United States Department of State

Washington, D.C. 20520

FY 2015 Burundi Country Operational Plan (COP)

The following elements included in this document, in addition to "Budget and Target Reports" posted separately on www.PEPFAR.gov, reflect the approved FY 2015 COP for Burundi.

1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

   Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the "COP 15 Targets by Subnational Unit" sheets that follow for final approved targets.

2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.

3) *Sustainability Index and Dashboard*

Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on www.PEPFAR.gov in the "FY 2015 Country Operational Plan Budget and Target Report."

Burundi Operational Plan

(COP/ROP) 2015

Strategic Direction Summary

April 17, 2015

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Goal Statement

PEPFAR Burundi has developed a country operational plan which aims to achieve epidemic control in 4 provinces with the highest burden of HIV within a two-year time frame. Programs were designed to align with the attainment of the 90-90-90 targets and 80% coverage of antiretroviral treatment (ART) in PEPFAR-supported sites by the end of USG FY 2017. We anticipate 50% of the scale-up to occur in FY16 and will strive to reach full 80% coverage by FY17. Prioritization of high burden geographic areas as well as priority and key populations (female sex workers [FSWs] and their clients, military and other vulnerable populations) in two years requires a substantial pivot given that resources will remain flat from the previous year. A minimum package of care, treatment, and support services was established for patients in currently supported locations other than those prioritized for epidemic control. Patients currently on care and treatment (both adults and pediatric patients), pregnant women provided ART through prevention of mother to child HIV transmission (PMTCT) sites and targeted prevention activities will be maintained. PEPFAR is working with the host country government to fully transition services in currently supported provinces to Government of Burundi (GOB) sites and other partners by the end of FY 17 with a possibility of moving into new provinces as budget permits. In line with the new World Health Organization (WHO) guidelines for treatment, PEPFAR Burundi will support the use of lifelong treatment generated by the PMTCT platform and improve linkages with the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) and GOB to provide ART and other treatment services to the majority of the eligible population. PEPFAR Burundi will scale-up ART coverage over the course of two years by providing technical assistance to the partners in charge of the national HIV response. After conducting site/volume yield and efficiency analyses, PEPFAR Burundi also identified 31 low yield sites in both high and low burden areas where support would immediately be discontinued for HTC, and ART patients transitioned to higher volume sites. Resources made available from discontinuation of non-core activities will be reallocated to scaling-up combination prevention and critical system support including supply chain, laboratory, quality assurance, human resources for health, health management information, and strategic information to achieve epidemic control.

1.0Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

Burundi has a population of 10,395,931 and is considered to have a low-prevalence mixed HIV epidemic. As of 2014, 1.3% of the population was living with HIV with approximately 4,700 annual deaths attributed to AIDS[1]. According to SPECTRUM estimates compiled by UNAIDS and the National AIDS Council (CNLS), approximately 83,000 individuals are living with HIV[2] but emerging data on prevalence and population suggest that this may be as high as 135,000. A new

[1] UNAIDS. "Burundi." Accessed March 26, 2015. http://www.unaids.org/en/regionscountries/countries/burundi.
[2] UNAIDS. "Burundi." Accessed March 26, 2015. http://www.unaids.org/en/regionscountries/countries/burundi.

DHS to be conducted in late 2015 as well as the reinstatement of ANC sentinel surveillance should help to provide better data in the near future.

Furthermore, it is estimated that the prevalence of HIV among key populations remains high, with a prevalence of 21.3% among female sex workers and a 4.8% among men having sex with men[3].

With support from PEPFAR and the GFATM, the GOB has strategically scaled up HIV/AIDS interventions and has worked towards developing a more sustainable model. The effectiveness of the response to the epidemic has been evidenced by a decline in HIV prevalence from 2.9% in 2001 to 1.3% in 2014. Burundi experiences extremely high adherence with survival rates among people with HIV on ART among the best in Africa: 91.2% at 12 months, 87.4% at 24 months and 83.9% at 36 months of treatment.[4]

Since 2002, Burundi has developed three national HIV strategic plans (NSPs) with the objective of defining clear priorities to coordinate the interventions of various donors.

Current gaps in achieving epidemic control include a high level of stigma and legal discrimination against MSM, weak laboratory capacity for EID and Viral Load services, low pediatric care and treatment coverage, and weak male participation in PMTCT.

Burundi is a low-income country with GNI of 777 USD per capita (PPP adjusted) and remains one of the poorest countries in the world, ranked 180 out of 187 countries on the 2014 UNDP Human Development Index[5].

Table 1.1.1 Key National Demographic and Epidemiological Data

	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	10,395,931	100%	2,361,367	22.71%	2,385,571	22.95%	2,863,430	27.54%	2,785,563	26.79%	Chart VI – Pop. Pyramid (SID)[6]
Prevalence (%)		1.3%									UNAIDS Burundi SNU estimates 2014

[3] Priorities for Local AIDS Control Efforts (PLACE) Study, 2013
[4] Global AIDS Response Progress Reporting 2013
[5] UNDP. "Human Development Reports." Table 1: Human Development Index and Its Components. Accessed March 26, 2015. http://hdr.undp.org/en/content/table-1-human-development-index-and-its-components.
[6] Source: Data is from Chart VI in the 2015 Sustainability Index and Dashboard since the data pack does not contain sex-disaggregated data for total population.

AIDS Deaths (per year)	4,700		n/a		n/a		n/a		n/a		UNAIDS Gap report, 2014
PLHIV	83,000						39,000		25,000		UNAIDS Gap report, 2014; <15 total is 19,000 but disaggregated data unavailable. Note: This number does not match the data pack number as the data pack info is for 15+ only. See note in data pack
Incidence Rate (Yr.)											
New Infections (Yr.)	3,765		467		477		1,562		1,089		PSN 2014-17
Annual births	420,626	n/a									Population projections 2008-2030, ISTEBU, June 2014
% >= 1 ANC visit	470,645	99%	n/a				n/a				EDSB 2010. Number estimated using 475,399 projected number of pregnant women in 2015 and using 99% coverage rate
Pregnant women needing ARVs	8082	1.7%									Calculated based on projected 475,399 pregnant women in 2015 and using the 1.7% ANC prevalence

											rate from CNLS
Orphans (maternal, paternal, double)	793,269										CNLS estimates 2015
TB cases (Yr.)	7,547										
TB/HIV Co-infection		19%									WHO/ Report 2012
Males Circumcised		33%									DHS2010
Key Populations	60,828										PLACE 2013
Total MSM*	9,346										PLACE 2013
MSM HIV Prevalence		4.8%									PLACE 2013
Total FSW	51,482										PLACE 2013
FSW HIV Prevalence		21.3%									PLACE 2013
Total PWID	n/a										
PWID HIV Prevalence	n/a										
Military	100000										Department of Defense Burundi 2014
Military HIV prevalence		1.3%									Department of Defense Burundi 2014
**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*											

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months)										
				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Total PLHIV (#)**	**In Care (#)**	**On ART (#)**	**Retained on ART 12 Months (#)**	**Viral Suppression 12 Months**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	10,395,931	1.3%	83,000	Data Not available	35,852	32,514	Data Not available	1,165,454	15,903	5,409
Population less than 15 years	4,746,738	Not available	19,000	Data Not available	2,464	2,268	Data Not available	52,564	802	308
Pregnant Women	464,257	1.7%	7,892	Data Not available	3,321	n/a	Data Not available	410,048	3,175	2,183
Military	100,000	1.3%	1300	904	772	772	Data Not available	15495	204	33
MSM	9,346	4.8%	449	Data Not available	Data Not available	Data Not available	Data Not available	Data Not available	Data Not available	Data Not available
FSW	51,482	21.3%	10,966	Data Not available	Data Not available	Data Not available	Data Not available	Data Not available	Data Not available	Data Not available
PWID	n/a	n/a	n/a	Data Not available	Data Not available	Data Not available	Data Not available	Data Not available	Data Not available	Data Not available
Priority Pop (specify)	n/a	n/a	n/a	Data Not available	Data Not available	Data Not available	Data Not available	Data Not available	Data Not available	Data Not available

HIV prevalence in general population.

According to a recent United Nations Joint Programme on HIV/AIDS (UNAIDS) report on Burundi, the HIV prevalence rate among adults age 15-49 years is 1.3%.[7] However, the National Strategic Plan against AIDS 2014-2017 notes that the prevalence rate varies according to age group.[8] The most affected age group is 35-39 year olds, who have a prevalence rate of 3.7%. Those between 40 and 44 years have a prevalence of 3.3%, 30-34 year olds a prevalence of 2.6% and 45-49 years of 2.4%. New HIV infections among 0-4 years account for 25% of all new infections due to the transmission of HIV from mother to child.

With regards to gender distribution, available data show a steady feminization of the HIV epidemic regardless of age. Indeed, the DHS II 2010 showed a 1.7% prevalence rate among women of childbearing age against 1% in men. This feminization of HIV infection is more pronounced in Bujumbura-Mairie with a prevalence of 5.9%, or 4 times the national average.

The UNAIDS SPECTRUM 2013 estimates show 3,765 new HIV infections: 2,116 cases among female and 1,649 in male, confirming the higher prevalence of HIV infection observed in women.[9]

According to the 2013 Priorities for Local AIDS Control Efforts (PLACE) Study, most of the new infections are found among heterosexual couples (43.31%); FSWs (4.90%); FSWs customers (23.52%) and their partners (6.15%).[10]

HIV prevalence in key populations.

Although Burundi is not considered a high-prevalence country, there are specific populations that demonstrate significantly higher prevalence rates. The 2013 PLACE Study estimated that there are 51,482 FSW in Burundi with a prevalence rate of 21.3%. The study estimated a 3.8% prevalence rate among their clients and 5.2% for their partners. The same study estimated 9,346 MSM with an HIV prevalence rate of 4.8%. The National Defense Force is also a priority population due to known high risk behavior among military personnel. Since current data is unavailable, the HIV prevalence for the general population is being utilized. However, studies in nearby countries have shown that the HIV prevalence rate among uniformed personnel is often higher than the general population. A military HIV sero-prevalence study in 2015/2016 will make more accurate data available.

There is no data related to the HIV prevalence among people who inject drugs as this population is virtually non-existent in Burundi.

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[7] UNAIDS. "Burundi Developing Subnational Estimates of HIV Prevalence and the Number of People Living with HIV." UNAIDS. 2014. Accessed March 26, 2015. http://www.unaids.org/sites/default/files/media_asset/2014_subnationalestimatessurvey_Burundi_en.pdf.

[8] NSP 2014-2017

[9] UNAIDS SPECTRUM 2013

[10] PLACE Study 2014

Prevalence is unevenly distributed nationally with eighty percent of the national burden found in 11 provinces: Bujumbura Mairie (contributing 13% to the overall burden), Bujumbura Rurale (12%), Ngozi (12%), Kayanza (9%), Gitega (7%), Muramvya (6%), Kirundo (6%), Karusi (5%), Cibitoke (5%), and Mwaro/Muyinga (4% each). The province of Bujumbura-Mairie has an estimated prevalence of 3.6%, almost 2.5 times the national average. The western region follows with an average prevalence of 1.8%, with peaks at 2.2% and 2.1% in the provinces of Bujumbura Rurale and Muramvya, respectively. The Northern Region is third, with 1.7%, while other regions have generally lower prevalence than the national average.

The 2013 PLACE Study, which was conducted in 66 communes called Priority Intervention Zones (PIZ), shows that the average prevalence in these areas is far higher than the national average at 6.4%.The Bujumbura Mairie PIZ showed rates at 6.8%, while they were 7.4% in PIZ of provincial chief towns and 3.6% in PIZ located in rural areas. [11]

1.2 Investment Profile

The HIV response in Burundi is funded primarily by two sources—PEPFAR (47%) and the GFATM (45%). The national government's contribution is estimated to be around 5 % while other donors contribute 3%. The national government has been steadily increasing their contribution to the response; however, there are insufficient domestic resources available to fill funding gaps in the immediate future.

PEPFAR support has been maintained at a similar funding level of $ 18,860,000 from FY2011 to FY2013, but declined to $17,360,000 in FY2014. The PEPFAR funding level is not expected to decline drastically in the near term given the categorization of Burundi as a long-term strategy (LTS) country.

The Country Coordinating Mechanism (CCM) submitted a concept note on January 30, 2015, based on the UNAIDS costed and prioritized NSP to access funds under the GFATM New Funding Model (NFM) allocation for the period of 2015-2017.

A mapping exercise started in June 2013 to assess and provide technical recommendations to the GFATM, USG, GOB, civil society organizations, and other partners to ensure programming and resources are well coordinated, non-duplicative, and cost effective. The results of this mapping have been critical to the development of PEPFAR Country Operational Plans (COPs) and proposals to GFATM. The results of the mapping help to eliminate duplication, maximize the USG and GFATM investment, and strategically align with domestic and other available resources to achieve epidemic control.

[11] PLACE Study 2014

Table 1.2.1 Investment Profile by Program Area[12]

Program Area	Total Expenditure	% PEPFAR	% GF	% GRP	% Other
Clinical care, treatment and support	**$13,891,149**	**16%**	**69%**	**10%**	**5%**
Community-based care	**$1,429,790**	**66%**	**26%**	**8%**	**0%**
PMTCT	**$4,373,455**	**63%**	**34%**	**3%**	**0%**
HTC	**$2,345,679**	**50%**	**50%**	**0%**	**%**
VMMC (NA)	-				
Priority population prevention	**$7,243,146**	**63.9%**	**28%**	**0.1%**	**8%**
Key population prevention	**$814,670**	**98%**	**2%**	**0%**	**%**
OVC	**$2,224,213**	**32%**	**68%**	**0%**	**0%**
Laboratory	**Included in HSS**				
SI, Surveys and Surveillance	**$1,171,000**	**86%**	**14%**	**0%**	**0%**
HSS	**$7,014,119**	**67%**	**29%**	**3%**	**1%**
Total	**$40,507,221**	**47%**	**45%**	**5%**	**3%**

Table 1.2.2 Procurement Profile for Key Commodities

Commodity Category	Total Expenditure	% PEPFAR	% GF	% GRP	% Other
ARVs	**$7,307,749.19**	**3.02%**	**86.06%**	**8.55%**	**2.36%**
Rapid test kits	**$2,342,323.13**	**46.25%**	**47.32%**	**-**	**6.43%**
Other drugs	**$1,164,261.18**	**30.81%**	**46.64%**	**21.47%**	**1.07%**
Lab reagents	**$784,473.32**	**28.49%**	**71.51%**	**-**	**-**
Condoms[13]	-	-	-	-	-
VMMC kits	-	-	-	-	-
Other commodities	**$815,350.26**	**99.19%**	-	-	**0.81%**
Total	**$12,414,155.08**	**21.71%**	**68.48%**	**7.05%**	**2.76%**

Table 1.2.3 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives

Funding Source	Total Non-COP Resources	Non-COP Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	$3,000,000	$3,000,000	1 (IHPB)	$4,501,184.09	Integrated health services including HIV/AIDS, MCH, FP and Malaria.
USAID TB	-	-	-	-	-
USAID Malaria	$12,000,000	$725,000	1 (IHPB)	same	Integrated health services including HIV/AIDS, MCH, FP and Malaria.
Family Planning	$3,000,000	$2,000,000	1 (IHPB)	same	Integrated health services including HIV/AIDS, MCH, FP and Malaria.
NIH	-	-	-	-	-
CDC NCD	-	-	-	-	-
Peace Corps	-	-	-	-	-
DOD Ebola	-	-	-	-	-
MCC	-	-	-	-	-
Private Sector	-	-	-	-	-
PEPFAR Central Initiatives	-	-	-	-	-
Total	**$18,000,000**	**$5,725,000**		**$4,501,184.09**	

[12] (GRP, National AIDS Spending Assessment , 2012), all amounts in 2012 USD

[13] No condoms were procured in 2014 because of overly large orders placed in 2013

1.3 National Sustainability Profile

The Sustainability Index identified the following elements as areas where the national HIV/AIDS response is currently weak and unsustainable : Epidemiological and Health Data, Access and Demand, Human Resources for Health, Commodity Security and Supply Chain, Quality Management, Domestic Resource Generation, Domestic Resource Commitments, Allocative Efficiency, Technical Efficiency, Public Access to Information, Oversight and Stewardship, and Policies, Laws, and Regulations. Of these, PEPFAR Burundi and key stakeholders have identified the following areas that are most urgently in need of attention:

- Epidemiological and Health Data: weaknesses related to the lack of routine HIV/AIDS data, Antenatal Care (ANC) Sentinel Surveillance, HIV prevalence/incidence, and viral load.
- Access and Demand: low uptake of HIV/AIDS prevention, care and treatment services especially in the provinces not supported by PEPFAR.
- Human Resources for Health: shortage of well-trained health workers to ensure rapid uptake of HIV/AIDS prevention, care and treatment services among priority populations and at high-yield sites
- Commodity Security and Supply Chain: deficiencies in both national-level procurement and distribution of commodities to the operational and facility-levels
- Quality Management: absence of robust national quality assurance system
- Domestic Resource Commitments: actual health expenditure of government is 13.7% (while Abuja target is 15%) and the proportion of domestic HIV expenditures financing the annual national response is around 5%.

There are a select few bi- and multi-lateral partners working on some of these areas. However, in terms of HIV/AIDS, PEPFAR and the GFATM are the two major donors in country.

- **Epidemiological and Health Data**: The Belgian Technical Cooperation (CTB) is working to strengthen this priority element; however there is a need for additional support from other partners in key disease areas, such as HIV/AIDS and PEPFAR is planning to fund select areas specific to HIV/AIDS.
- **Access and Demand**: GFATM and PEPFAR are supporting the country to reinforce this priority element and PEPFAR is planning to continue to fund this area.
  Human Resources for Health: The CTB is working to strengthen this priority element, but given that human resources is a broad area and CTB is focusing on general health, there is a need for HIV/AIDS specific technical support in this area and PEPFAR is planning to support targeted activities under this element.
- **Commodity Security and Supply Chain**: The French 5% Initiative has started to reinforce this priority element, but given that this element is very critical for the success of PEPFAR's HIV response in country, PEPFAR is planning to continue this support for critical commodities in PEPFAR-supported locations.

- **Quality Management**: PEPFAR has a unique and specific technical advantage in this area and no other donors are working on it, especially in relation to HIV/AIDS. PEPFAR has also seen significant improvement in uptake of PMTCT and other services where this activity has been rolled out. PEPFAR is planning to continue to implement interventions for quality improvement and quality management of HIV programs in the PEPFAR target provinces and expand to the non-PEPFAR provinces to support the Government's and GFATM's investments in ART.
- **Domestic Resource Commitments**: UNAIDS and WHO are advocating to the Government to increase its expenditures for Health and HIV. The Government of Burundi has committed to provide a 5% match to the total amount requested in the Concept Note submitted to the GFATM in January.

1.4 Alignment of PEPFAR investments geographically to disease burden

Figure 1.4.1 shows the correlation of total expenditure for 2013 relative to disease burden for each of the eight provinces covered by PEPFAR. Expenditure is highest in Bujumbura Mairie, a finding consistent with the high disease burden found in the capital. The same finding similarly holds true for Ngozi and Kayanza (and to some extent for Kirundo).

For the other provinces, it is difficult to draw any definitive conclusions as expenditure is low relative to disease burden in Bujumbura Rurale while it is high relative to burden in Karuzi, Muyinga, and Gitega. It is important to note that Karuzi and Muyinga were in a start-up phase this year as the IHP was only awarded in December 2013. Consequently, the rate of scale-up may have skewed the data. In Gitega, the higher expenditure may result from the size of the province and/or the fact that it includes a large urban center.

