United States Department of State

Washington, D.C. 20520

UNCLASSIFIED January 14, 2020

INFORMATION MEMO FOR AMBASSADOR REDDICK, Burundi

FROM: S/GAC – Ambassador Deborah L. Birx, MD

SUBJECT: FY 2020 PEPFAR Planned Country Allocation and Strategic Direction

Dear Ambassador Reddick:

First, I wanted to personally thank you and Deputy Chief of Mission for your dedication to PEPFAR and working every day to achieve the most possible with the United States taxpayers' dollars. The ability to translate these resources into effective and impactful programming has and continues to be core to our collective progress. Your PEPFAR team in country is extraordinary and we are fortunate to witness their passion and compassion. Last year you expanded your work across the country to ensure quality client centered programming.

We are very excited about your progress in:

- Scale-up of effective index testing, with 50% and 75% of HIV positives coming from index testing for males and females respectively in FY19 Q4. As PEPFAR Burundi continues to scale index testing, the team should continue their diligent focus on ensuring that elicited contacts from HIV positive clients are sexual contacts and biological children in order to maintain index testing efficiency.
- Efficiencies introduced into the Key Population (KP) programming resulted in higher yields and HIV positives identified in FY19 than previous years due to efforts directed at identifying those with highest active risk for acquiring HIV and the implementation of new outreach strategies. Linkage to treatment remained high (<96%) for all KP groups. In COP 2020, the PEPFAR Burundi team should introduce PrEP into KP programming.
- Strong partner management resulting in significant changes in the HIV testing program, revision of site tools, and facility staff job aides that have clearly contributed to the results achieved in HIV testing, linkage and treatment.

Together with the Government of Burundi and civil society leadership we have made tremendous progress together. Burundi should be proud of the progress made over the past 16 years of PEPFAR implementation and we are deeply grateful for the ongoing deep coordination with the Global Fund and UNAIDS.

We did want to highlight both overarching issues we see across PEPFAR and a few specific to Burundi. Full details will follow in a more comprehensive letter from your S/GAC Chair and PPM.

Throughout the PEPFAR family of supported countries and communities, five gaps are shared across the globe holding us collectively back from achieving Sustainable Development Goal 3 related to controlling the HIV AIDS epidemic:

1. Continued new HIV infections in adolescents and young women
2. Supporting key populations with prevention and treatment services
3. Ensuring men are diagnosed and treated early (testing positive and new on treatment (linkage surrogate))
4. Ensuring 15-35-year-old asymptomatic clients are maintained on treatment and virally suppressed (net new on treatment and treatment current growth, (retention surrogate))
5. Ensuring all children are diagnosed and are on the best treatment regimens and virally suppressed

Additionally, we have identified several challenges in the Burundi program that should be addressed during FY20 implementation and COP 2020 planning. These are as follows:

- FY19 results show performance issues in the provinces of Bujumbura Mairie and Gitega, especially in HIV testing and identification of positives in Bujumbura Mairie and expanding the current treatment cohort in Gitega. Clear understanding of root causes and solutions need to be discussed during COP 2020 planning and implemented during FY20. Additionally, only one of the six PEPFAR supported provinces showed positive outcomes in retaining its treatment cohort. Overall, results indicate that gains made in enrolling new clients enrolled on ART are lost based on retention issues with the treatment cohort.

- Progress on multi-month dispensing (3+ months) has been limited. Given food security issues in Burundi and the resulting population mobility, it is critical that patients are able to receive a 6-month drug supply. Policy advocacy and negotiation with UNDP, the Global Fund and the Ministry of Health must be prioritized.

- A significant number of sites across the 12 provinces newly receiving PEPFAR support lack health registers and have rudimentary HIV reporting tools. COP 20 discussions should include an implementation plan to introduce electronic health record (SIDAInfo) where feasible, and paper records as a minimum in order to develop confidence in data quality and results reporting.

In a recent Office of Inspector General audit around PEPFAR coordination there were four draft preliminary recommendations based on their discussions with PEPFAR staff in the field from four countries, three of their recommendations are relevant to this Country Operational Plan planning cycle related to target setting, tool development, and timelines. Although we just received the draft report a few days ago we did not want to wait another COP cycle to make substantive changes related to the recommendations. The first was around targets and target-setting and the need for a clear and transparent understanding and dialogue in establishing targets. PEPFAR targets are not PEPFAR's, but flow directly from the UNAIDS Fast Track Strategy of 2016. Since 2016, both the PEPFAR strategy and targets were directly derive from

the global communities of UNAIDS, WHO, and specifically Heads of State in their commitment to SDG 3 and are aligned to support the country's specific ambition towards those goals.

The global community in 2015 through their Heads of State committed to achieving SDG 3.3 by 2030 which for HIV is ending the HIV/AIDS epidemic as a public health threat. This was followed by a United Nations High Level Meeting on HIV/AIDS in June 2016, whereby these Heads of State committed to the 90/90/90 Fast Track Strategy. Essential to the strategy was 73% community viral load suppression (VLS) by 2020 and 86% community VLS by 2030 combined with increased prevention interventions and zero stigma and discrimination to ensure all ages, genders and risk groups have access to life saving prevention and treatment services. Also, in 2016, 22 PEPFAR-supported high HIV burden countries committed to the three Frees of Start Free, Stay Free, AIDS Free with 2020 targets of a decrease in new infections in children to 20,000, 85% of pregnant women on ART, AGYW new infections to < 100,000, 90% of children on ART and 25 million VMMCs. Since 2016 PEPFAR and the GF resources have been focused on achieving these global goals that have been translated to each country by UNAIDS and subsequently supported financially and technically by the PEPFAR family. Since 2016, PEPFAR has utilized these global commitment targets as PEPFAR targets with the commensurate increased funding to countries in 2016, 2017, and 2018 to achieve the goals set out by the Heads of State. Many countries have made tremendous progress towards these targets and others need to accelerate. Burundi is on track to achieve the 2020 and 2030 goals.

Over the past 4 years, PEPFAR resources were allocated based on need, performance, and specifically on the country's and communities' desire to achieve the SDG, Fast Track Strategy, and Three Free goals and country specific targets. Based on the OIG recommendation, S/GAC will take a different approach this year to target-setting. Our collective hope is that together we use this moment of reflection on progress and challenges along with the realization that the end of 2020 is only 11 months away to address these overarching challenges this year through COP 2019 implementation and use COP 2020 to maintain our progress, address any ongoing challenges and finally fund ambition for greater impact. Thus, S/GAC will not assign targets to countries but only provide notional budget levels. After the PEPFAR country team submits their targets the notional budget will then be adjusted to the presented level of ambition. Additional funding is available as ambition funding for treatment.

The PEPFAR Country/Regional Operational Plan (COP/ROP 2020) notional budget is **$18,850,000** inclusive of all new funding accounts and applied pipeline and reflects the following:

1. Sustaining the gains in treatment services based on your projected COP 2019 treatment result (FY2020 treatment current funded in COP19) $14,400,000
    a. The care and treatment budget is determined by all of your FY18 C/T expenditure services and commodities (no RTK commodities), including all aspects of the health system inclusive of human resources, laboratory and systems, commodities (exclusive of RTKs), an upward adjustment from FY19 treatment current to the FY2020 treatment current fully burdened cost of treatment services and commodities, and 100% of partner program management costs and data needs
    b. This Budget is broken down by

   i. Care and Treatment services including partner program management costs, FY2020 upward adjustment, EMR and data with surveillance, recency $11,800,000
   ii. ARV drugs and treatment commodities (everything except RTKs) $1,000,000
   iii. TB preventive treatment $100,000
   iv. For earmark purposes 50% of M/O costs $1,500,000
   v. Care and Treatment qualifies for ambition funds if addresses gap #3-5
2. Continued orphans and vulnerable children
   a. HKID or $1,500,000 dollars for continued historical OVC service
   b. 10% of M/O or $300,000
3. Continued expansion of Key Populations prevention and expansion of PrEP depending on country submitted targets
   a. Key Population (non-treatment) $1,000,000
   b. PrEP total: $200,000
4. RTK and service support to ANC HIV testing $250,000
5. Remaining 40% M/O based on COP19 $1,200,000

Total COP2020 notional budget of $18,850,000 (comprised of $18,802,903 new and $47,097 pipeline).

