United States Department of State

Washington, D.C. 20520

UNCLASSIFIED January 13th, 2021

INFORMATION MEMO FOR Ambassador Eunice Reddick, Burundi

FROM: S/GAC – Chair Julia Martin and PEPFAR Program Manager Pooja Vinayak

THROUGH: Ambassador Deborah L. Birx, MD

SUBJECT: Fiscal Year (FY) 2021 PEPFAR Planned Allocation and Strategic Direction

Dear Ambassador Reddick,

I sincerely hope that this note finds you and your team well, safe, and healthy. We are grateful for your leadership protecting staff through this difficult time.

This year has brought unprecedented challenges with the COVID-19 pandemic impacting the entire global community. Despite obstacles faced, what has remained unwavering is the tireless commitment and incredible resiliency of our PEPFAR program, partners, and team across the over 50 countries in which we work. This includes rapid program adaptations, emerging innovations, and client-centered solutions to ensure continuity of HIV services. As the threat of COVID-19 has impacted PEPFAR countries, PEPFAR country teams and programs have proven to be focused and resilient in the face of dual pandemics of HIV and COVID-19.

PEPFAR implementation over the past year has shown tremendous effort to maintain clients on treatment, initiating and accelerating client centered service delivery adaptations, while doing what was possible in HIV prevention programs deeply affected by COVID-19 shutdowns. Themes emerged across all of PEPFAR-supported countries. As the economic impact of COVID continues to be seen at both national and community levels, it is more important than ever to use granular data and expand what is working in specific SNUs for viral load coverage and suppression. We saw differential progress in this area independent of the impact of COVID19. Focus on and deep analytics of clients returning to care to ensure we are addressing the critical, persistent and new structural barriers will remain essential. Focusing on recent treatment interruption to understand how COVID may have created or exacerbated barriers to access and treatment continuity is essential. Across all countries we see persistent gaps in pediatric diagnosis, treatment and viral suppression. Particular attention should be paid to the pediatric cascade and identifying challenges by district and country for clear and actionable plans. In addition, leverage OVC, DREAMS and other resources for clear accountability to work with mothers and improve early infant diagnosis by two months of age and strengthen resiliency among at-risk women and girls. Community-led monitoring must raise visibility and appropriate response to the needs of populations already vulnerable before COVID. The assessment of needs, and strategies to reinforce OVC caregivers and HIV-affected families in crisis should contribute to budget and activity planning for care and treatment, DREAMS, OVC and wraparound resources. Careful analysis of expenditures at mechanism and program areas level, along with a focus on continuing to build relationships and co-planning with your partner government, the Global Fund, UN organizations and other donors will enable optimal use of resources. These relationships and planning efforts are critical to supply chain stability for key commodities as well as understanding COVID relief and other potential funding available in country to ensure most effective and efficient use of PEPFAR's contributions to the national HIV response in COP21.

We understand that specific programs will have carryover and others may not; these unused funds will be critical to ensure stabilization and expansion of critical prevention programming.

The COVID pandemic also laid bare the depth and breadth of inequities still across the globe and clear evidence that when constrained, Ministries of Health and governments make choices that differentially impact specific programming areas and specific populations. The pandemic revealed vulnerabilities in our non-public sector community efforts that we knew were present, and are now fully exposed, as these specific activities were the first to be dropped. Communities of women and children, and key populations including men who have sex with men, transgender individuals, sex workers, people who inject drugs, and people in prisons and other closed settings are not being adequately and sustainably supported by public-sector mechanisms. We have lost ground in all of our prevention services for all populations and for our most vulnerable and marginalized populations and must make every effort to recover.

Despite the disruptions caused by the COVID-19 pandemic, a number of countries have shown a level of resiliency were achieving epidemic control of HIV, and others are on the brink of epidemic control. With continued implementation, most PEPFAR countries are on a path to achieving program coverage goals. With that in mind, PEPFAR programs should focus on four key themes as we approach Country Operational Plan 2021 planning and implementation: advancing client-centered services; engaging with communities; implementing resilient and adaptive approaches; and supporting capacities for sustainable epidemic control.

We commend you and your team for your attention to the adoption and implementation of the public health policies that have the greatest impact on HIV, particularly as these very policies are critical to ensuring sustained HIV services during COVID-19. Also, we appreciate your role in supporting PEPFAR teams through this challenging period, and continuing to hold implementing partners accountable for their performance.

We are grateful to your incredible PEPFAR team in country, working together across agencies to ensure the most effective and efficient use of U.S. taxpayer dollars. We know there are strengths and weaknesses across the board and across the implementing agencies; and we look forward to working together to support those strengths and address those challenges.

We are very excited about your progress in:

- Expanding PEPFAR program support from 6 to all 18 provinces in Burundi through prioritizing high HIV burden facilities across the country and working with district health leadership teams as an integral part of the expansion. By supporting the government district health team structure, PEPFAR Burundi is investing in a sustainable model for the delivery of quality prevention and care.
- Rolling out national 3-5 multi-month dispensing of ARVs for adults and children, as well as expanding TLD national guidelines to include women of childbearing age. The accelerated pace of these policy changes has enabled a more simplified approach to HIV treatment that is client-centered.
- Launching and scaling community-based and led health delivery platforms to improve continuity of HIV treatment and adherence. The ‘PODI’ model of community ART delivery in homes and village gathering points and the OVC platform focus on enrolling HIV positive children with 100% of enrollees on treatment are important factors in ensuring >95% viral load suppression in all age bands.

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 18 years of PEPFAR implementation and we are deeply grateful for the ongoing deep coordination with the Global Fund and UNAIDS.

As you will see in COP guidance this year, there are no substantial changes in program direction. While assessing possible deficits in programming arising from COVID-19 our fundamental challenges continue and we again highlight 5 overarching issues we see across PEPFAR.

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. Ensuing all children are diagnosed and are on the best treatment regimens and virally suppressed

Moreover, we note the following specific key challenges in PEPFAR Burundi:

- Persistent issues in ensuring continuity of treatment of clients across all age/sex groups. In the 6 legacy provinces, there was client treatment loss suggesting that a focus on sustaining quality health care delivery with less intensive PEPFAR partner oversight is needed, and for expansion provinces that rudimentary client retention strategies must be implemented at an accelerated pace to avert further client loss.
- Difficulty with case finding specifically in Gitega province where epidemiological modeling indicates significant unmet treatment need. Reconsideration of geographic targeting based on transport routes and specific high-throughput facilities should direct index testing efforts.
- Commodity security – particularly laboratory reagents – has affected clinic operations and presents a risk to the further expansion of viral load and EID access

A fuller set of details, including funding earmarks and specific program direction are included in the accompanying COP/ROP 21 PEPFAR Planned Allocation and Strategic Direction Summary

Consistent with the approach from last year, PEPFAR teams will once again be responsible for setting their targets in consultation with stakeholders. Teams should bear in mind that PEPFAR targets are not PEPFAR's but flow directly from the partner country government's commitment to the UNAIDS and SDG 3 goals. Since 2016 PEPFAR and the Global Fund 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 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 did not fully achieve its FY20 goals but is on track to achieve 2030 goals early; sustaining the amazing gains will need to be our constant focus.

S/GAC will not assign targets to countries, but only provide notional budget levels sufficient to achieve the full SDG goal and sustain gains made. **Teams will develop their own targets across PEPFAR program areas, with the treatment current target no less than the result that was to be achieved in**

COP 2020. After the PEPFAR country team submits their COP 21 targets, the notional budget will then be adjusted to the presented level of ambition.

The PEPFAR Country/Regional Operational Plan (COP/ROP 2021) notional budget for Burundi is **$30,400,000** inclusive of all new funding accounts and applied pipeline. All earmarks and program direction provided below must be met. 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 control.

We are hoping this 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.

PEPFAR, with partner governments, multilateral partners, and communities, continues to move rapidly toward control of the HIV pandemic and plan for sustainability of programs. Achieving epidemic control for HIV will be a remarkable accomplishment, saving millions of lives, significantly lowering the burden of HIV/AIDS in countries and communities, reducing the future costs required to sustain the HIV response, and building sustainable public health systems capacity in host countries.

Please note that within the next few days our PEPFAR Chairs and PEPFAR Program Managers (PPMs), working closely with our CAST teams, will plan to review this planning letter and details contained, herein, with your wider PEPFAR country team. Where PEPFAR successfully navigated disruption due to COVID-19 during 2020, it was a result of strong teams, local partners, communities, dedicated health and community workers, leveraging longstanding capacities and platforms established by PEPFAR. Our teams, partners, and communities worked together to adapt and further innovate program implementation and models of service delivery so that the adverse impacts of a dual pandemic threat on essential HIV services were mitigated. Stakeholder engagement is essential for a productive and impactful planning process. Included in this planning letter is an outline of the expectations for engaging key stakeholders and civil society, as we continue to finalize our approach to hosting a virtual 2021 COP planning and approval process.

I am so grateful to you and your entire team for your leadership and engagement in the planning, review and implementation of the President's Emergency Plan for AIDS Relief (PEPFAR) program, along with the community and Government to enhance PEPFAR's program impact.