With only one year's worth of Expenditure Analysis (EA) data and the close-out of one project and the start-up of another during the same period, the data may be inconclusive at this time. However, the high spend in Muyinga and Gitega compared to the relatively low disease burden in those provinces played a role in PEPFAR Burundi's decision to transition both provinces from a general population focus under the IHP to a more limited key populations focus through the LINKAGES project and GBV interventions in Muyinga.

Figure 1.4.1 Percent of PLHIV by SNU and PEPFAR 2014 Expenditure per PLHIV

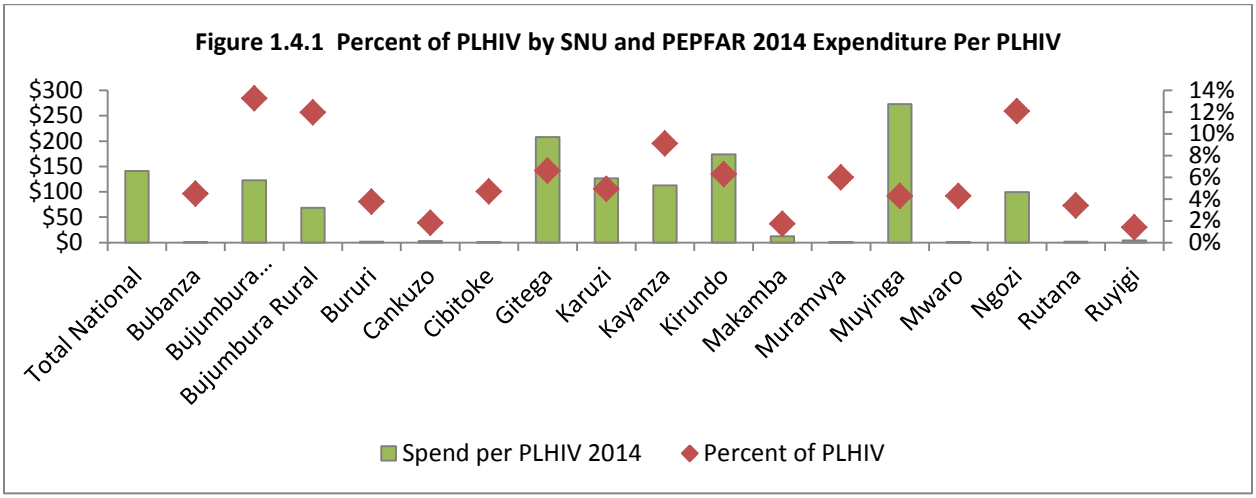


Figure 1.4.2 PLHIV by SNU, coverage of total PLHIV on ART & PEPFAR contribution

SNU	PEPFAR supported/ project	HIV Prevalence	PLHIV by SNU	% PLHIV by SNU	Current on ART (National) FY 14	Current on ART (PEPFAR) FY 14	% PEPFAR contribution to FY 14 Output for TX_CURR by SNU
National	**n/a**	**1.30%**	**90,551**	**100%**	**35,852**	**6,067**	**17%**
Bujumbura Mairie	PMTCT AP	4%	12,010	13%	15,514	709	5%
Bujumbura Rural	PMTCT AP	2.3%	10,840	12%	1,320	123	9%
Ngozi	PMTCT AP	1.7%	10,940	12%	1,913	253	13%
Gitega	PMTCT AP	0.9%	5,990	7%	3,841	342	9%
Kayanza	IHPB	1.7%	8,247	9%	1,735	1395	80%
Karusi	IHPB	1.1%	4,450	5%	701	276	39%
Kirundo	IHPB	1.1%	5,671	6%	2,303	1258	55%
Muyinga	IHPB	0.8%	3,880	4%	1,633	1711	105%
Rutana	No	1.2%	3,078	3%	488	n/a	n/a
Mwaro	No	1.6%	3,880	4%	522	n/a	n/a
Makamba	No	0.4%	1,540	2%	1,268	n/a	n/a

Bururi	No	0.7%	3,380	4%	1,800	n/a	n/a
Cibitoke	No	1.0%	4,250	5%	492	n/a	n/a
Bubanza	No	1.3%	4,065	4%	443	n/a	n/a
Ruyigi	No	0.4%	1270	1%	862	n/a	n/a
Muramvya	No	2.1%	5,420	6%	651	n/a	n/a
Cankuzo	No	0.9%	1,640	2%	366	n/a	n/a

1.5 Stakeholder Engagement

PEPFAR Burundi has consulted with key stakeholders including the Ministry of Public Health (MSPLS), UNAIDS, WHO, the CNLS, the National AIDS Program (PNLS), and civil society on the new PEPFAR global strategy and PEPFAR Burundi's work to align with it. Consultations have included: (1) presentations and exchanges on the PEPFAR 3.0 strategy aiming to reach epidemic control through prioritization of high burden geographic areas, focus on women of childbearing age, and key populations; (2) collaborative exercises to complete the sustainability index and dashboard; (3) sharing the data analysis and decision-making resulting from the site yield analysis and geographic coverage; (4) discussion on the approach PEPFAR Burundi is using to saturate areas of high HIV burden and prevalence with combination prevention activities in order to reach epidemic control in five provinces by 2017; and (5) initial discussions on transition plans.

MSPLS was briefed on the new PEPFAR strategy globally and in Burundi. Although there was some reluctance on the part of the Minister regarding changes proposed, after sharing and explaining the data, she and her team agreed to the proposed changes outlined. The discussions with the PNLS, civil society, and the CNLS will continue to ensure that transition plans are prepared and well executed. PEPFAR Burundi plans to continue regular quarterly coordination meetings with the GFATM and MSPLS to revisit and review data, as it is available, to ensure we continue to respond effectively and efficiently in the right places.

A one-day workshop for consultations with civil society organizations was organized, where the participants recognized the high quality of PEPFAR interventions and appreciated the goal of reaching epidemic control by focusing on targeted geographic areas and priority and key populations. However, they expressed their growing concern about the insufficient nutritional support to PLHIV provided by GFATM, the weakness of interventions in non-PEPFAR high-burden areas and the fact that CSOs are not benefiting from direct support of USAID financing. Recommendations were made to the PEPFAR Burundi team, including: the need to strengthen nutritional support and viral load monitoring, the extension of PEPFAR focused interventions, the strengthening of CSOs institutional capacity and their promotion to prime implementing partners. These recommendations were analyzed, discussed, and integrated into the COP . These include: better linkages with nutrition and feeding programs, strengthening viral load monitoring,

the identification of other "hotspot" and higher burden locations where the program should focus, and opening the opportunity for CSOs to receive prime partner status.

Building a more sustainable response to fighting HIV in Burundi is a fundamental priority for the USG team. Burundi's program has been involved in strategic engagement activities with the GOB over the last seven years and fosters a close and collaborative relationship based on annual Assistance Agreements and joint work planning to ensure that all USG efforts are aligned. The solid base PEPFAR has built with the GOB is recognized by our government counterparts, despite not having a Country Health Partnership. To further our joint planning and commitments, PEPFAR has implemented joint services and coverage mapping and ongoing approaches to continue coordination with the GFATM are being explored and applied. USG is currently a voting member of the CCM and is the Coordinator of the technical committee in charge of proposal development. The CNLS and the PEPFAR team initiated a new coordination framework this past year that will focus on information sharing and timely problem solving in the provision of HIV services – this framework will evolve in the coming year in conjunction with rolling out the new PEPFAR global strategy. Strategically, participants will discuss how to best document and hold each other accountable, the generation and use of data for decision-making, and establishing meaningful engagement of all stakeholders in the delivery of HIV services.

2.0 Core, Near-Core and Non-Core Activities

What, where, who, and why us?

The PEPFAR Burundi program is relatively small in budget, and the core, near-core, non-core exercise revealed that the program is predominantly focused where the disease burden is highest. There are, however, some activities that were not deemed critical to scaling-up treatment and reducing new infections, activities that should be taken over by other partners, and others that are important for the national program, but not deemed a priority for PEPFAR. Overall, the majority of the "core" activities are in Care and Treatment and PMTCT while most of the "non-core" activities identified are in Program/System Support.

While the PEPFAR program intends to continue its high-impact activities (e.g. PMTCT) in five of the eight provinces (4 scale-up to saturation plus one sustained), there was recognition that there may be scope for expansion to support epidemic control in Burundi. In high-burden locations where the GFATM is not performing well in an area of comparative advantage for PEPFAR, for instance, TA will be provided and/or the PEPFAR model will be scaled-up to ensure that more PLHIV are linked to care and treatment.

The Core: PEPFAR's comparative advantage in Burundi

PMTCT and HTC for women, their families and priority populations: The burden of HIV/AIDS in Burundi is disproportionately among women of reproductive age (15-49) and FSW. Therefore, PEPFAR Burundi is largely focused on providing PMTCT services and reaching women through the IHP and PMTCT Acceleration mechanisms. These mechanisms provide long-term, integrated health services, including HTC, PMTCT, STI management, and ANC, for women, their children and other family members. Supported sites also provide access to other priority populations, such as military personnel who are highly mobile and believed to engage in risky behavior which can expose family members.

These services aim to reach as many women as possible by being strategically located in the provinces that comprise 80 percent of the disease burden in Burundi. Recent data show that PEPFAR-supported sites have achieved 91 percent coverage for PMTCT services while the national rate is only 59 percent. Since PEPFAR has a clear comparative advantage in this area, the program is planning to provide additional TA to GFATM-supported sites in high-burden areas.

Support for "key" and "priority" populations: In addition to PMTCT and HTC services provided to key and priority populations, PEPFAR will continue to support targeted prevention and treatment, including condom distribution, PEP, STI and OI testing and management. In addition, the program will continue peer education and other outreach services that have been shown to reduce new infections.

Targeted health systems activities, lab equipment and commodities: The GFATM provides ART in Burundi except in PEPFAR-supported PMTCT sites. However, PEPFAR will continue to procure RTKs, cotrimoxazole, PEP, CD4 and viral load commodities, among other key

commodities essential to PEPFAR-specific activities. In addition, through SCMS, PEPFAR has comparative advantage in supply chain management, which is essential to the national management and distribution of drugs and commodities. Likewise, laboratory systems strengthening, which is part of the SCMS package of services, is fundamental to ensuring the smooth provision of PEPFAR-supported services. The DHS and LMIS are planned in COP15 as core activities that PEPFAR is uniquely positioned to conduct.

Targeted OVC activities: Historically, PEPFAR had supported targeted OVC activities through the IHP mechanism but a review of these activities indicated limited impact and a recommendation was made to realign these funds to a new, more strategic initiative. Based on discussions during and after the COP review, PEPFAR Burundi will be use its OVC funding, coupled with additional Family Planning funds, to create a new mechanism to prevent HIV in adolescent girls and young women. While Burundi is not a DREAMS Initiative country, the design of the new mechanism will take into account DREAMS guidance. While key activities are yet to be developed, the project target girls and young women ages 10 to 18, both in and out of school with a comprehensive package likely to include condom promotion and provision, HIV testing and counseling, post-violence care, contraceptive method mix, social asset building, social protection (education subsidies), and parenting/caregiver programs.

The Near-Core: Activities deemed critical to supporting the Core

The activities in this category are considered nonnegotiable, as they are fundamental to the success of "core" activity implementation. These include gender-based violence, which is considered a major contributor to HIV transmission, putting women and young girls at-risk, and preventing them from accessing appropriate care and treatment. In a similar vein, outreach activities to increase male involvement and participation in care, treatment and prevention are important to the success of HIV and AIDS interventions in Burundi. Targeted coaching and mentoring of healthcare workers in PMTCT sites have shown considerable success in terms of retaining women and children in care and preventing new infections. A number of studies are also planned in COP15 - PRISM, PLACE IBBS for key pops and military, ANC surveillance, etc. – because they will provide the data necessary to validate or refine current PEPFAR activities, particularly those focusing on key and priority populations.

The Non-Core: Activities to be transitioned

Identifying activities to transition was a challenge given that the Burundi program has already been very focused due to a limited budget and targeted approach. The PEPFAR team had dynamic discussions about whether certain activities could or should be implemented by other partners. For instance, organizational capacity-building for the PNLS and the medicines regulatory authority, although fundamental to the national program, should fall within the responsibility of WHO rather than PEPFAR. Performance-based financing for PMTCT sites will not be considered in COP15. Other systems-related activities that could not be obviously linked to increasing treatment coverage and reducing new infections were placed under non-core. These include support for the development of the National Health Account, support for the performance evaluation of the Country Coordinating Mechanism for the Global Fund, capacity building of the

Quality Control Lab of the National Institute of Public Health, and training of journalists and other media initiatives.

3.0 Geographic and Population Prioritization

Burundi has a generalized epidemic, although the HIV/AIDS burden is disproportionate among women of reproductive age. PEPFAR Burundi strategically targets HIV-positive women, their children, and partners and focuses on providing prevention, care, and treatment services. In FY14, PEPFAR operated in 8 of 17 provinces, representing 68% of the national HIV disease burden. These provinces are Kayanza, Kirundo, Muyinga, Karusi, Bujumbura Mairie, Ngozi, Gitega, and Bujumbura Rurale.

National ART coverage in Burundi remains low at 40% (of total eligible PLHIV, estimates based on WHO guidelines 2013 adapted by GOB in 2014). In order to achieve epidemic control, the PEPFAR program targets sites in the provinces with the highest burden of HIV disease, and lowest ART coverage. As a result of the yield analysis, we have identified that Bujumbura Rurale, Ngozi and Muramvya have the highest number of PLHIV nationwide and the lowest ART coverage. The program would like to scale up ART services in all three provinces but this is not feasible for FY16 given budget constraints. Thus the program will scale up services in Ngozi and Bujumbura Rurale where the PMTCT AP is already operating this year, and aim to transition into Muramvya in FY 17. Given that the burden of PLHIV is much lower in Muyinga, Gitega and Karusi, PEPFAR Burundi has decided to transition out of these three provinces for the general population but to scale up activities targeting key populations in specific hotspots inMuyinga and Gitega under the new LINKAGES project as key populations are seen as driving the epidemic there. Muyinga shares borders with both Rwanda and Tanzania and includes the major trucking routes connecting Burundi to those two countries and is thus a hotspot for FSW. Gitega is home to a large urban center which has been identified as a hotspot for FSW and MSM.

In order to reach 80% ART coverage in PEPFAR supported provinces by end of FY17, it is estimated that 19,302 additional patients will need to be supported with ART services. This will require identifying PLHIV through targeted HTC, PMTCT and interventions targeting key populations. In order to achieve these results with current funding levels, PEPFAR Burundi will aim to reach 46% treatment coverage by FY2016 and 80% by FY2017.

ART: ART services are currently supported by PEPFAR Burundi in 4 provinces under the IHP. In FY 15, the program intends to expand delivery of its high-impact ART services across two of these priority provinces: Kayanza, and Kirundo. Given that the remaining provinces, Muyinga and Karusi, are relatively low burden, ART services there will be transitioned to the GOB except for key populations and GBV interventions. Scale up of ART services to achieve at least 80% coverage on ART will thus be focused in four provinces - the two existing provinces under the IHP, and Ngozi and Bujumbura Rurale where coverage is relatively low despite good PMTCT saturation. Pediatric ART coverage will also be scaled up significantly to reach 40% (from 18%) coverage across all PEPFAR provinces by end of FY2017.

PMTCT: PMTCT services are currently being supported by PEPFAR Burundi in 8 provinces: Karusi, Kayanza, Kirundo and Muyinga under the IHP mechanism; and Bujumbura Mairie, Bujumbura Rurale, Gitega and Ngozi under the PMTCT-AP mechanism. In addition, in October 2014 PEPFAR, through the DOD, began supporting PMTCT activities aimed at military families at the Kamenge Military Hospital in Bujumbura. Recent data show that PEPFAR-supported sites have achieved 91% coverage for PMTCT services in these provinces, while the national rate stands at 59%. As a result of saturation, the PEPFAR program will shift to sustained status in Bujumbura Mairie with an eye towards transition in FY2017. The program will also transition to central support in Gitega, Muyinga, and Karusi provinces due to low HIV burden. The program will continue to scale up high impact PMTCT services in the other 4 provinces.

Support for "key" and "priority" populations: PEPFAR will continue to support targeted prevention, care and treatment services targeting key populations, namely FSW and MSM. Although the number of PLHIV is relatively low in Muyinga, this province has the largest number of FSWs and truck drivers given their proximity to the border. Given the high prevalence of HIV among FSWs (21.3%), PEPFAR Burundi will target known hotspots within this province and two other provinces with high HIV burden and similar key pop demographics (Bujumbura Mairie and Gitega).

PEPFAR Burundi will also target priority populations including military personnel, their dependents, and civilians in neighboring communities through focused interventions, such as targeted HTC, and condom promotion and distribution. Burundi has approximately 25,000 military personnel, comprised of mostly males between 25-34 years of age. These military personnel, their dependents and proximate communities represent a total target population of 100,000 persons who are spread across the country in five military regions. Military members may be at higher risk for HIV since they are highly mobile, have money, are young and are deployed both within and outside of the country.

OVC: As detailed above, PEPFAR will be reorienting OVC funding out of the IHP toward a new mechanism aimed at preventing new HIV infections in adolescent girls and young women. While the location of this project has not yet been determined, it is likely to be in only one province in order to maximize saturation and impact. The province will however be one of the four existing scale-up provinces. OVCs currently supported by PEPFAR through the IHP will be transitioned using existing funds. The program will continue to provide support for OVC and other community based activities that ensure linkage and retention in care, treatment adherence support and outreach services that have been shown to reduce new infections.

4.0 Program Activities for Epidemic Control in Priority Locations and Populations

4.1 Targets for priority locations and populations

Using a cascade approach, PEPFAR Burundi has calculated the required number of additional PLHIV to reach 80% ART coverage by FY17. The four provinces which PEPFAR currently supports for ART have an average coverage of 19% (APR 2015). In FY16, PEPFAR Burundi intends to scale up ART services in two of the current four provinces—Kirundo and Kayanza, and also in two additional provinces where only PMTCT has been supported—Bujumbura Mairie and Ngozi. The program aims to enroll 10,419 additional patients (adults and children) with the goal of having a total of 16,383 current on ART by FY 16. This represents an increase in coverage from 19% to 46% for adults (Table 4.1.1). In FY17, as per the data pack targets, we will continue to scale-up ART coverage in order to reach 80% coverage, and aim to have a total of 23,200 PLHIV on ART by FY 17. PLHIV required for meeting the target for newly initiated on ART in priority provinces will be identified and linked to care and treatment services via provider-initiated, voluntary, and targeted mobile counseling and testing services (military services only), using evidence-based best practices to inform services models. Based on prior-year program data, we anticipate that about half of those diagnosed HIV-positive through these platforms are linked to care programs.

In order to achieve epidemic control, PEPFAR Burundi will not only target general population in high prevalence provinces but will also prioritize several critical program streams including PMTCT, TB/HIV, priority populations including military and truck drivers, pediatrics, and key populations (such as FSW) to efficiently identity HIV-positive clients in these populations and effectively link them to care and treatment in a timely manner (Table 4.1.2). This represents an estimated 5,481 newly initiated on ART in FY 16.

PMTCT: Activities will focus on the diagnosis and initiation of ART for HIV-positive pregnant women in the 4 priority and 1 maintenance provinces. PEPFAR Burundi aims to test 95% of pregnant women in the priority provinces and enroll 95% of those testing HIV-positive into ART. This is expected to yield 1,985 newly initiated clients by end of FY16. In line with the new WHO guidelines (2013), PEPFAR will provide ART for pregnant women for two years. Clients initiated through the PMTCT platform will remain on lifelong treatment but transition to GOB/GFATM support at the end of the PMTCT cycle.

