in the age group of 9-17 years, including the current cohort in Bujumbura Mairie, Bujumbura Rural, Kayanza and Gitega (estimated at fewer than 5,000). OVC activities will be expanded in three additional provinces: Kirundo, Rumonge, and Makamba. While the new OVC activity will

target primarily girls, boys of the same age will also receive GBV prevention and response services and/or referrals. The local partner will build on the current AGYW project to implement the following package of services:

1. Health, with a focus on helping adolescent girls and boys access HIV prevention information and services, access to other health and nutrition services and/or referrals, sexual and reproductive health, and GBV prevention and response services, including better access to adolescent-friendly services;
2. Case-management, with a focus on family-centered, strengths-based case-management and monitoring and achievement of progress toward outcomes and benchmarks associated with health, stability, safety, and schooling through case-managers during household visits;
3. Education assistance to facilitate enrollment and progression in primary and secondary education, returning back to school for out-of-school girls, and vocational training;
4. GBV prevention and response with a particular focus on 9-14 year old girls and boys, and;
5. Socio-economic support to families with a focus on parents/caregivers and older girls through digital and traditional saving groups.

2.4 Alignment of PEPFAR investments geographically to disease burden

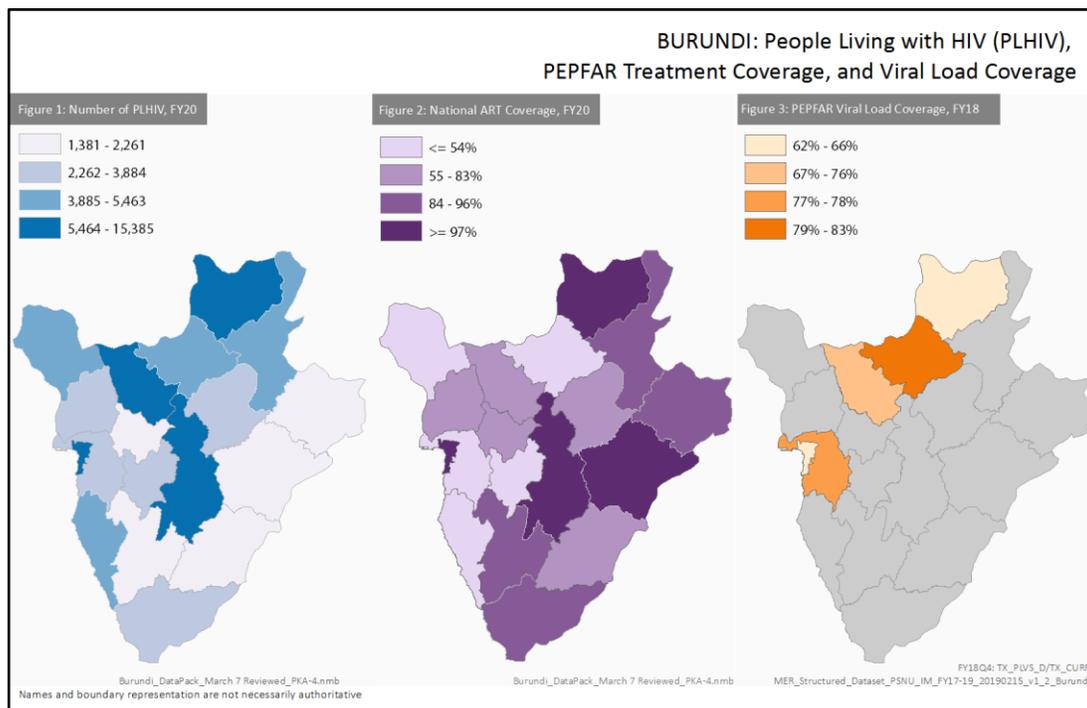
In response to the GOB's request during COP18 planning, the PEPFAR program in Burundi will expand nationally to all of the country's 18 provinces and 46 health districts. To develop an effective strategy and sharpen the focus on delivering high-quality HIV services, PEPFAR Burundi used the latest DHS data and spectrum estimates, combined with subnational data on current achievements and gaps, specific needs of sub-categories of population, available resources and infrastructures at the district level. Two categories of provinces have been identified to maximize resources and reach epidemic control: *Sustain* and *Optimize* provinces (Table 2.4.1 below). District-level data show varying degrees of success in case-identification and ART coverage in *Sustain* provinces. PEPFAR will continue to support passive but targeted testing approaches, to ensure that all ART patients continue to receive high-quality treatment and care services, including access to viral load testing and services to guarantee long-term viral load suppression. *Optimize* provinces will receive support to strengthen their case-finding strategies, expand ART coverage, improve the level of retention in care, and increase access to viral load testing.

Table 2.4.1

<i>Sustain</i> provinces	<i>Optimize</i> provinces
Focus on ART coverage, retention in care, access to viral load and suppression	Case detection, ART coverage, retention in care, access to viral load and suppression
Bujumbura Mairie, Bujumbura Rural, Kayanza, Kirundo, Ngozi, Ruyigi	Karusi, Gitega, Mwaro, Rumonge, Muramvya, Rutana, Cankuzo, Makamba, Cibitoke, Bubanza, Bururi, Muyinga

Geographic and population prioritization are expanded upon in Section 3.0

Figure 2.4.1 PLHIV, ART and viral load Coverage



2.5 Stakeholder Engagement

The NACP, technical and financial partners (WHO, UNAIDS, UNDP/GFATM), civil society representatives including KP organizations, PEPFAR IP, and other stakeholders provided input for COP19 through participation in key sessions during a strategic planning retreat held at the U.S. Embassy in Bujumbura in January 2019. These sessions were an opportunity to review PEPFAR and national data, discuss the main challenges at community and national levels, and collect their opinion on the proposed strategies towards epidemic control.

Workshops and working sessions with each category of stakeholders were organized separately, before and after the strategic planning retreat, to deepen the discussions on important subjects: strategies to reinforce community engagement in PEPFAR programs, key systemic challenges to be considered in the development of above-service delivery strategies (Table 6), the PEPFAR program's geographic expansion, and areas of synergies with the GFATM.

PEPFAR Burundi also engaged with stakeholders outside of the strategic planning retreat to update the tenofovir-lamivudine-dolutegravir (TLD) regimen transition plan and complete the commodities tools.

Stakeholders were also invited to take part in the COP19 review meeting, held in Johannesburg from March 4-8. Participants included the Minister of Health and the Fight against AIDS, the NACP Director, WHO, UNAIDS, UNDP, CSO representatives and Burundi's GFATM Portfolio Manager in Geneva. Stakeholders will continue to be engaged throughout the COP19 planning and implementation process.

Given the anticipated shifts (geographic and programmatic) in the PEPFAR program, the emphasis on epidemic control and the required increased efficiencies in resource deployment, strengthening the coordination with the GFATM and the NACP will be a critical component of the PEPFAR's partner management and coordination strategy.

COP19 implementation will include ongoing consultations, including sharing of quarterly results at the national and provincial levels.

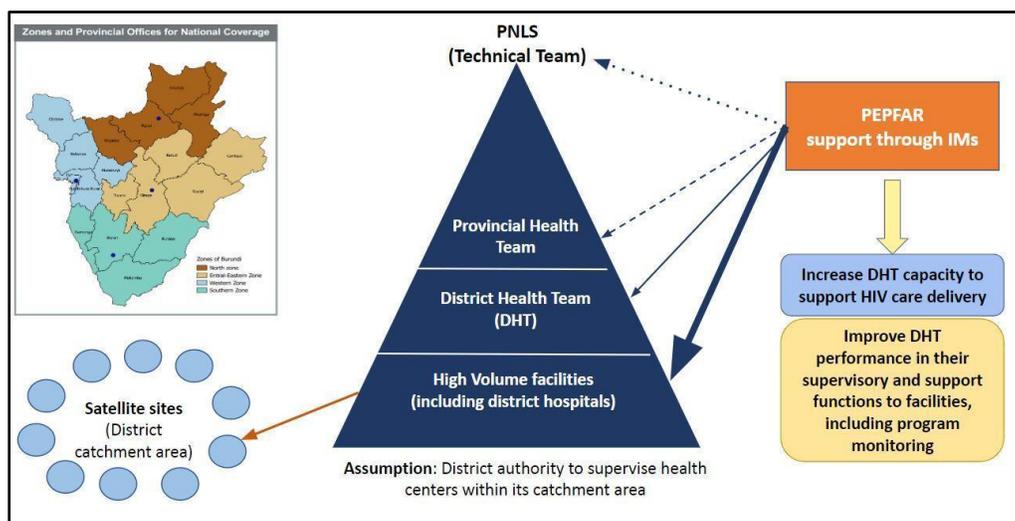
3.0 Geographic and Population Prioritization

3.1 PEPFAR Burundi's COP19 Geographic Shift

The GOB and its partners are dedicated to reaching the UNAIDS 95-95-95 targets with the aim of epidemic control in Burundi. The latest UNAIDS Spectrum estimates suggest that while progress has been made, the national HIV program efforts lack the coverage and intervention effectiveness needed to have a major impact on epidemic control of HIV in the country.

For that reason, the PEPFAR program will expand support in FY20 to cover the country's 18 provinces and 46 health districts. The geographic approach is described below (Figure: 3.1.1). The main objectives of this district-level approach are twofold: increase the DHT capacity to support HIV care delivery; ii) and improve the performance of DHT supervisory and support functions to health facilities.

Figure 3.1.1: Geographic Strategy for COP19



In each district, PEPFAR support will be directed to High-volume facilities, including district hospitals. Priority sites are described in the table below.

Table 3.1.1: Priority sites

- District hospitals
- high-volume sites (facility and community)
- High case-finding (optimize services) and large ART cohort (sustain services)
- Sites that support 80 percent of total patients in areas where the largest numbers of PLHIV to be reached reside
- TB reference health facilities
- KP hotspots
- Youth-friendly services

PEPFAR Burundi will complement the GFATM’s approach by providing technical assistance for optimized quality improvement and focused investments that prioritize epidemiologic impact. Geographically, the PEPFAR program will be operational at the provincial level by leveraging existing IP offices and operations. The three existing provincial PEPFAR offices will be maintained and strengthened, while another office will be established to cover the southern part of the country to ensure quality technical support and program oversight at the SNU level (Table 3.1: Zones and provincial offices for national coverage).

Table 3.1.2: Zones and provincial offices for national coverage

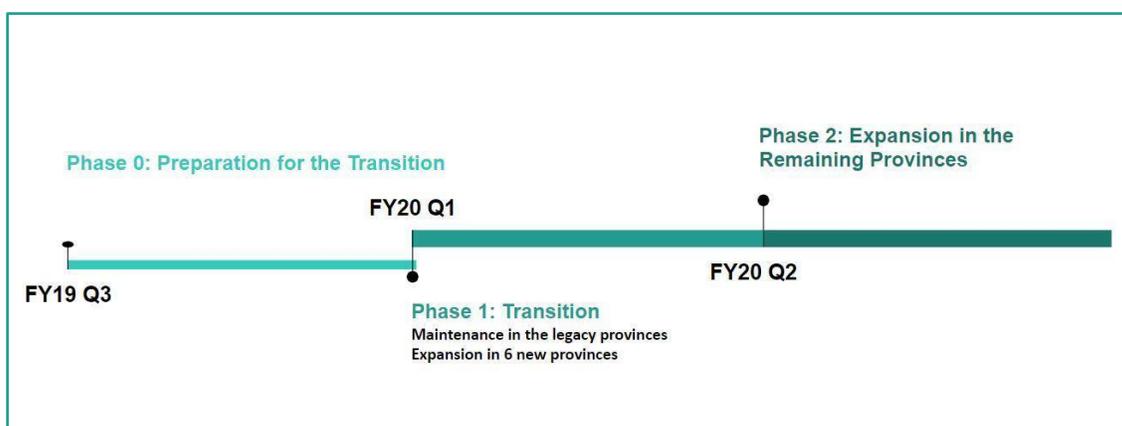
- **Northern Zone:** Kayanza, Muyinga, Ngozi & Kirundo - Existing office in **Ngozi**
- **Central-Eastern Zone:** Ruyigi, Cankuzo, Gitega, & Karusi - Existing office in **Gitega**
- **Western Zone:** Bujumbura Mairie, Bujumbura Rural, Cibitoke, Muramvya and Bubanza - Existing office in **Bujumbura Mairie**
- **Southern Zone:** Bururi, Makamba, Rutana, Mwaro & Rumonge – No office yet – Establishment of an office in **Bururi**.

PEPFAR implementing partners will adjust their technical assistance and mentoring approach to increase their site-level presence at high-volume sites and provide direct support to facility-based providers, particularly at low-performing sites with the capacity for significantly higher volume. They will also support the DHT to improve the quality of services provided. Frequent and consistent site-level monitoring will ensure that program strategies are being implemented with quality and efficiency, while course corrections are made as needed.

3.2 Phased Geographic Expansion

The three phase-expansion of the PEPFAR program will be implemented as follows (Figure 3.2.1: Timeline for national expansion).

Figure 3.2.1: Timeline for national expansion



Phase Zero: Preparation for the Transition

During FY19 Q3, PEPFAR will undertake district assessments, focused on monitoring and evaluation (M&E) capacity, quality of services, and key local barriers to support prioritization and to ensure that investments are aligned to the areas with the greatest needs. Appropriate adjustments will be made to generate savings for use during COP19 implementation.

Phase 1: Transition

During the first quarter of FY20, maintenance activities (see table 3.5.1) will be implemented in the legacy provinces: Bujumbura Mairie, Bujumbura Rural, Gitega, Kayanza, Kirundo, Ngozi, as well as in all military sites. The PEPFAR program will also expand in six new provinces, which have the largest gaps and needs: Mwaro, Cibitoke, Rumonge, Karusi, Bubanza, and Muramvya.