Teams will develop their own targets across PEPFAR program areas described above, with the treatment current target no less than the result that was to be achieved in COP 2019. Testing support outside of ANC should be consistent with any targets above FY2020 treatment current and be submitted with any ambition funding. Targets reflecting continued and sustained OVC programming. For PrEP, KP programming, and Preventive TB develop targets consistent with the level of budgets.

Again, the team has received a notional budget as noted above and a final budget approval will be contingent on the team's desired targets. As always funding is associated with a performance target that will be achieved with those resources. Targets and the subsequent approved budget should reflect the level of ambition the PEPFAR team in collaboration with the Government of Burundi and civil society of Burundi believes is critical for the country's progress towards controlling the pandemic and maintaining controlling.

Additionally, country teams and specifically agencies independently can request additive ambition funds in the OU FAST to be submitted, based on their stated increased ambition in Treatment with commensurate increased partner level targets. This funding is available to agency partners with the highest performance with evidence that they are addressing the one of the critical gaps outlined above. Budget requests must be consistent with the cost of expanded targets and address one of the gaps in programming #3-5 above. These requests should be discussed with the S/GAC chair and PPM during the January strategy retreat and tentatively approved and be submitted with the DataPack and FAST tool. The final budget and associated country level targets will be discussed and approved during the Johannesburg meeting.

We are hoping this new approach to target-setting and budget will establish an open dialogue on target-setting and empower teams to work with all stakeholders to plan a strategic and impactful COP. The expectation is for country teams and agencies to propose to S/GAC the targets they believe are achievable and feasible and hold their partner's accountable to that achievement. In addition, this new approach to target-setting gives high performing partners and agencies with additional aspirations the opportunity to do more to achieve even greater impact with additional ambition resources.

In the next 48 hours, more detailed descriptions of OU's programmatic successes and challenges will be conveyed to your wider PEPFAR team by the S/GAC Chair and PPM in a phone call, after which the detailed planning level letter will be immediately released.

Again, thank you for your work and we are looking forward to working with you to achieve your Fast Track Strategy and ultimately the SDG 3 goal.

Together we can.

Deborah Birx

United States Department of State

Washington, D.C. 20520

UNCLASSIFIED January 16, 2020

COP 2020 Planning Level Letter | PART 2

INFORMATION MEMO FOR AMBASSADOR EUNICE REDDICK, BURUNDI

SUBJECT: Fiscal Year (FY) 2020 PEPFAR Planned Allocation and Strategic Direction

With input from the field teams through the quarterly POARTS and from Headquarters Country Accountability and Support Teams, we have thoroughly reviewed progress of the program in your country over time and specifically the end of year results of the Country Operational Plan (COP) 2018 and current COP 2019 implementation as we plan for COP 2020. We have noted the following key successes and specific areas of concern:

Key Successes:

- Effective shifts in HIV testing interventions resulting in marked reductions in general HIV testing across all six PEPFAR supported provinces while maintaining or increasing the number of HIV positive persons identified.
- New interventions introduced into the Key Population (KP) programming have resulted in steady increases in HIV positive yields over FY19.
- Positive use of the new TX_ML indicator has allowed the PEPFAR team to begin to identify root causes of retention issues and differences between provinces and begin to immediately consider changes in program design that could be effective in reducing client loss.

Areas of Concern:

- FY19 results shows performance issues in the provinces of Bujumbura Mairie and Gitega, across all indicators but particularly in HIV testing and expanding the treatment cohort in Gitega.
- Transition to the WHO recommended first line ART remains slow. The effort to shift clients from TLE to TLD has been slower than anticipated with delays in updating national ART guidelines; so while 85% of TLD-eligible clients are on TLD, women of reproductive age were not eligible for TLD in FY19. Additionally, progress on multi-month dispensing (MMD 3+ months) has been limited due to concerns of ARV commodity stock sufficiency; the GOB policy on MMD 3+ remains un-implemented.
- With improvements in identifying positives and high linkage rates to treatment, PEPFAR Burundi program results show an on-going problem with client retention in treatment.

SECTION 1: COP 2020 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2019 (EOFY) tool, and performance data, the total COP 2020 planning level is comprised as follows:

TABLE 1: All COP 2020 Funding by Fiscal Year

OU Total	Bilateral				Central	TOTAL
	FY20	FY19	FY17	Unspecified	Unspecified	TOTAL
Total New Funding	$ 18,802,903	$ -	$ -			$ 18,802,903
GHP-State	$ 18,802,903	$ -	$ -			$ 18,802,903
GHP-USAID	$ -	$ -	$ -			$ -
GAP	$ -	$ -	$ -			$ -
Total Applied Pipeline				$ 47,097	$ -	$ 47,097
DOD				$ -	$ -	$ -
HHS/CDC				$ -	$ -	$ -
HHS/HRSA				$ -	$ -	$ -
PC				$ -	$ -	$ -
State				$ -	$ -	$ -
USAID				$ 47,097	$ -	$ 47,097
TOTAL FUNDING	$ 18,802,903	$ -	$ -	$ 47,097	$ -	$ 18,850,000

Note: All pipeline numbers provided and confirmed Agencies and based on agency reported available pipeline from EOFY 2019.

SECTION 2: COP 2020 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS**

PEPFAR Burundi should plan for the full Care and Treatment (C&T) level of $14,400,000 and the full Orphans and Vulnerable Children (OVC) level of $1,800,000 across all funding sources. The earmark levels on new funding are subsets of those amounts that must be programmed with specific types of funding due to Congressional requirements. The full amount programmed across all sources will be visible in the FAST.

TABLE 2: COP 2020 Earmarks by Fiscal Year *

Earmarks	COP 2020 Planning Level			
	FY20	FY19	FY17	Total
C&T	$ 8,000,000	$ -	$ -	**$ 8,000,000**
OVC	$ 1,500,000	$ -	$ -	**$ 1,500,000**
GBV	$ 967,425	$ -	$ -	**$ 967,425**
Water	$ -	$ -	$ -	**$ -**

** Countries should be programming to levels outlined in Part 1 of the COP 2020 Planning Level Letter. These earmark controls above represent the **minimum** amounts that must be programmed in the given appropriation year.*

TABLE 3: All COP 2020 Initiative Controls

	COP 20 Total
Total Funding	**$ 6,500,000**
VMMC	$ -
Cervical Cancer	$ -
DREAMS	$ -
HBCU Tx	$ -
COP 19 Performance	$ 5,000,000
HKID Requirement	$ 1,500,000

***See Appendix 1 for detailed budgetary requirements and other budgetary considerations.*

SECTION 3: PAST PERFORMANCE – COP 2018 Review

Table 4. PEPFAR Burundi FY19 Program Results (COP18) and FY20 Targets (COP19)

Indicator	FY19 result (COP18) 6 provinces	FY20 target (COP19) national
TX Current Adults	41,984	65,078
TX Current Pediatric	1,952	5,785
TB Preventive Therapy	4,241	28,924
TB Treatment of HIV Positive (TX TB)	272	N/A

Table 5. COP 2018 | FY 2019 Agency-level Outlays versus Approved Budget

OU/Agency	Sum of Approved COP/ROP 2018 Planning Level	Sum of Total FY 2019 Outlays	Sum of Over/Under Outlays
OU	$15,000,000	$15,513,610	($513,610)
DOD	$1,520,000	$1,108,307	$411,693
USAID	$13,480,000	$14,405,303	($925,303)

Outlays reported in this letter represent a snapshot in time. With respect to outlays reported as "central" (if/applicable), note those numbers are being included in this format for the first time this year and any reported under/over-outlays may be subject to further adjustments as the process for such funds is refined.