Sincerely,

Deborah Birx

Attachment: **Fiscal Year (FY) 2021 PEPFAR Planned Allocation and Strategic Direction Summary.**

CC: **S/GAC – Chair and PPM, Julia Martin and Pooja Vinayak**

Overview: Fiscal Year (FY) 2021 PEPFAR Planned Allocation and Strategic Direction

With input from the field teams through the quarterly POARTs, the agency self-assessments and from Headquarters Country Accountability and Support Teams (CAST), a thorough program review of your country over time has been conducted. This includes the end of year results of the Country Operational Plan (COP) 2019 and current COP 2020 implementation as we plan for COP 2021. We have noted the following key successes and challenges:

Successes:

1. Expanding PEPFAR program support from 6 to all 18 provinces in Burundi through prioritizing high HIV burden facilities across the country and working with district health leadership teams as an integral part of the expansion. By supporting the government district health team structure, PEPFAR Burundi is investing in a sustainable model for the delivery of quality prevention and care.
2. Rolling out national 3-5 multi-month dispensing of ARVs for adults and children, as well as expanding TLD national guidelines to include women of childbearing age. The accelerated pace of these policy changes has enabled a more simplified approach to HIV treatment that is client-centered.
3. Launching and scaling community-based and led health delivery platforms to improve continuity of HIV treatment and adherence. The 'PODI' model of community ART delivery in homes and village gathering points and the OVC platform focus on enrolling HIV positive children with 100% of enrollees on treatment are important factors in ensuring >95% viral load suppression in all age bands.

Challenges:

1. Persistent issues in ensuring continuity of treatment of clients across all age/sex groups. In the 6 legacy provinces, there was client treatment loss suggesting that a focus on how to sustain quality health care delivery with less intensive PEPFAR partner oversight is needed, and for expansion provinces that rudimentary client retention strategies must be implemented at an accelerated pace to avert further client loss.
2. Difficulty with case finding specifically in Gitega province where epidemiological modeling indicates significant unmet treatment need. Reconsideration of geographic targeting based on transport routes and specific high-throughput facilities should direct index testing efforts.
3. Commodity security – particularly laboratory reagents – has affected clinic operations and presents a risk to the further expansion of viral load and EID access

Given Burundi's status of near achievement of epidemic control, the following priority strategic changes and/or enhancements are recommended:

1. Routinize index testing as the main modality for case finding in all provinces. This will entail working to ensure that those provinces with less experience become experts in index testing implementation. Case finding will be essential to both closing the small treatment gaps remaining in specific age bands, and an efficient strategy to maintaining epidemic control.
2. Use the ANC, OVC and sex worker key population platforms to find positive children not yet in care. Use community structures to identify at-risk women and children and provide testing opportunities.
3. Build on success of 3-month MMD roll-out by expanding to 6-month MMD. Consider selecting specific provinces with stronger district health leadership teams and experienced facilities to shift to 6-month dispensing.

4. Continue to scale the PODI model and biometric-based Unique Identifier (UID) system to address challenges with continuity of treatment. Use the PODI model as a central strategy to retaining clients in treatment by addressing issues that prevent them from attending health facilities.
5. Work with the MoH lab leadership to identify provincial level strategies for increased viral load access in those provinces with nascent viral load testing programs.
6. Identify and develop longer term program plans for HIV prevention services for sex workers and MSM in specific parts of the country. This will be essential for maintaining epidemic control.
7. Utilize district and site level data to guide the partner level of effort in provinces with significant treatment gaps (e.g. Gitega) including site reprioritization and enhanced partner management.

SECTION 1: COP 2021 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2020 (EOFY) tool, and performance data, the total COP/ROP 2021 planning level is comprised as follows. *Note – all pipeline numbers were provided and confirmed by your agency.* Due to increased costs in FY 2020, including those due to COVID, and correspondingly lower applied pipeline going into COP21, COP envelopes have been decreased in some country programs so that S/GAC has funds reserved to address program gaps identified by PHIAs that have yet to be completed and to address other potential future requirements as the impacts of COVID on the program are better known. These funds will be allocated to country programs at a later date as appropriate.

TABLE 1: All COP 2021 Funding by Appropriation Year

	Bilateral				Central				Total
	FY21	FY20	FY19	Unspecified	FY21	FY20	FY19	Unspecified	TOTAL
Total New Funding	**$ 29,790,825**	**$ -**	**$ -**	**$ -**	**$ 400,000**	**$ -**	**$ -**	**$ -**	**$ 30,190,825**
GHP-State	$ 29,790,825	$ -	$ -		$ -	$ -	$ -		$ 29,790,825
GHP-USAID	$ -				$ 400,000				$ 400,000
GAP	$ -				$ -				$ -
Total Applied Pipeline	**$ -**	**$ -**	**$ -**	**$ 209,175**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 209,175**
DOD				$ -				$ -	$ -
HHS/CDC				$ -				$ -	$ -
HHS/HRSA				$ -				$ -	$ -
PC				$ -				$ -	$ -
USAID				$ 209,175				$ -	$ 209,175
USAID/WCF				$ -				$ -	$ -
State				$ -				$ -	$ -
State/AF				$ -				$ -	$ -
State/EAP				$ -				$ -	$ -
State/EUR				$ -				$ -	$ -
State/PRM				$ -				$ -	$ -
State/SCA				$ -				$ -	$ -
State/SGAC				$ -				$ -	$ -
State/WHA				$ -				$ -	$ -
TOTAL FUNDING	**$ 29,790,825**	**$ -**	**$ -**	**$ 209,175**	**$ 400,000**	**$ -**	**$ -**	**$ -**	**$ 30,400,000**

SECTION 2: COP 2021 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS**

Countries should plan for the full Care and Treatment (C&T) level of $14,000,000 and the full Orphans and Vulnerable Children (OVC) level of $1,500,000 of the PLL across all funding sources. These 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 2021 Earmarks by Appropriation Year*

	Appropriation Year			
	FY21	FY20	FY19	TOTAL
C&T	$ 14,000,000	$ -	$ -	$ 14,000,000
OVC	$ 1,500,000	$ -	$ -	$ 1,500,000
GBV	$ 950,000	$ -	$ -	$ 950,000
Water	$ -	$ -	$ -	$ -

*Only GHP-State and GHP-USAID will count towards the Care and Treatment and OVC earmarks.
**Only GHP-State will count towards the GBV and Water earmarks.

TABLE 3: COP 2021 Initiative Controls

	Bilateral	Central	TOTAL	Comments/Notes
Total Funding	$ 30,000,000	$ 400,000	$ 30,400,000	
Core Program	$ 30,000,000	$ -	$ 30,000,000	
Cervical Cancer	$ -	$ -	$ -	
Community-Led Monitoring	$ -	$ -	$ -	
Condoms (GHP-USAID Central Funding)	$ -	$ 400,000	$ 400,000	
DREAMS	$ -	$ -	$ -	
HBCU Tx	$ -	$ -	$ -	
One-time Conditional Funding	$ -	$ -	$ -	
Surveillance and Public Health Response	$ -	$ -	$ -	
VMMC	$ -	$ -	$ -	

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

TABLE 4: State ICASS Funding

	Appropriation Year			
	FY21	FY20	FY19	Unspecified
ICASS	$-	$-	$-	

SECTION 3: PAST PERFORMANCE – COP 2019 Review

Table 5. COP Country Level FY20 Program Results (COP19) against FY21 Targets (COP20)

Indicator	FY20 result (COP19)	FY21 target (COP20)
TX Current <15	2,720	7,337
TX Current 15+	61,167	68,568
TB Preventive Therapy	21,750	27,692

Table 6. COP 2019 | FY 2020 Agency-level Outlays versus Approved Budget

Agency	Sum of Approved COP/ROP 2019 Planning Level	Sum of Total FY 2020 Outlays	Sum of Over/Under Outlays
DOD	1,670,000	1,025,329	644,671
HHS/CDC	700,000	0	700,000
USAID	17,030,000	15,725,703	1,304,297
Grand Total	**19,400,000**	**16,751,032**	**2,648,968**

Table 7. COP 2019 | FY 2020 Implementing Partner-level Significant Over-Outlays versus Approved Budget

The following IMs outlayed at least 110 percent in excess of their COP/ROP19 approved level.