Phase 2: Expansion in the Remaining Provinces

The roll-out of the program in Bururi, Rutana, Muyinga, Cankuzo, Makamba, and Ruyigi will happen during the second quarter of FY20.

3.3 Sustain vs Optimize Provinces: Overall Details

PEPFAR Burundi has categorized Burundi’s 18 provinces into *Sustain* and *Optimize* provinces based on ART coverage gap. The differences between the two categories are described in the table below. More details are provided in the following subsections.

Table 3.3.1 Sustain Vs Optimize Summary

	<i>Sustain</i> provinces	<i>Optimize</i> provinces
Provinces	Bujumbura Mairie, Bujumbura Rural, Kayanza, Kirundo, Ngozi, Ruyigi.	Karusi, Gitega, Mwaro, Rumonge, Muramvya, Rutana, Cankuzo, Makamba, Cibitoke, Bubanza, Bururi, Muyinga
Main focus	ART coverage, retention, access to Viral Load and Suppression	Active case-finding, ART coverage, retention access to viral load and Suppression
Differentiated case-finding strategy	<p>The <i>proportion</i> of positives from index testing is 40% with 10% for community sites and 30% for facility sites</p> <p>Passive case-finding with focus on index testing, surveillance; index testing yield is 20% for adults and 12% of children.</p> <p>Kirundo, Kayanza, Ngozi and Bujumbura Rural have 0% in VCT</p>	<p>The <i>proportion</i> of positives from index testing is 40% with 10% for community sites and 30% for facility sites and VCT is 20% of positives.</p> <p>Stratification by PLHIV burden and coverage:</p> <ol style="list-style-type: none"> 1. High burden, low coverage: intensify index testing; 2. Low burden: low level of case-identification
Community engagement	Maintenance interventions Targeted programming to higher-risk populations (KP, OVC, AGYWs)	Key component of the PEPFAR strategy
Support to DHT	Light touch on a quarterly basis	Full package of support; Monthly to quarterly support from IM, depending on the level of priority of the districts.

3.4 Sustain vs Optimize Provinces: Level of Support

PEPFAR Burundi has differentiated the level of support provided to DHTs and sites in both *Sustain* (Figure 3.4.1) and *Optimize* provinces (Figure 3.4.2) based on epidemiological factors (PLHIV burden, TB co-infection rates, known hotspots, etc.), and structural factors (no donor support, low 95-95-95 achievements, etc.). Across *Optimize* and *Sustain* provinces, PEPFAR Burundi will implement a robust approach to partner management and stakeholder coordination that is responsive to data. Intense partner management and regular monitoring of performance

will ensure accurate data collection and recording, and improved use of data to readjust focus and to develop site-specific remediation plans. Regular coordination and collaboration with the GOB at the national and district-level, as well as the GFATM, will be crucial to maintain quality and to ensure a sustainable response.

Table 3.4.1: Level of Support Provided to *Sustain* Provinces

Sites with 100 or more ART or PMTC clients (high-volume sites) Prioritization of high yielding service delivery points	Quarterly supportive supervision visits, quality monitoring visits, clinical mentoring Ongoing mentoring and supervision by DHTs
Sites with 40 to 99 ART or PMTCT clients (satellite sites)	Semi-annual supportive supervision visits for quality monitoring Mentoring and experience sharing from high-volume sites
Sites with less than 40 ART and/or PMTCT clients or no/low HTS yield	Discontinuity of support from PEPFAR Sites that do not meet the HTS minimum levels will be transitioned to the MSPLS
Support to DHTs	Performance development (Re-trainings when necessary, supportive supervision) District level data analysis on a quarterly basis + remediation actions for poor performances

Table 3.4.2: Level of Support Provided to *Optimize* Provinces

High-priority, focus districts (highest burden and need) <ul style="list-style-type: none"> • High HIV, TB (and INH prevention measures), and STI burden • Low progress towards achievements of 95/95/95 goals • Local barriers and service delivery gaps 	Frequent, as-needed, technical assistance covered by a regional office/local staff
Medium-priority districts (districts with average needs) <ul style="list-style-type: none"> • Advanced progress towards achievement of 95/95/95 goals • Health facilities and community led-clinics have capacity-building needs 	Monthly technical assistance visits
Low-priority districts (districts with the lowest burden and needs) <ul style="list-style-type: none"> • Good progress towards reaching 95/95/95 goals 	Quarterly technical assistance visits

3.5 Sustain vs Optimize Provinces: Package of Services

In *Sustain* provinces, the PEPFAR program in close collaboration with the NACP and the GFATM, will continue to ensure that a maintenance package of services is implemented (see table next page).

Table 3.5.1: Sustain vs. Optimize Package of Services

<i>Activities that may receive PEPFAR Burundi Support</i>	<i>Sustain provinces</i>	<i>Optimize provinces</i>
First 95		
Demand creation for HTC for targeting key and priority populations	No	Yes
Index testing	Yes	Yes
Optimized PITC	Yes	Yes
Self-testing (provinces covered by the KP program)	Yes	Yes
Pediatric and adolescent HIV case-finding	Yes	Yes
Men case-finding	Yes	Yes
Mapping to locate new emerging KP hotspots	No	Yes
Commodities support for testing (test kits and reagents)	Yes	Yes
Integration of GBV prevention and response (provinces covered by the GBV program)	Yes	Yes
Second 95		
Same-day optimized regimen initiation	Yes	Yes
Bi-directional referrals and linkage between communities and facilities - Enhancing CSOs involvement	No	Yes
Innovative differentiated service-delivery approaches to reach low-coverage subgroups of population	No	Yes
Building providers capacity in KP, pediatric, OVC and adolescents treatment and care	No	Yes
Roll-out of the retention strategy	No	Yes
Implementation of the retention strategy	yes	yes
Expansion of MMS and Community ART points of distribution	No	Yes
Clinical services quality improvement (high-volume facilities)	Yes	Yes
Integration of GBV prevention and response (provinces covered by the GBV program)	Yes	Yes

Third 95		
Demand creation for viral load testing	No	Yes
Viral load testing capacity development	No	Yes
Improvement of lab-clinical interface and expansion of sample results referral system transmission	No	Yes
Enhanced viral load clinical management (clinical use of viral load data; monitoring and management of not virally suppressed patients)	Yes	Yes
Integration of GBV prevention and response (provinces covered by the GBV program)	Yes	Yes
PMTCT		
Testing of all pregnant women at ANC (+ index testing of partners & children + referral to OVC program if indicated)	Yes	Yes
Immediate ART enrollment of all HIV+ pregnant women	Yes	Yes
Reinforcement of postpartum retesting through the breastfeeding period	No	Yes
Rapid roll-out of GeneXperts for EID	Yes	Yes
Optimize EID sample transport network	No	Yes
Mentor-mothers peer-support groups	No	Yes
TB & HIV		
case-finding maximizing TB entry points (including TB suspects)	No	Yes
Promotion of presumptive TB diagnosis using GeneXpert to increase TB diagnosis	Yes	Yes
Support the implementation of TPT protocol with supportive supervision, monitoring of commodities' supply and capacity-building of health providers	Yes	Yes

3.6 Strengthening community engagement

While CSOs are key actors in the HIV/AIDS response in Burundi, several factors are hindering the full realization of the potential contribution of community health workers (CHWs) in the successful delivery of HIV and TB services, in particular for population-based HIV interventions. These factors include multiple competing actors with little coordination, unclear competencies, roles, and package of services; donor-driven management and funding; weak linkage with the health system; and poor supervision and quality control. During COP19, PEPFAR will contribute to the remediation of these issues. Community involvement in PEPFAR programming is anticipated to be more robust in *Optimize* provinces, which are still struggling to find undiagnosed PLHIV and enroll and keep them in care. Efforts will be made to correlate the density of CHWs to high PLHIV and KP burden areas, by reinforcing donor collaboration and CSO coordination.

Reinforcing the utilization of CHWs will help reduce human resources shortages at a provincial level, which remain a critical issue in Burundi, affecting HIV and TB healthcare delivery. Moreover, PEPFAR support to the revision of the task-shifting policy will be instrumental in improving the pediatric ART coverage.

Healthcare service providers at both the community and facility levels will be trained on the new strategies described in the revised national guidelines. Moreover, based on continuous monitoring of data and performances, PEPFAR will continue to refocus its efforts in locations with demonstrated high-yield testing results and target the highest risk subgroups of priority populations, including under-served or excluded vulnerable populations. Existing and new patient-centered community HIV models will be utilized to link priority population groups with available services. Bidirectional referrals between community and facility services will be fully integrated into PEPFAR programming at site and district levels.

In addition to the two local partners that will implement OVC and GBV programming, implementing mechanisms will be requested to strengthen community-based services alongside of the HIV clinical cascade. The package of PEPFAR interventions at the community-level include:

- Supporting community-based organizations to engage in demand creation activities, in particular for dolutegravir (DTG)-based regimens and viral load testing;
- Increasing the level of effort by CHWs to increase high-impact testing, linkage, and referral or transfer to public health facilities, and ensuring the provision of differentiated models of care adapted to various sub-groups of priority populations;
- Supporting functional community ART points of distribution and groups;
- Expanding community-lead treatment literacy efforts, comprising the development and dissemination of easily understandable and culturally appropriate materials;
- Supporting the roll-out of U=U (undetectable = untransmissible), seeking to reduce HIV-related stigma and discrimination and making sure that every PLHIV receives at least one annual viral load test and remains virally suppressed;
- Improving the efficiency of service delivery through improved models of care delivery across community and facility sites; and
- Ensuring community mobilization interventions that address harmful gender norms perpetuating GBV target all community influencers, including parents/caregivers, male partners of AGYW, faith and traditional leaders.

3.7 System functions strengthening at the district level (*Optimize* provinces)

The *Optimize* provinces, which have not received intensive PEPFAR support in the past, will be the majority of new PEPFAR supporting locations. The technical assistance provided to these new provinces will ensure an increased capacity of DHTs to support sites in delivering quality HIV services and help “boost” the scale-up of new HIV strategies. Key activities/outputs to improve DHTs capacity for systemic functions are described in the table below.

Table 3.7.1: System Activities for DHTs

<p>PLANNING SYSTEMS CAPACITIES</p> <ul style="list-style-type: none"> • Performance review and bottleneck analysis • Data analysis and sharing used in planning processes • Support in the development and monitoring of quarterly action plan 	
<p>PROCUREMENT AND SUPPLY CHAIN MANAGEMENT</p> <ul style="list-style-type: none"> • Improvement of efficiency in logistics • TA on Information systems • Improvement of stock control • Introduction of maintenance plans • Improvement of commodities distribution • Skills improvement on logistics management 	<p>DATA & INFORMATION SYSTEMS</p> <ul style="list-style-type: none"> • Improvement of registry of patient data for pediatric and adult patients • Improvement of facility-based information systems such as systematic cleaning of patient and facility records in SIDAInfos and data quality audits • Improvement of follow-up on defaulters
<p>QUALITY ASSURANCE/QUALITY IMPROVEMENT</p> <ul style="list-style-type: none"> • QI through the establishment of core standards and program reviews • QA/QI initiatives to target a particular problem or service, such as early infant diagnosis • Training to update providers' skills or introduce new norms, protocols, and strategies; • Technical skills improvement (lab technicians, providers trained on counselling) • Re-engineering of patient flow in high-volume facilities to decrease patient waiting times, improve internal referrals and increase the efficiency of services • Strengthening the links between community and health facilities to improve demand & access for services • Integration of community and facility HIV TB response 	<p>LABORATORY</p> <ul style="list-style-type: none"> • Assessment of turn-around time for laboratory tests to identify and address bottlenecks that cause major delays, and affect initiation and adherence to treatment. • Improvement of lab info for data quality control • Preventive maintenance of lab equipment • Plan developed for lab sample collection • Improved efficiency in logistics - logistics system more organized [better follow-up on patient status (viral load); pre-treatment of lab samples - faster processing of samples; reduced waiting time for lab results; improved quality of test results]

3.8 Priority populations

To achieve COP19 targets, the PEPFAR program is intensifying strategies for the following priority sites and populations in both *Sustain* and *Optimize* provinces.

Table 3.8.1: Priority populations

Priority populations
<ul style="list-style-type: none"> ● KPs (MSM, TG, Sex workers) ● Priority populations: sexual partners of KPs and PLHIV children of KPs; OVC; AGYW; fishermen, truck drivers, miners ● Other subgroups of the general population: men over 25; pregnant women, breastfeeding women, and infants through PMTCT ● TB patients ● STI patients ● Military

Province-level data show varying degrees of success in case-identification and ART coverage.

The following table showing the Spectrum estimates for case-identification by sex and age highlights the male and pediatric case identification gaps. Closing these gaps in the provinces with the greatest unmet need will accelerate progress towards the second and third 95.