Table 6. COP 2018 | FY 2019 Implementing Partner-level Outlays versus Approved Budget

Mechanism ID	Partner Name	Funding Agency	Approved COP 18 Planning Level	Total Outlays During FY 19	Over/Under FY19 Outlays
70018	Population Services International	DOD	1,400,000	625,799	774,201
0	Management and Operations	USAID	1,028,110	1,409,013	(380,903)
17552	FHI Development 360 LLC	USAID	1,500,000	2,142,514	(642,514)
17521	University of North Carolina at Chapel Hill, Carolina Population Center	USAID	600,000	1,139,727	(539,727)
18419	Centre d'Etudes et de Recherches en Population et Developpement	USAID	110,929	35,929	75,000

Outlays reported in this letter represent a snapshot in time. With respect to outlays reported as "central" (if/applicable), note those numbers are being included in this format for the first time this year and any reported under/over-outlays may be subject to further adjustments as the process for such funds is refined.

Table 7. COP2018 | FY 2019 Results & Expenditures

Agency	Indicator	FY19 Target	FY19 Result	% Achievement	Program Classification	FY19 Expenditure	% Service Delivery
DOD	HTS_TST	18,408	19,573	106%	HTS Program Area	$128,137	100%
	HTS_TST_POS	329	594	181%			
	TX_CURR	2,079	2,595	125%	C&T Program Area	$530,200	100%
	TX_NEW	443	589	133%			
USAID	HTS_TST	443,894	328,473	74%	HTS Program Area	$2,833,231	38%
	HTS_TST_POS	10,406	9,118	88%			
	TX_CURR	49,230	41,341	84%	C&T Program Area	$3,778,015	43%
	TX_NEW	8,789	8,509	97%			
	OVC_SERV	10,037	10,033	100%	OVC Major Beneficiary	$395,454	29%
					Above Site Programs	$1,158,297	
					Program Management	$3,443,864	

COP 2018 | FY 2019 Analysis of Performance

- **Effective shifts in HIV testing interventions** resulting in marked reductions in general HIV testing across all six PEPFAR supported provinces while maintaining or increasing the number of HIV positive persons identified. The efficiency of the testing program has improved dramatically while retaining the effectiveness of identifying persons that need HIV treatment. This change has been accomplished, in part, by the scale-up of index testing, with 50% and 75% of positives coming from index testing for males and females respectively in FY19 Q4 with a continued rise in absolute number of HIV positive persons identified. However, certain provinces still exceeded the testing target with ongoing need to focus testing on case finding through index testing.
- **New interventions introduced into the Key Population (KP) programming** have resulted in steady increases in HIV positive yields over FY19 with significant improvements in the 'reached' to 'HIV tested' ratio particularly among female sex workers. Linkage rates remained high (>96%) for all KP groups.
- **Positive use of the new TX_ML indicator** has allowed the PEPFAR team to begin to identify root causes of retention issues and differences between provinces and begin to immediately consider changes in program design that could be effective in reducing client loss.
- **FY19 results shows performance issues in the provinces of Bujumbura Mairie and Gitega**, across all indicators but particularly in HIV testing and expanding the treatment cohort in Gitega. FY19 is the first time that program results have lagged in Bujumbura

Mairie, and with significant burden of unmet need in Gitega, results remain below targets based on sub-national epidemiological data.

- **Transition to the WHO recommended first line ART remains slow.** The effort to shift clients from TLE to TLD has been slower than anticipated with delays in updating national ART guidelines; so while 85% of TLD-eligible clients are on TLD, women of reproductive age were not eligible for TLD in FY19. Additionally, progress on multi-month dispensing (MMD 3+ months) has been limited due to concerns of ARV commodity stock sufficiency; the GOB policy on MMD 3+ remains un-implemented.
- With improvements in identifying positives and high linkage rates to treatment, **PEPFAR Burundi program results show an on-going problem with client retention in treatment**. With the exception of Kirundo province, the active treatment cohort continues to lose clients thereby slowing progress to achieving the goal of 95% treatment coverage.

Care and Treatment, Case Finding, OVC, Above-Site

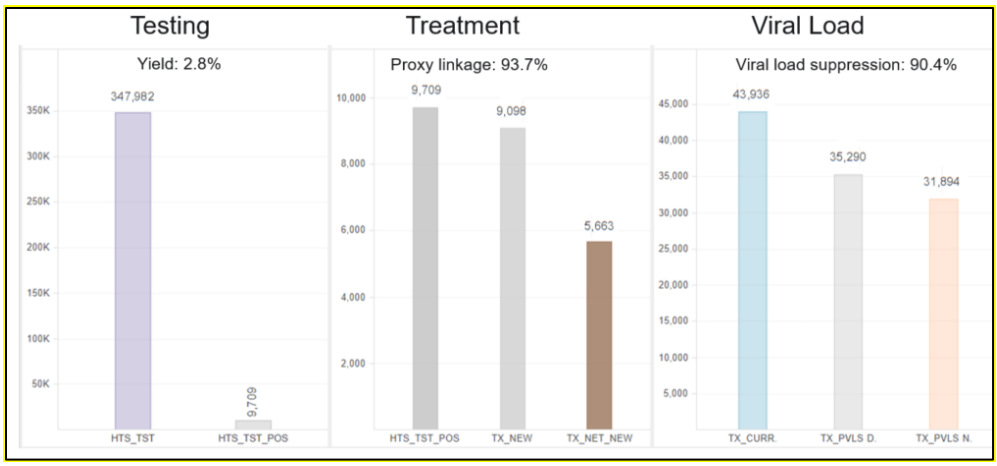
Burundi ART Coverage by Age and Sex

Men aged 15-29 present the most significant challenge for reaching 95% ART coverage along with children and adolescents of both sexes.