Mechanism ID	Partner Name	Funding Agency	Total Planning Level	Total Outlays	Outlay Delta Check
18579	Family Health International	USAID	$5,080,231	$5,703,838	($623,607)
17520	EngenderHealth, Inc.	USAID	$100,000	$476,041	($376,041)
18408	Family Health International	USAID	$0	$162,430	($162,430)
81568	CENTRE D'ETUDES ET DE RECHERCH E EN POPULATION ET DEVELOPPEME	USAID	$73,546	$128,686	($55,140)
104023		DOD	$140,000	$177,742	($37,742)

Table 8. COP 2019 | FY 2020 Results & Expenditures

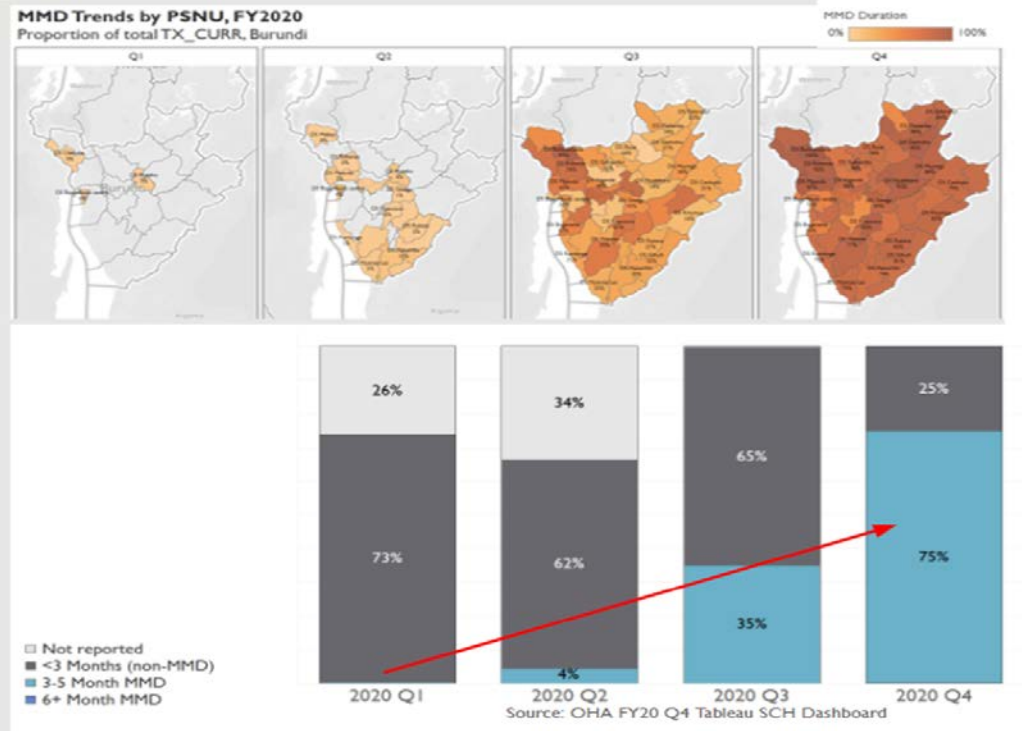
Agency	Indicator	FY20 Target	FY20 Result	% Achievement	Program Classification	FY20 Expenditure	% Service Delivery
DOD	HTS_TST	9,631	13,193	137%	HTS Program Area	$143,508	100%
	HTS_TST_POS	463	772	167%			
	TX_NEW	448	766	171%	C&T Program Area	$674,849	100%
	TX_CURR	3,040	3,109	102%			
USAID	HTS_TST	473,141	401,605	85%	HTS Program Area	$2,526,819	23%
	HTS_TST_POS	16,881	11,954	71%			
	TX_NEW	17,078	8,766	51%	C&T Program Area	$5,139,437	55%
	TX_CURR	67,823	60,778	90%			
	OVC_SERV	8,867	10,113	114%	OVC Beneficiary	$1,280,570	43%
					Above Site Programs $1,762,541		
					Program Management $3,361,856		

COP 2019 | FY 2020 Analysis of Performance

Burundi Program Successes and Challenges

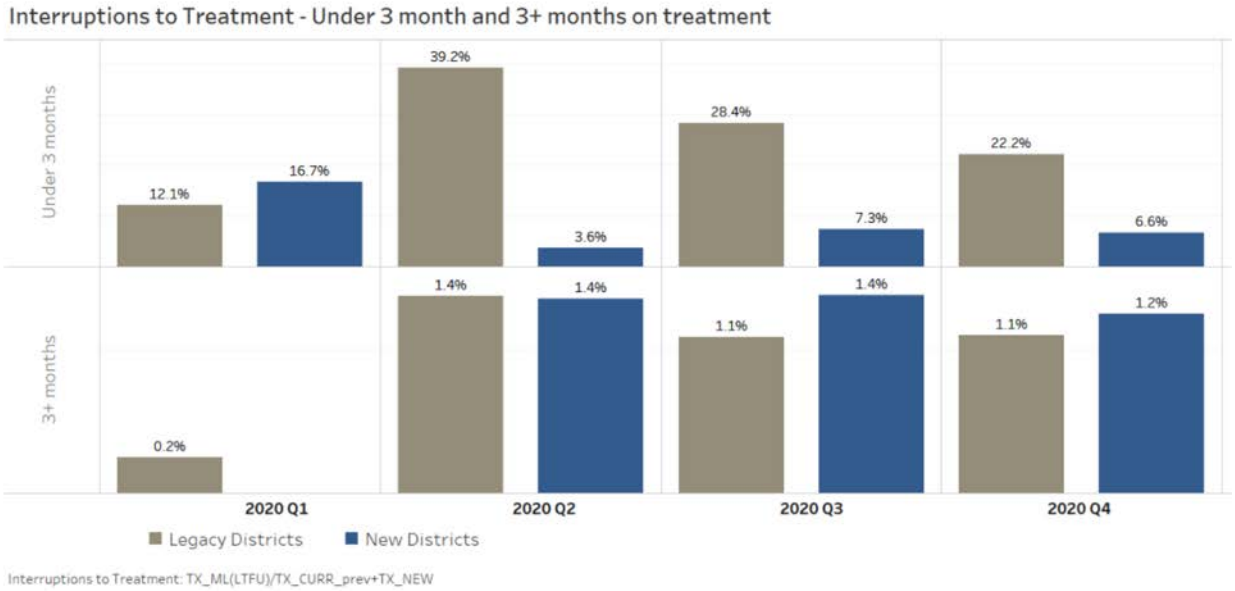
Treatment

PEPFAR Burundi has initiated and fast-tracked implementation of 3-5 month MMD for all age bands with support from the GoB/ PNLS policy put into action in response to COVID. Capitalizing on the momentum, COP21 should plan for 6-month MMD and providing the PNLS with regular updates on the positive implementation of its policy. All persons stable on treatment should be receiving 3 months ARV supply or greater by the end of COP 2021.

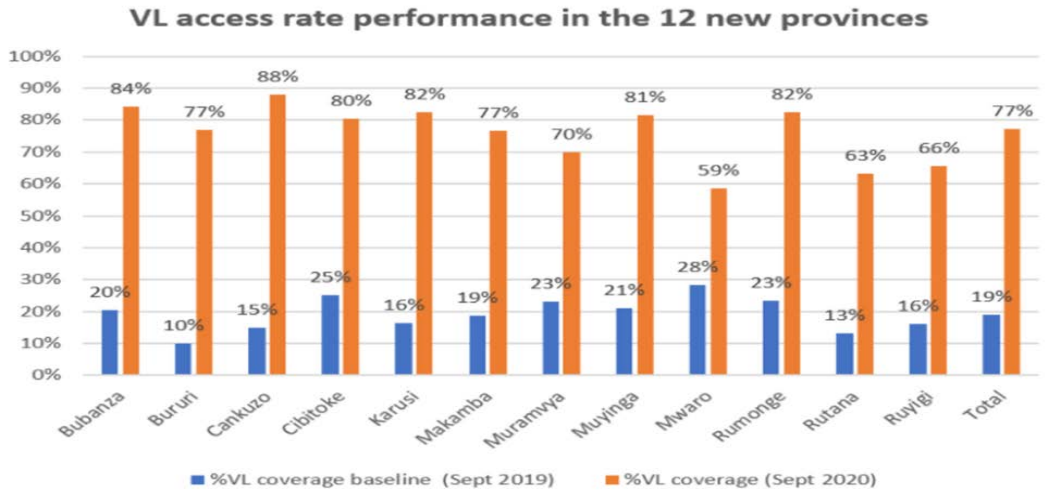


Treatment growth results did not reach the COP19 targets. While dedicated effort was made in transitioning to new provinces, TX_NET_NEW by FY20 quarter was less overall than the same quarters in FY19. For linkage to and retention in care, a deep analysis is needed to understand the profile of clients and the timing of those lost from treatment. Program results showed differences between the legacy versus new provinces in terms of the timing of when clients are LTFU. Partner management approaches may need to differ to address specific needs in provinces and districts with greater loss of clients. The implementation and scale up of the PODI model for community ART delivery should be core to the retention strategy.