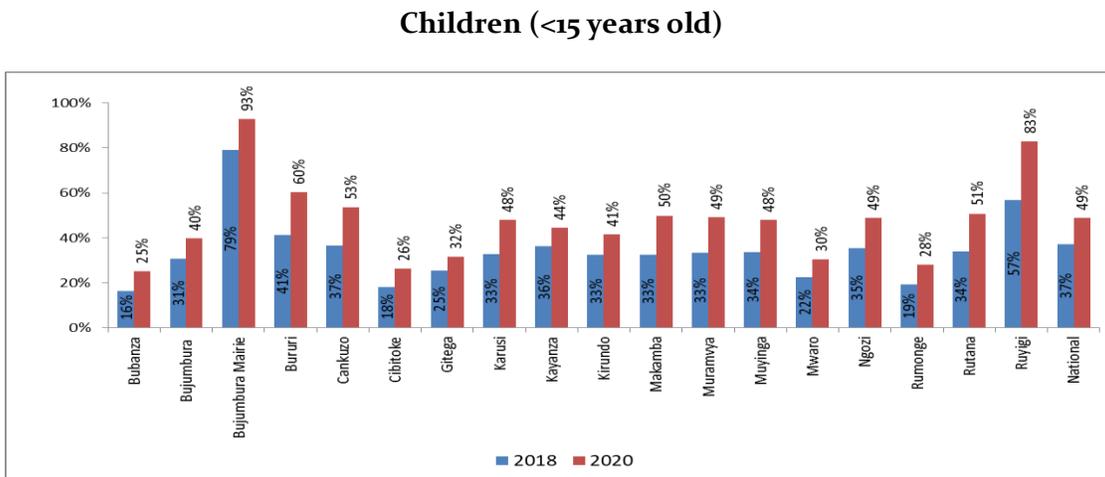
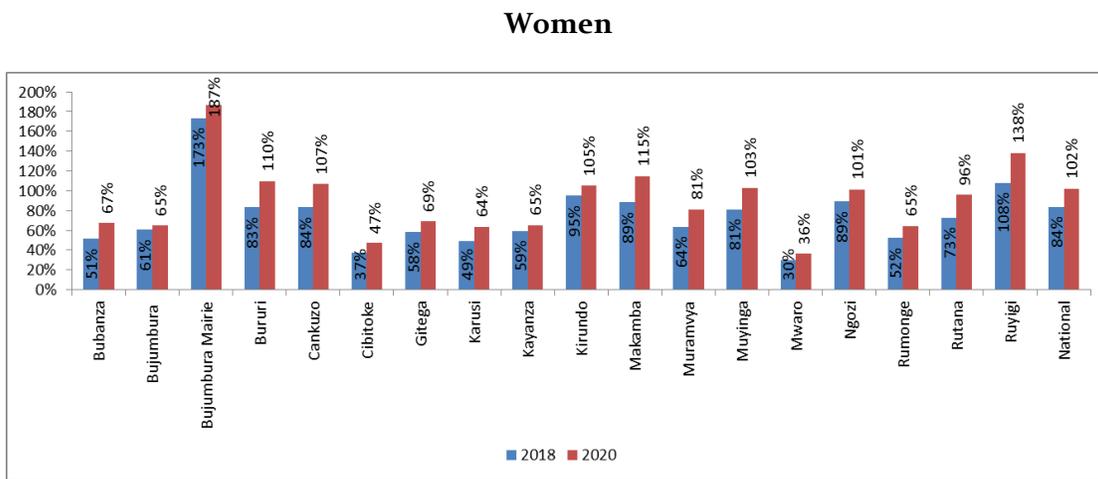
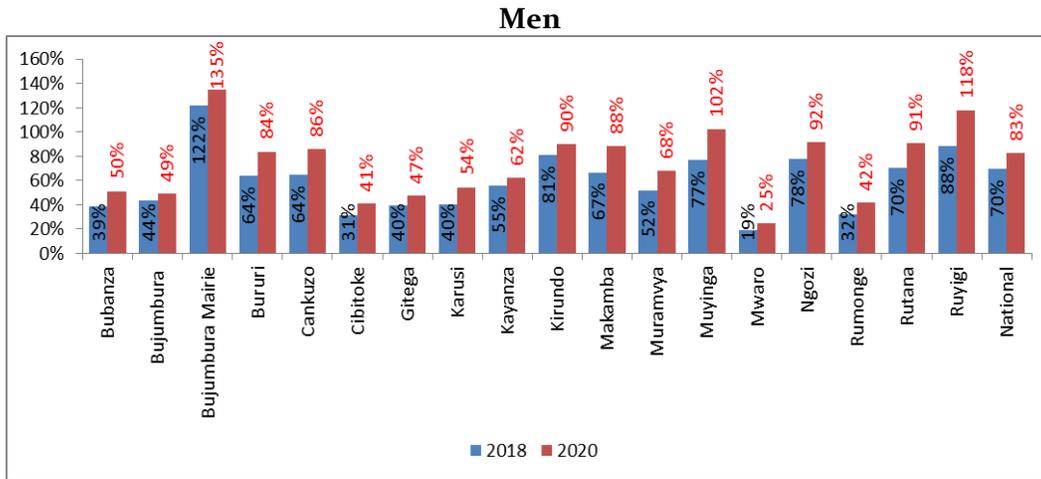
Table 3.8.2: Case identification by sex and age (First 95, Spectrum estimates, 2018)

Men			Women			Children		
PLHIV	Who know their HIV+ Status	1st 95	PLHIV	Who know their HIV+ status	1st 95	PLHIV	Who know their HIV+ status	1st 95
33,691	23,196	69%	49,284	43,689	89%	9,782	3,687	38%

Age- and sex-disaggregated analyses show that men and children have the greatest ART coverage gaps, with national coverage currently at 70 percent (vs. 84 percent for women) and 37 percent, respectively. See figure 3.8.1 ART coverage rate for men, women, and children by province. These gaps are bigger in *Optimize* provinces, from 19 percent ART coverage for men in Mwaro to 70 percent in Rutana; from 16 percent ART coverage for children to 41 percent in Bururi.

Consequently, PEPFAR is directing its partners to scale up successful strategies tailored by age- and gender, for both case-identification and ART linkage, in geographic locations with the greatest needs and the highest burden. Globally, IPs will be directed to tailor HIV programs to address specific local needs to achieve epidemic control efficiently in both *Sustain* and *Optimize* provinces.

Figure 3.8.1: ART Coverage Rate for Men, Women, children by Province (Second 95, Spectrum estimates)



Standard Table 3.1

Table 3.1 Current Status of ART saturation				
Prioritization Area	Total PLHIV/% of all PLHIV for COP19	# Current on ART (FY18)	# of SNU COP18 (FY19)	# of SNU COP19 (FY20)
Scale-up Aggressive	38,255 (48%)	17987	4	13
Sustained (including Military)	41,623 (52%)	47573	3	6

4.0 Program Activities for Epidemic Control in Optimized Locations and Populations

In COP19, based on available PEPFAR and national data and discussions with the GOB, PEPFAR Burundi will expand and scale up programming to provide technical assistance and commodity support to 12 additional provinces in Burundi, termed “*Optimize provinces*,” as described in Section 3.

In these provinces, PEPFAR Burundi will support aggressive case-finding, ART initiation, retention on ART, and access to viral load monitoring at high-priority sites that comprise 80 percent of the total ART cohort. The program’s support to DHTs and sites will be tailored depending on PLHIV, TB, STI burden, and progress towards 95-95-95 goals, with the highest-priority districts receiving frequent, as-needed technical assistance by a regional office and local staff; medium-priority districts receiving monthly technical assistance visits; and lower-priority districts receiving quarterly technical assistance visits.

4.1 Finding the Missing, Getting them on Treatment, and Retaining them Ensuring Viral Suppression

1st 95: PEPFAR Burundi’s testing strategy has pivoted based on Annual Program Reporting FY18 data that showed low yield at voluntary testing and counseling (VTC), with improving yield through index testing and increasing volume. In COP19, PEPFAR Burundi will focus on index testing of all new HIV-positive individuals, including in PMTCT settings. The program will support HIV testing of clients entering services through STI, TB, and GBV post-violence care entry points, and all women at ANC and Post-ANC. PITC approaches will be more targeted, with the introduction of validated screening tools for adults and children. Support for low-yield modalities, including VTC, will be progressively discontinued in FY20 in *Optimize Provinces*.

Across all testing modalities, PEPFAR Burundi will ensure that a rights-based *approach* to case-finding is undertaken; informed consent is consistently requested; clients requesting a test are not denied; and IPV/GBV referrals to non-clinical GBV services (psychosocial, legal, child protection, economic strengthening) are offered to survivors of violence in all facilities and community sites implementing index testing.⁹

Across all populations in *Optimize* Provinces, PEPFAR Burundi’s testing strategy will rely on three pillars, as described in the table 4.1.1.

Table 4.1.1: Testing Strategy Pillars

Policy and Guidelines	Community Engagement	Quality Improvement
<ul style="list-style-type: none"> • Support full implementation of policy updates (PBF indicators, testing age of consent, task shifting) • Support national guidelines update to reflect latest WHO guidance. 	<ul style="list-style-type: none"> • Optimize coordination and linkage between community health workers and facility sites/staff • Optimize existing strategies at the community level and accelerate successful practices 	<ul style="list-style-type: none"> • Define national quality standards • Validate the HIV screening tool for adults and pediatrics • Promote HTS literacy for service providers and clients • Develop and disseminate standardized SOPs, job aids, scripts and reporting cascades

2nd 95: In *Optimize* provinces, PEPFAR Burundi will support the transition to TLD by December 2019 and the removal of nevirapine (NVP)-based regimens, along with the expansion of Treat All, including strengthening same-day ART initiation. In FY18, 50 percent of clients initiating ART did so on the same day as diagnosis, with 75 percent initiating ART within one week. In Q1 of FY19, 75 percent of clients initiated ART on the same day as diagnosis, with 91 percent initiating by one week.

To support retention of clients on ART, PEPFAR Burundi will work across all levels of the health system, including at the community, facility, district, and national levels, with effective partner management and close collaboration with the GFATM. At the community level, PEPFAR will support community and civil society engagement, and will strengthen DSD models, including expanding community ART distribution points from 17 to 46 districts. At the facility level, patient management approaches will include the optimized use of the SIDAInfo EMR and CommCare

⁹ New HIV Testing Strategies in PEPFAR COP19: Rollout and Human Rights Concerns, amFAR, 2019 Available at: <https://www.amfar.org/cop19/>

systems for tracking and communicating with clients, along with the national expansion of MMS at high-volume sites. At the national level, PEPFAR will support the transition from paper-based systems to SIDAInfo, while increase the interoperability of SIDAInfo across the facility, district, and national levels through dataset improvements and linking patient data to unique identifiers. PEPFAR Burundi will work closely with the NACP to support revision of the MMS policy and development of a DSD policy with a national implementation plan.

3rd 95: PEPFAR Burundi will support a differentiated approach to viral load monitoring in *Optimize* provinces with the goal of 80 percent viral load monitoring coverage by the end of FY20.

In these provinces, PEPFAR will transfer successes and lessons learned from viral load monitoring scale-up in *Sustain* provinces by taking a holistic approach through:

1. Optimization of the laboratory network (further described in Section 4.8)
2. Increasing provider and client demand creation and management/use of viral load results:
 - a. Client and provider viral load literacy
 - b. Strengthening community to facility linkage for clients requiring viral load test
 - c. Intensified monitoring and management of unsuppressed PLHIV
 - d. Enhanced adherence support
3. Increasing viral load testing capacity at the site and laboratory level:
 - a. Improve lab-clinical interface and expand sample and results referral system transmission
 - b. Enhance clinical use of viral load clinical data
 - c. Use tools for patient tracking to reduce LTFU and to flag clients requiring viral load test at each visit
 - d. Ensure laboratories prioritize samples from children and pregnant and breastfeeding women

PEPFAR Burundi will reach high-risk and priority populations including adult women, adult men, pediatrics, OVC, AGYW, adolescents, and KPs through assessment of gaps, using needs-responsive and evidence-based approaches. The strategies for each population profile are described below.

4.1.1 Adult Women

For adult women, national FY18 data indicates that 84 percent of women living with HIV are on ART. In *Optimize* provinces in FY20, the ANC platform will be leveraged for case-finding to reach and test sexual partners and biological children of positive women. Adult women will also be reached through HIV-positive male index testing. Through all modalities, referrals to intimate partner violence (IPV)/GBV and social risk reduction services will be supported. Women who are identified as positive through the ANC platform will be referred to PMTCT platforms and linked to community-based mentor mothers/peer support groups to enhance adherence and retention, including demand creation for viral load monitoring during pregnancy and breastfeeding. At the national level, PEPFAR Burundi will work with the NACP to revise/update DSD guidelines to

extend MMP to pregnant and breastfeeding women and their families. For viral load monitoring, providers will be sensitized on the importance of regular monitoring during pregnancy and breastfeeding to align with the national guidelines, especially at sites that demonstrate a low level of viral load access for pregnant and breastfeeding women.

4.1.2 Adult Men

For adult men, national FY18 data indicates that 70 percent of men living with HIV are on ART, and PEPFAR FY18 data indicates that men's uptake of HIV testing is approximately 1:3 compared with adult women when PMTCT testing is excluded; this is especially low in the 15-29 year age bands. Viral load access and suppression for men was consistently lower than that of women across all 15 and older age bands in FY18.

In COP19, PEPFAR Burundi will improve case-finding in *Optimize* provinces for adult men through three main testing approaches: targeted PITC using a risk screening tool; HIV self-testing; and index testing through HIV-positive women and female sex workers, with referrals to IPV/GBV services as indicated. Male-friendly services (testing, ART, and viral load) will be provided through "men-only" and evening clinic hours and will draw on evidence-based PEPFAR Solutions from other contexts.¹⁰ Men enrolling or current on ART will be encouraged to join male-only peer adherence groups and will receive targeted treatment literacy information, including on the U=U campaign to increase demand for viral load monitoring and to sensitize men to the importance of ART adherence.