KEY POPULATIONS: PEPFAR Burundi will target key populations to increase treatment coverage (specifically FSW, their clients, and MSM) by strengthening the national response with a focus on prevention, identification of positive clients and active linkages to care and treatment. PEPFAR Burundi will also consider FSW as a priority group for PMTCT, and include referrals between FSW and PMTCT interventions.

PEDIATRICS: Given the challenges of increasing Burundi's relatively low pediatric ART coverage (currently 21%), PEPFAR Burundi will aim to achieve 40% pediatric ART coverage by FY17 - instead of the recommended 80%. Reaching 40% pediatric coverage in 2 years aligns with the NSP.

TB/HIV: PEPFAR Burundi has committed to enroll 223 new TB/HIV patients.

Consistent with past programming, PEPFAR Burundi will not procure ARVs for treatment, but will contribute to coverage results by supporting treatment services. The program will continue to procure ARVs for PMTCT clients only in PEPFAR supported PMTCT sites.

Table 4.1.1 ART Targets in Priority Sub-national Units for Epidemic Control

SNU	Total PLHIV	Expected current on ART(2015)	Additional patients required for 80% ART coverage	Target current on ART (in FY16) *TX_CURR*	Newly initiated in FY 16 *TX_NEW*
Bujumbura Rural	**8,800**	260	**6,780**	**3,953**	**3,392**
	6,700	1,497	**3,863**	**4,141**	**2,335**
Kayanza	**4,600**	**1,481**	**2,199**	**3,553**	**1,388**
Kirundo	**8,900**	660[14]	**6,460**	**4,498**	**3,304**
Ngozi	**1,300**	**805**	**235**	**922**	**118**
Military					
Total	**30,300**	**4,703**	**19,537**	**17,067**	**10,537**

Table 4.1.2 Entry Streams for Newly Initiating ART Patients in Priority Districts (FY 16)

Entry Streams for ART Enrollment	Tested for HIV (in FY16)	Identified Positive (in FY16)	Enrolled on ART (in FY16)
Clinical care patients not on ART		unavailable	
TB-HIV Patients not on ART*	1462	191	172
HIV-positive Pregnant Women*	129,474	1,985	1,886
Other priority and key populations*	572,004	9,138	7,310
Total	702,940	11,314	9,368

[14] 2015 #s are GFATM-supported asPEPFAR does not currently support ART in these provinces

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	**Population Size Estimate (priority SNUs)**	**Coverage Goal (in FY16)**	**FY16 Target****
FSW	51,482 (national)	3.8%	1931
MSM	9,346 (national)	2.2%	205
Military	*100,000 (national)	45%	45,000
Total	**160,828**		

* Includes military and their family members.
**The team will only be supporting prevention services for KPs and military.

Table 4.1.5 Targets for OVC and Pediatric HIV Testing, Care and Treatment					
	Estimated # of Children PLHIV (<15)	**Target # of active OVC (FY16 Target) OVC_SERV**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services (FY16 Target) OVC_ACC**	**Target # of children tested (FY16 Target)**	**Target # of children on ART**
Bujumbura Rural Kayanza Kirundo Ngozi	2040 1547 1071 2040	tbd tbd tbd tbd	tbd tbd tbd tbd	8,074 3,297 1,692 7,118	546 501 491 505
TOTAL	**11,628**	**14550**	**N/A**	**20,180**	**2,043**

4.2 Priority population prevention

Although the majority of HIV infections in Burundi occur in the general population, recent surveys[15] have shown that key and priority populations, such as FSW (and their clients), MSM, and military personnel, contribute significantly to the burden of disease with prevalence rates of 21.3%, 4.8%, and 1.3%, respectively. These populations will be prioritized for targeted prevention and linkage to care activities.

PEPFAR Burundi will support high-impact core interventions in COP15 for key populations including: targeted education and HTC of key and priority populations, improved linkages to combination prevention services, strengthened referral networks, condom/lubricant promotion and distribution, targeted "test and treat," STI testing and treatment services, PMTCT for FSWs and the military and their partners, post-exposure prophylaxis (PEP) and linkage to clinical care

[15] Integrated Bio-Behavioral Surveillance (IBBS), 2011; Priorities for Local AIDS Control Efforts (PLACE) Study, 2014.

services for victims of sexual and gender-based violence. ART is provided by the GFATM, but PEPFAR will continue to target and identify key and priority populations and ensure that they are directly linked to treatment services including positive health and dignity (PHDP) activities.

As detailed earlier, PEPFAR Burundi has decided to transition out of Muyinga and Gitega provinces for the general population but to scale up activities targeting gender-based violence (GBV) and sexual violence (SV) survivors in Muyinga, and Key Populations in both provinces under the new LINKAGES Project as these populations are seen as driving the epidemic there. The transition decisions are based on UNAIDS sub-national prevalence estimates, program data, and initial information from the PLACE Study 2014 and civil society organizations working with key populations. As these sites will be assessed as the new project starts, exact site data is not yet known. The project will be transitioning from the previous projects and scaling up in mid to late 2015. The focus will be specifically on key populations – including MSM, which has not been a focus of PEPFAR programming in the past, and FSW and their clients, as well as other populations identified in initial assessments and mapping activities that will take place in mid-2015. PEPFAR Burundi doesn't anticipate any challenges with commodities, as the GOB through GFATM has estimated reaching 80% coverage in its NSP and procurement plans. It is important to note that civil society and community-based organizations have been and will continue to be an integral part of project design at all levels and play a critical role in patient care and support from case identification to retention. Civil society organizations in Burundi are often the first point of connection and/or care for key populations. Although civil society organizations tend to need additional support and capacity to design, manage, and implement activities, they are integral to the successful functioning of programming, as their members/staff are members of the communities we are trying to reach.

PEPFAR Burundi will also target military personnel, their dependents, and neighboring communities through focused interventions, such as targeted HTC, and condom promotion and distribution. Burundi has approximately 25,000 military personnel, comprised of mostly males between 25-34 years of age. These military personnel, their dependents and proximate communities represent a total target population of 100,000 persons who are spread across the country in five military regions. Military are at higher risk for HIV as most are highly mobile within and outside of the country. Due to the sensitivities of military sites and personnel and agreements with the Burundian Minister of Defense, site and yield analysis were not completed for the DOD program.

There remain significant challenges to reaching key and priority populations, including limited data to inform programming decisions, harmful national laws and policies that marginalize and criminalize certain populations (e.g. MSM), and a general lack of recognition of the role that GBV and SV play in perpetuating the HIV epidemic in Burundi. Despite these challenges, the MSPLS with the GFATM has identified FSW, MSM, and other vulnerable populations as priorities for HIV prevention, care, and treatment. The LINKAGES project will work with local civil society

organizations and other key stakeholders to assess the situation and proceed with care and confidentiality to ensure beneficiaries are protected.

4.4 PMTCT

The PEPFAR program currently supports 363 health facilities offering a high-quality package of PMTCT services beginning with routine opt-out testing in ANC and including syphilis screening, clinical monitoring and a complete course of ARV prophylaxis for HIV-positive mothers and their babies. Where maternity services are offered, routine opt-out testing is also conducted for all mothers who present for delivery with unknown HIV status. Follow-up of mother-infant pairs after delivery includes infant feeding education, family planning (FP) counseling and services, CTX prophylaxis for exposed infants, referral to OVC programs, EID, and referral to ART for all mothers and for those infants testing positive.

Burundi began roll-out of Option B+ in January of 2015. At the national level, and in collaboration with other partners, PEPFAR will continue to support the PNLS to ensure the successful adoption of the new guidelines throughout the country. Given the already high ART retention rate there are no significant concerns about the transition from Option B to Option B+. Nonetheless, programmatic efforts will be made to ensure that women are effectively transitioned from PMTCT Option B to lifelong ART services.

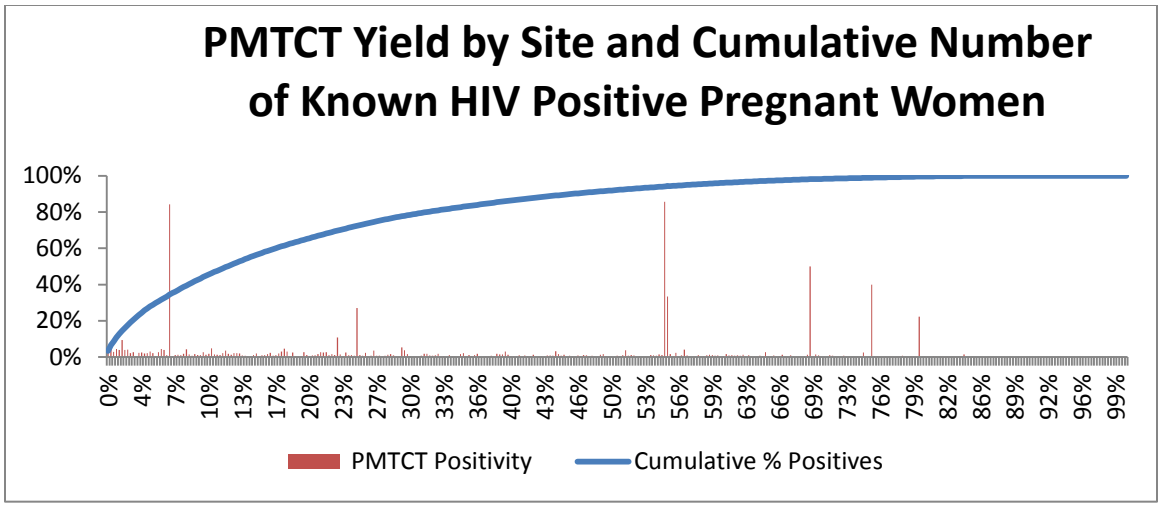
PMTCT activities have shown great success in Burundi, achieving 88% ART coverage of women with known HIV+ status in the PMTCT AP-supported provinces. Given that women of childbearing age are a priority population, PMTCT remains a key intervention for achieving epidemic control nationally. Core PMTCT services will continue as under COP14, including the procurement of ARVs for PMTCT prophylaxis. [16] The program will also continue to provide TA to the PNLS to assist provinces supported by the GOB/ GFATM to build their capacity to deliver quality PMTCT services.

Male involvement, which is seen as an important contribution to HIV care and treatment given the severe GBV challenges, is still quite weak in Burundi. Increasing male participation in PMTCT using the Men as Partners model successfully piloted under the EngenderHealth RESPOND project, will continue to be a focus.

Interventions implemented by the ASSIST project in the COP 14, initially in 4 provinces, have been shown to be very successful and will be scaled-up in two additional provinces this year. These include the coaching and mentoring of health care workers in quality improvement and the scale-up and supervision of Quality Improvement Committees at select facilities.

<u>Efficiency Analysis</u>

[16] These are the only ARVs procured by the PEPFAR program in Burundi.



PEPFAR supported PMTCT services at 356 sites in 2014. Of 356 sites, 52 reported 0 positives and 94 reported 4 or fewer positives in the last year. As shown in Figure 4.4.1, 32% of sites (116) identified 80% of positives and 219 sites identified 5 or more positives. In our yield analysis, of the sites with less than 5 positives, we also took into consideration HTC yield and HIV positivity. Sites with greater than 1% HIV positive rates were retained with the assumption that they have potential to generate new positives as they scale up, given their location in high burden geographic areas. Sites with recent start-up, district hospitals (which play an important role in providing maternity services to HIV-positive women) and those located in hotspots were also retained. This analysis therefore generated 31 sites from which PEPFAR Burundi will transition in addition to those in Gitega, Muyinga, and Karusi.

4.5 HIV testing and counseling (HTC)

HTC activities supported by the PEPFAR Burundi are consistent with WHO minimum standards and target communities and individuals with an emphasis on key populations. Activities implemented in 2014 were seen to be effective with 1.24% of the targeted individuals tested identified as HIV-positive and referred to clinical services for WHO staging, TB screening, CTX/ARV eligibility assessment and care. In COP 15, HTC services will continue to be provided in 265 health facilities to reach 80 percent treatment coverage and ensure that HIV-positive individuals are diagnosed and linked to care as soon as possible. Key interventions supported in COP 2015 include: linkages to prevention[17], care, and treatment services for pregnant women and their families, the military, FSW and MSM, and procurement of key HTC commodities through SCMS. Youth- and family-friendly comprehensive clinical services will also be provided in high prevalence and high burden provinces.

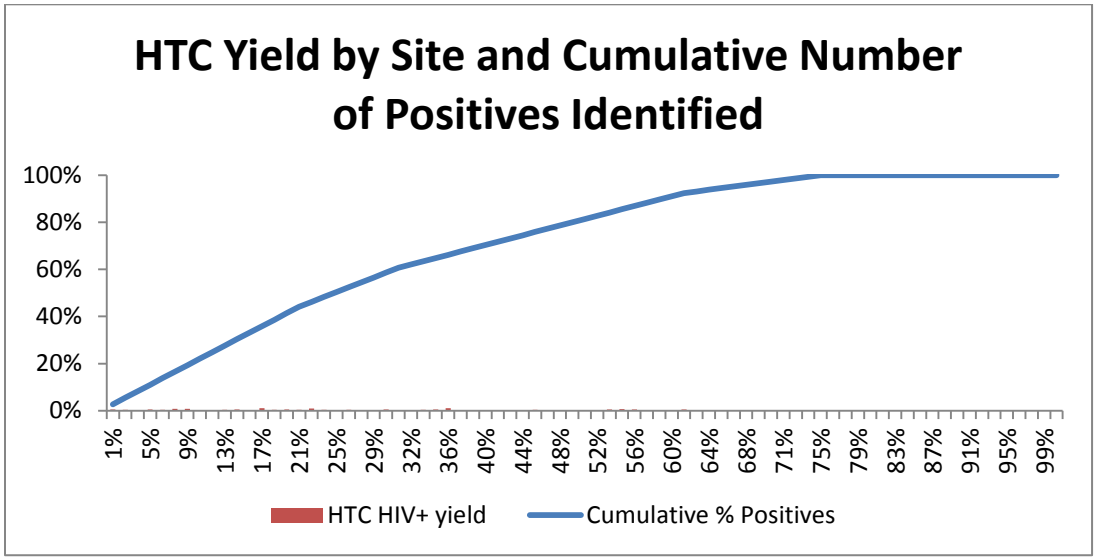
[17] Includes services for sero-discordant couples, referral to condom distribution points, PEP in-line with the WHO 2013 guidance (within 72 hours and related to injection safety among HCWs, victims of SV, and HIV- people who are exposed)linkage of children and youth who test negative to OVC services, and peer education.

PEPFAR also continues to identify innovative ways to encourage men to access HTC, but the demand for voluntary testing is still suboptimal. In order to move Burundi closer to "sustainable" in the Domestic Services (yellow) of the SID, the success of these interventions – as well as increasing the men's knowledge of HIV prevention and treatment, reducing stigma, and related GBV – will be very important.

In 2014, following TWG recommendations, the program supported the MSPLS to change the national algorithm for testing and counseling to be more reflective of Burundi's epidemic. A technical team is working on the review of the national algorithm for testing and counseling.

The DOD supports prevention, testing and counseling services for the military, their families, and surrounding communities, an estimated 100,000 people. In 2014, PEPFAR supported the construction of a new clinic which will be delivering HTC, HIV prevention, and care services to this target population.

Efficiency Analysis



PEPFAR supported HTC at 363 sites in 2014, 23 of which reported zero positives and 61 reported four or less positives in the last year. As shown in Figure 4.5.1, 36% of sites (132) identified 80% of positives and 279 sites identified 4 or less positives. Ninety-one sites are located outside of priority districts for 2016 and support will be redirected. Of the 84 sites identified as low yield, 77 are located in priority districts and required further scrutiny. In PEPFAR Burundi's yield analysis, of the sites with less than 5 positives, PMTCT yield and HIV positivity were also taken into consideration. Sites with greater than 1% HIV positive rates were retained with the assumption that they have potential to generate new positives as they scale up given their location in high burden geographic areas. We have identified 31 sites from which PEPFAR Burundi will no longer provide HTC services. The remaining sites will be prioritized for SIMS visits to identify constraints, increase partner performance, and assess testing models/practices.

4.6 Facility and community-based care and support

Partners will continue to support a standard package of care and support services in priority provinces, including TB screening and referral for diagnosis and treatment. Although transitioning out of Muyinga and Gitega, 2 provinces with low prevalence, the same package of care and support services will continue to be provided for key populations in these provinces. The core and near-core activities include: STI and OI screening and treatment, CTX, condom distribution and other prevention activities, integration with nutrition, malaria and pediatric programs, and EID (see Appendix A for more detail). PEPFAR will be procuring commodities to support these activities, except condoms, which are purchased by the GFATM and UNFPA.

Partners will work on strengthening linkages between facility and community-based services, since initial SIMS visits have shown an important gap in this particular domain. Intervention points that provide HIV services (HTC, key populations interventions, condom distribution, etc.) will be provided with standardized systems for tracking successful referral of HIV-positive clients to HIV care and treatment services.

Retention of patients in care will remain a high priority; the 8% loss to follow-up rate is good but there are areas for improvement. A special focus will be on children and adolescents. PEPFAR Burundi will utilize community support groups and other innovative strategies to keep people in care and ensure they are started on ART when eligible. In order to reach the 80% saturation requirement for ART, and to meet the new WHO guidelines recommending CD4 ≤ 500 as eligibility criterion, PEPFAR partners will set targets for CD4 testing accordingly. SCMS will provide the needed technical support for forecasting and distribution of lab commodities in order to address the limited access to CD4 testing due to stock-outs of reagents reported at recent SIMS assessments.

4.7 TB/HIV

TB is the most common OI among PLHIV in Burundi. In 2013, the WHO estimated the incidence of TB/HIV at 19%, ranking Burundi among the 41 countries where the burden of co-infection is the heaviest. TB activities in Burundi are almost completely supported by the GFATM. Regarding HIV/TB co-infection, the GFATM and other partners have been supporting the following activities: (1) systematic HIV testing among TB patients through the integration of HIV testing in all centers of TB care; (2) surveillance of HIV sero-prevalence among TB patients; (3) systematic integration of HIV prevention messages in structures for management of tuberculosis; (4) early initiation of antiretroviral therapy for patients on TB treatment; and (5) capacity building of centers for diagnosis and treatment so that they are able to provide quality services with a regular supply of medicines, equipment and consumables necessary for the diagnosis and treatment of co-infected patients. The management of TB/HIV co-infection has considerably progressed; before 2010, less than 50% of diagnosed TB patients were screened for HIV, this figure increased to almost 90% in 2013. Coverage of co-infected patients on Cotrimoxazole prophylaxis has also

evolved from 47% in 2009 to 95% in 2013 while ART coverage increased from 32% to 64% during the same period.

While PEPFAR doesn't the procure TB drugs, it contributed to achieving results by working the GOB/GFATM to complement the above-described activities in target provinces, to ensure systematic TB screening among HIV-positive people and reinforcing the referral systems between HIV/AIDS and TB services wherever indicated. Individuals who are symptomatic of TB are oriented to TB setting for diagnosis. Follow-up to ensure that patients completed the referral, is easier as most large HIV testing sites also conduct TB diagnosis. Last year's data indicates that 97% of HIV positive individuals (2,915 patients of 3,012) oriented to TB settings, completed the referral. To ensure access to TB diagnosis at HIV testing sites that do not offer TB diagnoses, the National TB Program (PNLT) has set up a system for collecting and transporting sputum. The diagnosis is made according to the national guidelines and algorithms provided by the PNLT to all health facilities.