Legacy and New Districts - Interruptions to Treatment



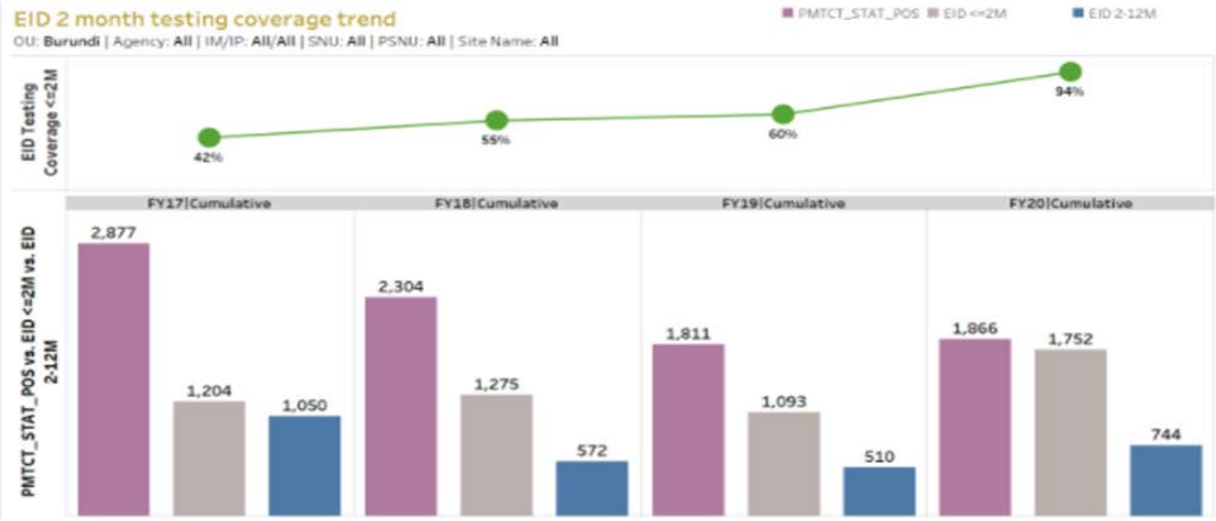
Through the geographic expansion of support to provinces, PEPFAR has contributed to exponential expansion of viral load coverage despite significant shortages in lab reagents due to COVID related shipping delays. The careful use of operational labs and instrumentation as well as innovation in sample transport allowed for strong national results in FY20.



PMTCT

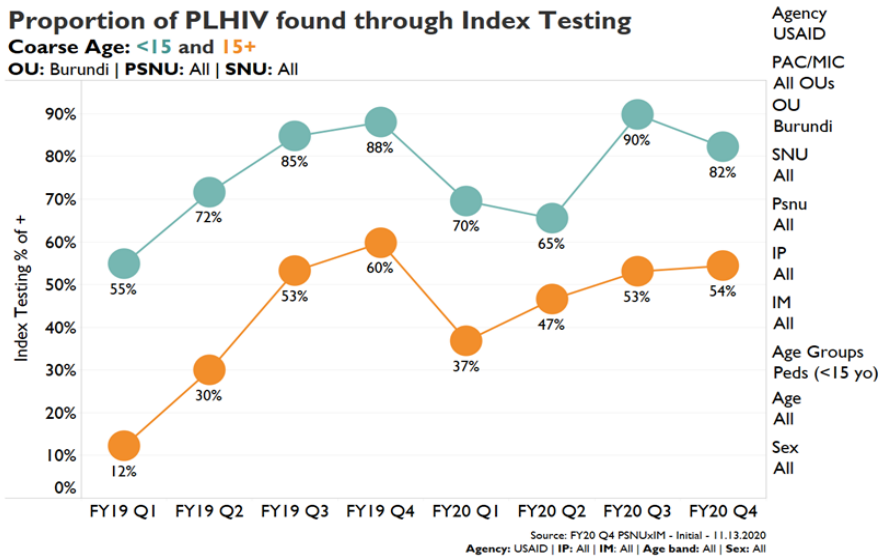
Burundi has a strong PMTCT cascade, as indicated by linkage to ART and VLS for both pregnant and breastfeeding women, and follow up of infants. As an example below, 99% of infants recorded in the 2 year birth cohort had documented status, with only 9% of infants having unknown HIV status (i.e. unknown or died). However, ANC1 testing declined in FY20, both in volume and coverage, which suggests potential missed opportunities. Recommend an assessment of rapid test kits at sites and how a fall in ANC attendance may also be a factor for the decreases seen. Viral load coverage is also low

among pregnant women. An assessment of whether this is a data capture/quality issue or timing of pregnancy related to routine viral load testing or a true program quality issue should be clarified.



Pediatrics

Burundi has had significant success with scaling up index testing for case identification of children - this is now the major modality through which children were identified in FY20, and despite some Q1/Q2 dips in the legacy provinces, was strengthened in late FY20. However, pediatric case finding underperformed in FY20 across age bands for all partners despite the positive scale up of index testing. The program should consider conducting an audit of pediatric indexing for adult clients on ART as part of the pediatric surge, and should rapidly roll out index testing SOPs. In 2021, the program should consider incorporating new data from pediatric risk screening tool analysis into 2021 Spectrum estimates.



FY20 Target Achievement, All ages (0-50+ yo)
OU: Burundi | **PSNU:** All | **SNU:** All

Target achievement: 50% - 64% | >85% | 65% - 85%

	HTS_TST	HTS_TST_POS	TX_NEW	TX_CURR
Grand Total	85%	71%	51%	90%
LINKAGES	109%	95%		
Reaching an AIDS Free Generation (RAFG)	72%	64%	51%	88%
TMEC	125%	72%	51%	93%

View Type: Mechanism
FY: FY20
Agency: USAID
PAC/MIC: All OUs
OU: Burundi

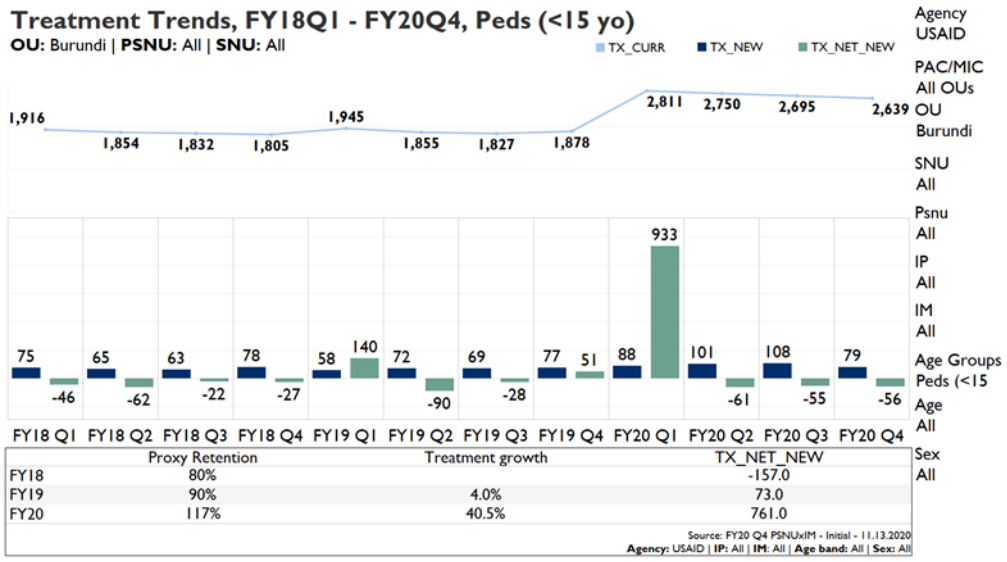
FY20 Target Achievement, All ages (0-50+ yo)
OU: Burundi | **PSNU:** All | **SNU:** All

		<01	01-04	05-09	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50+
LINKAGES	HTS_TST		41%	18%	8%	255%	203%	547%	286%	162%	40%	25%	9%
	HTS_TST_POS		67%	28%	10%	120%	119%	401%	246%	171%	54%	41%	19%
Reaching an AIDS Free Generation (RAFG)	HTS_TST		84%	47%	41%	75%	97%	144%	107%	63%	30%	22%	32%
	HTS_TST_POS		34%	28%	26%	63%	53%	138%	114%	88%	44%	45%	47%
	TX_NEW	61%	32%	21%	20%	51%	41%	111%	93%	75%	37%	37%	38%
	TX_CURR	6%	19%	46%	74%	78%	55%	98%	66%	82%	98%	98%	128%
TMEC	HTS_TST		224%	25%	39%	128%	509%	685%	383%	127%	29%	21%	21%
	HTS_TST_POS		53%	23%	23%	109%	552%	936%	595%	192%	30%	22%	23%
	TX_NEW	33%	42%	18%	18%	77%	389%	581%	361%	140%	23%	17%	16%
	TX_CURR	4%	27%	45%	48%	75%	130%	152%	122%	96%	80%	95%	86%

Source: FY20 Q4 PSNUxIM - Initial - 11.13.2020
Agency: USAID | **IP:** All | **IM:** All | **Age band:** <01, 01-04, 05-09 and 9 more | **Sex:** All

SNU: All
Psnu: All
IM: All
IP: All
Age Groups: All ages
Age: All
Sex: All

Treatment growth for children was minimal in FY20 with loss from the TX_CURR cohort. Identify root causes for interruption in treatment (IIT) for C/ALHIV, especially for younger children <5 and 5-9 as well as those lost <3 months on treatment, and continue to expand coverage for OVC services for high burden sites for those <20 years of age.