4.1.3 Pediatrics

FY18 data shows that 37 percent of children under 15 living with HIV (CLHIV) are on ART, and viral suppression is lower than adults, indicating a critical need for effective strategies across the pediatric clinical cascade. The program will train, mentor, and provide supportive supervision to providers on CLHIV care and treatment, including age-appropriate status disclosure and transition to adult care that reflects the national guidelines. For case-finding, PEPFAR Burundi will increase access to infant virological testing (EID; more in Section 4.8) to increase the number of HIV-exposed infants tested by two months of age through demand-creation activities in mentor mother groups and reducing sample turnaround time (TAT). In addition, PEPFAR will support the use of a validated risk-screening tool in the highest volume outpatient setting where children are seen (ambulatory/outpatient department), in addition to targeted PITC at high-yield entry points and index testing of biological children from HIV-positive adult clients.

To support ART initiation and retention in care for children, PEPFAR-supported sites will encourage family-based appointments on the same day and with the same provider for the whole family, as well as family-based adherence sessions and viral load demand creation. Linkage with the PEPFAR OVC programs will also ensure effective case-management. For older children and

¹⁰ PEPFAR Solution on Male Friendly Clinics in Lesotho: <https://www.pepfarsolutions.org/solutions/2018/11/6/male-friendly-clinics-demand-creation-targeting-hiv-infected-men-to-access-comprehensive-health-services>

adolescents, peer support groups that draw from evidence-based models will be utilized.¹¹ To ensure children and infants living with HIV are on the most optimal ARV regimens, PEPFAR will continue to support the rollout of LPV/r pellets and provider training and caregiver education on accurate dosing. PEPFAR Burundi will work with implementing partners to conduct regular reviews of treatment outcome indicators for children by weight band and ARV regimen.

At the national level, PEPFAR will advocate for guideline revisions to include task-shifting for pediatric ART initiation, and will support the phasing out of NVP and efavirenz-containing regimens, transitioning to DTG-containing regimens for children weighing over 20kg; and transitioning to raltegravir instead of nevirapine for neonates.

4.1.4 OVC, AGYW, and Adolescents

In the OVC/AGYW program, collaboration and coordination with the main clinical IP, Reaching an AIDS Free Generation (RAFG) implemented by FHI360, will be enhanced to refer and test for HIV at least 90 percent of OVC. A bi-directional referral network will be established between the PEPFAR clinical program and the OVC/AGYW program to ensure coverage of services and increase the number of HIV-positive children enrolled in the OVC program. For adolescents not reached through the OVC/AGYW program, PEPFAR Burundi will support index testing of adolescents with an HIV-positive parent or caregiver and children of KPs. In addition, the program will support policy changes to lower the age of testing to 12 years of age. To ensure that services are responsive to adolescents, peer support for those newly-diagnosed will be supported and evidence-based approaches (e.g. modeled on the Zvandiri program¹²) will be used, creating flexible/extended hours at facilities as well as adolescent-friendly corners. HIV-positive OVC will receive psychosocial support to enhance adherence to treatment and improve their ART retention, viral load suppression, and school retention. Furthermore, their parents/caregivers will receive socio-economic support through saving groups or income-generating activities to strengthen the household's ability to pay for school fees and medical costs for children under 17 years of age.

4.1.5 KPs

The KP program will remain flexible, adapting expected results from the UNDP-supported KP-specific FY20 Integrated Bio-Behavioral Survey. To increase case-finding volumes, the team will take state-of-the-art strategies to scale, including the use of index testing, self-testing, incentivized social networking strategies or Enhanced Peer Outreach Approaches (EPOA), and continued use of information communication technology. In all instances, the program will ensure KP-competency in service delivery, ensuring confidential services to mitigate harm, as well

¹¹ PEPFAR Solution on Operation Triple Zero for Children and Adolescents:

<https://www.pepfarsolutions.org/solutions/2018/10/30/operation-triple-zero-empowering-adolescents-and-young-people-living-with-hiv-to-take-control-of-their-own-health>

¹² PEPFAR Solution on Zvandiri program for Adolescents:

<https://www.pepfarsolutions.org/adolescents/2018/1/13/zvandiri-peer-counseling-to-improve-adolescent-hiv-care-and-support?rq=zvandiri>

as offering differentiated service delivery models via KP-specific drop-in centers. Offering comprehensive health services, these centers compliment HIV testing and treatment with complementary services, such as family planning, mental health, and/or violence mitigation services, that increase the program's ability to find, test, and retain KPs living with HIV. The program will also expand its use of risk assessments, ensuring those who are higher risk as KPs are tested. Key to success will be case-finding among the hard to reach, i.e. those who are challenged to identify fully as KP. Hence, additional service delivery strategies are warranted, such as engaging with private sector health providers where greater anonymity is needed.

ARV enrollment, retention, and viral suppression strategies will build upon past successes, highlighting patient navigation strategies. For FY20, the program will also expand its use of information communication technology to enhance retention. With the overall geographic expansion, often being optimized based on KP hotspots along trucking routes, the program will continue its efforts to train public and private sector healthcare providers in KP-competent prevention and treatment services.

4.2 Prevention, specifically detailing programs for priority programming:

In COP19, PEPFAR Burundi will support the NACP by incorporating evidence-based combinations of HIV prevention activities into all clinical and community-based programs. Specific populations and approaches to prevention activities include:

4.2.1 Gender-based and intimate partner-based violence (crosscutting)

In COP19, USAID Burundi will launch a new three-year activity with the objective of improving the integration of GBV prevention and response into HIV services. This technical assistance modeled activity will have a local Burundian organization as its prime and will be focused on ensuring that GBV prevention and response is integrated into HIV prevention and clinical cascade of all PEPFAR interventions. The main areas of focus will include improving GBV and HIV prevention for adolescent girls, young women, and key and vulnerable populations; improving GBV case-identification and response in HIV index testing and partner notification; and improving clinical post-GBV care in HIV service delivery. Using a technical assistance model, the new activity will directly support current PEPFAR IPs to integrate effective GBV prevention and response activities into their work. The new activity will prioritize strengthening data systems, data analytics, and site-level monitoring; utilize a process of continuous QI at the site and partner level, and ensure that gender equality and the elimination of stigma and discrimination forms are addressed meaningfully in partner work plans.

4.2.2 AGYW and Children

The OVC program will focus on AGYW and children with special emphasis on primary prevention of sexual violence and HIV risk reduction for 9-14 year old boys and girls. It will integrate the three evidence-informed, PEPFAR developed modules (Module 1: Healthy and Unhealthy Relationships; Module 2: Making Healthy Decisions about Sex; and Module 3 Understanding Non-

consensual Sex) into existing prevention curricula. Adolescent boys and girls, with focus on 9-14 year olds, will be trained on GBV prevention and will be screened for sexual abuse, encouraged to report, and referred for medical and non-medical services, including post-exposure prophylaxis and medical/legal certificates. The program will also strengthen caregivers and community leaders' capacity to prevent, respond and support victims.

4.2.3 KPs

The program will continue to engage KPs via state-of-the art strategies such as microplanning (e.g., using mapping and size estimation data to assign peer outreach workers to hot spots based ratios of peer outreach workers to peers, and peer contacts within hotspots). The program will provide services at hotspots and KP-specific drop-in centers that include both prevention and treatment services. In FY20, the program will use individualized risk-assessments to shift the focus of peer outreach away from high-volume/low-quality approaches toward more individual and personalized engagement aimed at encouraging messaging, commodity provision, and service uptake. This approach also supports prioritizing KP members who may be at higher risk for HIV. Stigma, discrimination, and violence mitigation strategies will be enhanced, working with KP community members to reduce internalized stigma, as well as KP-competency training with health service providers, law enforcement personnel, and other social service providers to increase access to services. The program will enhance its U=U campaign, not only as a treatment literacy strategy but also as a means to reduce HIV-related stigma in PLHIVs and KP communities.

4.2.4 Military populations

Military personnel contribute to the burden of new HIV infections with an estimated prevalence of 1.8 percent. PEPFAR Burundi will continue to support high-impact interventions for high-risk sub-populations within military and other priority populations such as AGYW near FSW hotspots and military bases. The priority population prevention package will include advocacy and demand-creation to increase awareness, uptake, and acceptability of relevant prevention and clinical services. It will also include education and skills to reduce HIV risk and accurately identify HIV prevention methods, sustain behavior change, promote gender-equitable principles, address HIV stigma and discrimination, provide or refer HIV testing, facilitate linkage to care for HIV-positive individuals, condom promotion, distribution, and skills buildings.

4.3 Additional country-specific priorities listed in the planning level letter

Starting in FY19, PEPFAR Burundi will ensure implementation of context-, age-, gender-, and systems- specific approaches to significantly improve case-finding, linkage, retention, and viral load suppression, and to reduce all barriers and gaps along the 95, 95, 95 cascade at site and district levels.

Testing strategies are being optimized to find the “left-behind” HIV-positives and initiate them on treatment. Optimizing testing strategies requires eliminating non-targeted testing, scaling active index testing, self-testing, and optimized PITC, while ensuring that these modalities are implemented with quality and fidelity across all sites. In FY18/2019, the program identified consistent low yield at VCT under the national prevalence, with low yet improving yield through index testing, and created a remediation plan with IPs to implement a testing surge. Remediation strategies include weekly reporting and analysis of program data, supportive supervision to ensure compliance with the new testing guidelines, and the systematic use of the screening tool and clinical mentoring.

PEPFAR Burundi is also implementing strategies to increase the volume of KPs tested and linked to treatment: optimization of the EPOA, given its demonstrated ability to gain better access to networks of KPs and increase reach, uptake of HIV testing, and HIV case-detection; scaling-up of the self-testing for hard-to-reach and hidden KP sub-categories; use of virtual approaches to improve reach and case-finding; and micro-planning and use of data for planning and quality improvement. Better analysis of data, including a better understanding of the reasons for losses, is required to inform the design of targeted interventions to address losses. Challenges with meeting targets are also due to issues with target-setting for case-finding, including a lack of available data. PEPFAR Burundi continues to advocate for the implementation of a new IBBS during FY19, to ensure that planning, at a strategic and operational levels, is based on reliable and up-to-date data. Finally, the program will accelerated the use of lessons and best practices, as well as cross-organizational and cross-country learning.

Updated testing policies prioritizing case-finding and targeted testing strategies are in place and have been disseminated to all provinces. PBF indicators reflect the new testing strategies, and the GAFTM is aligning its interventions to the GOB’s new orientations in terms of case-finding. With the support and readiness of the GOB and its partners to focus on high-yield testing strategies, PEPFAR Burundi plans to achieve its 2020 targets.

ART policies will be revised to integrate the latest WHO recommendations, as well as lessons learned and best practices from the implementation of strategies in some PEPFAR provinces. During FY19, the PEPFAR team will work closely with the GOB and the IM to develop a national scaling-plan of DSD. For the second and third 95, PEPFAR Burundi will continue implementing the following scale-up service package, with a stronger involvement of CHWs: scale-up of same-day optimized ART regimens initiation through a linkage agent model; scale-up of DSD, including an effective implementation of the MMS policy and the expansion of the Community ART points of distribution and support groups); use of peer navigators and case managers to improve the active tracking of LTFU in conjunction with the optimization of CommCare; and adherence counseling and demand-creation for viral load monitoring; and improvement of the SIDAInfo’ patient database for a better adherence and retention monitoring (quantification of issues around low treatment coverage performance and the impact of low 12-month retention).

PEPFAR Burundi will expand a family treatment model to address the challenges of children not receiving care in the same place as their parents. Adolescent and male friendly models will be promoted.

PEPFAR Burundi actively manages all implementers with data-driven discussions and corrective actions. This active partner management allows for the sharing of promising practices among implementers in a timely manner, and ensures coordination and collaboration among IM at the national and provincial levels.

PEPFAR Burundi innovates continually to identify more effective and efficient programming modalities and strategies to achieve its annual targets.

4.4 Commodities

COP19 will coincide with MSPLS adding two addenda to the national guidelines that will affect future commodity policy in Burundi, including new testing strategies and the introduction of the optimized ART regimens.

The MSPLS decided to transition to TLD all adolescent boys, adult men and women over 49 years of age. The completion of the TLD transition of all eligible patients is expected to start in May 2019, and end by September 2019. PEPFAR and the GFATM will need to provide strong support to help the NACP achieve this ambitious goal.

At the same time, Burundi is engaged to phase out all NVP-based ART regimens as soon as possible (with the exception of nevirapine oral solution that will continue to be used for infant prophylaxis). All patients not eligible for TLD will be on TLE. For those who are on TLE, they are recommended to move from TLE600 (currently used) to TLE400 which is a newly recommended dosage. This transition will start in November 2019. Pediatric regimens will be optimized to include regimens that include LPV/r pellets (already used in Burundi) for pediatric patients under 20kgs of weight and regimens that include DTG 50mg for patients between 20-30kgs of weight; male patients over 30kgs of weight will be transitioned to TLD.

MMS will scale-up in all provinces. For this purpose, Burundi will begin procuring 90-tablet (3-month ARV supply) bottles of TLD in October 2019 for stable ART patients.

The GFATM will continue to be the most important donor for HIV commodities, accounting for 63 percent of procurement, followed by PEPFAR (25 percent of HIV commodity procurement) and the GOB (11 percent of HIV commodity procurement).

Following agreements at the COP19 Meeting in Johannesburg in March 2019 to reduce duplication, the GFATM will be the sole procurer of Abbott Determine™ HIV-1/2 kits and HIV 1/ 2 STAT-PAK® DIPSTICK in COP19, while PEPFAR Burundi will cover national HIV self-test kits (HIVST) demand for the HIVST scale-up across all provinces and support rational distribution of RTKs. PEPFAR will continue to complement the GFATM by procuring Cotrimoxazole to prevent OIs.