In FY15, PEPFAR Burundi will continue to support TB/HIV co-infection management (223 new TB/HIV patients will be enrolled) in the five priority provinces. In COP 2015, PEPFAR will assist in: training health providers on the management of HIV/TB co-infection and other opportunistic infections and improve access of TB patients to HIV services, including pre- and post-test counseling. PEPFAR Burundi will also be supporting the MSPLS in the roll-out of new guidelines which include systematic INH prophylaxis to prevent TB in all newly diagnosed HIV-positive patients and systematic test and treat for all PLHIV who are also TB-positive.

4.8 Adult treatment

In COP15, PEPFAR Burundi will be supporting the GOB to implement the 2013 WHO guidelines which were adapted by the MSPLS in 2014. ART will be provided for PLHIV with CD4 ≤ 500, and test and treat will be applied to HIV-positive partners in sero-discordant couples, to all HIV-positive FSW and MSM, to all HIV/TB co-infected patients, all HIV-infected children < 5 years, and all HIV-positive pregnant or breast-feeding women (Option B+). The aim is to start patients on treatment earlier to reduce transmission and unnecessary death, and to help Burundi achieve the UNAIDS 90-90-90 targets.

Regarding the distribution of PLHIV on treatment, Bujumbura-Mairie and Gitega provinces alone amount to more than 50% of PLHIV on ART, with 43% and 11%, respectively.[18] It is important to note that this does not fully reflect numbers of PLHIV in need of treatment in these provinces, but includes the number of patients traveling from neighboring provinces in search of services.

While the GFATM procures ART nationally, PEPFAR partners will continue to provide ART to pregnant and breast-feeding women in PEPFAR-supported facilities, including the military, and will provide clinical and support services to their children and families to ensure retention. In

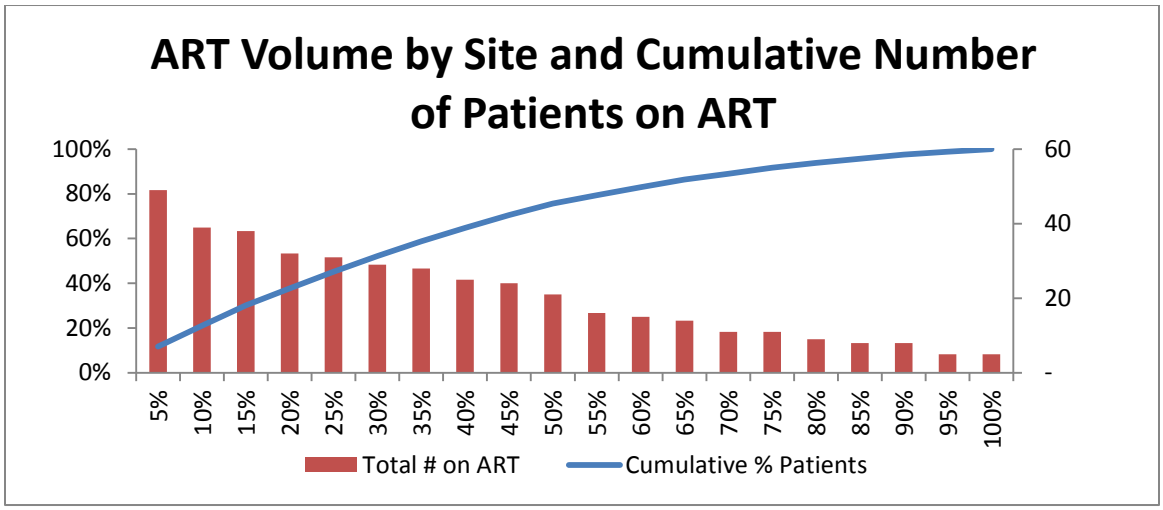
[18] CNLS report/Sept 30, 2014

addition, support will be provided to ensure FSW and MSM are linked to support, care and treatment services, including "test and treat" ensuring direct linkage to treatment.

PEPFAR will contribute to achieving 80% ART coverage through its continued TA support to ART sites in Kirundo and Kayanza, provinces and expand ART services to Ngozi and Bujumbura Rurale where we are currently only covering PMTCT. These provinces were targeted because they are in high burden geographic areas but have extremely low ART coverage.

Partners will also support clinical monitoring through viral load testing. Under the submitted Concept Note, the GFATM will procure PCR and viral load diagnostic commodities and PEPFAR will provide other laboratory commodities in the target provinces. PEPFAR intends to work with the GOB the GFATM, and a private hospital to assess partnerships to procure point of care machines so PCR and viral load can be scaled-up. This will take time to negotiate and implement; however, initial discussions have begun and will continue in COP15. The PEPFAR team will continue to provide strategic planning support for the National Supply Chain system (through SCMS) and for CAMEBU (the central medical store), including the warehousing and distribution of commodities. This will include support for a smooth national roll-out of viral load commodities once plans for procurement have been finalized.

Efficiency Analysis



PEPFAR provided technical assistance for ART in 363 sites in 2014. Of patients on treatment, 80% were seen in 29% (17) of PEPFAR supported ART sites. Patient volume in the remaining 20% of sites (346) ranged between 0 and 258, with only 20 sites (excluding sites with zero patients) reporting less than 50 patients.

4.9 Pediatric treatment

The Burundi PEPFAR team will continue to support the GOB in its implementation of the NSP 2014-2017, which has outlined specific and ambitious targets on pediatric HIV: 54% of eligible

HIV-infected children receive ARV treatment by 2017; 90% of orphans and children infected or affected by HIV/AIDS attending clinics are tested for HIV; and 55% of infants born to sero-positive mothers receive their first PCR test by two months of age by the end of 2017. Following the core, near-core, non-core analysis, the program has identified the following key interventions: linkage and retention in care services for HIV-positive children, including psychosocial support, clinical services, clinical and laboratory monitoring using both CD4 and viral load, case-finding activities both at facility and community level, and in-service and pre-service training. Activities targeting OVC will include training of CHWs, monitoring, follow-up, and community mobilization to ensure linkage and retention in care of this target population.

At the national level, Burundi has only achieved 14% ART coverage for children under 15 (CNLS, October 2014). PEPFAR Burundi is in a unique position to close the pediatric HIV treatment gap. Through its integrated approach, partners can identify more children infected and affected by HIV sooner. The IHP in particular has implemented strategies for more active case finding of children living with HIV. These strategies include systematic testing of children of mothers testing positive in ANC, systematic testing of children of adults testing positive in other services, and increased focus on PITC in key services such as pediatric hospitalization and community and inpatient therapeutic feeding programs. As a result, PEPFAR partners have succeeded in reaching 25% of HIV-positive children in the 4 provinces covered by the IHP. Based on the success of these efforts in those provinces and the recognition of how ART is lagging in some of the PMTCT provinces, these strategies will also be scaled up in all PEPFAR provinces, including Ngozi and Bujumbura Rurale where pediatric coverage currently stands at 5%.

In COP14, EID targets were not met due to challenges with the national system. Until late 2014, there was only one PCR machine in country, and it was out of order for most of 2014. When the machine was finally repaired, the reagents in stock had all expired resulting in nearly zero tests performed last year. For COP15, PEPFAR Burundi will work with the GOB to ensure that this situation is not repeated. Strategies will include technical support for procurement and supply chain management to ensure that reagents and test kits are consistently available; supporting the GOB in negotiations with a CSO partner who has a new machine in order to ensure that they will accept samples from the public sector when needed; and purchase of three POC EID machines to supplement the national system and provide regional access. One of these may be purchased through a first-of-its-kind PPP with a private hospital in Bujumbura.

In-line with the 2013 WHO Guidelines, all children <5 will receive treatment under Burundi's 2014 guidelines revision. Pediatric ARVs are supported by the GFATM but PEPFAR will continue to play a leading role in identifying HIV-positive children through the strategies detailed above and ensuring that front-line health care providers have the knowledge and skills needed to initiate pediatric patients on ART.

4.10 OVC

UNAIDS estimates there are 793,269 OVC in Burundi, with 89,000 among them orphaned due to HIV/AIDS. OVC face multiple problems: (1) most of them leave their home when their parents die; (2) they are deprived of their property; (3) they have no access to basic needs; and (4) they are subject to stigma and discrimination; (5) they are at increased risk for abuse and for contracting HIV/AIDS themselves.

Multiple social, cultural and demographic factors put adolescent girls and young women at even higher risk than their male peers. These include strong traditional gender norms, a sharp decrease in school enrollment after primary education with a dropout risk of 10%, and a highly feminized HIV epidemic with prevalence among women at 1.7% versus 1% for men. Other factors include early sexual debut with 11% of young women having had a first pregnancy by the age of 18, overall fecundity (6.2 births/woman) and high rates of transactional sex as evidenced by a recent PLACE study which found that 35% of adult women respondents had engaged in transactional sex at least once in their lives.

Due to these factors, PEPFAR Burundi's new OVC strategy will target vulnerable adolescent girls and young women with the aim of keeping them in school and empowering them to make healthy choices for themselves and their future children. The target population will be adolescent girls and young women between the ages of 10 to 18 with a different package of activities for ages 10-14 and 15-18 based on their specific needs.

While specific activities have yet to be defined we expect to offer a targeted mix of condom promotion and provision, HIV testing and counseling, post-violence care, social asset building, social protection (education subsidies), and parenting/caregiver programs. Additional Family Planning funds will also be used for the 15-18 group to focus on contraceptive method mix and other reproductive health activities.

5.0 Program Activities to Maintain Support for Other Locations and Populations

5.1 Sustained package of services in other locations and populations

In Burundi, PEPFAR has decided to transition one province that has reached PMTCT saturation, Bujumbura Mairie, to a sustained package of services. The package of services supported in this maintenance province will continue to include a continuum of clinical services for pregnant women and their families, with activities that support linkage and retention in care; and will also continue to provide prevention, testing, care, and treatment services for key populations. OVC services have not been supported in these regions previously, and therefore will not be part of the maintenance package. The major focus will be on ensuring the sustainability of the gains already achieved in preparation for transition to central support in FY 17.

In PMTCT programming, PEPFAR will support integrated PMTCT and maternal and child health (MCH) services through the continuum of care, including HTC in ANC clinics, PMTCT Option B+ services, FP, clinical monitoring in PMTCT, care and support of mothers and their families, care of HIV-exposed infants, retention in PMTCT programming, and transition of women post-partum to ART services. Additionally, PEPFAR will continue to support training and mentoring of health care providers in the two transition provinces to ensure that quality of services remains high after the transition. Testing of pregnant women and linkages to care and treatment will be performed in facilities that have high yield only. Additionally, HIV-exposed infants will receive PCR testing. PEPFAR will also continue to procure key testing commodities for mothers and HIV-exposed infants, lab commodities, and ARVs used in PMTCT programs for these provinces. PEPFAR will continue to support trainings on a variety of supply chain and commodities issues.

Additionally, PEPFAR will support key populations prevention programming in Bujumbura Mairie, which will include testing and linkage to care and treatment services. Additionally, care and treatment services at the facility level will be supported at a few key facilities in areas frequented by key populations, through a new mechanism, LINKAGES, that will begin in FY 16.

All of the activities continued in this sustained package are considered essential to ensure high quality standards for PLHIV who are being followed at facilities in sustained provinces.

In terms of targets, the team has put forth targets related to HTC occurring in PMTCT. Testing targets were determined based on knowledge of the PMTCT program here in Burundi. Pregnant women here have been sensitized to the need for HIV testing during pregnancy and are regularly requesting the test during ANC. The testing target reflects the testing of the majority of pregnant women who will be coming in for MNCH/ANC services. The PMTCT treatment targets for Bujumbura Mairie are large as this province includes the capital which is home to roughly 10% of the country's population. HTC and ART targets reflect testing and care and treatment of key populations in this region. The targets are based on the idea that key populations represent about 5% of the population in Bujumbura Mairie. HTC targets for FY16 represent approximately 5% of the previous year's testing targets. The ART targets are based on a prevalence of 1.7%, which is slightly higher than the national average to reflect a higher level of positivity in an urban center with key populations in the mix.

When costing the sustained package, the team reviewed the unit expenditures (UEs) for activities occurring in Bujumbura Mairie. As the province will be in sustained mode and active engagement at the facilities will be scaled down, a number of UE inputs were removed or halved to reflect the reduced IPs presence at the sites. Equipment and furniture expenses were deleted from the UE inputs; personnel, travel transport, program management, SI, and other recurrent expenditures expense inputs were reduced by half as well. As a result of these reductions, there are UE cost savings that range from 50% to 20%.

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Non-priority Districts[19]

Sustained Volume by Group	Expected result APR 15	Expected result APR 16	Percent increase (decrease)
HIV testing in PMTCT sites	39695+	**26,486**	**(33%)**
HTC (only maintenance ART sites in FY 16)	85,699+	**0**	**(100%)**
Current on care (not yet initiated on ART)	0	**0#**	**N/A**
Current on ART	0	**0**	**N/A**
OVC	1552+	**0***	**N/A**

5.2 Transition plans for redirecting PEPFAR support to priority locations and populations

Transition of general prevention and clinical services to central support will occur in three provinces currently being supported by PEPFAR Burundi—Muyinga, Karusi and Gitega. All of these provinces have a relatively low prevalence and Muyinga also has a low burden. While Gitega does have a higher burden, this is due to population, not prevalence and hence not necessarily the best use of limited resources. Both Gitega and Muyinga do have higher numbers of key populations, especially FSW, and so, as the transition out of general pop services is occurring, there will be scale up of key pop activities.

The transition of prevention and clinical services at facilities in these provinces will occur in stages over the course of FY16, and will involve discussions and planning with GFATM and GOB which have already begun. Of note, the GFATM concept note funding level was based on targets that reflect 80% coverage of PLHIV in Burundi, so there are no concerns about ARV stock-outs as PEPFAR transitions out of sites in these provinces.

OVCs had not previously been supported in these provinces so there is no need for transition of OVC activities. In light of the new OVC strategy however, OVC activities in Kirundo province under the IHP will transition out over the course of FY16 using existing funds.

Transition of specific technical assistance activities will also occur this year, despite the fact that the HIV program in Burundi has been relatively focused and targeted from inception due to a limited budget. One key program area from which PEPFAR will transition support is performance-based financing (PBF). While PBF is a key intervention nationally here in Burundi, all PBF support in non-PEPFAR provinces stems from multiple partners, including World Bank funding. The PEPFAR team in Burundi has begun discussions with the GOB for transition of these funds from PEPFAR support to GOB. The team believes that the transition of support will

[19] +This number is estimated, as there were no provincial-level targets in COP14. This number reflects the total PEPFAR DSD targets in COP14 for PMTCT_STAT, HTC_TST and OVC_SERV divided by the proportion of PLHIV living in Bujumbura Mairie.
#There will be no care target as all key populations are eligible for ART based on the new National Burundi Guidelines.
*HTC, ART services have not been part of the package of services provided in this province in the past.

be feasible by the start of FY16. Prevention interventions that will be transitioned include general behavior change communication (BCC) activities, training of journalists on HIV, and national HIV prevention media campaigns on Voice of America. These prevention interventions have been selected for transition as they are not evidenced-based to aid in achieving epidemic control. A number of HSS activities will no longer be supported, as these interventions also do not directly impact epidemic control. For the majority of these activities, support will end before the start of FY16.

In addition to geographic and activity transition, the PEPFAR country program will also be transitioning out of specific facilities throughout the country. After review, the IPs will be instructed to leave 31 in the remaining four scale-up provinces. These31 represent facilities that have been in service for longer than 12 months, have tested more than 600 people, and have not had more than 4 HIV-positive individuals identified in either HTC or PMTCT.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

Health System Strengthening

Based on health systems bottlenecks to delivery of HIV services, PEPFAR Burundi's core systems strengthening activities focus on laboratory strengthening, strategic information, supply chain management, service delivery, and human resources for health (HRH). Based on PEPFAR Burundi's budget ceiling, the first two activities listed are core to COP15, while the latter are near-core.

6.1 Laboratory strengthening

PEPFAR Burundi will continue to support laboratory system strengthening, in coordination with the GOB, GFATM, and other key stakeholders. Through the SCMS project, PEPFAR has supported the development of a National Lab Strategy and an implementation roadmap is in the finalization stage. PEPFAR will continue to procure key HIV lab commodities and provide TA and support to the Lab LMIS for improved quality services.

In accordance with the core, near-core and non-core exercise, PEPFAR partners will focus on the following core activities:

1) Procurement of lab commodities;
2) Technical assistance;
3) Quality assurance programs for HIV rapid testing, CD4 testing, early infant diagnosis (EID) and HIV viral load testing;
4) Support for lab equipment maintenance in PEPFAR supported provinces;
5) Support for sample transport network ;

In the PEPFAR supported provinces, the SCMS project has procured lab equipment for PMTCT AP and IHP projects: 16 BD FACSCount machines for CD4 counting, 9 biochemistry spectrophotometers, 8 hematology machines and other laboratory materials and supplies. Partners have also supported lab equipment, in order to ensure the equipment are functioning on a continuous basis.

PEPFAR partners will ensure that these activities align with the National Lab Strategy and contribute to reach the new 90-90-90 targets supported both by PEPFAR and UNAIDS and the ultimate goal of epidemic control.

6.2 Strategic information (SI)

PEPFAR Burundi has been working with the MSPLS, PNLS, GFATM, CNLS, and the CTB to update the health information system (HIS) structure to collect and report on key data for HIV/AIDS. There is a critical need for HIV/AIDS-related data in Burundi at all levels and in all technical areas. Currently, our support has ensured gender and age disaggregation, streamlined registers and streamlined

indicators for HIV/AIDS information, assessed the routine health information system, developed key population size estimations, and a PLACE Study, and started an assessment for ANC sentinel surveillance. Going forward, PEPFAR will focus its support on ensuring the PNLS is able to effectively collect, analyze, and use results, implement ANC sentinel surveillance, and understand the epidemic at the national and sub-national levels. The support is focused on the national level to ensure Burundi has quality national and sub-national data to use for decision-making and prioritization of high burden areas. Key data collection activities to be implemented in conjunction with the government and GFATM include ANC sentinel surveillance, Demographic and Health Survey (DHS), two Integrated Bio-Behavioral Surveys (military and key populations), key population mapping, and an assessment to help inform a future study on individuals in care, but not on ARVs. In addition, targeted technical assistance for data use will be prioritized, as we work with the government and the GFATM to start to use yield and burden analysis to better target programming and partners for epidemic control. Having ANC sentinel surveillance re-launched in the country after five years without this data will ensure consistent understanding and trends of the HIV epidemic.

The HIV Impact Assessment is planned for next year and will help PEPFAR Burundi understand the coverage and impact of key HIV services. PEPFAR will work on an HIV Strategic Information Plan with the GFATM and GOB to ensure an HIV Impact Assessment can be effectively planned for FY17, as DHS will take place in late 2015. This will ensure SIMS, MER, mapping activities, evaluations, special studies, surveys, and routine data are used for gap assessment, targeting, and strategic funding decisions. In order to improve monitoring of HIV-exposed infants, PEPFAR will continue to work with the government to ensure supervision forms for mother-baby pairs continue to be reported so HIV-exposed infants are identified, tested, and followed.

Internally, the PEPFAR team will prioritize the development of a Strategic Information Plan that will outline how PEPFAR will review results and evaluation findings from all PEPFAR data streams and will share this information with partners and government entities routinely.