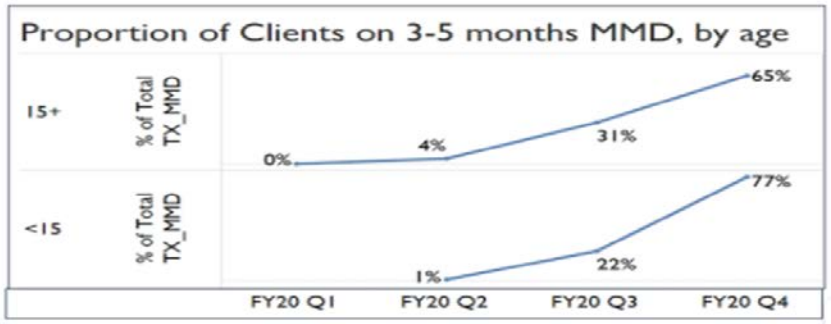


	Proxy Retention	Treatment growth	TX_NET_NEW
FY18	80%		-157.0
FY19	90%	4.0%	73.0
FY20	117%	40.5%	761.0

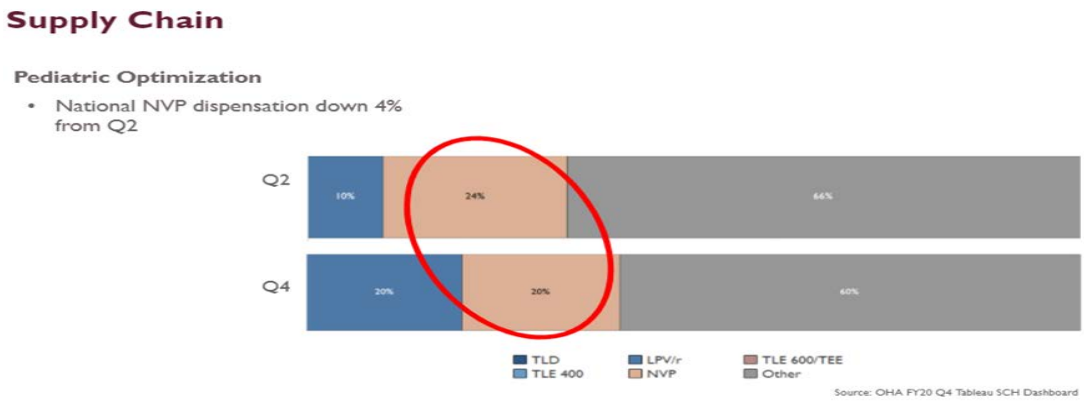
Source: FY20 Q4 PSNUxIM - Initial - 11.13.2020
Agency: USAID | **IP:** All | **IM:** All | **Age band:** All | **Sex:** All

Agency: USAID
PAC/MIC: All OUs
OU: Burundi
SNU: All
Psnu: All
IP: All
IM: All
Age Groups: Peds (<15
Age: All
Sex: All

The expansion of MMD3-5 from 0% in Q1 to 77% in Q4 for children <15 years of age was also a significant success in FY20 which included development of materials for OVC case managers and providers, and conducting an assessment of provider perceptions for MMD for children to understand barriers to care.

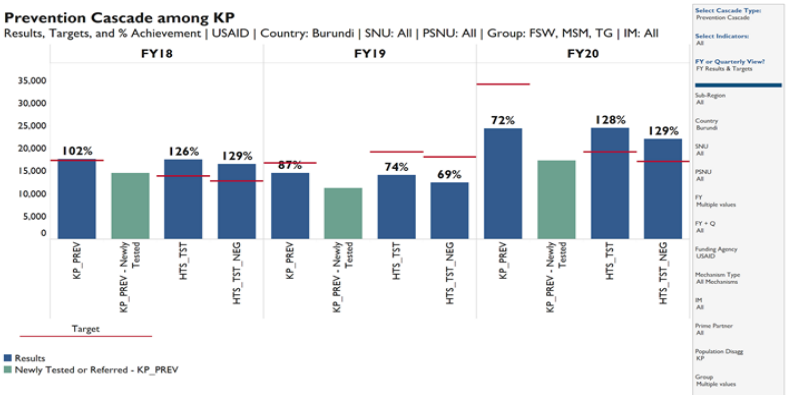


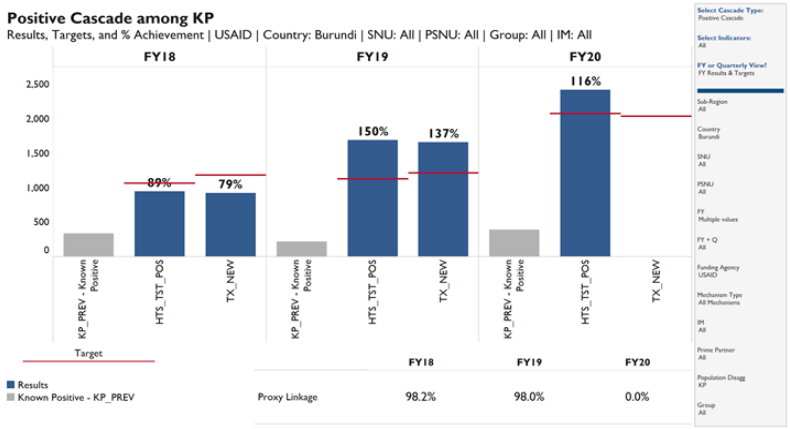
Nevarapine is still administered among pediatric clients. PEPFAR must work closely with the GoB for DTG10 quantification/approval for use in the pediatric regimen. This will end the use of NVP in the country which currently represents 20% of pediatric clients on ART.

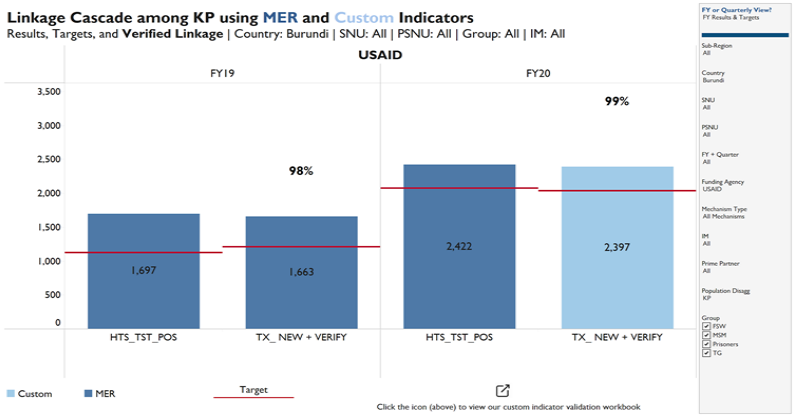


Key Populations

The geographic expansion of the KP program showed positive results. KPs were tested and linked successfully. Linkage rates remain strong at 99% (with hand-over of clients to the clinical partner for treatment services). However, while the HIV+ yield remains considerably higher than the general population, the lack of IBBS data represents a challenge as there is no benchmark for a positive yield. FY20 saw small decreases in yield. The program needs to increase targeted testing/EPOA in new geographies, as well as greater use of private sector facilities and online/virtual strategies to reach older/harder to find MSM/TG/FSW.

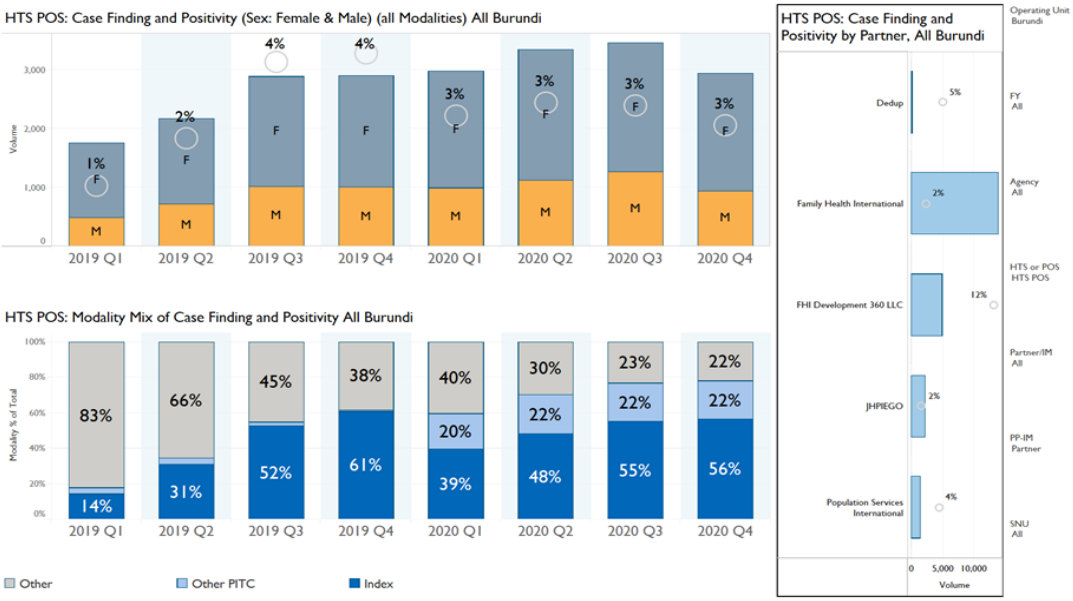






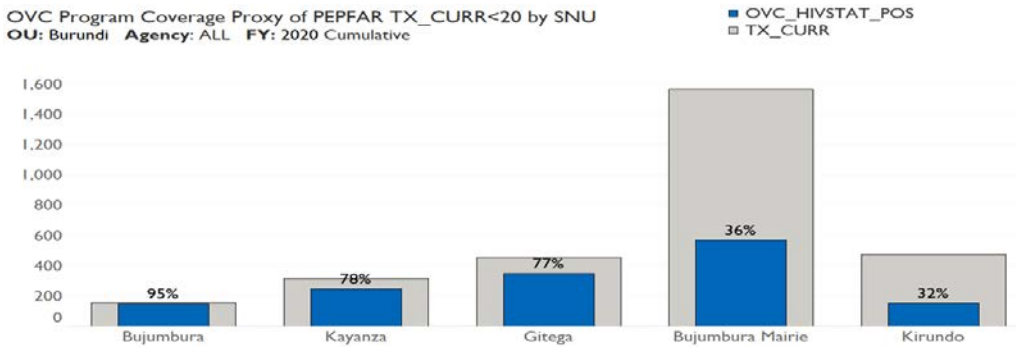
Case Finding

Testing volume decreased indicating programmatic efficiency. While Burundi did not meet the HTS positive target (achieved 73.4%), the volume of positive patients identified in FY20 was higher than that of last FY19 and with fewer tests performed. Case finding remains skewed towards females versus males, and index testing is not yet fully optimized.