As Burundi evolves toward HIV epidemic control, the target in ART coverage is ambitious: set at 79,878, while donors have budgeted to cover 72,308 people on ART. In terms of potential gaps, the participants in the COP19 Meeting in Johannesburg in March 2019 predicted a gap of about \$3 million for ART coverage. It was decided that key donors and other stakeholders would remain engaged to find ways to close the gap and consider possible reprogramming of the GFATM budget, as well as monitoring program progress. PEPFAR and the GFATM committed to covering a gap in ARVs in Burundi, should the program successfully enroll in treatment the targeted 79,878. PEPFAR and the GFATM made this commitment in the presence of the honorable Minister of Health, the Director of the NACP, and CSO representatives.

As PEPFAR's viral load testing target for Burundi increased, from 54,600 tests to 65,561 tests, PEPFAR will increase its allocated viral load budget by \$1,218,521, and provide 38,874 viral load tests and related supplies.

For EID reagents and consumables, PEPFAR will procure half of the EID commodities and consumables needs on Abbott machines (complementing the GFATM) and the total needs for GeneXpert HIV-1 Qual cartridges to conduct point-of-care (POC) or near-POC EID.

To support the initiation of HIV-positive clients on TPT, PEPFAR Burundi will procure GeneXpert MTB/Rif cartridges to complement the quantity already supported by the GFATM.

4.5 Collaboration, Integration and Monitoring

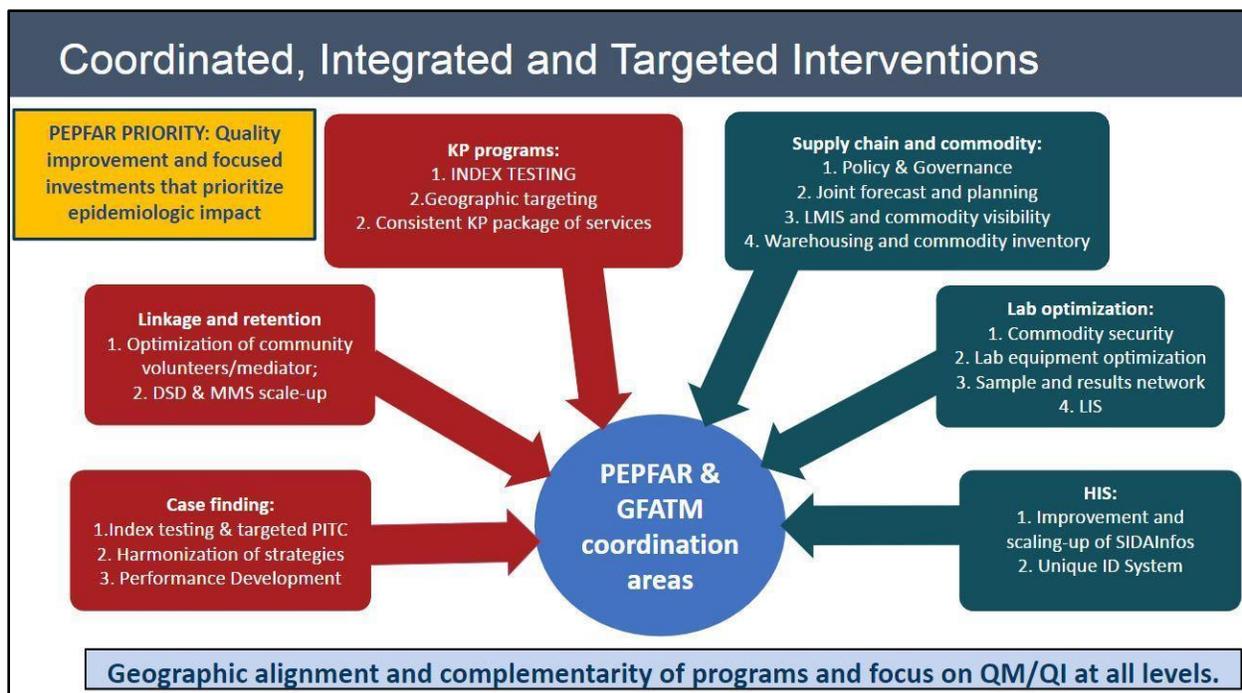
4.5.1 Coordination with the GFATM

PEPFAR Burundi collaborates closely with the current GFATM Principal Recipient (PR), UNDP, as well as with the Geneva-based portfolio manager. The US government is represented in the CCM. PEPFAR Burundi actively shares information on planning and progress in the country, and UNDP has participated in performance review meetings and in the COP19 development process.

During FY19, PEPFAR Burundi participated in joint site evaluation visits and national stakeholders meetings for harmonization and alignment with other in-country financing mechanisms and reviews program implementation frameworks, work plans, budgets, procurement and supply chain plans. The PEPFAR Burundi and the IPs' commodity supply chain and laboratory focal points meet regularly with UNDP and NACP representatives to coordinate quantification, supply planning, distribution, and systems strengthening.

During COP19 implementation, key areas of synergy will include the programmatic level (case-finding, linkage and retention, KP programs) and the systemic level (supply chain and commodity, lab optimization, and health information systems), as illustrated in the following figure.

Figure 4.5.1: Coordination with the GFATM



PEPFAR Burundi and the GFATM teams will continue to link closely through the CCM, the Health Donors Group, PEPFAR Burundi stakeholders’ meetings, and informal meetings to evaluate adjustments required based on new evidence (consultants’ reports, evaluation reports, new national guidelines, scale and/or remediation plans).

4.5.2 Partner management and coordination

PEPFAR Burundi has begun monthly one-on-one review meetings with IPs, concentrating on site-level performances, barriers to progress, data quality, and capacity challenges. IPs will be directed to work more closely with high-volume site leadership and district health officers to facilitate more rapid improvement, verify actual practice, carry out data spot checks, assist in monitoring the rolling out of best practices, including index client testing, same day initiation of optimized ART regimens, and differentiated service delivery. Weekly monitoring of index testing data will be conducted to ensure rapid scale-up of index testing approaches and alignment of PEPFAR testing strategies to maximize yield.

From a management perspective, the PEPFAR team is monitoring expenditures with each IP, ensuring partners' resources are focused on achieving targets within COP outlay limits and gaining efficiencies. Clear and regular communication with IPs and with IP headquarters' offices is being conducted for active course correction and the development of quality work plans that reflect program shifts and strategic implementation of the program. PEPFAR Burundi will participate in joint coordination meetings with the NACP team members, UNDP, WHO, and IPs working at the non-service delivery level to monitor progress and results of HSS activities, address constraints, and advance policy and programmatic issues.

With respect to community systems and CSO engagement, there is insufficient coordination among the CSO key players at the site-level (volunteers, peer-educators, case managers and/or health mediators) and with health service providers, impact on HIV testing, treatment, and retention. For COP19, PEPFAR will support and encouraged enhanced CSO engagement in finding men, children and adolescents, and tracking and tracing HIV patients who failed to return to care/treatment. Working with CSOs will allow targeted interventions to help return patients back to treatment, document their treatment in another setting, or document their death or LTFU. PEPFAR Burundi is considering quarterly coordination meetings with key GFATM sub-recipients, IP sub-partners, and the NACP representatives to improve community-based HIV services and their linkage to health facilities.

To ensure that adjustments will be made already during FY19 to optimize the implementation of the COP19 strategy, IPs will develop individual surge strategies addressing priority program areas. In addition, IPs will be encouraged to work more closely with DHTs to address weaknesses within health governance systems. IPs will build DHTs capacity to adequately provide leadership and oversight functions within their area of responsibility, in particular where there is an overall poor accountability of performance towards attaining 95-95-95 goals.

4.6 Targets for optimized locations and populations

Standard Table 4.6.1

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Optimized Provinces			
Entry Streams for ART Enrollment	Tested for HIV (APR FY20) <i>HTS_TST</i>	Newly Identified Positive (APR FY20) <i>HTS_TST_POS</i>	Newly Initiated on ART (APR FY 20) <i>TX_NEW</i>
Total Men	105,368	8,298	4,965

Total Women	317,055	8,000	4,418
Total Children (<15)	31,184	1,583	758
Total from Index Testing	38,772	7,143	7,000
<u>Adults</u>			
TB Patients	5,565	168	167
Pregnant Women	249,118	2,225	2,181
KPs	19233	2082	2042
Priority Populations	9,631	536	507
Other Testing	138,876	11,287	11,070
Previously diagnosed and/or in care			81
<u>Pediatrics (<15)</u>			
HIV Exposed Infants	3,371	34	34
Other pediatric testing			
Previously diagnosed and/or in care			2

Standard Table 4.6.3

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY20)	FY20 Target (KP_PREV)
KPs			
<i>Bubanza FSW</i>	1419	90%	1277
<i>Bubanza MSM</i>	109	90%	98
<i>Bubanza TG</i>	N/a	N/a	35
<i>Bururi</i>	N/a	N/a	N/a
<i>Cankuzo</i>	N/a	N/a	N/a
<i>Cibitoke FSW</i>	2412	90%	2171
<i>Cibitoke MSM</i>	186	90%	168
<i>Cibitoke TG</i>	N/a	N/a	60
<i>Gitega FSW</i>	1381	79%	1085
<i>Gitega MSM</i>	441	49%	214
<i>Gitega TG</i>	N/a	N/a	130
<i>Karusi FSW</i>	2720	90%	2448
<i>Karusi MSM</i>	210	90%	189
<i>Karusi TG</i>	N/a	N/a	67

<i>Makamba FSW</i>	1203	90%	1083
<i>Makamba MSM</i>	186	90%	168
<i>Makamba TG</i>	N/a	N/a	60
<i>Muramvya</i>	N/a	N/a	N/a
<i>Muyinga FSW</i>	3334	90%	3001
<i>Muyinga MSM</i>	257	90%	231
<i>Muyinga TG</i>	N/a	N/a	82
<i>Mwaro</i>	N/a	N/a	N/a
<i>Rumonge FSW</i>	2176	90%	1959
<i>Rumonge MSM</i>	168	90%	151
<i>Rumonge TG</i>	N/a	N/a	54
<i>Rutana FSW</i>	2412	90%	2171
<i>Rutana MSM</i>	185	90%	167
<i>Rutana TG</i>	N/a	N/a	60
TOTAL	18799		17129

Standard Table 4.6.4

Table 4.6.4 Targets for OVC and Linkages to HIV Services

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY20 Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY20 Target) OVC*
Bujumbura Mairie, Bujumbura Rural, Gitega, Kayanza, Kirundo, Rumonge Makamba	9,267	8,867	7,682
TOTAL	9,267	8,867	7,682

4.8 Viral Load and Early Infant Diagnosis Optimization

In FY18/FY19, PEPFAR, GFATM, and WHO/AFRO consultants completed several optimization activities. These activities found that Burundi has sufficient Abbott and OPP-ERA platforms to cover national needs in viral load and EID, and that the 24 GeneXperts procured by the GFATM are underutilized and could be used for EID without compromising TB diagnosis.

In FY18, PEPFAR supported access to viral load monitoring for 77 percent of PLHIV on ART, with 90 percent of those suppressed who received a test. For EID, 60 percent of HIV-exposed infants (HEIs) received a test by two months of age and 74 percent received a test by 12 months of age. While these numbers are promising, the program has ambitious targets in FY20 to increase viral load access to 80 percent in *Sustain* provinces through transferring best practices, and to reach 90 percent in *Optimize* provinces, with a target of 80 percent HEIs receiving an EID by two months of age across Burundi. To reach these ambitious goals, PEPFAR Burundi plans to implement both site-level and above service-delivery level improvements to the national laboratory network,

taking into account previous optimization efforts and complementarities with the GOB and the GFATM.

In FY19, PEPFAR will support a laboratory optimization exercise to identify the optimal sample referral network for viral load, EID (convention and POC/near-POC) and TB samples, and to optimize the placement of potential new platforms. At the COP19 Meeting in Johannesburg, stakeholders discussed phasing out the OPP-ERA platforms as they are not WHO-prequalified; if the GOB and the GFATM confirmed this decision, PEPFAR will consider bringing in an additional viral load/EID platform(s) through a reagent rental model and would carry out an additional laboratory optimization activity to ensure correct geographic placement.

At the above-service delivery level in COP19, PEPFAR will work to boost the capacity of the NACP and DHTs for EID and viral load through knowledge exchange of best practices from PEPFAR sites. The program will also collaborate with NACP to develop an adequate and functional QM/CQI system to scale up quality laboratory services, including enrolling laboratories in CDC's EQA program. In terms of laboratory information systems (LIS), PEPFAR will assess the feasibility of launching a LIS in limited sites in COP19 with the goal of expansion to additional sites in upcoming years. In addition, PEPFAR will expand support for sample collection, transportation and results return from six provinces to the remaining 12 provinces.

In COP19, the major change to Burundi's laboratory network will be the leveraging of the GFATM's existing GeneXpert network for EID. PEPFAR Burundi will support the FY20 goal set by the NACP to conduct 40 percent of total EID tests as POC or near-POC EID in order to reduce TAT and increase early case-finding rates for HIV-positive infants. To prepare for the integration of near-POC or POC EID testing into the conventional network, PEPFAR Burundi will procure only GeneXpert HIV-1 Qual reagents and consumables needed for EID and will train operators in the HIV-1 Qual protocol. The results from the FY19 laboratory optimization activity will be key in informing the shift in sample referral networks from conventional only to a combination of near-POC/POC.

At the site-level (facility and laboratory), challenges and barriers (e.g., weak demand-creation, sample transport, sample backlogs, etc.) to the viral load and EID diagnostic cascade will be assessed regularly through the use of facility/laboratory scorecard and quarterly monitoring tools, and remediation plans will be implemented. PEPFAR will also make use of the viral load/EID Reference Manual¹³ to guide remediation plans.