	PLHIV Estimates			Current on ART			ART Coverage			Remaining Needing ART		
Age	PLHIV Female	PLHIV Male	PLHIV Total	Current ART Female	Current ART Male	Current ART Total	ART Coverage Female	ART Coverage Male	ART Coverage Total	Remaining Needing ART Female	Remaining Needing ART Male	Remaining Needing ART Total
<01	144	153	297	77	75	152	53%	49%	51%	67	78	145
01-04	963	987	1,950	303	280	583	31%	28%	30%	660	707	1,367
05-09	1,439	1,469	2,908	715	672	1,387	50%	46%	48%	724	797	1,521
10-14	1,642	1,636	3,278	1,054	935	1,989	64%	57%	61%	588	701	1,289
15-19	2,207	1,816	4,023	1,816	1,116	2,932	82%	61%	73%	391	700	1,091
20-24	3,481	2,262	5,743	4,362	1,322	5,684	125%	58%	99%	-881	940	59
25-29	4,298	2,457	6,755	5,847	1,858	7,705	136%	76%	114%	-1,549	599	-950
30-34	5,112	2,642	7,754	6,474	2,430	8,904	127%	92%	115%	-1,362	212	-1,150
35-39	6,603	3,354	9,957	7,846	3,622	11,468	119%	108%	115%	-1,243	-268	-1,511
40-44	7,393	4,147	11,540	6,579	3,335	9,914	89%	80%	86%	814	812	1,626
45-49	6,170	3,907	10,077	6,108	3,544	9,652	99%	91%	96%	62	363	425
50+	10,753	9,052	19,805	10,180	8,824	19,004	95%	97%	96%	573	228	801
<70% 70-80% 80-90% 90%+												

COP18 Overall Performance

Treatment new results were strong as well as linkage proxies, but these results were not carried through to treatment net new results, which were approximately 60% of new treatment enrollment underscoring a challenge of client retention and/or limited understanding of client mobility. Viral load suppression is high, but access to viral load must continue to be prioritized in FY20 and COP20.



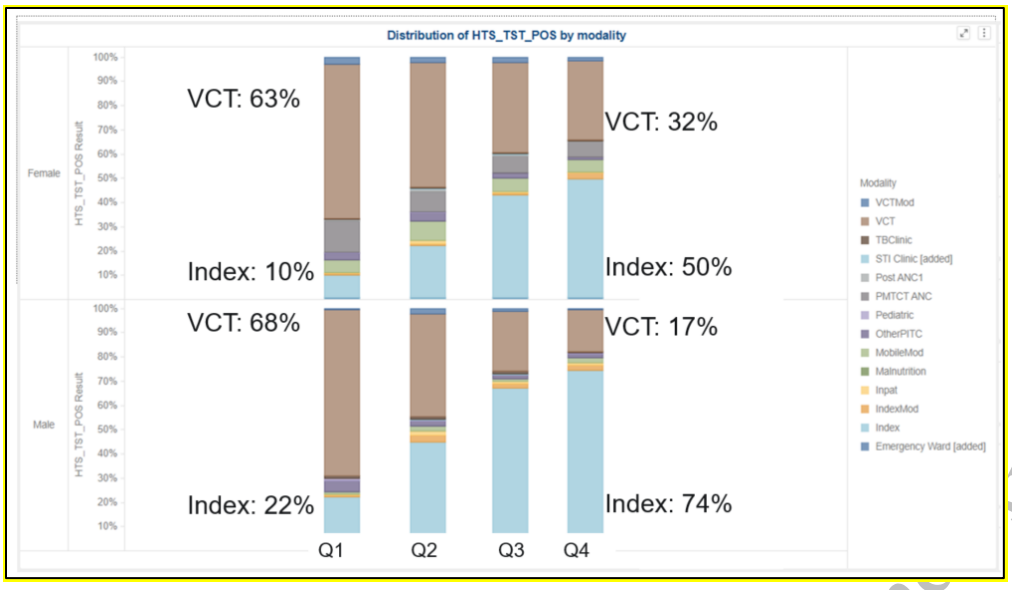
Performance Trends

Overall trends for the PEPFAR Burundi show strong movement in reducing generalized testing. PEPFAR Burundi identified more HIV positive clients in FY19 than in FY18 and achieved the result with a 50% reduction in tests performed between the two fiscal years. However, while the new on treatment result grew from FY18 and the program achieved 98.5% of its targets for this indicator, the current treatment target was not achieved due to client retention challenges.

Indicator	FY17 Cum. Results	FY17 Target	FY17 %	FY18 Cum. Results	FY18 Target	FY18 %	FY19 Cum. Results	FY19 Target	FY19 %
HTS_TST	748,820	449,826	166%	678,339	382,717	177.2%	347,982	462,302	75.3%
HTS_TST_POS	10,792	9,047	119%	8,261	7,648	108.0%	9,709	10,735	90.4%
TX_CURR	35,680	41,111	87%	38,273	44,260	86.5%	43,936	51,309	85.6%
TX_NET_NEW	5,066			2,593			5,663		
TX_NEW	9,314	10,553	88%	7,566	8,067	93.8%	9,098	9,232	98.5%
TX_PVLS (D)	23,811	40,853	58%	26,219	31,247	83.9%	35,290	43,717	80.7%
TX_PVLS (N)	21,264	36,609	58%	23,653	27,763	85.2%	31,894		

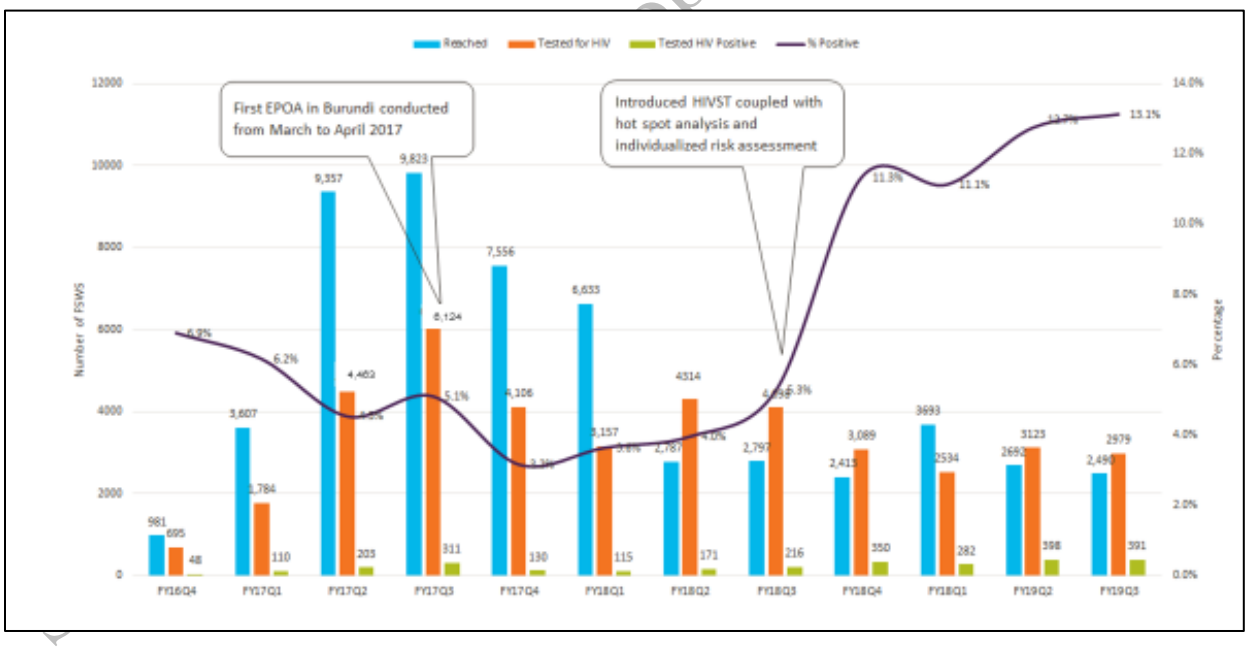
COP 18 Trends – Distribution of positives by testing modality & sex