PEPFAR Burundi proposes an assessment this year to better understand the gaps and challenges in collecting routine, quality data on people living with HIV in care, but not yet on treatment. This assessment will also provide technical assistance to MSPLS. This is a major information gap for the country and PEPFAR.

6.3. National supply system

PEPFAR has worked closely over the last few years with the GOB and GFATM to ensure improved Supply Chain systems through training and coaching of staff in procurement, quantification, warehousing systems, and monitoring and evaluation. Despite the

improvements noted, recent results from the National Supply Chain Assessment indicate continued deficiencies in procurement and distribution of commodities to the operational and facility-level, especially in non-supported locations.

In COP15, the USG plans to continue supporting the supply chain system, but given funding limitations, much of PEPFAR activities will focus on sustaining the transfer of expertise and information to ensure GOB's ownership. Core activities will include: technical assistance on HIV commodities, quantification and supply planning; technical support for warehousing and distribution of commodities; and technical support for strategic planning for the National Supply Chain system. Near-core activities will consist of: training (quantification, drug management, etc.) at national and subnational levels and building the capacity of CAMEBU to innovate and improve management and service delivery.

6.4. Service delivery

Regarding service delivery (Access and Demand), the sustainability index showed weakness in uptake of HIV/AIDS prevention, care, and treatment services and programs among key populations and individuals infected and affected by HIV/AIDS. This was especially true in the provinces not supported by PEPFAR.

PEPFAR continues to prioritize quality and rapid uptake of HIV/AIDS prevention, care, and treatment services and has a comparative advantage in QI/QM. Over the next two years, PEPFAR will continue to increase uptake of HIV/AIDS services in priority locations and will support the GOB in collaboration with the GFATM with targeted TA in geographic areas that will have the most impact. Core activities PEPFAR will support include: provision of HTC services and linkages to prevention, care, and treatment services for priority and key populations, integration of PMTCT/MCH services and continuum of care services (HTC in ANC clinics, FP and linking HIV-positive individuals to and retaining in care/ART/PMTCT services); activities promoting integration of HIV with routine pediatric care, nutrition services and maternal health services, malaria prevention and treatment; activities that support HTC and linkage to care to widen the access, utilization and uptake by families and adolescents; linkage of victims of SV to clinical care services , including PEP.

6.5. Human Resources for Health (HRH)

The shortage of competent and motivated HRH is now recognized as one of the major constraints to the health system in Burundi. In the past years the USG supported the GOB in building HRH for the provision of HIV/AIDS services through capacity building for health providers in target provinces. In addition to the in-service training, 115 new health workers will graduate in March 2015 from a pre-service training program as a result of PEPFAR-supported strengthening efforts to the Medical Schools of three universities in Burundi.

In the next two years, PEPFAR will contribute to human resources capacity building as a near core activity and will provide support in: 1) maintaining the training of health providers and CHW in target locations; 2) support pre-service training to enhance production of qualified human resources to provide quality HIV/AIDS services; and 3) promoting the use of the task shifting approach, especially for the prescription of ARVs.

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Laboratory Strengthening											
Provide TA to MSPLS to conduct the annual quantification workshop for HIV Lab commodities (RTKs, CD4, VL and EID reagents and supplies)		• Accurate forecasts and supply plans documented • Quantification report		OHSS HLAB	SCMS	Commodity Security and Supply Chain7.0	**X**	X	X	X	X
Procurement of lab reagents and testing consumables for HIV rapid testing, CD4, EID and viral load for PEPFAR Implementing Partners		• HIV testing performed • Monitoring of patients in Care & on ART performed		HTXS, HBHC, PDCS, MTCT, HVCT	SCMS	Commodity Security and Supply Chain 7.0	**X**	X	X	X	X
Procurement of lab equipment for PEPFAR Implementing Partners		• 3 POC machines for EID/VL procured • 5 BD CD4 FACSCount procured • 3 PIMA CD4 machines procured • 5 Hematology counters procured • 10 spectrophotometers procured		HLAB HBHC PDTX $516,000	SCMS	Commodity Security and Supply Chain 7.0		X	X	X	X

Procurement of lab equipment and commodities for DOD sites		• 1 POC machine for EID/VL procured; • 2 PIMA CD4 machines procured • 4 Hematology counters procured • 4 spectrophotometers procured		HLAB HBHC PDTX	DOD	Commodity Security and Supply Chain 7.0		X	X		X
Support to National LMIS for Lab		Lab data reporting improved		HLAB HVSI	SCMS	Commodity Security and Supply Chain 7.0	X			X	X
Provide Technical Assistance to design norms and standards for Lab.		• Norms and standards for labs available; • Guidelines for lab equipment harmonization designed		OHSS HLAB $85,000	SCMS	Commodity Security and Supply Chain 7.0	X		X	X	X
Conduct Lab Quality Improvement & Quality Assurance activities		• Lab service quality baseline is available • Lab staff at district and facility level trained • Quality of lab services improved		OHSS	SCMS	Commodity Security and Supply Chain 7.0	X		X	X	X
Support MSPLS for updating HIV testing algorithm		• HIV national testing algorithm updated • HIV modules updated and validated • Lab staff are trained		HLAB OHSS	SCMS	Commodity Security and Supply Chain 7.0	X		X	X	X
Support lab equipment maintenance in PEPFAR supported facilities		• National strategy for lab maintenance developed; • Lab staff are trained on			IHP PMTCT AP	Commodity Security and Supply Chain 7.0			X	X	X

		maintenance of CD4, VL and EID machines; Contracts for lab equipment maintenance signed									
Support sample transport network in PEPFAR supported facilities		• A national strategy for sample transport is developed Transport of EID and VL DBS specimens to reference labs and results return to sites.		HLAB OHSS		Commodity Security and Supply Chain 7.0	X	X	X	X	X
Health Information Systems											
SIMS	PEPFAR Sites are monitored, quality improved; SIMS Planner	PEPFAR program quality is improved; targets are reached; PEPFAR model promoted government and GFATM	HVSI	HVSI	GHPRO	Performance Data 16.0	X	X	X	X	X
Build and improve National HIV/AIDS Program M&E System	National Program collects, analyzes and uses quality data with support	National Program collects, analyzes and uses quality data	HVSI	HVSI	MEASURE Evaluation	Epi and Health Data 8.1; Performance Data 16.0	X	X	X	X	
Mentoring/ Coaching in quality data collection and analysis at community, facility and district level	Clinical Quality improvement committees established	Improved uptake of HTC, PMTCT, ART services in scale up provinces/ districts;	OHSS	OHSS	URC ASSIST	Performance Data 16.0; Quality Management 8.0; Access and Demand 9.8	X	X	X	X	
Surveys and Surveillance											
DHS	Population-based representative sample survey completed with HIV module and HIV testing results at the sub-national level	Data disseminated and used; government and stakeholders make decisions on priority locations and populations	HVSI $170,000	HVSI	ICF Macro/ MEASURE DHS	Epidemiological and Health Data 8.1	X			X	

IBBS key pops	Survey completed with GF PR and results available at the national and sub-national levels	Improved availability and use of epidemiological data on FSW and MSM in Burundi.	HVSI	HVSI	LINKAGES (FHI360)	Epidemiological and Health Data 8.1	X	X	X	X	
IBBS military	Survey completed with Minister of Defense and MSPLS and results available at the national and sub-national levels	Improved availability and use of epidemiological data on military personnel.	HVSI $300,000	HVSI	DOD	Epidemiological and Health Data 8.1	X	X	X	X	
ANC Sentinel Surveillance	WHO Assessment implemented and information used by stakeholders	National AIDS Program effectively implements routine ANC sentinel surveillance; understand the epidemic at the national and sub-national levels.	HVSI	HVSI	MEASURE Evaluation	Epidemiological and Health Data 8.1	X	X	X	X	
Mapping key populations	Technical assistance to the National AIDS Program and GFATM PR; key populations mapped	Stakeholders understand the epidemic and hotspots at the national and sub-national levels for key populations; data disseminated and used for decision making	HVSI	HVSI	LINKAGES	Epidemiological and Health Data 8.1	X	X	X	X	
M&E											
Technical assistance for development of national pre-ART tracking system	Pre-ART tracking system in development.	Pre-ART tracking system established.	HIVSI	HVSI	USAID/ DOD	Epidemiological and Health Data 8.1	X	X			

Program evaluations and special studies (PMTCT and Gender Programming)	Data collection and analysis for evidence-based interventions that support epidemic control	Data used and disseminated in conjunction with government for scale up, increase demand	HVSI	HVSI	PMTCT AP FHI360; BRAVI Engender Health	Performance Data 16.0; Quality Management 8.0; Access and Demand 9.8	X	X	X	X	
Supply Chain Management											
Provide TA on HIV commodities, quantification and Supply planning.	Annual national supply chain plan Quarterly reviews and updates supply plans Annual commodity expenditure forecast Quarterly commodity expenditure forecast reports Reports on quarterly reviews and Quarterly commodity expenditure forecast	Annual national supply chain plan Quarterly reviews and updates supply plans Annual commodity expenditure forecast Quarterly commodity expenditure forecast reports Reports on quarterly reviews and Quarterly commodity expenditure forecast	OHSS $587, 783	OHSS	SCMS ID: 14593	Commodity Security and Supply Chain 7.0	X	X	X		
Provide technical support for Warehousing & Distribution of all commodities.	Implementation of Warehousing SOPs and business processes Use of LMIS Manual and Tools Active distribution system between CAMEBU and district pharmacies	Use of LMIS Manual and Tools Active distribution system between CAMEBU and district pharmacies	OHSS $587, 783	OHSS	SCMS ID: 14593	Commodity Security and Supply Chain 7.0	X	X	X		X

Provide technical support for strategic planning for the National Supply Chain system	Development and validation of a National Supply Chain Strategic Plan (from PMP). TWGs implemented and strengthened, engaging all relevant stakeholders in financing, demand planning, distribution	Implementation of national supply chain strategic plan and regularly reviewed with stakeholders. (PWS)	OHSS $587, 783	OHSS	SCMS ID: 14593	Commodity Security and Supply Chain 7.0	X	X	X		
Human resources for Health											
Training (quantification, drug management, etc.) at national and sub national levels. Training of CAMEBU leadership in SOPs, KPIs and optimized business processes (receiving, stacking, picking, packing, dispatching)	Training Curricula developed and validated Number of staff trained) at national and sub national levels. Number of CAMEBU officers trained in SOPs, KPIs and optimized business processes (receiving, stacking, picking, packing, dispatching)	Number of staff trained at national and sub national levels.	OHSS $266,155	OHSS	SCMS ID: 14593	Human Resources for Health 12.0			X		X
Training of Health Care Workers in military clinics.	Number of Military Clinic HCWs trained	Number of Military Clinic HCWs trained .	OHSS	OHSS	PSI ID:14592	Human Resources for Health 12.0	X	X		X	
Build the capacity of the Central Medical Store (CAMEBU) to innovate and improve management and service delivery.	Improve CAMEBU performance of key indicators of warehousing efficiency by 35%. Reduced stock out rate; Improved order turn-around time;	Improve CAMEBU performance of key indicators of warehousing efficiency by 75%. Reduced stock out rate; Improved order turn-around time;	OHSS $587, 783	OHSS	SCMS ID: 14593	Human Resources for Health 12.0			X		X

	Reduced percentage of total stock that expired in previous reporting period; Improved order fulfillment rate	Reduced percentage of total stock that expired in previous reporting period; Improved order fulfillment rate									
Training of health providers and community health workers	Number of Heath workers trained Number of community workers trained	Number of Heath workers trained Number of community workers trained	OHSS $266,155	OHSS	FHI 360 ID: 16663 FIH360 ID: 16664	Human Resources for Health 12.0	X	X	X	X	X
Pre-service training of the graduates from Medical Schools to capacitated them to provide quality HIV/AIDS services	Number of graduates trained to provide quality HIV/AIDS services	Number of graduates trained to provide quality HIV/AIDS services	OHSS $266,155	OHSS	FHI 360 ID: 16663 FIH360 ID: 16664	Human Resources for Health 12.0	X	X	X	X	X
Task shifting approach for the prescription of ARVs.	Number of health providers (nurses) providing ARVs medication	Number of health providers (nurses) providing ARVs medication	OHSS $266,155	OHSS	FHI 360 ID: 16663 FIH360 ID: 16664	Human Resources for Health 12.0	X	X	X	X	x
Health care providers training in SGBV and PEP.	Number of health care providers trained in SGBV and PEP.	Number of health care providers trained in SGBV and PEP.	OHSS $600,000	HVOP	EngenderHealth ID:14592	Human Resources for Health 12.0	X	X	X	X	X
Service delivery											
Support implementation and scale-up of Men as partner 's programs (MAP)in healthcare facilities	Number of victims of sexual violence linked to clinical care services	Number of victims of sexual violence linked to clinical care services	OHSS $600,000	HVOP	EngenderHealth ID: 14342	Access and Demand 10.8	X	X		X	

Implement SASA and MAP programs to prevent GBV in community and reduce gender related barriers to accessing care services.	Gender-equitable norms/relationship behaviors in the community promoted and improved to prevent SGBV and support survivors.	Gender-equitable norms/relationship behaviors in the community promoted and improved to prevent SGBV and support survivors.	OHSS $600,000	OHSS	EngenderHealth ID:14592	Access and Demand 10.8	X	X	X	X	X
Support the National TWG for Advocacy for policy to prevent SGBV and support to survivors.	SGBV TWG develops and implements advocacy agenda in support of SGBV prevention, equitable gender norms, and multisectoral services for SGBV survivors. Identify SGBV advocacy priorities with the Ministry of Gender and TWG members	Update priorities with the Ministry of Gender and TWG	OHSS $600,000	OHSS	EngenderHealth ID:14592	Policies, Laws and Regulations 11.0				X	
Linking HTC services to prevention , care, and treatment, services for priority and key populations	Number of people tested positive linked to prevention , care, and treatment	Number of people tested positive linked to prevention , care, and treatment	HVCT $438,000	HVCT $438,000	FHI 360 ID: 16663 FIH360 ID: 16664	Access and Demand 10.8	X	X		X	
Integrating PMTCT/MCH services and continuum of care services (HTC in ANC clinics, FP and linking HIV-positives to and retaining in care/ART/PMTCT services)	Number of health facilities integrating PMTCT/MCH services and continuum of care services	Number of health facilities integrating PMTCT/MCH services and continuum of care services	MTCT **$1,231,225** HTXS PDTX **142,707**	MTCT **$1,231,225** HTXS PDTX **142,707**	FHI 360 ID: 16663 FIH360 ID: 16664	Access and Demand 10.8	X	X	X	X	X

Promoting integration of HIV with routine pediatric care, nutrition services and maternal health services, malaria prevention and treatment	Number of facilities integrating HIV with routine pediatric care, nutrition services and maternal health services, malaria prevention and treatment		PDTX	PDTX	FHI 360 ID: 16663 FIH360 ID: 16664	Access and Demand 10.8	X	X	X	X	X

7.0 Staffing Plan

The PEPFAR Burundi team has done an initial review of staffing in relation to sustaining epidemic control and to implement the new PEPFAR business model. As a result, we have found that the staffing situation remains aligned for the Department of Defense activities and the USAID activities under PEPFAR and resources are aligned with programmatic areas of core and near core to sustain epidemic control. There is sufficient emphasis on staff support in technical areas that are wholly supported by PEPFAR such as clinical care, treatment, PMTCT, HTC, and OVC. Although the team and management have made efforts to ensure coverage for the implementation and intensity of monitoring activities required through SIMS, there are still challenges the team will face given current shifts in regional support and staffing in Embassy Bujumbura.

However, currently, the PEPFAR Burundi USAID team is experiencing dramatic shifts in staffing and support due to the transition of administrative, contracting, human resources, and financial support from the East Africa Regional Mission in Nairobi to the Rwanda Mission. In addition, there are three critical PEPFAR positions (PEPFAR Team Leader, M&E Specialist, and Senior Health Team Leader) for the PEPFAR team, which are vacant and five critical office positions (covered by other funding sources), which are being brought on this fiscal year for contracts, human resources, and malaria. All of the PEPFAR-supported positions were solicited several months ago (in the latter half of 2014) and are in process of hiring; the job descriptions will be updated to reflect SIMS and will have important focus on monitoring, data collection, and use. Both of these shifts and vacancies require the overall program to make significant adjustments until these positions are filled, and will not allow the program to bring additional staff on board in the next fiscal year (in addition, there are space limitations at Embassy Bujumbura which cannot be adjusted at this time). Staff are being utilized across program areas to implement SIMS, and job descriptions across USAID (not just PEPFAR) will be adjusted to reflect the skills and time required to implement SIMS.

As an interagency team, PEPFAR Burundi has begun to analyze the impact of full implementation of SIMS while recognizing that the prioritization of sites and geographic areas would reduce the total number of sites requiring visits by approximately 34%. Given that we have not yet conducted a full implementation year of SIMS, we have estimated specific increases based on 16% coverage of all implementation sites we would be monitoring with COP15 funds. As of March 2015 we estimate an overall CODB increase of 4% with the primary drivers being ICASS, CSCS, LE staff pay, and program travel costs.