OVC

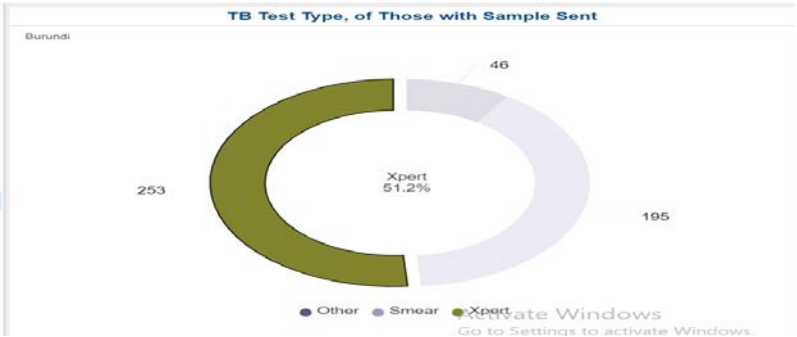
The program significantly increased support for C/ALHIV from 312 in FY20 Q2 to 1,466 in Q4 with 100% of HIV+ clients enrolled in treatment. The OVC program has shown strong improvement in proxy coverage of TX_CURR <15 (94%), however due to large numbers of ALHIV, the proxy coverage of TX_CURR <20 continues to need improvement (49%). The OVC program must continue to prioritize support for C/ALHIV in order to offer 90% of children and adolescents on treatment the opportunity to enroll in the OVC program, with particular focus on adolescents.



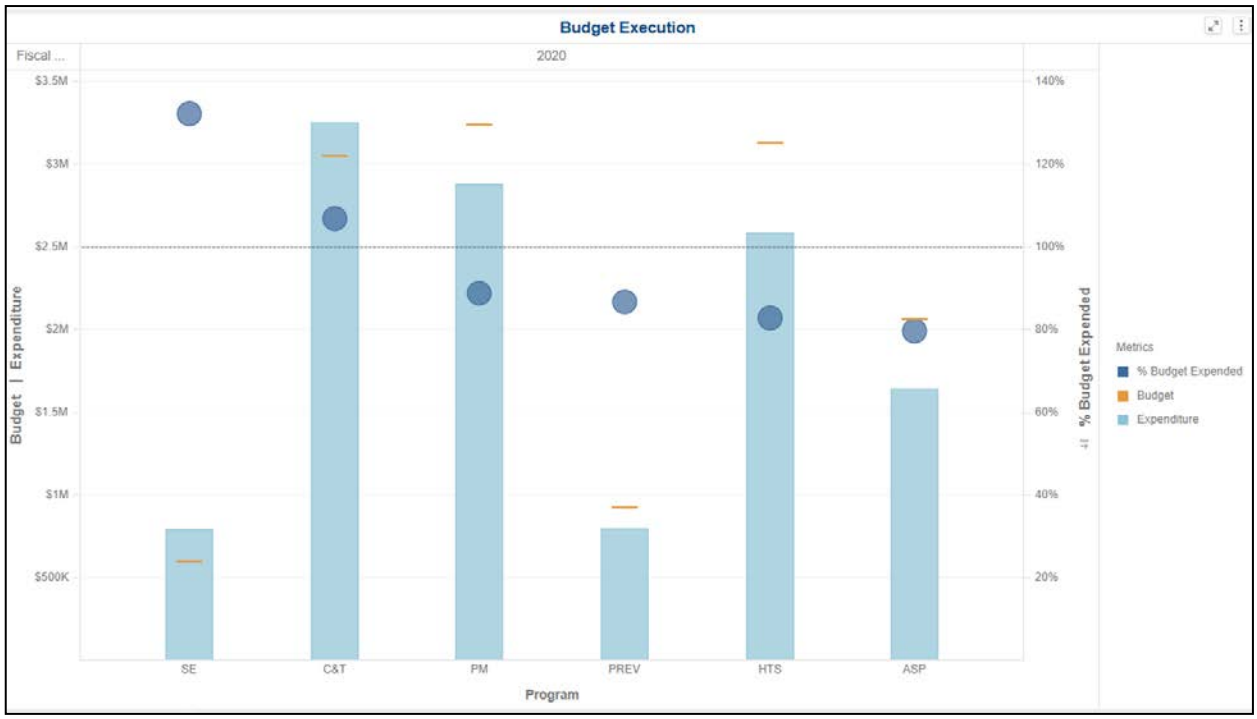
Lab Strengthening

The PNLS has been supported in its roll out of the IBIPIMO app, custom design to enhance lab results reporting and decrease turn around time for viral load and EID. The IBIPIMO app has been integrated at all labs and allows clients to receive their results directly; a strong clinet-centered strategy. The IBIPMO is used on GeneXpert platform to perform EID. From these platforms, the turn around time for EID has reduced to be within 5 days.

With strong results in the TB/HIV screening program and TPT, the number of specimens screened through GeneXpert remains sub-optimal at 51% at Q4 FY20. Shift to Xpert testing must begin in COP20 and be fully realized in COP21.



COP 19– Budget vs Expenditure by Program
At the country level, there was underspending in above-site programming, testing, prevention, and program management. There was overspending in socio-economic programs and care & treatment.



Partner and Financial Performance

- Population Services International, funded by DOD, have met their targets and are performing well.
- The following partners funded by USAID have met their targets and are performing well:
    - FHI360 (LINKAGES) met general testing targets, albeit with lower index testing results than expected due in part to the pause on index testing at the start of FY20.
- The following partners, funded by USAID underperformed:
    - JHPIEGO (TMEC/RISE) underperformed in case finding (HTS_TST_POS and TX_NEW), and PMTCT. This is a new partner hampered by a delayed start to program delivery due to required country registrations.
    - FHI (RAFG) underperformed in testing and treatment new.
    - SWAA Burundi (GIR'ITEKA) underperformed in GEND_GBV.
    - Conseil Pour L'education et le Developpement (WIYIZIRE) underperformed in OVC, however, as a new partner, the start-up period is often slow due to administrative matters.
- Additionally, there is significant underperformance in the current on treatment cohort in Gitega.
- Recommendations for improved performance are:
    - Routinize index testing as the main modality for case finding in all provinces. This will entail working to ensure that those provinces with less experience become experts in index testing implementation.

- Reconsideration of geographic targeting in Gitega based on program results. Transport routes and specific high-throughput facilities should direct index testing efforts. Increased partner management will be necessary during partner transitions.
- Scale UID system and utilize data to avoid reduce re-testing and track patient transfers.
- Implement Pediatric Surge to address case finding, retention, and adherence among children; work with providers on improving uptake of pediatric index testing.

SECTION 4: COP/ROP 2021 DIRECTIVES

The following section has specific directives for COP 2021 based on program performance noted above. Please review each section carefully including the minimum program requirements and specific country directives.

Minimum Program Requirements (MPR)
All PEPFAR programs – bilateral and regional– were expected to have the following minimum program requirements in place by the beginning of COP20 implementation (FY2021). Adherence to these policies and practices is essential to the success of all PEPFAR programs at the national, subnational, and service delivery levels (e.g. facility, school, community). 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.

All PEPFAR programs are expected to meet all of the requirements below, and the COP21 Planning Meeting will include a review of the status of each requirement, including assessment of implementation (including barriers) at the point of client services. To the extent that any requirement(s) have not been met by the time of the COP21 Planning Meeting, the PEPFAR country team will need to present a detailed description of existing barriers and the remediation plans proposed that will allow them to meet the requirement(s) prior to the beginning of FY2021. The list will be included in the Strategic Direction Summary (SDS), as well.

Failure to meet any of these requirements by the beginning of FY2022 may affect the country program budget. The minimum requirements for continued PEPFAR support include the table on the following page.

Table 9. COP/ROP 2021 (FY 2022) Minimum Program Requirements

Minimum Program Requirement	Status and issues hindering Implementation
Care and Treatment	
1. Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	National roll-out in all 47 districts, 289 sites directly supported by PEPFAR; More focus needed on children, adolescents and KPs.
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 who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV-based ART regimens.	Circular from the MOH to start TLD transition to all women of reproductive age newly tested positive; however approximately 36% of clients are still on TLE regimen and NVP is still in use in pediatric cases.

3. Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	Rapid expansion of 3-month MMD during COP19. Advocacy needed for 6-month MMD.
4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by the end of COP21, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	Near 100% HIV positive clients screened for TB with 1.2% positivity. TPT completion rates improving over FY19 but at ~75% with low rates among newly enrolled on ART. INH provided in all provinces. New combination drug options needed.
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 results delivered to caregiver within 4 weeks.	VL coverage is 83% with >90% suppression. TB testing is near 100% for the HIV treatment cohort. National lab strategy developed with TWG in place; new instruments under procurement with rationalization of Xpert machines completed.
Testing	
1. 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 should be offered testing for HIV.	Index testing - Rapid scale up of index testing across all populations in in place with upwards to 75% of HIV positives identified through index testing. Increased focus on pediatric index testing (children of adult index cases) through pediatric surge. Review of the national tools to improve the integration of IPV screening and monitoring in index texting services, including consent, and reporting of adverse events. Self-testing - On-going roll-out of self-testing in the 13 provinces supported by the KP program.
Prevention and OVC	
1. 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	PrEP on track to be implemented in COP 20. PrEP national strategy in development, supported by PEPFAR and GF resources.

partners of index cases, key populations and adult men engaged in high-risk sex practices*)*	
2. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and 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	OVC services aligned geographically with most HIV burdened areas and with a focus on a comprehensive package of services. Consolidation of the comprehensive prevention and treatment service package for OVC and adolescent ages 0-17 years, of both sexes, and their household members. All children in the OVC cohort have a known HIV status.
Policy & Systems	
1. 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.	No user fees applied
2. 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.	Evidence that CQI is active among partners; registers for tracking lost to follow-up and MMD shows a focus on quality assurance; SIMS visits activated through third party contractor evidence of measuring against site standards
3. 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.	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. U=U messaging and Viral Load Literacy activities and tools will be further rolled out in KP-supported provinces as well in provinces with a greater focus on male case finding, treatment and retention in care.
4. Clear evidence of agency progress toward local, indigenous partner direct funding.	Local partner engaged for SIMS visits, and transition to two new local partners began work in FY20.
5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	Progress not realized. Fiscal space in small for health spending; economic health is weak.
6. Monitoring and reporting of morbidity and mortality	Vital registries in Burundi are not well-

outcomes including infectious and non-infectious morbidity.	developed presenting challenges for documenting morbidity and causes. Focus for PEPFAR has been on developing and rolling out SIDA-Info for HIV treatment and client tracking.
7. Scale-up of case surveillance and unique identifiers for patients across all sites.	Active development of a web-based version of SIDA-Info, with fingerprint integrated, as step in the establishment of a national unique identifier system. Recency testing stalled in FY20 due to COVID-19, implementation is scheduled to begin in FY21.

In addition to meeting the minimum requirements outlined above, it is expected that Burundi will consider all the following technical directives and priorities:

Table 10. COP 2021 (FY 2022) Technical Directives

Burundi Specific Directives
HIV Treatment
1. Focus on quality of treatment delivery (i.e. linkage, continuity of treatment) across all 18 provinces with particular focus on those 'new' provinces with very basic HIV program delivery structures in place.
2. Viral load access expanded to 'new' provinces to allow for attainment of national coverage for the third 90.
3. Pediatric case finding and treatment enrollment building on the COP20 surge measures.
4. Expand PODI coverage as part of a sustainable community ART delivery platform.
HIV Prevention
1. Identify locations across the country where program data suggests sex workers and MSM reside and develop longer term program plans for how to address prevention needs using indigenous community structures.
2.Utiltize the results of the stigma index to develop prevention responses to stigma and discrimination among specific populations.
3. Scale PrEP particularly in the key populations most at-risk.
Other Government Policy or Programming Changes Needed
1.Shift to 6 months MMD.

COP 2021 Technical Priorities

Client Centered Treatment Services

COP21 planning must ensure treatment continuity for all current and new clients. To do this, programs must specifically and thoroughly address the challenge of interrupted antiretroviral treatment, especially after initiating ARVs and through young adulthood. Maintaining epidemic control, as measured by the proportion of PLHIV with viral suppression, will require long-term, continuous adherence to ART for an adult population that is 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 free, fit the lives of the clients, and empower clients to on ART to stay the course. PEPFAR requires development and full implementation of key client-centered policies and practices at the site-level, including client education on the benefits of lifelong treatment, optimized treatment (dolutegravir-

based therapy) and multi-month dispensing, convenient and safe ARV access arrangements, and community and client participation in design and evaluation of services.

Pediatric- and Adolescent-Centered Services

In COP21, PEPFAR programs are required to demonstrate improvement in pediatric case finding, including safe and ethical index testing, to close HIV treatment gaps across age and sex bands. Programs must move forward with the introduction and broad use of pediatric DTG formulations in FY21 (COP20), with full implementation expected to occur during the first quarters of FY22 (COP21). Programs need to further advance pediatric- and adolescent-specific continuity of treatment programming, including age-appropriate differentiated models of care and leveraging bidirectional synergies with clinical and OVC implementing partners. Countries must develop a comprehensive plan to achieve ≥ 90% viral load coverage and viral load suppression across all age and sex bands. To further reduce morbidity and mortality, clinical programs should include an evidence-based advanced HIV disease package of care for children and adolescents.

Community-led Monitoring

In COP 21, 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.

Pre-Exposure Prophylaxis (PrEP)

In COP 2021, PrEP should continue to be made widely available with a focus on getting PrEP, (including possible new PrEP options) to the people that need it. Groups to be prioritized for PrEP include HIV negative partners of index cases key populations including sex workers, men who have sex with men, transgender persons, people in prisons and other closed settings, people who inject drugs, adolescent girls and young women and, pregnant and breastfeeding women, in areas with high HIV incidence or with higher risk partners, and other identified serodifferent couples. Groups should be tailored to the OU's epidemic context.

TB/HIV

TB/HIV services must be integrated, including DSD and MMD models for both TB and TB preventive treatment (TPT). All PLHIV must be routinely screened for TB and have access to molecular diagnostic testing and/or point of care tests such as LF-LAM. TPT is considered routine HIV care, and all country programs must have offered TPT to all PLHIV on treatment by the end of COP21; targets have been set accordingly. Countries should budget for full coverage, and plan to use optimal regimens (3-HP) as supply allows.

Advanced HIV disease

The advanced disease package of care should be fully integrated into clinical care and includes diagnostics and therapeutics for tuberculosis and cryptoccal meningitis as well as cotrimoxazole. Countries should budget adequately for commodities including urinary LAM, CrAg, amphotericin B and flucytosine. Please see section 6.5.2 of the COP guidance.

DREAMS

DREAMS funding is allocated within your COP 2021 planning level and must be used exclusively for the goal of HIV Prevention among adolescent girls and young women (AGYW) in DREAMS SNUs in accordance with all DREAMS and COP 2021 Guidance. In addition to ensuring that all DREAMS beneficiaries complete the core package of relevant services, priorities for COP21 DREAMS

implementation include systematically identifying and engaging AGYW that are most vulnerable to HIV acquisition; particularly pregnant AGYW and those who are mothers; improving the package of economic strengthening services offered to AGYW (including exploring potential job opportunities through PEPFAR); ensuring evidence-based curricula are implemented with quality and fidelity; enhancing mentoring selection, training, compensation and supportive supervision processes; and accelerating PrEP uptake for AGYW in DREAMS SNUs.

OVC

To support the Minimum Program Requirement described above, in COP 21 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, pediatric case finding, case conferencing, shared confidentiality, joint case identification, and data sharing. In high volume clinics within high burden SNUs, at least 90% of children (<age 19) in PEPFAR-supported treatment sites should be offered enrollment in OVC programs. OVC staff placed in clinics (e.g., as linkage coordinators, case managers, etc.) should have the capacity to assess child and family needs (including food and economic security) and to offer appropriate referrals. 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.

Cervical Cancer Screening and Treatment:

Funding for cervical cancer screening and treatment of pre-invasive lesions. The target for screening must be equal to half of the TX_CURR for women age 25-49. All teams performing cervical cancer screening must adhere to the PEPFAR screening guidance and report into the cervical cancer MER indicators. Basic treatment should be available for pre-cancerous lesions at the site of screening except under exceptional circumstances. All sites performing screening should establish clear referral mechanisms for patients needing treatment not available on site such as LEEP or evaluation for potential invasive cancer. Patient referral between sites should be facilitated and outcomes of the referral tracked to assure appropriate treatment and to allow reporting of results.

Condoms and Lubricants

Condoms are key to a successful combination HIV prevention approach and are a cost-effective tool for preventing other sexually transmitted infections and unintended pregnancies. PEPFAR's goal is to ensure high levels of use, equitable access to, and sustained demand for condoms and lubricants among key and priority populations and low-income groups. In COP21, through the Condom Fund, GHP-USAID will provide $20.3 million in assistance to PEPFAR-supported countries to procure and deliver condoms and lubricants to address key condom supply and demand issues This funding is in addition to funds allocated for condom programming and additional condom/lubricant procurement in each country from COP21 country funding as determined during the COP planning process.