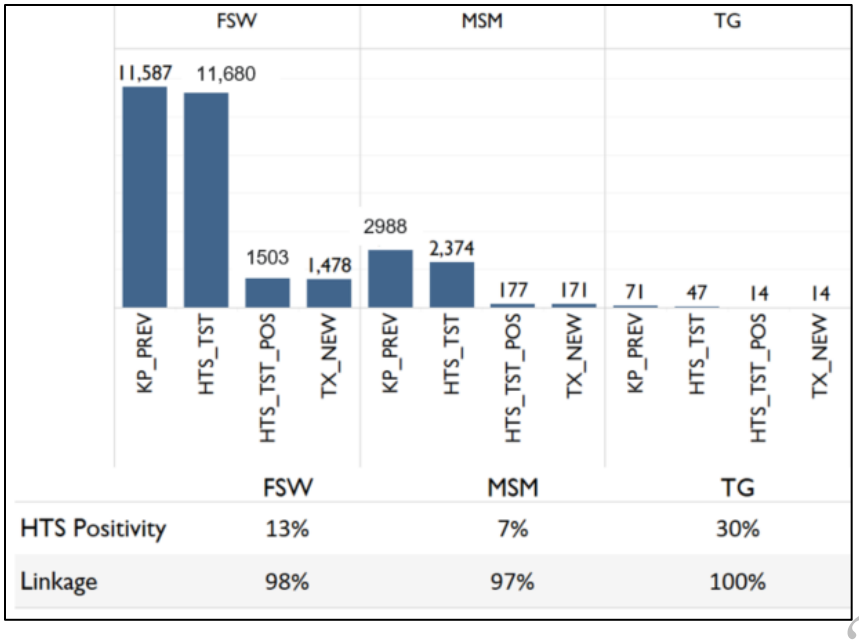
Over the course of FY19, the contribution of index testing to the HIV test positive results grew from 22% to 74% in men and 10% to 50% in women with a similar downward shift in voluntary testing. Partner shifts to case finding strategies resulted in higher yields and HIV positive persons identified and linked to treatment.



COP 18 KP Results

Case finding trends among FSWs changed over FY19 with consistently more HIV testing done versus 'reached' with prevention services and a commensurate rise in yield and more women identified and linked to treatment.





	FSW	MSM	TG
HTS Positivity	13%	7%	30%
Linkage	98%	97%	100%

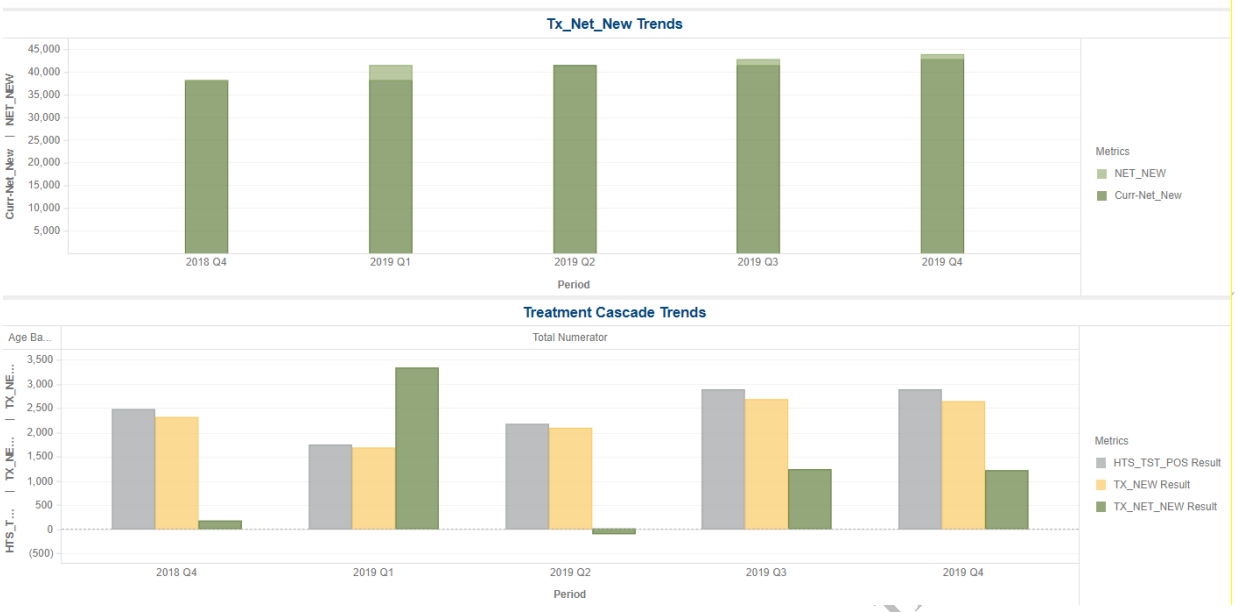
COP 18– TX_CURR Achievement by Province

Gitega and Bujumbura Mairie are the two most HIV burdened provinces in Burundi with sizable transport routes and economic centers; targets were set based on the assumption that there was unmet treatment need and are geographic locations were people would seek services. However, the treatment current results were underwhelming and particularly poor in Gitega.

Province	TX_CURR Target	TX_CURR Result	TX_CURR Achievement
Bujumbura	1,277	1,468	115%
Bujumbura Mairie	22,440	20,832	93%
Gitega	14,083	4,204	30%
Kayanza	4,003	3,451	86%
Kirundo	5,758	7,363	128%
Ngozi	1,669	4,023	241%
Total	**49230**	**41341**	**84%**