APPENDIX A REQUIRED

Table A.1 Program Core, Near-core, and Non-core (ART) Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	• Provision of HTC services and linkage to PREVENTION, care, and treatment services in priority provinces for PLHIV, for HIV+ pregnant women and their children in PMTCT sites, for key pops, and for priority populations (including military sites) • Provision of Pre-ART and ART patient care for PLHIV (CTX , STI and OI treatment: service provision as well as direct technical support to the site • Linkage to and provision post-exposure prophylaxis (PEP) for targeted populations: victims of sexual violence • Procurement and distribution of ART for PEPFAR IPs (ARVs for PMTCT, PEP, military) • Clinical monitoring , care and support for PLHIV, including HIV+ mothers and their families • Procurement of key commodities for PEPFAR IPs (RTK and lab tests for clinical monitoring (including CD4 and VL), reagents, lab equipment and commodities, 3 POC machines for EID and VL • Cotrimoxazole prophylaxis (procurement and distribution) • Support for retention and adherence support (PLHIV support groups and expert patients) • TB screening and referral for diagnosis and treatment • STI and OI screening and treatment • Targeted condom promotion and distribution	• In-service training and mentoring for clinicians and other providers to provide adult care and treatment, PMTCT, pediatric care and treatment • Pre-service training for clinicians and other providers to provide PMTCT, pediatric care • Promote integration with nutrition services and malaria prevention and treatment • Prevention of onward transmission of HIV for PLHIV (PHDP) • Pediatric adherence support and linkage with community-based HIV-related services • Community mobilization to support OVC (hygiene, shelter, Education and healthcare) • Implement SASA and MAP programs to prevent GBV in community • Gender-based violence(training, male-involvement (PMTCT, PEP • Quality improvement	• Technical Assistance on register development (MEASURE)

	• **Support integrated PMTCT (option B+)/MCH service delivery for pregnant HIV+ women and prophylaxis for their children (HTC in ANC clinics, FP and linkage to care and ART)** • **Procurement of ART for HIV+ pregnant women and their children in PMTCT sites** • **Provision of EID and facility based services for exposed infants, including procurement of commodities for EID and transport of samples** • **Linkage to pediatric services and retention in cares for HIV+ children** • **Promote case finding (multiple entry points) and integration of pediatric HIV treatment services into MCH platforms** • **Test and treat for Key pops Focus on targeted populations – women of childbearing age, FSW, military and family members** • **Test and treat for Key pops** • **Targeted HTC and linkage to care for key/priority pops** • **Targeted prevention / condoms for key pops** • **Active site monitoring (SIMS)** • **Provision of services for OVC** • **Monitoring/follow-up of OVC receiving services**	**activities: (e.g. data collection for results monitoring) in PMTCT sites** • **Training and coaching of HCWs in targeted facilities (PMTCT)** • **Supervision in PMTCT sites**	
Sub-national level	• **Training of community health workers in OVC services**	• **HCW training, community outreach (GBV)** • **Civil society orgs capacity building (USAID Forward)** • **Clinical youth-and family-friendly comprehensive HTC services (training and supervision** • **Strengthen supervision of Quality improvement committees at select facilities and community (ASSIST) and regular quarterly**	• **Performance based financing**

		review meetings • Support implementation and scale-up of Men as partner 's programs (MAP)in healthcare facilities	
National level	• TA on Supply chain management and systems strengthening • Technical support for Warehousing & Distribution of commodities • Technical support for strategic planning for the National Supply Chain system • Drugs and commodity procurement (reagents, ART for PMTCT, RTK, POC diagnostics) • Support to National LMIS and lab systems strengthening • DHS Follow up and analysis (AIS to be put in COP 16) • Procurement of drugs and commodities (RTK, STI , CTX) • Condom promotion and distribution • study on patients in care (non on treatment) • Support to the National Lab strategy including lab equipment standardization, lab technology harmonization • Development of a military electronic health information network (MeHIN)	• Pre-and in-service training for HCWs in adult and pediatric care • Research and studies (PRISM, PLACE, MOT, ANC surveillance, IBBS follow up and analysis , HMIS) • Training Health Care Workers (military clinics) • Strengthen the capacity of the Central Medical Store (CAMEBU) to innovate and improve supply chain management and service, drug quantification, drug management) at national and sub national levels • Support the National TWG to Advocacy for policy to prevent SGBV and support to survivors	• Targeted assistance to medicines regulatory authority • Governance and management support at national level (National Health Account; CCM evaluation) • Strengthen the medicines Quality Control Lab of INSP (Equip the QC lab, Train staff) (PROMOTING QM) • Strengthen the organizational capacity of the PNLS • Support the CCM Burundi in the evaluation of its performance • Identify priorities to improve its capabilities and LCM Priorities for capacity improvement and governance Strengthening • Training journalists Establish a national medicines quality monitoring program (PROMOTING QM) • Media support (VOA)

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

HTC	• HTC - entry point to prevention, care, treatment, and support, linkage to care	• Clinical youth- and family-friendly comprehensive services (training and supervision)	N/A

	• Procurement of key commodities for PEPFAR IPs (RTK) • HTC services (procurement of RTK and lab test) • HTC for key pops/priority populations (including linkage to care)		
PMTCT	• Family-focused PMTCT • Family Planning among women HIV+ • PMTCT for targeted key pops/priority populations • Clinical monitoring /Care and support for HIV+ mothers and families • EID	• Male involvement (linked with PMTCT services) • (Training and mentoring of health care workers • Supervision Quality improvement committees at select facilities and community • Coaching and mentoring of health care workers • Data collection and analysis Data collection and analysis Supervision for QI (Committees) – clinical and community-based	• Performance based financing
Care and Treatment	• STI and OI screening and treatment • Condom distribution • Procurement of key commodities for PEPFAR IPs (CTX, STI med gen pop, HIV+ monitoring commodities (CD4, VL) • Treatment for pregnant HIV+ women and prophylaxis for their children • Post-exposure prophylaxis (ART) • Distribution of ART and related commodities • Facility based services for exposed infants • EID • COTRIM • Activities promoting integration with routine pediatric care, nutrition services and maternal health services, malaria prevention and treatment. • Activities that support HTC and linkage to care to widen the access, utilization and uptake by families and adolescents • Follow up of new born from women HIV+	• Pre-and in-service training for HCWs in adult and pediatric care • HBC package of services for targeted populations • In-service training for clinicians and other providers to provide pediatric care • In-service training for clinicians and other providers to provide adult care •	N/A

	• **Community support to HIV+ children** • **Clinical services to HIV+ children** • **Clinical and laboratory monitoring of children and adolescents on treatment (CD4/VL reagents)** • **Pediatric adherence, retention, and linkages between programs and with the community to reduce loss to follow up** • **Activities promoting case finding and integration of pediatric HIV treatment services into MCH platforms** • **Sample transport and results return for pediatric specimens at the site level (CD4/VL)** • **Service delivery for option B+, including support for clinic personnel** • **HIV care and treatment drug delivery – distribution costs to facility level.** • **Direct service provision as well as direct technical support to the site** • **Test and treat for Key pops** • **PHDP package implementation and integration**		
Prevention	• **Targeted condom promotion and distribution** • **Targeted** • **peer education Targeted PEP, CTX ,** • **Targeted HTC and linkage to care** • Prevention of onward transmission of HIV for PLHIV	**GBV prevention, and health response for SV survivors**	**N/A**
OVC	• **TBD**	**N/A**	**N/A**
Program/system support	• **HIV commodities Quantification and Supply planning** • **Warehousing & Distribution National Supply Chain technical support** • **Training at national and sub national levels** • **Lab system strengthening** • **SIMS**	• **Data collection and analysis for evidence-based interventions** • **Training Health Care Workers in military clinics – HTC, STI, etc. Strengthen the capacity of the Central Medical Store (CAMEBU) MAP in healthcare facilities Civil society orgs capacity-building**	• National (moving towards districts) strengthening the organizational capacity of the PNLS • Financial costing • National Health Account • Support the CCM Burundi in the evaluation of its performance • Identify priorities to improve its

	• **Study on clients in care (not on TX)** • **Procurement of key commodities for PEPFAR IPs (lab equipment and commodities other than CD4 and VL reagents, 3 POC machines for EID and VL)** • **Lab equipment and commodities for Military clinics** • **Development of a military electronic health information network (MeHIN)** • **Commodities (reagents, RTK, POC diagnostics)** • **LMIS and systems strengthening** • **DHS (AIS to be put in COP 16)**	**(USAID Forward)** • **Advocacy for policy to prevent SGBV and support to survivors** • **Health care providers training SGBV and PEP** • **Data quality improvement activities** • **Research and studies (PRISM study, PLACE Study, MOT, ANC surveillance)** • **IBBS key pops** • **IBBS military follow up and analysis** • **HMIS** •	capabilities and LCM Priorities for capacity improvement and governance Strengthening • Develop a performance improvement plan to fulfill the eligibility criteria and minimum performance standards National HIV/AIDS media • Training journalists Establish a national medicines quality monitoring program (PROMOTING QM) • Strengthen the medicines Quality Control Lab of INSP (Equip the QC lab, Train staff) (PROMOTING QM) • Strengthen the capacity of the medicines regulatory authority (DPML) (PROMOTING QM)

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition End date	Notes
Targeted assistance to national lab, medicines regulatory authority	Phasing Out	0	0	1	September 2015	

Governance and management support at national level (National Health Account; CCM evaluation)	Phasing Out	0	0	1	September 2015
Media support (VOA)	Phasing out	$100,000	0	1	September 2015
Performance based financing for PMTCT	Transition to GoB with WB financing	$552,092	0	2	September 2015
BCC activities	Phasing Out	0	0	2	September 2015
Totals					

APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend

$US 0	$US $17,360,000	$US $17,359,423

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	$2,702,909
HVAB	Abstinence/Be Faithful Prevention	0
HVOP	Other Sexual Prevention	$685,059
IDUP	Injecting and Non-Injecting Drug Use	0
HMBL	Blood Safety	0
HMIN	Injection Safety	0
CIRC	Male Circumcision	0
HVCT	Counseling and Testing	$2,428,684
HBHC	Adult Care and Support	$373,691
PDCS	Pediatric Care and Support	$2,512,712
HKID	Orphans and Vulnerable Children	$617,457
HTXS	Adult Treatment	$2,900,997
HTXD	ARV Drugs	$3,301
PDTX	Pediatric Treatment	$6,602
HVTB	TB/HIV Care	0
HLAB	Lab	$2,050,796
HVSI	Strategic Information	$745,000
OHSS	Health Systems Strengthening	$1,249,586
HVMS	Management and Operations	$1,082,628
TOTAL		**$17,359,423**

B.2 Resource Projections

Resource requirements for the COP 2015 were based on the Country Office's experiences in this sector, and a variety of sources from host government departments which produce targets and projections, international donors (their documented in-country experiences),

and partner organizations which provided an additional set of target projections and financial "experience". In addition there are several documents which provided strategic and cost projection information. Notable references include: Burundi National AIDS Strategic Plan 2014-2017; Burundi National Health Account 2011-2012; and, the Global Fund Concept Note – 2015. Initial adjustments to the program were based on a 9 person TDY team representing PEPFAR partners from DOD, OGAC and USAID/Washington staff which traveled to Burundi to assess the current situation and provide suggested program adjustments. The program budget was developed in Burundi in coordinated consultations with the Washington offices of OGAC, DOD and USAID.

Burundi COP15 Targets by Province: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
_Military Burundi	20,509	176	1,247	112	951
Bujumbura Mairie	-	-	-	-	-
Bujumbura Rural	175,858	4,164	4,422	3,392	3,775
Gitega	-	-	-	-	-
Karusi	-	-	-	-	-
Kayanza	92,939	2,640	4,705	2,335	4,016
Kirundo	45,109	1,484	3,730	1,388	3,184
Muyinga	-	-	-	-	-
Ngozi	199,905	3,959	4,940	3,304	4,217
Total	**534,320**	**12,423**	**19,044**	**10,531**	**16,143**

Burundi COP15 Targets by Province: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
_Military Burundi	13,708	-	-
Bujumbura Mairie	-	-	-
Bujumbura Rural	-	-	-
Gitega	-	-	-
Karusi	-	-	-
Kayanza	-	-	-
Kirundo	-	-	2,488
Muyinga	-	-	-
Ngozi	-	-	-
Total	**13,708**	**-**	**2,488**

Burundi COP15 Targets by Province: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
_Military Burundi	2,400	30
Bujumbura Mairie	26,486	1,033
Bujumbura Rural	29,616	180
Gitega	-	-
Karusi	-	-
Kayanza	31,045	125
Kirundo	33,613	366
Muyinga	-	-
Ngozi	35,199	282
Total	**158,359**	**2,016**

HIV/AIDS Sustainability Index and Dashboard

To assist PEPFAR and government partners in better understanding each country's sustainability landscape and making informed investment decisions, PEPFAR teams and stakeholders completed the inaugural **Sustainability Index and Dashboard (SID)** during COP 2015. This new tool assesses the current state of sustainability of national HIV/AIDS responses across 15 critical elements, scores for which are displayed on a color-coded dashboard. As the SID is completed over time, it will allow stakeholders to track progress across these components of sustainability. On the pages that follow, you will find the 2015 country dashboard as well as the questionnaire responses that determined the scores. The legend for the colors depicted on the dashboard is below.

Dark Green Score (17-20 pts) **(sustainable and requires no additional investment at this time)**
Light Green Score (13-16.9 pts) **(approaching sustainability and requires little or no investment)**
Yellow Score (7-12.9 pts) **(emerging sustainability and needs some investment)**
Red Score (0-6.9 pts) **(unsustainable and requires significant investment)**

Sustainability Analysis for Epidemic Control: Burundi

Epidemic Type: Generalized/Concentrated
Income Level: Low Income
PEPFAR Categorization: Targeted Assistance
COP 15 Planning Level: $17,360,000

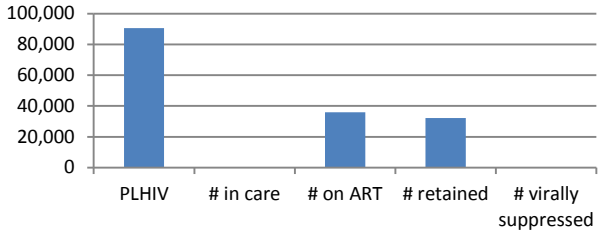
UNSUSTAINED → SUSTAINED

SUSTAINABILITY DOMAINS and ELEMENTS

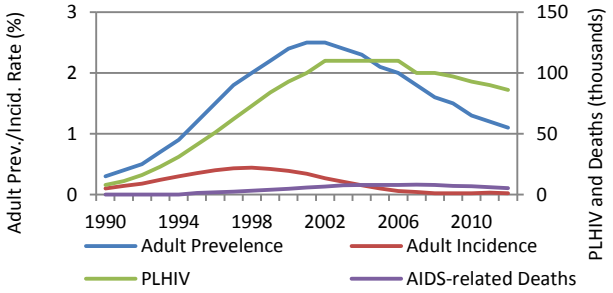
Institutionalized Data Availability	Score
1. Epidemiological and Health Data	8.1
2. Financial/Expenditure Data	13.3
3. Performance Data	16.0
Domestic Program and Service Delivery	
4. Access and Demand	9.8
5. Human Resources for Health	12.4
6. Commodity Security and Supply Chain	7.0
7. Quality Management	8.0
Health Financing and Strategic Investments	
8. DRM: Resource Generation	13.0
9. DRM: Resource Commitments	0.0
10. Allocative Efficiency	7.0
11. Technical Efficiency	12.5
Accountability and Transparency	
12. Public Access to Information	13.0
13. Oversight and Stewardship	11.5
Enabling Environment	
14. Policies, Laws, and Regulations	11.0
15. Planning and Coordination	15.0

CONTEXTUAL DATA

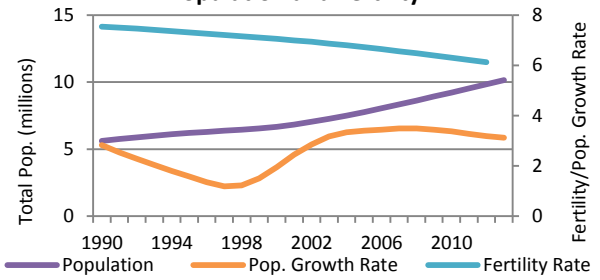
Care and Treatment Cascade



Epidemiological Data

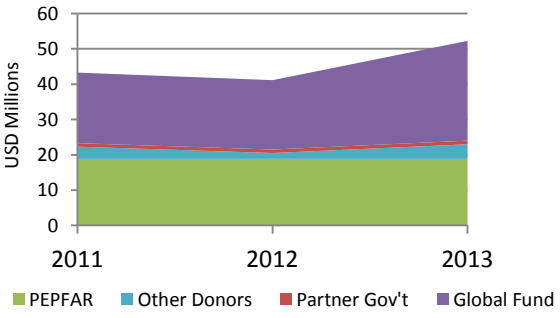


Population and Fertility

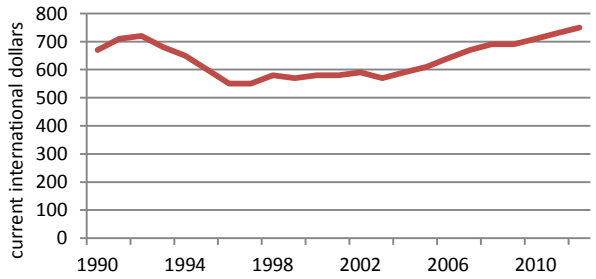


CONTEXTUAL DATA

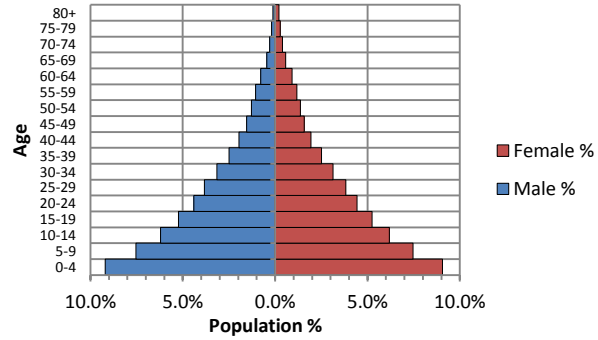
Financing the HIV Response



GNI Per Capita (PPP)



Population Pyramid (2014)



Domain A: Institutionalized Data Availability

What Success Looks Like: Using local and national systems, the Host Country Government collects and makes available timely, comprehensive, and quality HIV/AIDS data (including epidemiological, economic/financial, and performance data) that can be used to inform policy, program and funding decisions.

1.Epidemiological and Health data: Host Country Government routinely collects, analyzes and makes available data on the HIV/AIDS epidemic and its effects on health outcomes. HIV/AIDS epidemiological and health data include size estimates of key populations, PLHIV and OVC, HIV incidence, HIV prevalence, viral load, AIDS-related mortality rates, and co-infection rates.			**Source of data**	**Notes/Comments**
Q1. **Who leads**: Who leads/manages the planning and implementation of HIV/AIDS epidemiological surveys and/ or surveillance (convenes all parties and makes key decisions)?	◉ A. Host Country Government/other domestic institution ○ B. External agency with host country government ○ C. External agency, organization or institution ○ D. Not conducted	4.5	DHS 2010, planning 2015/2016; PLACE2014; IBBS planning 2014/2015.	
Q2. **Who finances**: Within the last three years, what proportion of the latest HIV/AIDS epidemiological data survey did the host country government fund?	○ A. 80-100% of the total cost of latest survey was financed by Host Country Government ○ B. 60-79% of the total cost of latest survey financed by Host Country Government ○ C. 40-59% of the total cost of latest survey financed by Host Country Government ○ D. 20-39% of the total cost of latest survey financed by Host Country Government ○ E. 10-19% of the total cost of latest survey financed by Host Country Government ◉ F. 0-9% of the total cost of latest survey financed by Host Country Government	0	In country budget with sources of funding from most recent DHS HIV/AIDS Section, AIS, key population surveys, or other population-based survey.	
Q3. **Comprehensiveness of Prevalence and Incidence Data**: Does Host Country Government collect HIV prevalence and or incidence data?	○ No, the government does not collect HIV prevalence or incidence data ◉ Yes, the government collects (check all that apply): ☑ A. HIV prevalence ☑ Collected by age ☑ Collected for children ☑ Collected by sex ☑ Collected by key population ☑ Sub-national data ☐ Collected every 3 years ☑ Data analyzed for trends ☑ Data made publicly available ☐ B. HIV incidence ☐ Collected by age ☐ Collected for children ☐ Collected by sex ☐ Collected by key population ☐ Sub-national data ☐ Collected every 3 years ☐ Data analyzed for trends	2.4	No incidence reports, however, Spectrum does provide estimates; for Prevalence, yes, there are several… DHS2010; PLACE2014; IBBS2011	

	☐ Data made publicly available			
Q4. **Comprehensiveness of Viral Load Data**: Does Host Country Government collect viral load data?	◉ No, the government does not collect viral load data ○ Yes, the government collects viral load data (check all that apply): ☐ Collected by age ☐ Collected for children ☐ Collected by sex ☐ Collected by key population ☐ Sub-national data ☐ Collected every 3 years ☐ Data analyzed to understand trends	0	N/A, however, ANSS (CS) clinic does collect viral load for their clients but they do not routinely share the data.	
Q5. **Key Populations**: Does the Host Country Government conduct size estimation studies for key populations?	○ No, the host country government does not conduct size estimation studies for key populations ◉ Yes, the government conducts key population size estimates (check all that apply): ☑ Men who have sex with men (MSM) ☑ Female sex workers ☐ Transgender ☐ People who inject drugs (PWID) ☐ Government finances at least 50% of the size estimation studies ☑ Government leads and manages the size estimation studies	1.2	PLACE Study 2014	
	Epidemiological and Health Data Score:	8.1		

2. Financial/Expenditure data: Government collects, tracks and analyzes financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS from all financing sources, costing, and economic evaluation for cost-effectiveness.			**Source of data**	**Notes/Comments**
Q1. **Expenditure Tracking**: Does the host country government have a nationally agreed upon expenditure tracking system to collect HIV/AIDS expenditure data?	○ No, it does not have a national HIV/AIDS expenditure tracking system ◉ Yes, the government has a system to collect HIV/AIDS expenditure data (check all that applies): ☑ A. Collected by source of financing, i.e. domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others ☑ B. Collected by expenditures per program area, such as prevention, care, treatment, and health systems strengthening ☐ C. Collected sub-nationally ☑ D. Collected annually ☑ E. Data is made publicly available	4	NHA 2012, 2013; NASA 2014. Not yet validated and no agreement on the accuracy/ concensus; Concept Note 2015 Proposal refined the expenditure data (not an official document).	