¹³ PEPFAR viral load/EID Reference Manual:
<https://www.pepfar.net/ect-m/isme/layouts/15/start.aspx#/>

5.0 Program Activities for Epidemic Control in Sustained Locations and Populations

5.1 COP19 Programmatic Priorities

In *Sustain* provinces, the PEPFAR Burundi program, in close collaboration with the NACP and the GFATM, will continue to ensure that a maintenance package of services is implemented (See table 3.5.1).

5.1.1 Focus on care and treatment, and viral load suppression for adults and children living with HIV

PEPFAR Burundi support will focus on the provision of ART optimized regimens and quality services in high-volume sites, ensuring adherence and retention as well as provision of quality viral load services for those PLHIV newly or already enrolled on ART. IPs will ensure that quality standards of care and treatment services are accessible and sustained for all patients already enrolled in treatment through the provision of technical assistance to high-volume sites. They will work with the DHT to maintain high-quality services in all sites in the catchment area of the district. In addition, HIV services will proactively identify patients in need of TPT and manage patients with co-morbidity and resistances. Monthly and quarterly reviews of retention efforts will be jointly undertaken by IP staff, site-level providers, and PEPFAR teams for course correction.

The use of routine viral load testing for ART monitoring and early identification of treatment failure will be strengthened. The results of the viral load tests will serve for patients' management and timely clinical decision-making. Timely and suitable switching to second-line ARV regimens for those patients who fail their first-line regimens will be reinforced.

Together with host country governments, PEPFAR and other stakeholders are working to improve the frequency and quality of key epidemiologic markers; however, implementing these studies and building surveillance systems requires time and substantial resources. PEPFAR supports the implementation of country-led, population based HIV Impact Assessments to measure HIV-relevant services, uptake and health outcomes and to monitor and inform policy and programming. A PEPFAR HIV Impact Assessment (PHIA) will be implemented in FY20 to collect specific valid program data on treatment coverage and community viral load suppression.

PEPFAR Burundi will continue the delivery of services for HIV infected children using an integrated, comprehensive, and family-centered approach. The program will support pediatric case-finding, the provision of a comprehensive care package, and ensure the availability of essential laboratory services, including viral load monitoring. PEPFAR will improve adherence to treatment, retention in care, and viral suppression for the existing cohort of children and adolescents on treatment, using complementary approaches that include differentiated youth services and peer-to-peer adherence support and case management to newly initiated patients and existing clients. This will be done through counseling, education, regular monitoring of scheduled appointments, identifying clients who miss their scheduled appointments, tracing of defaulters and engaging them back to care, and facilitating linkage with community services, including community-level adherence support. Continuous quality improvement will be supported in order to maintain the standard of care provided to children and adolescents patients.

5.1.2 Case detection of pockets of HIV-infection subgroups of population that are yet to be identified

These sub-categories include men, children, adolescents, and KPs who will be prioritized. Modest targets that have an impact on epidemic control have been allocated (see table below). COP19 will shift towards conducting fewer test with resultant high yield.

Micro-targeting will be implemented in *Sustain* districts that still have large proportions of men, adolescents, and children who have not been diagnosed.

Age- and sex-disaggregated analyses show that men and children have the greatest ART coverage gaps (with coverage currently at 32 percent and 29 percent, respectively).

Table 5.1.1: Targets Optimize vs Sustain Provinces

PSNU	Entry Streams for ART Enrollment	Tested for HIV (APR FY20) <i>HTS_TST</i>	Newly Identified Positive (APR FY20) <i>HTS_TST_POS</i>	Newly Initiated on ART (APR FY 20) <i>TX_NEW</i>
<i>Sustain</i> provinces	Men (>25 Yrs)	28,536	2,491	2,435
	Children	7,523	402	398
	Adolescents	14,634	325	313
	FSW	6,350	762	746

	MSM	1,483	89	87
<i>Optimize provinces</i>	Men (>25 Yrs)	46,869	3,465	3,394
	Children	23,661	1,181	1,161
	Adolescents	34,167	1,001	967
	FSW	9,771	1,086	1,064
	MSM	815	49	49

5.1.3 Other programmatic priorities

To complement interventions implemented during COP18, and in order to reach and maintain epidemic control in sustain districts, the following additional programmatic priorities will be implemented to ensure that specific populations are reached:

- *The OVC program*, which will be expanded in three of the *Sustain* provinces (Bujumbura Rural, Gitega and Kirundo) will work alongside KPs, clinical, and community partners to increase case-finding among children at high risk of HIV. Many older children living with HIV still need to be identified and linked to treatment. Index case testing among HIV-affected families will need to be improved. The OVC program will strengthen efforts to scale up testing for children of HIV-positive FSW in all drop-in centers and enroll them in the OVC Program. The OVC program will reinforce mother-baby cohort monitoring by prioritizing HEI for enrollment in the OVC program and providing specialized case management to HIV-positive mothers and their HEI. Finally, the OVC program will work through several partners to identify and enroll hard-to-reach OVC populations at high risk of HIV infection, such as children living and working on the street and children exposed to sexual violence, to ensure children are assessed for HIV risk and referred for testing. The OVC program will work closely with public health facilities, relevant government agencies, and clinical partners to improve treatment linkage, retention, adherence, and viral suppression. Treatment outcomes for children and adolescents continue to be affected by inadequate adolescent-focused psychosocial services concentrating on adherence and disclosure issues, insufficient training of service providers to provide counselling on adherence issues tailored for older children and parents, and sub-optimal patient monitoring practices. The OVC program will focus on psychosocial support for HIV-positive children and their families, while increasing youth-friendly services and peer-to-peer engagement to improve adherence and retention.
- *The GBV program* will be implemented in four of the *Sustain* provinces: Bujumbura Mairie, Bujumbura Rural, Gitega and Kirundo. The program will ensure the integration of GBV services (prevention, mitigation, and post-violence care) into existing PEPFAR-supported HIV services.

5.2 Targets for sustained locations and populations

Standard Table 5.2.2

Table 5.2.2 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Provinces			
Sustained Support Volume by Group		Expected result APR 19	Expected result APR 20
HIV testing in PMTCT sites	<i>PMTCT_STAT</i>	178,402	249,118
HTS (only sustained ART sites in FY18)	<i>HTS_TST/HTS_TST_POS</i>	2%	1%
Current on ART (National on ART: 79,878)	<i>TX_CURR</i>	39,220	70,863
OVC	<i>OVC_SERV</i>	4,179	5,533

5.3. Establishing service packages to meet targets in *Sustain* provinces

During FY20, the aim is to provide a package of services to maintain the current level of response. COP19 will prioritize stopping or reducing elements of service packages across all locations that have ceased to produce adequate yield and no longer serve the PEPFAR program in reaching targets. Specifically, COP19 will discontinue universal testing, passive index client testing, and the testing of low-risk children and adolescents. Instead, COP19 will focus on the rollout of evidence-based packages of services proven to make the biggest contribution to epidemic control. It should be noted that the linkage to treatment, retention on treatment, essential laboratory services for PLHIV and PMTCT service packages do not differ between *Sustain* and *Optimize* provinces, as these interventions are critical to the quality of services in all sites, regardless of district prioritization. The main difference in the package of services is the level of involvement of the community health workers and the declines in outreach services.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

Above-site investments in COP19 will continue to leverage systems investments by the GOB and the GFATM to strengthen site-level impact and address the main challenges identified in the SID and in program implementation, leading to epidemic control. The main areas of focus in COP19 will be the following:

6.1 Lab Support and Supply Chain Management

Laboratory capacity was identified as the only “red” category in the SID, citing the lack of adequate and consistent capacity to perform timely DNA PCR and viral load testing at a large scale. Above-site investments in the laboratory and supply chain management systems are critical to ensuring viral load and commodity distribution at the site-level. Commodity security support and quality of national commodity supply chain management are identified as system barriers. Activities to address these issues include forecasting and quantification, including for MMS, quality assurance systems, warehousing, inventory management, and commodity distribution. Another activity is providing support and supervision to DHTs for the usage of LMIS to inform accurate reporting of commodity consumption.

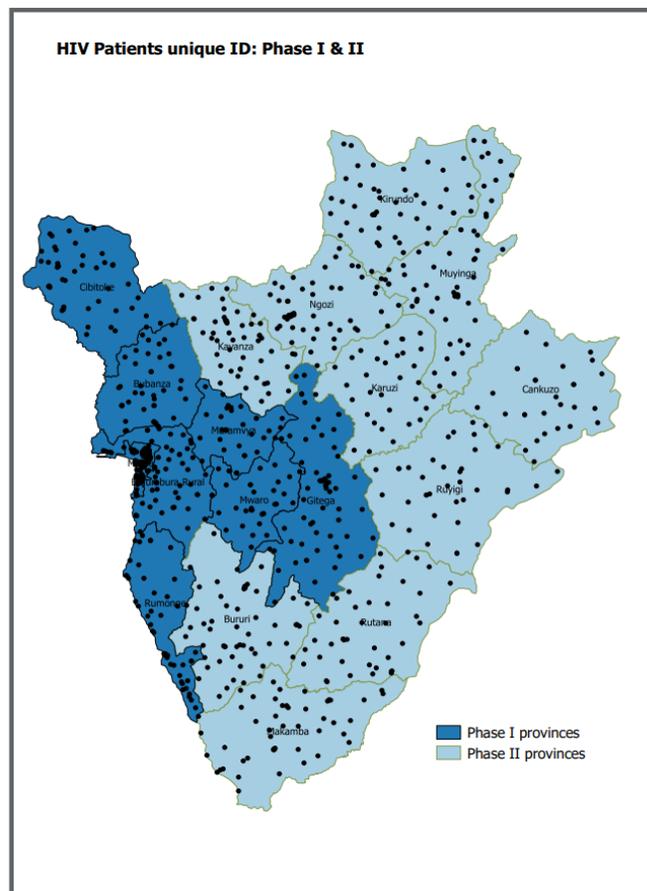
Working collaboratively to leverage the resources of the GFATM and MSPLS, lab services will be supported to increase viral load and EID and DNA PCR coverage. Support to the National AIDS Program will continue for a functional QM/QI system to scale up lab services, including viral load and EID scale-up. Technical assistance will continue for viral load/EID transport and the development of a sample transport system for the rapid return of results. Access to viral load, EID and TB will expand based on a national lab strategy mapping completed in COP18. Development and implementation of EQA and QI programs will take place at the lab hubs.

6.2 Information Systems

Information systems were highlighted as “yellow” in SID due to lack of adequate quality management QM/QI system with dedicated leadership or a current QM/QI plan for HIV care and treatment. The development of interoperable platforms for SIDAInfo and DHIS2 and for DHIS2 and DATIM are key priorities. To address this, COP19 will prioritize capacity-building in the utilization of data systems that are able to communicate with each other and exchange data in a common format. There will be efforts to improve the SIDAInfo user interface, robustness and to improve web-based performance. The aim will be to record all patients in SIDAInfo at high-volume sites in all provinces. We will align system indicators with revised service delivery indicators, aiming for SIDAInfo to exchange 75 percent of data with DHIS2. Capacity-building activities will include using data on testing yields to identify the highest yield entry points and to review and revise HTS/TX/ANC/viral load stock registers and in SIDAInfo to reflect entry points for priority testing locations, to record index patient testing, and to adapt the software with new

strategies, policies, and guidelines. PEPFAR Burundi will implement unique identifiers in two phases. Phase I will include Bujumbura Mairie and neighboring provinces, due to the movement of patients who are seeking quality health care services or employment opportunities in Bujumbura Mairie, as well as FSWs who are mobile. This phase also includes Gitega due to the numerous sites in the same area and it is the second highest-burden province after Bujumbura Mairie. The GOB also made the decision that Gitega is now the political capital of the country, while Bujumbura Mairie remains the economic capital of the country. Gitega is also in the central region of the country and the hub of main corridors and roads. During Phase I, the program will also cover the majority of fishermen, FSWs, and other mobile populations. The aim is to start implementing the second phase, which targets the other provinces before the end of FY20.

Figure 6.1: Unique Identifier Phased Expansion.



6.3 Policy, Governance, Technical Guidance and Support

Advocacy on the national level for policies and guidelines that support the full national implementation of Test and Start remain a priority, as does the recently completed National Testing Strategy revision, which will support more focused testing at the facility level, alongside

differentiated models of service delivery, and multi-month prescribing and dispensing, to support 95-95-95 goals. Support to the Directorate of Pharmacy, Drugs and Laboratories in lab coordination and implementation of the lab network is needed, through a functional lab committee managing roll-out of QA/QI for viral load, optimized use of GeneXpert machines, and monitoring of HIV testing strategies, including QA. Policy development and strategic planning in supply chain forecasting and planning will support improved stock management and TLD transition. PEPFAR will work to initiate and build capacity in technical working groups such as the national lab and pediatrics TWG.

6.4 Human Resources for Health: Workforce Development and Pre-Service Training

A strong, well-qualified workforce is the cornerstone of providing high-quality HIV services to patients. Military officers from the School of Nurses (Ecole Paramédicale Militaire) will receive pre-service training to enhance the capacity to provide quality HIV services. Technical assistance will also help to develop an electronic military health information system.

The ultimate goal of health systems investments at the country level is to ensure that the conditions exist to enable the success of PEPFAR investments at all levels of the system and to bring the national health system into a higher level of functioning and capacity. The indications the system is working will be the achievement of benchmarks and outcomes. Table 6 investments in conjunction with site investments address epidemic control priorities by improving the supply chain and commodity supply and ensuring stock-outs of key commodities are avoided. Information system investments improve the availability, reliability, and accuracy of data needed to monitor the epidemic and track coverage rates for testing, treatment, and viral load coverage. Table 6 investments leverage systems investments by the host country and other donors through complementarity and additionality. We believe that benchmarks and outcomes adequately define support to enable monitoring of Table 6 investments.