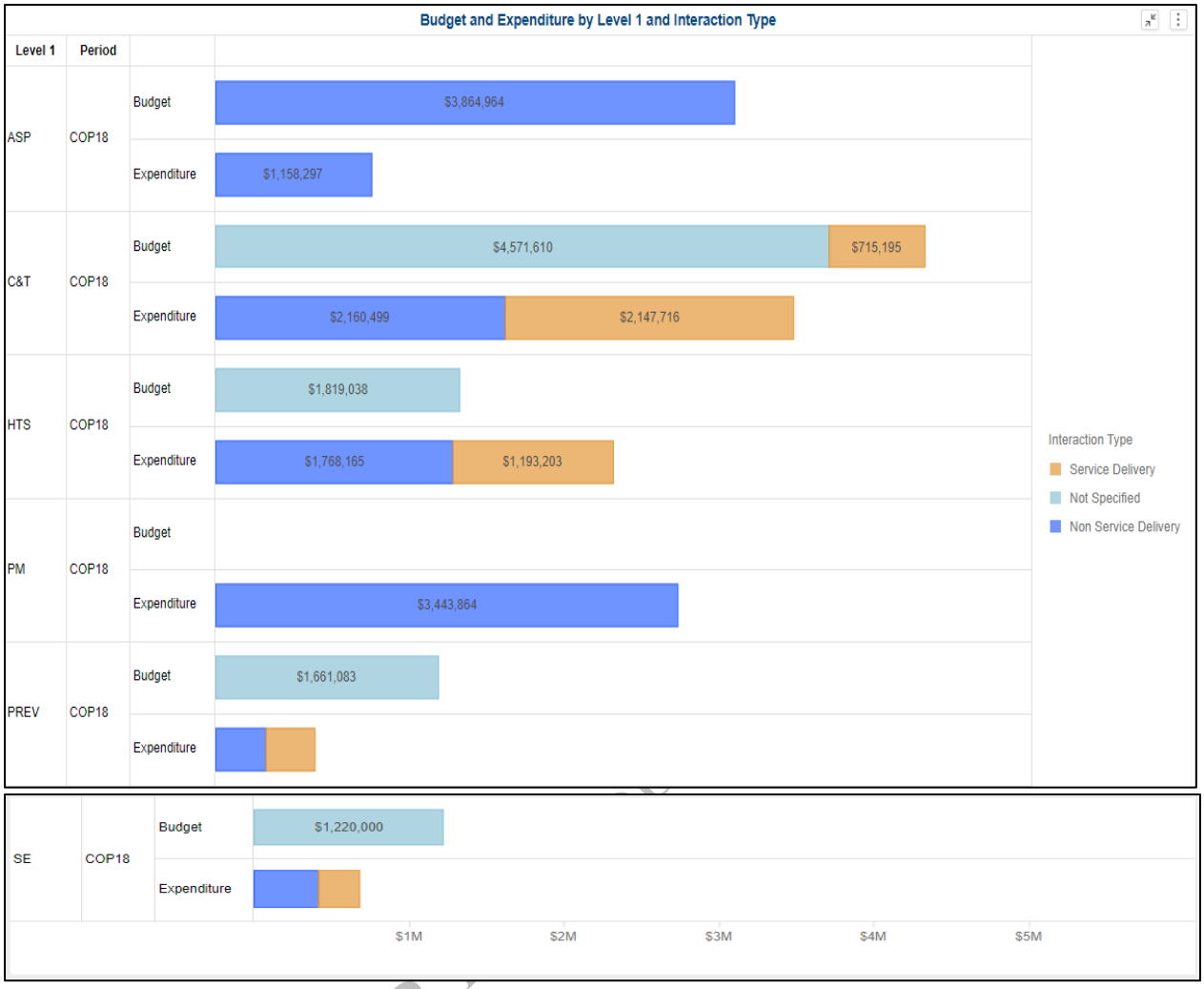
COP 18– TX_NET_NEW Trends

Trends in net new on treatment are complicated by the addition of clients currently enrolled on treatment in Gitega being accounted for within PEPFAR reporting for the first time in FY19. Discounting for those already on ART, Kirundo province and the facilities supported through the US Department of Defense (DoD)/PEPFAR accounted for all the true growth in the current treatment cohort. Retention efforts in Kirundo and the DoD-supported sites must be transferred to other provinces for a national change in client retention to be realized.



COP 18– Budget vs Expenditure by Program

At the country level, there was underspending in above-site programming, care & treatment, prevention, and socio-economic programs. There was overspending in testing programs.



National and Provincial Level Results

- Index testing: Positive growth to >65% of all new positives from index testing modality across all six PEPFAR supported provinces with high yields indicating quality focused testing. Caution to ensure contacts of index cases are sexual contacts or biological children and that the risk of over testing of contacts be mitigated with good partner management.

- Marked reduction in generalized testing from FY18 but retaining the number of new positives identified demonstrates program quality and efficiency. However, at a sub-national level, there were differences between provinces with significant under-testing in Gitega and Bujumbura Mairie and testing targets exceeded in other provinces. The overall yields increased highlighting efficiencies gained, but the OU test positive target was not met.
- ART coverage lags in both sexes under 15 years and in males up to 30 years of age.

- Treatment new targets were not met by Gitega and Bujumbura Mairie and treatment current slowed by poor treatment retention.
- The overall number of persons actively receiving ART has increased in FY19 but at a slower rate of growth than would be expected based on the number of new persons enrolled on ART. This points to a potential problem with persons not retained in treatment and/or problems with client tracking through data systems.
- Viral load coverage was 85% overall for six provinces but results were low for Gitega, Kayanza in particular.

Partner Performance

- Population Services International, funded by DoD, has met their targets and are performing well.
- FHI 360 mechanisms Youth Power and LINKAGES, funded by USAID have met their targets and are performing well.
- FHI 360 mechanism RAFG, funded by USAID, underperformed in the areas of testing and PMTCT. Additionally, there is significant underperformance in the current on treatment cohort in Gitega and Bujumbura Mairie. Recommendations for improved performance are:
    - Disaggregate testing and test positive data by facility and province to determine where index testing should be emphasized to ensure case finding, eliminate excess generalized testing, and ensure test positive targets are achieved in FY20.
    - Standard messaging by ARV providers and ARV dispensing staff on proactively identifying clients that may transfer or move.
    - Increase attention to accurate recording of follow-up of clients with missed appointments, including review of current RAFG register.
    - Develop targets for retention for each facility by age/sex.
    - Weekly tracking of results & high volume facility performance review
    - Monthly district/sub-partner performance meetings & review of facility performance and systems issues and bottlenecks; formulation of remediation plans/process.
    - The PMTCT_EID FY19 targets for less than 2 months were not met. With strong ANC and post-natal care, this is an issue of access to EID testing and sample transportation in a context of low volume testing. Conduct a rapid triangulation of the number of positive pregnant women in a given period of time and by province, projected EID volume and GeneXpert locations to determine areas within provinces that could benefit from POC or near-POC EID.

COP18 Testing Expenditures, Multiple Mechanisms

HTS_TST_POS Achievement and % of HTS Budget Expended by IM Grid

Implementing Mechanism	Period	COP18			
	Prime Partner	HTS Budget	HTS Expenditure	% HTS Budget Expended	HTS_TST_POS % Achievement (with Result)
Total		$1,349,005	$2,299,577	170.46%	90.44%
17552 : LINKAGES	FHI Development 360 LLC	$130,006	$602,576	463.50%	183.35%
18579 : Reaching an AIDS Free Generation (RAFG)	Family Health International	$973,649	$1,568,864	161.13%	75.94%
70018 : 70018 HIV Prevention, Care and Treatment for the Burundi National Defense Forces	Population Services International	$245,350	$128,137	52.23%	180.55%

COP18 Care and Treatment Expenditures, RAFG

Period	Implementing Mechanism	Prime Partner	C&T Budget	C&T Expenditure	% C&T Budget Expended
COP18	18579 : Reaching an AIDS Free Generation (RAFG)	Family Health International	$2,737,864	$2,049,793	74.87%

COP18 TX_CURR Results by Province, RAFG

Province	TX_CURR Target	TX_CURR Result	TX_CURR Achievement
Bujumbura	1,277	1,468	115%
Bujumbura Mairie	22,440	20,832	93%
Gitega	14,083	4,204	30%
Kayanza	4,003	3,451	86%
Kirundo	5,758	7,363	128%
Ngozi	1,669	4,023	241%
Total	**49230**	**41341**	**84%**

COP18 PMTCT Results, RAFG Results

Indicator	Target	Results	Achievement
PMTCT_ART	2,422	2,445	101%
PMTCT_EID 0-2 months	1945	1055	54%
PMTCT_EID 2-12 months	483	503	104%
PMTCT_STAT Coverage	95%	83%	
PMTCT_STAT Yield (PMTCT_STAT_POS/PMTCT_STAT)	1.5%	1.9%	

SECTION 4: COP 2020 DIRECTIVES

The following section has specific directives for COP 2020 based on program performance noted above. Please review each section carefully including the minimum program requirements and specific country directives.

All PEPFAR programs – bilateral, regional, and country pairs – are expected to have the following minimum program requirements in place no later than the beginning of COP 2019 implementation (FY 2020). Adherence to these policies and practices are essential to the success of all PEPFAR programs at the national, subnational, community, and service delivery levels. Evidence demonstrates that lack of any one of these policies/practices significantly undermines progress to reaching epidemic control and results in inefficient and ineffective programs.