Q2. **Quality of Expenditure Tracking**: Is the Host Country Government tracking expenditures based on international standards? What type of expenditure data are available in the country, i.e. NHA, NASA, others: _____	○ No, they are not using any international standards for tracking expenditures ◉ Yes, the national government is using international standards such as WHO National Health Accounts (NHA), National AIDS Spending Assessment (NASA), and/or methodology comparable to PEPFAR Expenditure Analysis or the Global Fund new funding tracking model.	5	In country citations for latest NHA 2012 and 2013, NASA 2014, government expenditure tracking report, Global Fund new funding model for country.	
Q3. **Transparency of Expenditure Data:** Does the host country government make HIV/AIDS expenditure data (or at a minimum a summary of the data) available to the public?	○ No, they do not make expenditure data available to the public Yes, check the one that applies: ○ A. Annually ◉ B. Bi-annually ○ C. Every three or more years	3	NHA and NASA and the Global Fund concept note 2015.	
Q4. **Economic Studies:** Does the Host Country Government conduct special health economic studies or analyses for HIV/AIDS, i.e. costing, cost-effectiveness, efficiency?	○ No, they are not conducting special health economic studies for HIV/AIDS ◉ Yes, check all that apply: ☑ A. Costing studies or analyses ☐ B. Cost-effectiveness studies or analyses ☐ C. Efficiency studies or analyses ☐ D. Cost-benefit studies or analyses	1.25	Costing activities for the NSP, concept note, eMTCT plan, etc.	
	Financial/Expenditure Data Score:	**13.25**		

3. Performance data: Government collects, analyzes and makes available HIV/AIDS service delivery data. Service delivery data is analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including adherence and retention.			**Source of data**	**Notes/Comments**
Q1. Collection of service delivery data: Does the host country government have a system to routinely collect/report HIV/AIDS service delivery data?	○ No, the government does not have an HIV/AIDS service delivery data collection system ◉ Yes, service delivery data are collected/reported for (check all that apply): ☑ A. For HIV Testing ☑ B. For PMTCT ☐ C. For Adult Care and Support ☑ D. For Adult Treatment ☐ E. For Pediatric Care and Support ☑ F. For Pediatric Treatment ☑ G. For AIDS-related mortality	5	HIV/AIDS service delivery HMIS policy/SOP and latest report citation: quarterly reports available and annual reports (nationally available); GFATM reports semi-annual.	There is some concern that reporting on care and support (ie. those not yet on ART) is not complete or accurate.
Q2. Analysis of service delivery data: Does the Host Country Government routinely analyze service delivery data to measure Program performance? i.e. continuum of care cascade, coverage, retention, AIDS-	○ No, the government does not routinely analyze service delivery data to measure performance ◉ Yes, service delivery data are being analyzed to measure (check all that apply): ☑ A. Continuum of care cascade, including testing, care, treatment, retention and adherence ☑ B. Results against targets ☑ C. Coverage	4		PMTCT is completed quarterly; for treatment and care, not clear. Routinely defined as at least annually, dependent on the indicator. Following trends annually yes. Data available for yield analysis or for AIDS-related death rates,

related mortality rates?	☑ D. Site specific yield for HIV testing (HTC and or PMTCT) ☐ E. AIDS-related death rates			however, not routinely used for decision-making.
Q3. Comprehensiveness of service delivery data: Does the host country government collect HIV/AIDS service delivery data in a manner that is timely, accurate and comprehensive?	○ No ◉ Yes, service delivery data are being: (check all that apply): ☑ A. Collected at least quarterly ☑ B. Collected by age ☑ C. Collected by sex ☑ D. Collected from all clinical sites ☐ E. Collected from all community sites ☑ F. Data quality checks are conducted at least once a year	5		HMIS adult and children is the age disaggregation (not by standard intervals); MEASURE Evaluaton PRISM Report 2014.
Q4. Transparency of service delivery data: Does the host country government make HIV/AIDS program performance and service delivery data (or at a minimum a summary of the results) available to the public routinely?	○ No, they do not make program performance data available to the public Yes, check the one that applies: ◉ A. At least annually ○ B. Bi-annually ○ C. Every three or more years	2	PNLS and other program annual reports, such as CNLS (Global Fund PR) widely available in print but not online.	
	Performance Data Score:	**16**		

THIS CONCLUDES THE SET OF QUESTIONS ON THE INSTITUTIONALIZING DATA AVAILABILITY DOMAIN

Domain B. Domestic Program and Service Delivery

What Success Looks Like: Host country institutions (inclusive of government, NGOs, civil society, and the private sector), the domestic workforce, and local health systems constitute the primary vehicles through which HIV/AIDS programs and services are managed and delivered. Optimally, national, sub-national and local governments have achieved high and appropriate coverage of a range of quality, life-saving HIVAIDS prevention, care and treatment services and interventions. There is a high demand for HIV/AIDS services, which accessible and affordable to poor and vulnerable populations at risk of infection (i.e. key populations, discordant couples, exposed infants), are infected and or are affected by the HIV/AIDS epidemic.

4. Access and Demand: There is a high uptake of HIV/AIDS prevention, care and treatment services and programs among key populations and individuals infected and affected by HIV/AIDS, especially among those in the lowest socio-economic quintiles.			**Source of data**	**Notes/Comments**
Q1. Access to ART: What percent of facilities in high prevalence/burden locations are provided ART prescription and client management services?	◉ This information is not available Check the one answer that best describes the current situation: ○ A. More than 80% of facilities in high prevalence/burden locations are providing ART. ○ B. 50-79% of facilities in high prevalence/burden locations are providing ART. ○ C. 21-49% of facilities in high prevalence/burden locations are providing ART. ○ D. 20% or less of facilities in high prevalence/burden locations are providing ART.	Q1 Score: 0	SIMS visits. Annual and quarterly reports by site from the CNLS. Per discussions with stakeholders on February 18, 2015.	The facilities are not ranked as such by the government. Option B+ and new WHO Guidelines (2014) will be rolled out in 2015.
Q2. Access to PMTCT: What percent of facilities in high prevalence/burden locations are providing PMTCT (Option B+)?	◉ This information is not available Check the one answer that best describes the current situation: ○ A. More than 80% of facilities in high prevalence/burden locations are providing Option B+. ○ B. 50-79% of facilities in high prevalence/burden locations are providing Option B+. ○ C. 21-49% of facilities in high prevalence/burden locations are providing Option B+. ○ D. 20% or less of facilities in high prevalence/burden locations are providing Option B+.	Q2 Score: 0	SIMS visits. Annual and quarterly reports by site from the CNLS. Per discussions with stakeholders on February 18, 2015.	The facilities are not ranked as such by the government. Option B+ and new WHO Guidelines (2014) will be rolled out in 2015.
Q3. Who is delivering HIV/AIDS services: What percent of Care and Treatment clients are treated at public service delivery sites? These can include government-supported or accredited domestic private, civil society, or faith-based operated services. (i.e. those sites that receive commodities from the government and/or follow government protocols).	○ This information is not available Check the one answer that best describes the current situation: ◉ A. 80% or more of HIV/AIDS care and treatment clients are treated at public service delivery sites ○ B. 50-79% of HIV/AIDS care and treatment clients are treated at public service delivery sites ○ C. 20-49% of HIV/AIDS care and treatment clients are treated at public service delivery sites ○ D. Less than 20% of HIV/AIDS care and treatment clients are treated at public service delivery sites	Q3 Score: 3	CNLS Annual and quarterly reports (by site).	
[illegible]	○ This information is not available Check the one answer that best describes the current situation:	Q4 Score: 3	No national data available.	Key populations are accessing the same facilities as the general

Q4. Services to key populations: What percent of key population HIV/AIDS prevention program clients receive services at public service delivery sites? These can include government-supported or accredited domestic private, civil society, or faith-based operated services. (i.e. those sites that receive commodities from the government and/or follow government protocols).	◉ A. 80% or more of key population HIV/AIDS prevention program clients receive services at public service delivery sites ○ B. 50-79% of key population HIV/AIDS prevention program clients receive services at public service delivery sites ○ C. 20-49% of key population HIV/AIDS prevention program clients receive services at public service delivery sites ○ D. Less than 20% of key population HIV/AIDS prevention program clients receive services at public service delivery sites			population. Specific civil society sites will have data but there is no national data.
Q5. Uptake of services: What percent of PLHIV are currently receiving ART? _____%	○ This information is not available Check the one answer that best describes the current situation: ○ A. 80% or more of PLHIV are currently receiving ART ○ B. 50-79% of PLHIV are currently receiving ART ◉ C. 20-49% of PLHIV are currently receiving ART ○ D. Less than 20% of PLHIV are currently receiving ART	Q5 Score 2	Total population on ART: 35,852. Total PLHIV: 83,000. Source: CNLS, 2014.	
Q6. Rights to Access Services: Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, key populations, and those who may access HIV services about these rights?	Check the one answer that best describes the current situation: ○ No, the government does not recognize a right to nondiscriminatory access to HIV services for all populations. ◉ Yes, there are efforts by the government (check all that apply): ☑ educates PLHIV about their legal rights in terms of access to HIV services ☑ educates key populations about their legal rights in terms of access to ☐ National policy exists for de-stigmatization in the context of HIV/AIDS ☑ national law exists regarding health care privacy and confidentiality protections ☐ government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found	Q6 Score 1.8	Law of 12 May 2005 judicial protection of PVVIH; National Strategic Plan. No specific protections for key populations.	
	Access and Demand Score	**9.8**		

5. Human Resources for Health: HRH staffing decisions for those working on HIV/AIDS are based on use of HR data and are aligned with national plans. Host country has sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. Host country trains, deploys and compensates health workers providing HIV/AIDS services through local public and/or private resources and systems. Host country has a strategy or plan for transitioning staff funded by donors.			**Source of data**	**Notes/Comments**
	Check the one answer that best describes the current situation:	Q1 Score: 0	Human Resources National Strategy 2014- Agreement based	

Q1. **HRH Sufficiency**: Does the country have sufficient numbers of health workers trained in HIV/AIDS to meet the HIV service delivery needs?	○ This information is not available ◉ A. No, HIV service sites do not have adequate numbers of staff to meet the HIV positive patient demand ○ B. Yes, HIV service sites do have adequate numbers of staff to meet the HIV patient demand (check all that apply) ☐ HIV facility-based service sites have adequate numbers of staff to meet the HIV patient demand ☐ HIV community-based service sites have adequate numbers of staff to meet the HIV patient demand, and CHWs have appropriate linkages to high HIV burden/ volume community and facility sites		Strategy 2014; Agreement based on discussions with stakeholders on February 18, 2015	
Q2. **HRH Transition**: What is the status of transitioning PEPFAR and other donor supported HIV/AIDS health worker salaries to local financing/compensation?	Check the one answer that best describes the current situation: ○ A. There is no inventory or plan for transition of donor-supported health workers ○ B. There is an inventory and plan for transition of donor-supported workers but it has not been implemented to date ○ C. There is an inventory and plan for transition of donor-supported workers, but it has been only partially implemented to date. ○ D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan ◉ E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated	Q2 Score: 3	National Budget, Ministry of Health and the Fight against AIDS budget line 2015	
Q3. **HRH Financial reform:** Has financial reform been undertaken in the last 5 years to address government financing of health workers?	Check the one answer that best describes the current situation: ○ A. No financial reform has been undertaken in the last 5 years to address government financing of health workers ◉ B. Financial reforms have been undertaken in the last 5 years to address government financing of health workers (check all that apply): ☑ Wage reform to increase salaries and or benefits of health workers ☑ Increase in budget allocation for salaries for health workers	Q3 Score: 2	Joint Ministerial Orders to increase the health worker salaries 2012; Performance-based Financing Strategy 2008	
	Check the one answer that best describes the current situation: ○ A. HIV/AIDS content used by pre-service institutions is out of date (has not been updated within the last 3 years) - For example, an average national score of RED in SIMS AS-SF "Pre-Service Education" CEE ◉ B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply):	Q4 Score: 1.4	The current training program for paramedical personnel (nurses) was updated in 2013 and includes a module on HIV/AIDS.	

Q4. **Pre-Service**: Does current pre-service education curricula for health workers providing HIV/AIDS services include HIV content that has been updated in last three years?	☐ content updated for all HIV/AIDS services ☑ updated content reflects national standards of practice for cadres offering HIV/AIDS-related services ☐ updated curriculum is problem based/competency based ☐ updated curriculum includes practicums at high volume clinical/ social services sites ☐ institutions that track students after graduation			
Q5. **In-Service**: To what extent is the country institutionalizing PEPFAR/other donor supported HIV/AIDS in-service training (IST) into local training systems?	Check the one answer that best describes the current situation: ○ A. National IST curricula institutionalizes PEPFAR/other donor-supported HIV/AIDS training. ◉ B. There is a strategy for institutionalizing PEPFAR/other donor-supported IST training and it is being implemented. ○ C. There is a strategy in place for institutionalizing PEPFAR supported IST training but it is not being fully implemented to date. ○ D. There is not a strategy in place for institutionalizing PEPFAR/other donor supported IST training.	Q5 Score: 2	There is a National Strategy for HR Capacity Building 2014 as well as an Operational Plan for Implementation (currently in development).	There is effort on behalf of PEPFAR to engage the national program in all training, as well as other stakeholders, however, it is not systematic.
Q6. **HRIS**: Does the government have a functional Human Resource Information System (HRIS) for the health sector?	Check the one answer that best describes the current situation: ◉ A. No, there is no HRIS ○ B. Yes, the government does have a HRIS (check all that apply) ☐ The HRIS is primarily funded by host country institutions ☐ There is a national interoperability strategy for the HRIS ☐ The government produces HR data from the HRIS at least annually ☐ The government uses data from the HRIS for HR planning and management	Q6 Score: 0	Consultant Report end of 2014 from BTC to discuss long-term eHealth Plan (which would include HRH), however, there is no current HRH electronic system.	
Q7. **Domestic funding for HRH**: What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are funded with domestic resources?	Check the one answer that best describes the current situation: ○ This information is not known ○ A. Less than 20% ○ B. 20-49% ○ C. 50-79% ◉ D. 80% or more	Q7 Score: 4	National Budget, Ministry of Health and the Fight against AIDS budget line 2015	
	Human Resources for Health Score		**12.4**	

6. **Commodity Security and Supply Chain:** The National HIV/AIDS response ensures a secure, reliable and adequate supply and distribution of quality products, including drugs, lab and medical supplies, health items, and equipment required for effective and efficient HIV/AIDS prevention, care and treatment. Host country efficiently manages product selection, forecasting and supply planning, procurement, warehousing and inventory management, transportation, dispensing and waste management reducing costs while maintaining quality.			**Source of data**	**Notes/Comments**
Q1. **ARV domestic financing**: What is the estimated obligated funding for ARV procurement from domestic public revenue (not donor) sources?	Check the one answer that best describes the current situation: ○ This information is not known ◉ A. 0-9% obligated from domestic public sources ○ B. 10-29% obligated from domestic public sources ○ C. 30-79% obligated from domestic public sources ○ D. 80% or more obligated from domestic public sources	Q1 Score: 0	Data from NASA 2014, NHA 2012 and 2013, SCMS/MSH, Global Fund PR	
Q2. **Test Kit domestic financing:** What is the estimated obligated funding for Rapid Test Kits from domestic public revenue (not donor) sources?	Check the one answer that best describes the current situation: ○ This information is not known ◉ A. 0-9% obligated from domestic public sources ○ B. 10-29% obligated from domestic public sources ○ C. 30-79% obligated from domestic public sources ○ D. 80% or more obligated from domestic public sources	Q2 Score: 0	Same as above	
Q3. **Condom domestic financing**: What is the estimated obligated funding for condoms from domestic public revenue (not donor) sources?	Check the one answer that best describes the current situation: ○ This information is not known ◉ A. 0-9% obligated from domestic public sources ○ B. 10-29% obligated from domestic public sources ○ C. 30-79% obligated from domestic public sources ○ D. 80% or more obligated from domestic public sources	Q3 Score: 0	Same as above	
Q4. **Supply Chain Plan:** Does the country have an agreed-upon national supply chain plan with an implementation plan or a thorough annually-reviewed supply chain SOP?	○ A. No, there is no plan or thoroughly annually reviewed supply chain SOP ◉ B. Yes, there is a Plan/SOP. It includes these components: (check all that apply) ☑ Human resources ☑ Training ☑ Warehousing ☑ Distribution ☑ Reverse Logistics ☑ Waste management ☑ Information system ☑ Procurement ☑ Forecasting ☑ Supply planning and supervision	Q4 Score: 4	Drug Management SOP 2014, National Committee for Drug Management Statue 2013, Lab and Equipment Policies 2014, Ministry of Public Health and Fight against AIDS Thematic Group for Medicines 2010.	