7.0 Staffing Plan

The PEPFAR team includes the USAID HIV team, acquisition and assistance staff, financial staff, and the Department of Defense (DOD) program manager. The USAID Health Team Leader also serves as a point of contact to S/GAC in the absence of a PEPFAR Coordinator's Office. The interagency space is small, highly collaborative, and efficient. The USAID and DOD teams coordinate interagency processes seamlessly through monthly and quarterly data reviews, POARTs, and COP development, allowing the teams to focus on intra-agency partner management and technical roles as appropriate. The increasingly complex demands of managing a sustained epidemic control program, transitioning to local partnerships, and addressing stakeholder coordination needs, had led to the creation of a new management and supervisory position. During COP18, the USAID Burundi office team received Mission approval for a new Personal Services Contractor position. The Senior HIV Advisor will assume technical leadership and management of the USAID PEPFAR team, including coordination with S/GAC as point of contact. At the time of COP19 submission, this new position was undergoing final NSDD-38 approvals.

To support the ambitious goals for a transition to local partners and for sustained epidemic control, the USAID Burundi team will also create three new PEPFAR-funded positions. These new positions fall under the "USAID LES" initiative. Two of these positions will be locally recruited foreign-service nationals under Chief of Mission authority, with office space inside the Embassy compound. The positions will support intra-agency partner management and provide technical expertise in the laboratory/clinical/quality improvement space. The third position will be a locally recruited consultant not under Chief of Mission authority, with office space outside of the Embassy and co-located with PEPFAR/USAID implementing partners, supporting performance development for sustained epidemic control and local ownership transition.

Implementation of recency testing will be performed following a new HIV positive test in a phased approach under a surveillance protocol working to establish an understanding of new infections by geography and specific populations. To support the successful implementation of recency testing in Burundi in FY20, ensuring appropriate integration and coordination with existing implementing partners, coordination with the PNLS and with key stakeholders, USAID will increase its cost-of-doing-business funding envelope with a transfer from CDC's recency budget. The funding will support the creation of a new position with laboratory expertise and a laboratory-focused scope of work.

Additionally, the USAID cost-of-doing-business in COP19 will increase to accommodate funding for a third-country national personal-services contractor Acquisition and Assistance Assistant to support the USAID PEPFAR team with all matters related to procurement and contract/grant management of the local partner initiative.

Due to the small staffing footprint and security-related restrictions on up-country travel, the PEPFAR Burundi program utilizes a third-party contractor to conduct the majority of SIMS visits.

APPENDIX A -- GEOGRAPHIC PRIORITIZATION

Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1

SNU	COP	Prioritization	Results reported	Attained 90-90 (81%) by Each Age and Sex Band to Reach 95-95 (90%) Overall																								
				Treatment Coverage of APR by Age and Sex																								
				<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		Overall TX
F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M					
Bubanza	COP17	Scale-up: Stimulation	APR17	0%	0%	18%	24%	17%	19%	11%	11%	35%	17%	74%	21%	79%	45%	65%	46%	47%	45%	41%	38%	55%	42%	61%	64%	64%
	COP18	Attained	APR18	0%	0%	27%	38%	33%	33%	20%	16%	52%	23%	93%	23%	100%	58%	94%	61%	65%	64%	48%	46%	64%	53%	63%	71%	61%
	COP19	Attained	APR19	25%	21%	27%	38%	31%	30%	20%	16%	47%	25%	86%	27%	96%	51%	87%	69%	60%	60%	45%	48%	60%	56%	59%	79%	49%
Bujumbura	COP17	Scale-up: Stimulation	APR17	7%	19%	33%	18%	38%	23%	36%	33%	55%	35%	73%	21%	78%	32%	70%	42%	70%	60%	51%	29%	68%	54%	62%	62%	55%
	COP18	Attained	APR18	79%	110%	36%	35%	42%	29%	42%	41%	67%	41%	82%	23%	75%	35%	69%	45%	80%	81%	53%	34%	71%	69%	56%	57%	58%
	COP19	Attained	APR19	48%	48%	27%	28%	20%	22%	47%	43%	28%	48%	49%	11%	64%	37%	75%	49%	78%	61%	20%	13%	22%	14%	41%	58%	40%
Bujumbura Mairie	COP17	Scale-up: Stimulation	APR17	42%	32%	41%	47%	73%	57%	101%	85%	128%	91%	242%	86%	422%	146%	383%	208%	207%	135%	160%	119%	130%	114%	132%	137%	150%
	COP18	Attained	APR18	65%	64%	62%	65%	94%	76%	119%	105%	150%	111%	252%	88%	379%	121%	471%	228%	288%	216%	174%	143%	151%	135%	125%	135%	165%
	COP19	Attained	APR19	72%	64%	228%	227%	120%	120%	188%	178%	133%	146%	284%	95%	500%	248%	730%	473%	363%	351%	80%	69%	74%	56%	105%	129%	210%
Dunani	COP17	Scale-up: Stimulation	APR17	38%	57%	33%	7%	41%	38%	32%	48%	38%	47%	92%	49%	127%	84%	80%	121%	52%	55%	51%	33%	108%	58%	164%	96%	74%
	COP18	Attained	APR18	125%	167%	49%	16%	70%	65%	54%	69%	56%	63%	104%	59%	168%	95%	142%	189%	86%	96%	72%	52%	118%	74%	170%	108%	100%
	COP19	Attained	APR19	125%	167%	49%	16%	67%	63%	52%	67%	52%	71%	92%	61%	148%	91%	125%	182%	80%	96%	67%	58%	104%	77%	150%	103%	90%
Cankuzo	COP17	Scale-up: Stimulation	APR17	67%	100%	11%	28%	34%	42%	26%	36%	42%	53%	120%	38%	265%	145%	95%	108%	88%	89%	54%	52%	71%	62%	90%	67%	75%
	COP18	Attained	APR18	125%	188%	18%	54%	63%	65%	38%	56%	54%	68%	134%	44%	363%	138%	175%	188%	135%	180%	63%	75%	79%	79%	93%	74%	98%
	COP19	Attained	APR19	125%	188%	18%	54%	58%	60%	38%	53%	49%	77%	118%	47%	318%	134%	154%	182%	119%	174%	58%	78%	73%	82%	86%	78%	101%
Cibitoke	COP17	Scale-up: Stimulation	APR17	5%	15%	24%	15%	19%	17%	16%	12%	22%	13%	33%	11%	40%	40%	38%	31%	33%	37%	39%	53%	48%	34%	60%	39%	35%
	COP18	Attained	APR18	0%	78%	26%	16%	25%	28%	15%	16%	22%	12%	37%	13%	45%	43%	42%	38%	0%	0%	45%	68%	54%	43%	64%	45%	45%
	COP19	Attained	APR19	36%	94%	3%	22%	27%	24%	22%	17%	33%	17%	46%	47%	46%	48%	41%	56%	42%	76%	50%	48%	60%	47%	41%		
Gitega	COP17	Scale-up: Stimulation	APR17	5%	4%	6%	11%	30%	27%	57%	51%	49%	44%	41%	21%	34%	20%	43%	18%	63%	34%	86%	46%	96%	65%	98%	83%	52%
	COP18	Attained	APR18	15%	18%	9%	15%	33%	30%	67%	60%	71%	61%	53%	32%	42%	24%	49%	21%	76%	40%	90%	48%	110%	77%	96%	85%	68%
	COP19	Attained	APR19	101%	101%	102%	105%	102%	105%	102%	105%	102%	105%	102%	105%	102%	105%	102%	105%	102%	105%	102%	105%	102%	105%	102%	105%	102%
Karusi	COP17	Scale-up: Stimulation	APR17	14%	0%	19%	10%	33%	25%	47%	43%	19%	28%	33%	15%	56%	29%	80%	47%	65%	53%	55%	46%	45%	55%	51%	59%	46%
	COP18	Attained	APR18	71%	18%	29%	17%	47%	42%	70%	66%	36%	40%	47%	30%	64%	39%	91%	57%	96%	69%	71%	59%	52%	72%	54%	63%	68%
	COP19	Attained	APR19	89%	54%	29%	17%	45%	40%	68%	64%	34%	45%	43%	35%	60%	43%	84%	58%	88%	77%	66%	61%	49%	81%	50%	73%	56%
Koyenzi	COP17	Scale-up: Stimulation	APR17	5%	0%	23%	15%	30%	32%	43%	51%	39%	48%	83%	56%	93%	72%	64%	68%	62%	71%	49%	51%	65%	60%	59%	58%	58%
	COP18	Attained	APR18	16%	0%	30%	22%	41%	42%	52%	63%	50%	58%	89%	62%	106%	72%	76%	81%	75%	86%	51%	57%	64%	65%	54%	58%	64%
	COP19	Attained	APR19	79%	69%	69%	70%	37%	38%	75%	90%	50%	78%	94%	80%	128%	252%	108%	178%	142%	147%	25%	47%	32%	48%	58%	86%	87%
Kirundo	COP17	Scale-up: Stimulation	APR17	35%	0%	28%	22%	24%	27%	49%	32%	113%	55%	189%	94%	157%	123%	110%	93%	88%	88%	72%	78%	81%	82%	75%	99%	90%
	COP18	Attained	APR18	76%	31%	39%	27%	32%	40%	60%	39%	132%	69%	222%	100%	185%	140%	134%	112%	113%	107%	74%	81%	80%	85%	69%	95%	96%
	COP19	Attained	APR19	69%	56%	99%	90%	57%	56%	100%	105%	84%	69%	125%	148%	132%	167%	128%	177%	162%	147%	39%	47%	52%	64%	84%	110%	99%
Makamba	COP17	Scale-up: Stimulation	APR17	33%	38%	42%	25%	23%	28%	31%	28%	58%	27%	131%	25%	188%	80%	141%	150%	78%	91%	69%	67%	87%	69%	94%	81%	79%
	COP18	Attained	APR18	94%	94%	56%	42%	41%	58%	48%	48%	78%	38%	160%	36%	235%	95%	233%	220%	118%	151%	84%	90%	103%	92%	100%	93%	104%
	COP19	Attained	APR19	125%	125%	52%	42%	38%	55%	46%	46%	73%	43%	141%	41%	206%	91%	205%	210%	104%	145%	78%	90%	90%	92%	88%	93%	97%
Muramvya	COP17	Scale-up: Stimulation	APR17	0%	13%	19%	22%	32%	38%	37%	28%	23%	34%	56%	35%	59%	40%	64%	68%	62%	40%	65%	38%	72%	54%	101%	91%	58%
	COP18	Attained	APR18	63%	188%	28%	38%	50%	58%	43%	31%	47%	68%	43%	69%	43%	101%	82%	96%	72%	79%	55%	83%	71%	105%	103%	76%	
	COP19	Attained	APR19	125%	188%	28%	38%	46%	56%	54%	41%	29%	50%	64%	49%	64%	48%	89%	86%	84%	82%	73%	56%	76%	79%	93%	99%	71%
Muyinga	COP17	Scale-up: Stimulation	APR17	16%	27%	24%	22%	24%	26%	36%	36%	55%	26%	201%	62%	245%	184%	124%	167%	90%	121%	66%	108%	68%	119%	45%	54%	79%
	COP18	Attained	APR18	21%	63%	54%	31%	40%	47%	53%	54%	77%	37%	228%	72%	282%	194%	202%	310%	136%	183%	81%	152%	89%	158%	48%	65%	103%
	COP19	Attained	APR19	63%	83%	51%	31%	39%	46%	51%	52%	72%	42%	201%	80%	251%	187%	178%	288%	120%	162%	75%	128%	74%	133%	45%	73%	106%
Mwaro	COP17	Scale-up: Stimulation	APR17	5%	5%	4%	9%	28%	16%	65%	50%	34%	45%	16%	10%	12%	11%	19%	7%	31%	13%	41%	18%	54%	27%	56%	31%	27%
	COP18	Attained	APR18	14%	14%	4%	10%	34%	31%	78%	57%	48%	78%	21%	13%	14%	18%	21%	11%	34%	15%	45%	19%	60%	32%	58%	33%	32%
	COP19	Attained	APR19	28%	28%	4%	10%	32%	29%	74%	54%	44%	82%	20%	16%	13%	20%	19%	12%	31%	17%	42%	20%	56%	37%	54%	37%	33%
Ngazi	COP17	Scale-up: Stimulation	APR17	63%	33%	31%	22%	36%	34%	31%	30%	66%	41%	233%	98%	259%	306%	124%	198%	85%	135%	68%	78%	77%	75%	64%	56%	84%
	COP18	Attained	APR18	94%	47%	52%	43%	62%	56%	44%	39%	75%	44%	219%	94%	315%	252%	183%	316%	108%	180%	71%	95%	80%	86%	61%	58%	86%
	COP19	Attained	APR19	32%	32%	61%	62%	24%	25%	21%	18%	37%	24%	81%	56%	118%	158%	78%	149%	74%	90%	15%	21%	20%	20%	21%	20%	51%
Rumonge	COP17	Scale-up: Stimulation	APR17	13%	10%	13%	6%	29%	16%	32%	30%	43%	41%	58%	30%	61%	24%	35%	26%	54%	32%	70%	34%	103%	53%	75%	64%	46%
	COP18	Attained	APR18	42%	48%	17%	12%	36%	19%	46%	42%	64%	53%	74%	40%	74%	29%	41%	38%	59%	41%	71%	40%	114%	60%	74%	68%	55%
	COP19	Attained	APR19	42%	48%	17%	12%	34%	18%	44%	40%	58%	58%	69%	45%	68%	31%	38%	42%	55%	47%	66%	44%	100%	63%	69%	70%	49%
Rukwa	COP17	Scale-up: Stimulation	APR17	75%	20%	28%	36%																					