For COP 2020, the failure to meet any of these requirements will result in reductions to the PEPFAR Burundi budget. (See Section 2.2. of COP Guidance)

Table 9. COP 2020 (FY 2021) Minimum Program Requirements

	Minimum Program Requirement	Status	Outstanding Issues Hindering Implementation
Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[1]	Fully adopted and implemented across all age, sex and risk groups; linkage to treatment >95%	
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing >30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all	As of December 2019, national TLD policy includes women of reproductive age; 85% of eligible HIV treatment cohort had transitioned to TLD but representing predominately male clients. NVP regimes still in use (small	Transition plan to TLD not yet updated and implemented. Provider misinformation about stability (undetectable VL requirement) – detectable VL on NVP regimen seen as reason not to transition to TLD

[1] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015

	nevirapine-based regimens.[2]	numbers) in part due to the incomplete TLD transition.	
	3. Adoption and implementation of differentiated service delivery models, including six-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[3]	Limited implementation of MMD; stalled quantification and procurement	Confirmed ARV shortfalls projected by early 2020. Lack of GOB concurrence and guidance on using MMD as a program quality tool.
	4. All eligible PLHIV, including children, should have been offered TB preventive treatment (TPT) by end of COP20; cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[4]	Near 100% HIV positive clients screened for TB with 1.2% positivity; INH provided universally; TPT completion rates improving over FY19 but only to ~74% with low rates among newly enrolled on ART. TPT for children is not yet implemented at site-level.	TPT completion rates may improve with newer, shorter course TPT treatment – lack of budget funds. Lack of sufficient coordination between PNLS, PNLIT and UNDP (as the lead procurement partner) on quantification needs; Delays in procuring sufficient quantities of INH"
	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and	VL coverage within the 6 PEPFAR supported provinces is 85% with >90% suppression; focus will move to ensuring access in 12 'newly' PEPFAR supported provinces TB testing is near 100% for the HIV treatment cohort.	

[2] Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019
[3] Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016
[4] Latent Tuberculosis infection: Updated and consolidated guidelines for programmatic management. Geneva: World Health Organization, 2018

	results delivered to caregiver within 4 weeks.		
Case Finding	6. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5]	Rapid scale up of index testing across all populations in in place with upwards to 75% of HIV positives identified through index testing.	
Prevention and OVC	7. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)[6]	PrEP is not yet part of the prevention program and will be integrated in COP20.	
	8. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on:	OVC services aligned geographically with most burdened areas and with a focus on a comprehensive package of services; 76% of OVCs supported with known HIV status; majority of cohort in OVC program >10yo.	

[5] Guidelines on HIV self-testing and partner notification. Supplement to consolidated guidelines on HIV testing services. Geneva: World Health Organization, 2016 https://www.who.int/hiv/pub/self-testing/hiv-self-testing-guidelines/en/

[6] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015 (http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en).

	1) actively facilitating testing for all children at risk of HIV infection, 2) providing support and case management for vulnerable children and adolescents living with HIV 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.		
Policy & Public Health Systems Support	9. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[7]	No user fees applied	
	10. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[8]	Evidence that CQI is active among partners with clear improvements in many areas as seen in program data; new registers for tracking lost to follow-up and MMD shows a focus on quality assurance; SIMS visits now activated through third party contractor evidence of measuring against site standards	Small USG team prevents a robust number of CQI visits.

[7] The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care. Geneva: World Health Organization, December 2005

[8] Technical Brief: Maintaining and improving Quality of Care within HIV Clinical Services. Geneva: WHO, July 2019

	11. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	In progress – health facilities display and utilizing education visuals. CSO treatment providers leading on health care worker – client interaction to reduce stigma; facilities identified in urban areas that are trained specifically to interface effectively with KPs	VL access remains low in 12 provinces where PEPFAR has not provided support prior to FY20. Scaling access to VL with is a necessary part of improving VL literacy in these areas. Absence of strong campaign to promote U=U for VL demand creation and stigma reduction.
	12. Clear evidence of agency progress toward local, indigenous partner prime funding.	Multiple new awards to local partners in process	
	13. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	Progress not realized; ART procurement commitments in FY19 not met.	Fiscal space in small for health spending; economic health weakened.
	14. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Monitoring for morbidity and mortality began in FY19 with the TX_ML indicator and assessments of the current treatment cohort.	Vital registries in Burundi are not well developed presenting challenges for documenting morbidity and causes.
	15. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	Scale up use of and off-line module of SIDA-Info in active development as a step in use of unique identifiers for ART cohort	Information security considerations and patient privacy must be addressed while transitioning to an EMR system integrating Unique Identifiers.

In addition to meeting the minimum requirements outlined above, it is expected that Burundi will continue and accelerate efforts in the following areas.

Table 10. COP 2020 (FY 2021) Technical Directives

OU –Specific Directives
HIV Treatment
1. Commodity volumes supplied to sites: improve commodity security with UNDP to implement 6 month MMD; improve commodity quantification to increase confidence in supplies and use.
2. Line list NVP clients in each facility to track their timely transition to TLD; transition all men immediately to TLD.
3. Standard messaging by ARV providers and ARV dispensing staff on pro-actively identifying clients that may transfer to TLD and shift to MMD.
4. Increase attention to accurate recording of follow-up of clients with missed appointments; disaggregate analysis of clients lost by province, age and sex.
5. GoB circular on TLD including clear guidance on when a viral load test should and can be done as part of the TLD transition guidelines.
6. Update prevention and treatment job aides with new policies and/or guidance and post clearly in facilities.
7. Develop or adapt a quick referral for Enhanced Adherence Counseling for adolescents due to sub-optimal viral load suppression in this age category.
8. Continue to scale up TB Preventive Therapy, especially among those new on ART.
HIV Prevention
1. Introduce PrEP through Key Populations programs and other programs as appropriate.
Lab Support
1. Scale access to VL testing in 12 newly supported PEPFAR provinces; implement the VL Sample Transportation National Implementation plan.
2. Collaboration with partners and MoH to determine strategy for reagent rental agreements inclusive of maintenance support for lab instrumentation with replacement of holder VL equipment to avoid purchase of equipment; determine optimal means of replacing non-WHO prequalified instruments.
3. Accelerate planning for launch of recency testing to ensure implementation in FY20.
Other Government Policy or Programming Changes Needed
1. HIS: Required health registers at all sites. SIDAInfo should be implemented when feasible, but paper registers at minimum should be provided to sites with limited documentation.

COP 2020 Technical Priorities

Client and Family Centered Treatment Services

COP 2020 planning must specifically and thoroughly address the challenge of interrupted antiretroviral treatment and client loss, especially among young adults. Maintaining epidemic control, as measured by the proportion of PLHIV with viral suppression, will require long-term, continuous ART for a population that is often young and asymptomatic— and for whom HIV treatment is easily interrupted by drug side effects, inconvenience, lack of time, poor customer service, stigma and discrimination, or life circumstances. Maintaining long-term viral suppression necessitates planning and implementing services that are convenient and fit the lives of the clients, and make it easy for patients on ART to continue treatment. PEPFAR requires development and full implementation of key client-centered policies and practices at the site-level, including optimized treatment (dolutegravir-based therapy) and multi-month dispensing, convenient ARV pick-up arrangements, and community and client participation in design and evaluation of services. Burundi's must ensure 100% "known HIV status" for biological children of TX_CURR clients (15+), including chart review and retrospective elicitation of eligible biological children.