Burundi will have access to $400,000 from the Condom Fund in COP21/FY22, contingent upon adequate justification of need. Coordination with other donors that provide commodities, including the Global Fund, is also critical and expected. The process for estimating your country's total condom and lubricant need is outlined in the COP21 guidance. Among other items, this justification should include an outline of how Burundi will support condom programming in FY22 with funds from your base COP21, the Condom Fund, the GF and/or other donors, and the host-country government. Please note that in FY22 there will also be limited funding available to cover unexpected or emergency condom and/or lubricant requests from PEPFAR-supported countries. Access to these funds will be provided on a first come, first served basis, and OUs will be required to provide a justification for why their special request is being made.

PLHIV Stigma Index 2.0

PEPFAR teams are required to either fund host country PLHIV network-led implementation of the revised PLHIV Stigma Index 2.0 utilizing the standard methodology, or complement Global Fund or other donors financing implementation of the PLHIV Stigma Index 2.0, if it has not already been implemented in the country. If the revised PLHIV Stigma Index 2.0 has not been previously conducted in the country, then PEPFAR teams must work with UNAIDS, Global Fund or other donors to ensure its implementation during COP 21, whether supported by PEPFAR or other resources. Completion of the PLHIV Stigma Index 2.0 should be accompanied by a response and action plan discussed and agreed upon by all stakeholders that will address findings. Where the PLHIV Stigma Index 2.0 has already been conducted, COP/ROP 21 focus should be on concerted action to address findings.

Human Resources for Health (HRH) and Sustainability

Using data from the HRH Inventory completed in COP20 Q4, countries are expected to complete a comprehensive HRH analysis to optimize staffing at the site- and above-site-levels. PEPFAR programs in countries that will be near to or reach 95/95/95 in the COP20 implementation cycle are required to develop and implement plans to sustain their progress and effectively retain clients in quality HIV treatment programs. Results from the Sustainability Index and Dashboard (SID) 2019 should inform the OUs on their progress and gaps related to the policies and technical areas for inclusion in the sustainability plans. Resource alignment data should be used to understand the HIV funding landscape--especially with a more granular understanding of PEPFAR and GFATM investments-- who is paying for what services in order to enhance strategic collaboration and coordination and avoid duplication during the program planning cycle.

Cross-HIS Data interoperability - Use and Analysis

Improved data visibility, and analysis are essential for better understanding the HIV epidemic and reaching epidemic control.

PEPFAR Burundi should 1) consistently and continuously use and analyze data at the individual patient level with aim of program improvement (e.g. use patient level data to understand retention differences across patient cohorts and create more tailored risk models and intervention). 2) utilize available data interoperability solutions to harmonize and triangulate data across EMRs, commodities, pharmacy dispensation, laboratory data, HRH and other data.

Systems Investments

PEPFAR teams are expected to align systems investments with key systems barriers to achieving epidemic control. System investments should also be aligned to achieving and maintaining minimum program requirements for COP including adoption and use of unique identifiers, building country capacity in disease surveillance and other core competencies to achieve and maintain epidemic control including country ability to perform continuous quality improvement. Systems investments that have achieved their goals should be candidates for countries to assume responsibility to achieve the minimum program requirement for increased responsibility and increased government expenditures.

Faith and Community Initiative (FCI)

Building upon PEPFAR's standing principle to ensure "every dollar is optimally focused for impact", countries with continuing FCI investments should continue implementing best practices in accordance with FCI and COP21 Guidance. Priorities for COP21 FCI implementation for addressing gaps in reaching men and children include: coordination through an Inter-Faith Steering Committee to advance treatment literacy; and decentralized, continuing care through faith-engaged community posts, faith-engaged highly targeted HIV self-testing, and/or community adolescent treatment programs for youth living with HIV.

Innovative solutions and adaptive practices

There are extraordinary examples of innovation by our field teams and partners during COVID. These include adaptations and lessons learned that span across many of our technical and program areas as well as all countries we work in. Teams should look at ways to strengthen and improve our capacity to innovate, design, and create within the communities we serve. This includes systematically looking at the evidence base and how to learn from these examples as well as strengthen our methods to help scale proven strategies and interventions.

COP 2021 Active Engagement with Community and Civil Society (see section 2.5.3 of COP Guidance)

The full participation of community stakeholders and civil society in every stage of PEPFAR programming, planning, and monitoring as appropriate and consistent with applicable law, regulations and policy, from advocacy to service delivery, is critical to the success and sustainability of PEPFAR and the global effort to combat HIV. 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.

As in years past, civil society organizations are considered essential and invited to participate both in the virtual COP21 strategic planning meetings, as well as virtual approval meetings. .

This engagement, of both civil society, and of faith-based organizations/faith communities, specifically includes the sharing of FY 2020 Q4 and FY 2020 APR results and analyses and the convening of an in-country planning retreat with local stakeholders during the last two weeks of January 2021 in order to introduce and discuss all COP 2021 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP 2021. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In February and March 2021, PEPFAR will convene virtual meetings 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, faith-based organizations/faith communities, and multilateral partners. Specific guidance for the 2021 virtual meeting delegations will be provided separately.

Engagement with all stakeholders is required beyond the meetings and throughout COP/ROP 2021 development, finalization, and implementation. As in COP 2020, the draft Strategic Direction Summary (SDS) and Data Pack are required to be shared with both CSO and FBO stakeholders for their input and comments at least 48 hours prior to submission of these materials to the Embassy Front Office. Please refer to the COP/ROP 2021 Guidance for a full list of requirements and engagement timelines.

APPENDIX 1: Detailed Budgetary Requirements

Care and Treatment (C&T): The country COP 2021 minimum requirement for the C&T earmark is reflected in Table 2. If there is no adjustment to the COP 2021 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment earmark amount across new FY 2021 GHP-State and GHP-USAID funding. The Care and Treatment earmark will be calculated as the sum of the following:

- 100% Care and Treatment (C&T) Program Areas
- 50% Testing (HTS) Program Areas
- 100% Above Site Program: Laboratory System Strengthening
- 70% Pregnant and Breastfeeding Women Beneficiary Group
- Proportional % Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the C&T earmark)

Orphans and Vulnerable Children (OVC): A country COP 2021 minimum requirement for the OVC earmark is reflected in Table 2. Countries must program to the full OVC earmark amount across new FY 2021 GHP-State and GHP-USAID funding. The OVC earmark will be calculated as the sum of the following:

- 85% (DREAMS initiative funding — commodities planned under DREAMS initiative — Any HTS interventions planned under DREAMS initiative — Any C&T intervention planned under DREAMS initiative)
- 100% (OVC Beneficiary group funding — commodities planned under any intervention with OVC beneficiaries — Any HTS planned under interventions with OVC beneficiaries
- Proportional Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the OVC earmark)

Abstinence, Be Faithful/Youth (AB/Y) Reporting Requirement: If AB/Y-programmed activities do not reach a 50 percent threshold of all sexual prevention funding, as calculated by the formula below, in any country with a generalized epidemic, S/GAC is required to report to the appropriate Congressional committees on the justification for the decision. In such cases, teams should provide brief justifications and explain the rationale for prevention programming decisions given the epidemiologic context, contributions of other donors, and other relevant factors. The written justifications should be uploaded as 'Budgetary Requirements Justification' to the document library of FACTS Info.

Abstinence, Be Faithful/Youth (AB/Y) programming, formerly captured in the HVAB budget code, will now be captured by using a combination of prevention program areas and beneficiaries, which are identified in the formula below. The numerator captures those interventions that are Abstinence, Be Faithful/Youth (AB/Y) programming, and the denominator approximates all sexual prevention activities. The proportion of Abstinence, Be Faithful/Youth (AB/Y) programming as a proportion of all sexual prevention activities is calculated by dividing the numerator by the denominator:

Numerator

Prevention: primary prevention of HIV and sexual violence

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, and boys)

+

Prevention: community mobilization, behavior, and norms change

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, boys, adults, not disaggregated)

Denominator

Prevention: primary prevention of HIV and sexual violence (all populations)

+

Prevention: community mobilization, behavior, and norms change (all populations)

+

50 % Prevention: Not disaggregated (all populations)

Gender Based Violence (GBV): A country COP 2021 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total **new FY 2021** funding programmed to the GBV cross-cutting code. Your COP 2021 earmark is derived by using the final COP 2020 GBV earmark allocation as a baseline. The COP 2021 planned level of new FY 2021 funds for GBV can be above this amount; however, it cannot fall below it.

Water: County COP 2021 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total **new FY 2021 funding** programmed to the water cross-cutting code. Your COP 2021 earmark is derived by using the final COP 2019 water earmark allocation as a baseline. The COP 2021 planned level of new FY 2021 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 countries, Regional Programs and Country Pairs. PEPFAR has set a 70% goal **by agency** by the end of FY21, and must meet 40% by FY20. 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 agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY21 as appropriate through their COP 2020 submission.

State ICASS: Table 3 shows the amount that the OU must program under State for ICASS Costs.

COP 2021 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 2021 implementation whenever possible in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. If an agency/country combination has a history of over-outlays, or in cases where an agency/country COP envelope has increased in recent years, there may not be sufficient funding to maintain a 3 month buffer. Any agency that anticipates ending COP 2020 implementation (end of FY 2021) with a pipeline in excess of 3 months is required to apply this excessive pipeline to COP 2021, decreasing the new funding amount to stay within the planning level.