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	Total PLHIV	Expected current on ART (APR FY19)	Additional patients required for 80% ART coverage	Target current on ART (APR FY20) <i>TX_CURR</i>	Newly initiated (APR FY20) <i>TX_NEW</i>	ART Coverage (APR 20)
Optimized Aggressive	52,132	25,782	5,000	38,256	10,398	73%
Sustained	31,955	39,220	N/A	41,623	7,128	130%
Total	84,087	65,002	5,000	79,879	17,526	

APPENDIX B – Budget Profile and Resource Projections

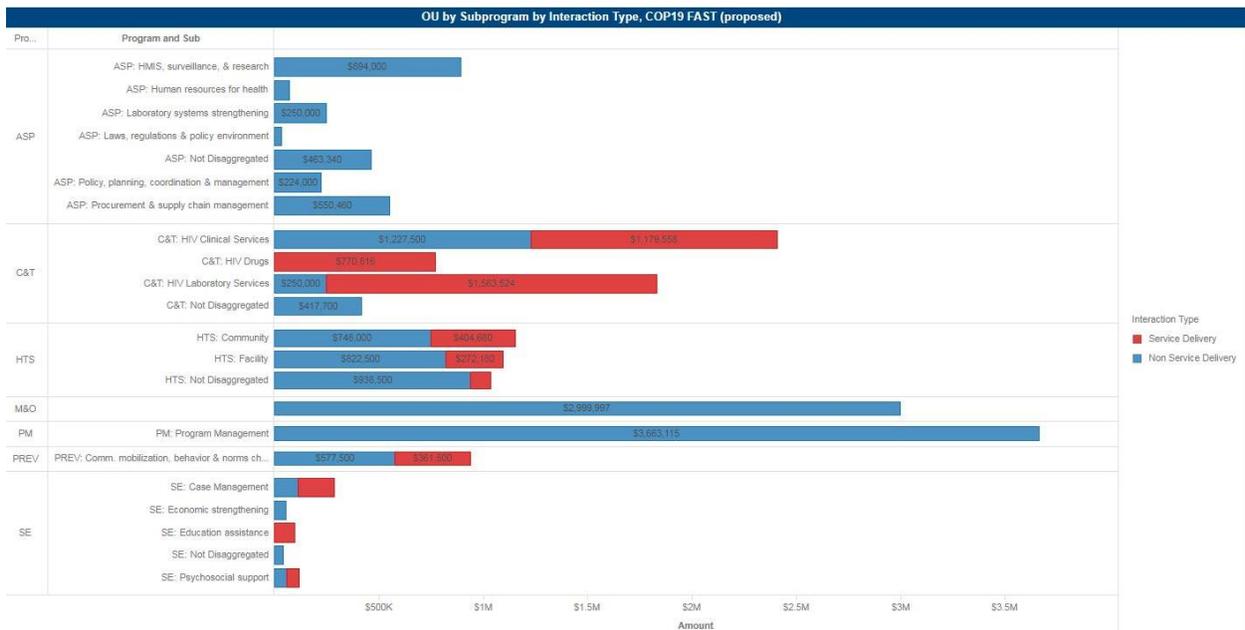


Table B.1.2 COP19 Total Planning Level

Applied Pipeline	New Funding	Total Spend
\$1,590,443	\$17,809,557	\$19,400,000

*Data included in Table B.1.2 should match FACTS Info records, and can be double-checked by running the “Summary of Planned Funding by Agency” report.

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	\$463,234
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	\$0
HVOP	Other Sexual Prevention	\$894,348
IDUP	Injecting and Non-Injecting Drug Use	\$0
HMBL	Blood Safety	\$0
HMIN	Injection Safety	\$0
CIRC	Male Circumcision	\$0
HVCT	Counseling and Testing	\$3,528,523
HBHC	Adult Care and Support	\$343,388
PDCS	Pediatric Care and Support	\$161,727
HKID	Orphans and Vulnerable Children	\$1,508,891
HTXS	Adult Treatment	\$2,448,662
HTXD	ARV Drugs	\$919,593
PDTX	Pediatric Treatment	\$651,494
HVTB	TB/HIV Care	\$109,225
HLAB	Lab	\$2,567,932
HVSI	Strategic Information	\$1,709,786
OHSS	Health Systems Strengthening	\$1,698,141
HVMS	Management and Operations	\$804,613
TOTAL		\$17,809,556

*Data included in Table B.2.2 should match FACTS Info records, and can be double-checked by running the “Summary of Planned Funding by Budget Code” report

B.2 Resource Projections

The resource envelope in COP19 increased when compared to the COP18 envelope, resulting in more new funding for programming. The COP19 Care & Treatment budget is \$5,804,993, which represents nearly 35 percent of the OU's total new money budget. The testing budget for COP19 has increased by more than \$1.1M when compared to COP18 and is also reflective of agreed-upon policy shifts for FY20 implementation. For COP19, Burundi was directed to budget to a higher OVC earmark than in past COPs, with over \$300,000 more allocated to the HKID budget code when compared with COP18 levels. Additionally, PEPFAR successfully allocated budget to meet a new COP19 GBV earmark of nearly \$1M. Of the total OU budget, 91 percent of the funding is allocated to USAID, with the remaining 9 percent to DOD.

Each mechanism was costed out in the FAST by reviewing mechanism-level PEPFAR interventions, deliverables, and budgets from the FY18 work-plans. Activity managers revised COP19 PEPFAR interventions for additional detail or clarity, and a systematic review of the most appropriate program area + beneficiary group combinations were identified for each implementing mechanism. The process of costing out each mechanisms' budget was a collaborative process that involved discussions with each implementing partner providing the USG team with detailed work-plan budgets. Given the resource envelope for COP19, budgets were carried forward by using FY18 as a baseline after which PEPFAR interventions were revised and adjusted by PEPFAR Activity Managers based on agreed-upon shifts in policy and implementation. The PEPFAR team studied the FAST visualizations to ensure budgets were aligned in accordance with targets set in the data pack and according to the overall programmatic strategies for COP19.

APPENDIX C – Tables and Systems Investments for Section 6.0

The Table 6-E tab and SRE Tool-E tab of the Table 6 and SRE Excel workbook should be saved as a PDF and attached here in Appendix C.

The final Excel workbook should be considered a part of the SDS and submitted at the same time.

APPENDIX D– Minimum Program Requirements

The minimum requirements for continued PEPFAR support include:

1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups.

Test and Start has been launched nationally with variable rates of success by district. Test and Start will be fully implemented in PEPFAR-supported provinces in FY19 and will be expanded nationally to all provinces by the end of FY20.

2. Adoption and implementation of differentiated service delivery models, including six-month MMS and delivery models to improve identification and ARV coverage of men and adolescents.

In FY18, MMS was implemented in 17 percent of PEPFAR sites due to NACP concerns of stock-outs. In COP19, PEPFAR Burundi will work with the GOB and GFATM to ensure sufficient ART stocks for the full implementation of MMS and DSD. COP19 orders will be 90-day pill bottles to accelerate MMS. PODIs will be expanded from 17 to 48 districts in FY20.

3. Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine-based regimens (required in COP18).

PEPFAR Burundi is working to transition all eligible patients to TLD by December 2019, including adolescent boys, adult men, and women above the age of 49. PEPFAR Burundi will also participate in national-level discussions on expanding TLD access to women of reproductive age. UNDP is currently working to cancel orders for NVP-based regimes, and NVP will be phased out by late 2019.

4. Scale up of index testing and self-testing, and enhanced pediatric and adolescent case-finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established (required in COP18).

A national index testing policy was approved in November 2018 and a dissemination plan is currently being implemented with the leadership of the NACP and PEPFAR Burundi, including a differentiated geographic testing strategy (high burden and low coverage vs. low burden). Performance-based financing indicators are now aligned to incentivize positive tests. A testing manual is being finalized. Non-targeted testing in legacy provinces will be eliminated.

5. TB preventive treatment (TPT) for all PLHIV must be scaled up as an integral and routine part of the HIV clinical care package (required in COP18).

TPT pilot implementation is in place in a few pilot sites. After a stock out in FY18 and Q1 FY19, INH is back in stock and rapid scale-up of TPT will be implemented in FY19 and FY20 to reach 40 percent of eligible ART clients.

Coordination is taking place with GFATM and a national scale-up plan is being developed with PNILT and NACP.

6. Direct and immediate (>95 percent) linkage of clients from testing to treatment across age, sex, and risk groups.

FY18 data showed linkage to ART initiation at 75 percent for same day and 90 percent within seven days. PEPFAR Burundi is working towards 85 percent linkage by COP19 and rolling out a retention strategy as described in Section 4.

7. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC, TB, and routine clinical services, affecting access to HIV testing and treatment and prevention (required in COP17 and COP18). N/A

8. Completion of viral load/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including >80 percent access to annual viral load testing and reporting.

PEPFAR Burundi, in collaboration with NACP, GFATM, and stakeholders, will be working at the above-service delivery level and at the site-level to complete viral load/EID optimization exercises by the end of COP19 and to develop a QM/CQI system. Further information is detailed in Section 4 and in Appendix C (Table 6).

9. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity (required in COP18).

In COP19, PEPFAR Burundi will initiate the groundwork for establishing case-based surveillance through SIDAInfo. The development of a standalone surveillance system is challenged by weak HMIS infrastructure and sensitivities around the use of biomarkers identification. In COP19, PEPFAR will start tracking mortality and loss to follow up data through the new MER indicator, TX_ML, and can triangulate with Ministry of Health mortality data.

10. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls in high HIV-burden areas, 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV

who require socioeconomic support, including integrated case-management (required in COP17 and COP18).

In COP19, the comprehensive OVC service package will be provided to 9,267 adolescent girls and boys aged nine-17 in seven provinces. A bi-directional referral network will support referral to and from pediatric clinical care and treatment.

11. Evidence of resource commitments by host governments with year after year increases (required in COP14).

The GOB has increased its commitment year to year from 2018 to 2020.

12. Clear evidence of agency progress toward local, indigenous partner prime funding (required in COP18).

PEPFAR Burundi plans to shift at least 30 percent of IMs to local partners by the end of FY20. In COP19, PEPFAR Burundi will award two new local partners, one for GBV and one for OVC.

13. Scale up of unique identifiers for patients across all sites.

There is currently no national identification system due to a lack of political will and of HMIS capacity and infrastructure. Talks have begun with NACP about piloting a unique identifier in COP19. Specifically, NACP is willing to explore the feasibility of a fingerprint ID system on a pilot basis. PEPFAR Burundi is initiating the groundwork for establishing case-based surveillance through SIDAInfo.

Table 6

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
USAID	FHI Developm	ASP: Laws, regulations & policy environment	Key Pops: Not disaggregated	\$ 35,000.00	Information and sensitization for public and government officials	Stigma and discrimination resulting in reduced access to	COP18	COP20	TWG Meeting minutes at least quarterly documenting challenges faced by KPs in
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	\$ 350,460.00	Forecasting, supply chain plan, budget, and implementation	Security and quality of national commodity supply chain management system	COP18	COP19	1. No stock outs and zero expiries; Commodity forecasting matches consumption and reduces risk of stock-outs and expiries 2. Phased implementation of MMS nationally – targets to be determined by
USAID	Chemonics Internatio	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	\$ 200,000.00	Training in supply chain systems	Security and quality of national commodity supply chain	COP18	COP19	90% of health districts roll out and implement LMIS
USAID	Family Health International	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	\$ 250,000.00	Lab quality improvement and assurance	Lab diagnostic access and lab quality	COP18	COP20	1. Achieve 85% VL access (80% VL access in optimized provinces; 90% VL access in legacy provinces); 2. TX_PVLS 95% 3. 10-20% lab samples tested and passed QA standards;
USAID	Family Health International	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	\$ 160,000.00	Clinical guidelines, policies for service delivery	Implementation of the national case finding strategy with fidelity	COP18	COP19	1. Expanded national case-finding strategy implemented with fidelity in at least 12 provinces; 2. Expanded national ART and TB PREV strategy implemented in at least 12 provinces. 3. TB PREV target of 28,992 achieved
USAID	Family Health International	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	\$ 250,000.00	HMIS systems	Limited access to electronic patient record system (SIDA Info) at HIV treatment delivery sites and no link to DHIS2 or LMIS.	COP18	COP19	100% of patients recorded in SIDA Info; SIDA Info exchanging 75% of data with DHIS2; reducing LTFU using TX_ML to limite LTFU to 10%
DOD	Population Services	ASP: Human resources for health	Priority Pops: Military & other uniformed services	\$ 70,000.00	Pre-service training	DOD: Insufficient qualified human resources to provide HIV services	COP18	COP19	Trained 35 military personnel for 7 facilities
DOD	Population Services	ASP: HMIS, surveillance, & research	Priority Pops: Military & other uniformed services	\$ 90,000.00	HMIS systems	DOD: Poor record keeping in military settings and access to	COP19	COP20	Health Information system in use at 7 covered military facilities on bases
USAID	INTRAHEALTH INTERNATIONAL	ASP: Not Disaggregated	Non-Targeted Pop: Not disaggregated	\$ 210,000.00	Service organization and management systems	Lack of local partners impedes local ownership, sustainability, and efficiency of HIV program	COP18	COP20	Local partners achieve identified prime readiness targets by EOFY