Community-led Monitoring

In COP 20, all PEPFAR programs are required to develop and support and fund a community-led monitoring activity through State Department Ambassador's small grants in close collaboration with independent, local civil society organizations and host country governments. Collaboration with community groups, civil society organizations and patients/beneficiaries can help PEPFAR programs and health institutions diagnose and pinpoint persistent problems, challenges, and barriers to effective service and client outcomes at the site level. Note: In Embassies where a small grants program does not exist, other mechanisms may be discussed.

Pre-Exposure Prophylaxis (PrEP)

Groups to be prioritized for PrEP include those testing negative in index testing but remaining at increased risk of HIV acquisition by virtue of unprotected exposure to a PLHIV with unsuppressed viral load, key populations including sex workers, men who have sex with men, transgender persons, people who use drugs, adolescent girls and young women, including pregnant and breastfeeding women, in areas with high HIV incidence or with high risk partners, and other identified serodiscordant couples. (Groups will be tailored to country context).

TB Preventive Treatment (TPT)

TPT is considered routine HIV care, and all country programs must have offered TPT to all PLHIV on treatment by the end of COP20; targets have been set accordingly. Countries should budget for full coverage, and plan to use optimal regimens (3-HP) as supply allows.

OVC

To support the Minimum Program Requirement described above, in COP20 clinical sites and OVC implementing partners should jointly develop formal relationships, such as a memoranda of understanding (MOU), outlining the roles and responsibilities of each member of the multi-disciplinary care team and addressing key issues such as bi-directional referral protocols, case conferencing, shared confidentiality, and joint case identification. PEPFAR-supported treatment

clinicians should play a key role in training OVC community case workers to build their knowledge in areas such as adherence, retention, and disclosure. In COP20, OVC and clinical implementing partners in Burundi must work together to ensure that 90% or more of children and adolescents on ART with PEPFAR support in OVC provinces are offered the opportunity to enroll in the comprehensive OVC program. Additionally, 95% or higher of OVC should have a known HIV status, and 95% or higher of OVC living with HIV should be on ART.

PLHIV Stigma Index 2.0

PEPFAR teams are required to either fund host country PLHIV network-led implementation of the revised Stigma Index 2.0 or complement Global Fund or other donors financing implementation of the Stigma Index 2.0, if it has not already been implemented in the OU. This revised U.S. government compliant version can begin the process of baseline data collection for evaluating the future impact of interventions on reducing stigma and can inform future HIV program planning. If the revised Stigma Index 2.0 has not been previously conducted in the OU, then PEPFAR teams must work with UNAIDS, Global Fund or other donors to ensure its implementation during COP 20, whether supported by PEPFAR or other resources.

COP 2020 Stakeholder Engagement (see section 2.5.3 of COP Guidance)

Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional and international civil society and community stakeholders, multilateral partners and the host country government. With your leadership, PEPFAR is leading the way in facilitating transparent processes and in sharing data and results. Continued meaningful engagement with these groups throughout the development and implementation of COP 2020 remains a requirement for all PEPFAR programs, and as such the COP 2020 process will engage with stakeholders early and frequently. This engagement specifically includes the sharing of FY 2019 Q4 and FY 2019 APR results and analyses and the convening of an in-country planning retreat with local stakeholders during the last two weeks of January 2020 in order to introduce and discuss all COP 2020 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP 2020. It is critical that meaningful involvement of civil society and community input is solicited and incorporated in every step of the process. In alignment with sustained control of the epidemic, the intentional outreach and inclusion throughout this process of civil society and community organizations that directly work with key and priority populations should be a priority of the PEPFAR field team. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund New Funding requests with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In February and March 2020, PEPFAR will convene in-person meetings in Johannesburg, South Africa, Bangkok, Thailand, and Atlanta, GA where outstanding decisions will be discussed and finalized. In addition to host-country representatives, the meetings will also include representatives from local and international civil society and community organizations and multilateral partners. Specific guidance for the 2020 meeting delegations have been provided elsewhere. Engagement with all stakeholders is required beyond the meetings and throughout the COP 2020 development and finalization process. As in COP 2019, the draft Strategic

Direction Summary (SDS) and Data Pack are required to be shared with stakeholders for their input and comments at least 72 hours prior to submission of these materials to the Embassy Front Office. Please refer to the COP 2020 Guidance for a full list of requirements and engagement timelines.

APPENDIX 1: Detailed Budgetary Requirements

Table 11: New Funding Detailed Initiative Controls

	COP 2020 Planning Level			
	FY20			COP 20 Total
	GHP-State	GHP-USAID	GAP	
Total New Funding	$ 18,802,903	$ -	$ -	$ 18,802,903
GHP-State (base)	$ 12,302,903			$ 12,302,903
COP19 Performance	$ 5,000,000			$ 5,000,000
HKID Requirement ++	$ 1,500,000			$ 1,500,000

++DREAMS countries with GHP-USAID funding can use FY20 GHP-USAID funding to meet their FY20 HKID Requirement. These countries include: Kenya; Nigeria; South Africa; Tanzania; Uganda; and Zambia

Care and Treatment: If there is no adjustment to the COP 2020 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment amount from Part 1 of the planning level letter across all funding sources. Additionally, due to Congressional earmarks, some of the care and treatment requirement must be programmed from specific funding sources, as indicated above in Table 2. Your care and treatment requirement for the purposes of Congressional earmarks is calculated as the sum of total new FY 2020 funding programmed to the HTXS, HTXD, HVTB, HBHC, PDTX, PDCS, HLAB budget codes, 80% of the total funding programmed to the MTCT budget code, and 50% of the total funding programmed to the HVCT budget code.

Orphans and Vulnerable Children (OVC): Countries must program to the full OVC amount from Part 1 of the planning across all funding sources. Your OVC requirement is made up of the HKID Requirement (see details below) and 85% of the DREAMS non-HKID programmed funds for all new FY 2020 funds. Additionally, due to Congressional earmarks, some of the OVC requirement must be programmed from specific funding sources, as indicated above in Table 2. The COP 2020 planned level of new funds for the OVC earmark can be above this amount; however, it cannot fall below it.

HKID Requirement: OU's COP 2020 minimum requirement for the HKID budget code is reflected in Table 3 and is a subset of the OVC earmark. Your COP 2020 HKID requirement is derived based upon the approved COP 2019 HKID level inclusive of OVC and prevention intervention for children under 19 budget codes. The COP 2020 planned level of new funds for HKID can be above this amount; however, it cannot fall below it.

Gender Based Violence (GBV): OU's COP 2020 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total ***new FY 2020***

funding programmed to the GBV cross-cutting code. Your COP 2020 earmark is derived by using the final COP 2019 GBV earmark allocation as a baseline. The COP 2020 planned level of new FY 2020 funds for GBV can be above this amount; however, it cannot fall below it.

Water: OU's COP 2020 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total ***new FY 2020 funding*** *programmed to the water cross-cutting code. Your COP 2020 earmark is derived by using the final COP 2019 water earmark allocation as a baseline. The COP 2020 planned level of new FY 2020 funds for water can be above this amount; however, it cannot fall below it.*

Transitioning HIV Services to Local Partners: To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs. PEPFAR has set a 70% goal ***by agency*** *by the end of FY20 and must meet 40% by FY19. Each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services. Therefore, each OU agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY20 as appropriate through their COP 2019 submission.*

COP 2020 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)

All agencies in Burundi should hold a 3 month pipeline at the end of COP 2020 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. Any agency that anticipates ending COP 2019 implementation (end of FY 2020) with a pipeline in excess of 3 months is required to apply this excessive pipeline to COP 2020, decreasing the new funding amount to stay within the planning level.