Q5. **Stock:** Do Public and Private Sector Storage facilities (Central and intermediate level) report having HIV and AIDS commodities stocked according to plan (above the minimum and below the maximum stock level) 90% of the time?	○ A. No, storage facilities report having commodities stocked according to plan (above the minimum and below the maximum stock level) less than 90% of the time ◉ B. Yes, storage facilities report having commodities stocked according to plan (above the minimum and below the maximum stock level) 90% or more of the time ☑ Both public and (if they exist in the country) private storage facilities at central level ☐ Both public and (if they exist in the country) private storage facilities at intermediate level	Q5 Score: 2	Global Fund Principal Recipient consultations 2014 and 2015. Global Fund Concept Note 2015.	HIV/AIDS commodities centralized still; private sector storage facilities do not play a significant role in the HIV/AIDS commodities response.
Q6. **Assessment**: Was an overall score of above 80% achieved on the SCMS National Supply Chain Assessment? (If a different credible assessment of the national supply chain has been conducted, you may use this as the basis for response. Note the details and date of the assessment in the "source of data" column.)	○ A. No assessment has been conducted nor do they have a system to oversee the supply chain ◉ B. Yes, an assessment was conducted but they received below 80% ○ C. No assessment was conducted, but they have a system to oversee the supply chain that reviews: ☐ Commodity requirements ☐ Commodity consumption ☐ Coordinates procurements ☐ Delivery schedules ○ D. Yes, an assessment was conducted and they received a score that was 80% or higher	Q6 Score: 1	2011 SCMS/MSH with the Government conducted the assessment at the National Level - the overall score was not produced, however, the assessment was completed. For each section of the assessment the scores were well below 80%, thus we feel this response reflects that the composite score would be less than 80%.	
	Commodity Security and Supply Chain Score	**7**		

7. **Quality Management:** Host country ensures that HIV/AIDS services are managed and provided in accordance with established national/global standards and are effective in achieving positive health outcomes (reduced AIDS-related deaths, reduced incidence, and improved viral load/adherence). Host country has institutionalized quality management approaches in its HIV/AIDS Program that ensure continued quality during and following donor to government transitions.			**Source of data**	**Notes/Comments**
Q1. **Existence of System**: Does the government have a functional Quality Management/Quality Improvement (QM/QI) infrastructure?	◉ A. No, there is no QM/QI infrastructure within national HIV/AIDS program or MOH ○ Yes, there is a QM/QI infrastructure within national HIV/AIDS program or MOH. The infrastructure (check all that apply): ☐ Routinely reviews national HIV/AIDS performance and clinical outcome data ☐ Routinely reviews district/regional HIV/AIDS performance and clinical outcome data ☐ Prioritizes areas for improvement	Q1 Score: 0	Agreement by government stakeholders on February 18, 2015	

Q2. **Strategy:** Is there a current (updated within the last 2 years) national QM/QI strategy that is either HIV/AIDS program-specific or includes HIV/AIDS program-specific elements?	◉ No, there is no HIV/AIDS-related QM/Q strategy ○ B. Yes, there is a QM/QI strategy that includes HIV/AIDS but it is not current (updated within the last 2 years) ○ C. Yes, there is a current QM/QI strategy that includes HIV/AIDS program specific elements ○ D. Yes, there is a current HIV/AIDS program specific QM/QI strategy	Q2 Score: 0	Agreement by government stakeholders on February 18, 2015	
Q3. **Guidelines:** Does national HIV/AIDS technical practice follow current WHO guidelines for PMTCT and ART?	○ A. No, the national practice does not follow current WHO guidelines for PMTCT or ART ◉ B. Yes, the national practice does follow current WHO guidelines for: ☑ PMTCT (option B+) ☑ Adult ART ☑ Pediatric ART ☑ Adolescent ART ☑ Test and treat for specific populations	Q3 Score: 4	The transition to the 2013 WHO guidelines is in process. 2014 Care and Treatment Guidelines for Burundi.	
Q4. **QI Data use**: Does the host country government monitor and use data for HIV/AIDS quality improvement?	○ A. No, there is no monitoring for HIV/AIDS quality improvement ◉ B. Yes, there is monitoring for HIV/AIDS quality improvement. Monitoring includes: ☑ All sites ☑ Use of data to determine quality of program or services ☑ Making recommendations and action plan for mid-course corrections	Q4 Score: 4	Review of the National Strategic Plan for HIV/AIDS 2014; CNLS annual and quarterly reports and meetings (PMTCT for example).	
Q5. **Post-transition:** Does the host country government monitor whether the quality of HIV/AIDS service outcome is maintained at sites where PEPFAR/other donors have transitioned from a direct implementation role?	◉ A. No, there is no quality monitoring at sites post-transition ○ B. Yes, there is quality monitoring at transition sites. Monitoring includes: ☐ All transition sites ☐ Review of service outcomes ☐ Client feedback on changes in quality ☐ Quality improvement action plan ○ C. PEPFAR/other donors have never supported direct service delivery in the country	Q5 Score: 0	For example World Bank HIV/AIDS Project close out "MAP II" 2011 and CHAI close out 2011	
		Quality Management Score	**8**	

THIS CONCLUDES THE SET OF QUESTIONS ON THE DOMESTIC PROGRAM AND SERVICE DELIVERY DOMAIN

Domain C. Health Financing and Strategic Investment

What Success Looks Like: Host country government is aware of the financial resources required to effectively and efficiently meet its national HIV/AIDS prevention, care and treatment targets. HCG actively seeks, solicits and or generates the necessary financial resources, ensures sufficient resource commitments, and uses data to strategically allocate funding and maximize investments.

8. Domestic Resource Mobilization: Resource Generation: The host-country government costs its national HIV/AIDS response, solicits and generates revenue (including but not limited to tax revenues, public sector user fees, insurance, loans, private sector and other strategic partnerships, and/or other innovative sources of financing) and allocates resources to meet the national budget for HIV/AIDS.			**Source of data**	**Notes/Comments**
Q1. Domestic budget: Is there a budget line item for HIV/AIDS in the national budget?	○ A. No, there is no budget line item for HIV/AIDS in the national budget ◉ B. Yes, there is an HIV/AIDS budget line item under the Health budget ○ C. Yes, there is an HIV/AIDS program-based budget across ministries ○ D. Yes, there is an HIV/AIDS program-based budget across ministries and the budget contains HIV/AIDS program indicators	Q1 Score: 3	Budget Law 2015	
Q2. Budgetary Framework: Does the country's budgeting process utilize a Medium-Term Expenditure Framework (MTEF) or Medium-Term Fiscal Framework (MTFF)?	○ A. No ○ B. Yes, but it does not include a separate costing of the national HIV/AIDS strategy or program ◉ C. Yes, and it includes a separate costing of the national HIV/AIDS strategy or program	Q2 Score: 6	CDMT 2014-2016	
Q3. Fiscal Policy: Does the country pass the MCC scorecard indicator for fiscal policy? (Countries without an MCC scorecard: Is general government net lending/borrowing as a percent of GDP averaged across 2011-2013 greater than (i.e. more positive than) -3.1 percent?)	◉ Yes ○ No	Q3 Score: 4	OGAC-provided data sheet (follows tab E) derived from: http://www.mcc.gov/pages/selection/scorecards	
Q4. Domestic public revenue: What was annual domestic government revenue as a percent of	Check the appropriate box for your country's income category: FOR LOW INCOME ○ A. More than 16.4% (i.e. surpasses category mean) ○ B. 14.8%-16.4%, (i.e. 90-100% of category mean) ◉ C. Less than 14.8%, (less than 90% of category mean) FOR LOW MIDDLE INCOME	Q4 Score: 0	OGAC-provided data sheet (follows tab E) Original Source: IMF Government Finance Statistics	

domestic government revenue as a percent of GDP in the most recent year available? (domestic revenue excludes external grants)	◯ D. More than 22.3% (i.e. surpasses category mean) ◯ E. 20.1-22.3% (i.e. 90-100% of category mean) ◯ F. Less than 20.1% (less than 90% of category mean) FOR UPPER MIDDLE INCOME ◯ G. More than 27.8% (i.e. surpasses category mean) ◯ H. 25.0%-27.8% (i.e. 90-100% of category mean) ◯ I. Less than 25.0% (less than 90% of category mean)			
Score for Domestic Resource Mobilization: Resource Generation:		**13**		

9. **Domestic Resource Mobilization: Resource Commitments:** Host country government makes adequate multiyear resource commitments to achieve national HIV/AIDS goals for epidemic control and in line with the available fiscal space. These commitments for the national HIV/AIDS program ensure a well-trained and appropriately deployed workforce, functioning health systems, sufficient commodities and drugs, and local institutions at all levels able to perform activities and carry out responsibilities.			**Source of data**	**Notes/Comments**
Q1. Benchmarks for health spending: **African countries:** Is the government meeting the Abuja commitment for government health expenditure (at least 15% of General Government Expenditure)? **Non-African countries:** Is government health expenditure at least 3 percent of GDP?	◯ A. Yes ◉ B. No	Q1 Score: 0	WHO and World Bank (see attached tab)	Burundi is at 13.7%
Q2. Domestic spending: What proportion of the annual national HIV response are domestic HIV expenditures financing (excluding out-of-pocket)? _____%	◉ A. Less than 10% ◯ B. 10-24% ◯ C. 25-49% ◯ D. 50-74% ◯ E. 75% or Greater	Q2 Score: 0	NASA 2012 was 5.6%, which is more reliable, however, not validated.	The NASA is not validated and there is concern around the accuracy of 2013 data.
	◉ A. None or information is not available ◯ B. 1-9%	Q3 Score: 0	All donor funded, even civil society organizations and clinics are donor funded for these activites.	Key pops are not tracked separately from the general population in public health facilities.

Q3. Key population spending: What percent of key population-specific interventions are financed with domestic public and domestic private sector funding (excluding out of pocket expenditure)?	○ 10-24% ○ 25-49% ○ 50-74% ○ 75% or Greater			
Score for Domestic Resource Mobilization: Resource Commitments:		**0**		
10. **Allocative Efficiency:** The host country analyzes and uses relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. For maximizing impact, data are used to choose which high impact program services and interventions are to be implemented, where resources should be allocated, and what populations demonstrate the highest need and should be targeted (i.e. the right thing at the right place and at the right time).			**Source of data**	**Notes/Comments**
Q1. Data-driven allocation: Does the host country government routinely use existing data to drive annual HIV/AIDS program investment decisions?	○ A. No, data are not used annually ◉ B. Yes, data are used annually. Check all that apply: ☑ Epidemiological data are used ☑ Health/service delivery data are used ☑ Financial data are used ☐ There is integrated analysis across data streams ☐ Multiple data streams are used to model scenarios	Q1 Score: 6	Concept Note 2015 and the National Strategic Plan for HIV/AIDS 2014-2017; annual reports, meeting reports.	
Q2. Geographic allocation: Does the host country government use data to determine the appropriate number and location of HIV/AIDS service sites (proportional to yield or burden data)?	◉ A. The government does not consider yield or burden when deciding on the number and location of HIV/AIDS service sites ○ B. Less than 20% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients ○ C. 20-49% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients ○ D. 50-79% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients	Q2 Score: 0	DSNIS (National Department of Health Information System) and CNLS have started separate mapping activities, however, further follow up is needed, as the data is not able to be used yet.	

	○ E. 80% or more of HIV/AIDS service delivery sites yield 80% or more of new positive HIV test results or ART clients			
Q3.Data driven reprogramming: Do host country government policies/systems allow for reprograming investments based on new or updated program data during the government funding cycle?	○ A. No, there is no system for funding cycle reprogramming ◉ B. Yes, there is a policy/system that allows for funding cycle reprogramming but it is seldom used ○ C. Yes, there is a system that allows for funding cycle reprogramming and reprogramming is done as per the policy but not based on data ○ D. Yes, there is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy and is based on data	Q3 Score: 1	Mid-term review of National Strategic Plan for HIV/AIDS 2014 - 2017	
		Allocative Efficiency Score: **7**		

11. **Technical Efficiency:** Through enhanced processes, economies of scale, elimination of waste, prevention of new infections, expenditure analysis, strategic targeting, and other technical improvements, the host country is able to achieve improved HIV/AIDS outcomes within the available resource envelope (or achieves comparable outcomes with fewer resources). Thus, maximizing investments to attain epidemic control.			**Source of data**	**Notes/Comments**
Q1. Unit costs: Does the Host Country Government use expenditure data or cost analysis to estimate unit costs of HIV/AIDS services? (note: full score of five points can be achieved without checking all disaggregate boxes).	○ A. No ◉ B. Yes (check all that apply): ☐ Annually ☑ For HIV Testing ☑ For Care and Support ☑ For ART ☑ For PMTCT ☑ For VMMC ☑ For OVC Service Package ☑ For Key population Interventions	Q1 Score: 5	National Strategic Plan for HIV/AIDS 2014 - 2017 mid-term review and the Concept Note 2015	

Q2. Improving efficiency: Which of the following actions is the Host Country Government taking to improve technical efficiencies?	Check all that apply: ☐ Using findings from cost-effectiveness or efficiency studies to modify operations or interventions ☐ Streamlining management to reduce overhead costs ☑ Reducing fragmentation to lower unit costs, i.e. pooled procurement, resource pooling ☑ Improving procurement competition ☑ Integration of HIV/AIDS into national or subnational insurance schemes (private or public) ☐ Scaling up evidence-based, high impact interventions and reducing interventions without evidence of impact ☐ Geographic targeting in high burden/high yield sites to increase impact ☐ Analysis of expenditure data to establish appropriate range of unit costs	Q2 Score: 1.5	National Strategic Plan for HIV/AIDS 2014 - 2017 mid-term review and the Concept Note 2015	For key populations targeting is occuring, however, for other populations and services this is not routinely occuring.
Q3. Loss ratio: Does host country government have a system to measure the proportion of domestic public HIV/AIDS spending that supports direct service delivery (not administrative/overhead costs)?	◉ A. No ○ B. Yes	Q3 Score: 0	NASA 2014, which is not yet validated and not a system.	
Q4. Benchmark prices: Are prices paid by the government for first-line ARVs and Test Kits within 5% variance of international benchmark prices (UNAIDS Investment Case)?	Check boxes that apply: ☐ They are not paying for any ARVs ☑ They are not paying for any test kits ☑ They are paying no more than 5% above the international benchmark price for first line ARVs ☐ They are paying no more than 5% above the international benchmark price for test kits	Q4 Score: 2	http://apps.who.int/hiv/amds/price/hdd/Default.aspx	Purchasing small number of ARVs for adult treatment, no test kits. The median treatment cost per year for HIV drugs in Burundi in 2014 is $100.86.
Q5. ART unit costs: Have average unit costs for providing ART in the country reduced within the last two years? Unit cost 2 years ago: $ _____	○ A. No ◉ B. Yes	4	Government purchase order, 2014.	WHO, Global Price Reporting Mechanism - http://apps.who.int/hiv/amds/price/hdd/

Current unit cost: $ _____				
			Technical Efficiency Score:	**12.5**

THIS CONCLUDES THE SET OF QUESTIONS ON THE HEALTH FINANCING AND STRATEGIC INVESTMENT DOMAIN

Domain D. Accountability and Transparency

What Success Looks Like: Host government upholds a transparent and accountable resolve to be responsible to its citizens and international stakeholders (donors) for achieving planned HIV/AIDS results, is a good steward of HIV/AIDS finances, widely disseminates program progress and results, and provides mechanisms for eliciting feedback.

12. Public Access to Information: Host government widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, large contract awards, etc.) related to HIV/AIDS. Program and audit reports are published publically.			**Source of data**	**Notes/Comments**
Q1. OBI: What is the country's "Open Budget Index" score? (Alternative for countries lacking an OBI score: What was the country's score on the most recent Public Expenditure and Financial Accountability Assessment (PEFA) for PI-10: "Public Access to Fiscal Information"?)	○ A. Extensive Information (OBI Score 81-100; or PEFA score of A- or better on element PI-10) ◉ B. Significant Information (OBI Scores 61-80; or PEFA score of B or B+ on element PI-10) ○ C. Some Information (OBI Score 41-60; or PEFA score of B-, C or C+ on element PI-10) ○ D. Minimal Information (OBI Score 21-40; or PEFA score of C- or D+ on element PI-10) ○ E. Scant or No Information (OBI Score 0-20; or PEFA score of D or below on element PI-10) ○ F. There is neither Open Budget Index score nor a PEFA assessment to assess the transparency of government budget	Q1 Score: 7.0	OGAC-provided data sheet (follows tab E) Data derived from Open Budget Index (http://survey.internationalbudget.org/) and PEFA data (www.pefa.org)	
Q2. National program report transparency: Does the host country government make an annual national HIV/AIDS program progress report and or results publically available?	○ A. No, the national HIV/AIDS program progress report or presentation of results is not made public ◉ B. Yes, the national HIV/AIDS program progress report and/or results are made publically available (Check all that apply): ☑ On Website ☐ Through any type of media ☑ Disseminate print report or presentation of results	Q2 Score: 4.0	CNLS Annual reports	
	○ A. No audit is conducted of the National HIV/AIDS program, or the audit report is not made available publically	Q3 Score: 2.0	CNLS undergoes annual audits and reports are available - all available	

Q3. Audit transparency: Does the host country government make an annual national HIV/AIDS program audit report publically available?	◉ B. Yes, the national HIV/AIDS program audit report is made public. Check all that apply: ☐ On website ☐ Through any type of media ☑ Disseminate print report		in print, not online.	
		Public Access to Information Score: **13**		

13. **Oversight and Stewardship**: Government institutions are held accountable for the use of HIV/AIDS funds and for the results of their actions by the electorate and by the legislature and judiciary. Public employees are required to account for administrative decisions, use of resources, and results obtained. There is timely and accurate accounting and fiscal reporting, including timely audit of public accounts and effective arrangements for follow-up. There are mechanisms for citizens and key stakeholders to review and provide feedback regarding public programs, services and fiscal management.			**Source of data**	**Notes/Comments**
Q1. Availability of Information on Resources Received by Service Delivery Units. PEFA score on PI-23 was C or higher in most recent assessment.	○ A. PEFA assessment never conducted, or data unavailable ○ B. PEFA was conducted and score was below C ◉ C. PEFA was conducted and score was C ○ D. PEFA was conducted and score was B ○ E. PEFA was conducted and score was A	Q1 Score: 1.0	OGAC-provided data sheet (follows tab E) Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org)	
Q2. Quality and timeliness of annual financial statements. PEFA score for element PI-25 was C or higher in most recent assessment. Actual scores are ____	Check A or B; if B checked, select appropriate disaggregates: ○ A. PEFA assessment never conducted, or data unavailable ◉ B. PEFA was conducted and score was C or higher for: ☑ (i) Completeness of the financial statements ☑ (ii) Timeliness of submission of the financial statements ☑ (iii) Accounting standards used	Q2 Score: 5.0	OGAC-provided data sheet (follows tab E) Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org)	
	Check A, B, or C; if C checked, select appropriate disaggregates:		National Strategic Plan for HIV/AIDS 2014 -	

Q3. Government Channels and Opportunities for Civil Society Engagement: Does host country government have formal channels and opportunities for diverse civil society groups to engage and provide feedback on its HIV/AIDS policies, programs, and services?	○ A. No, there are no formal channels or opportunities ○ B. No, there are no formal channels or opportunities but civil society is called upon in an ad hoc manner to provide inputs and feedback ◉ C. Yes, there are formal channels and opportunities for civil society engagement and feedback. Check all that apply: ☑ During strategic and annual planning ☑ In joint annual program reviews ☑ For policy development ☑ As members of technical working groups ☑ Involvement on evaluation teams ☐ Giving feedback through social media ☑ Involvement in surveys/studies ☑ Collecting and reporting on client feedback	Q3 Score: 5.5	2017 Review open to CSO; Joint Annual Review CSO participation; CSO participates in CCM as voting members as well;	
Q4. Civil society Enabling Environment: What score did your country receive on the 2013 Civicus Enabling Environment Index (EEI), which measure the socio-cultural, socio-economic and governance environments for civil society? If your country is not included in the EEI, are there any laws or policies that prevent a full range of civil society organizations from providing oversight into the government's HIV/AIDS response?	◉ A. EEI score of 0-0.38; or if no EEI score, there are laws or polices that restrict civil society playing an oversight role ○ B. EEI score of 0.39-0.50; or there are no laws that restrict civil society playing a role in providing oversight of the HIV/AIDS response but in practice, it is not accepted by government ○ C. EEI score of 0.51 - 0.76; or there are no laws or policies that prevent civil society from playing a role in providing oversight of the HIV/AIDS response and civil society is very actively engaged in providing oversight	Q4 Score: 0.0	OGAC-provided data sheet (follows tab E) Data derived from Civicus Enabling Environment Index (civicus.org/eei/)	
		Oversight and Stewardship Score: **11.5**		

THIS CONCLUDES THE SET OF QUESTIONS ON THE ACCOUNTABILITY AND TRANSPARENCY DOMAIN

Domain E. Enabling Environment

What Success Looks Like: Relevant government entities demonstrate transparent resolve and take actions to create an enabling policy and legal environment, and provide technical and political leadership to coordinate an effective national HIV/AIDS response.

14. **Policies, Laws, and Regulations:** Host country develops, implements, and oversees a wide range of policies, laws, and regulations that will achieve coverage of high impact interventions, ensure social and legal protection and equity for those accessing HIV/AIDS services, eliminate stigma and discrimination, and sustain epidemic control within the national HIV/AIDS response.			**Source of data**	**Notes/Comments**
Q1. Structural obstacles: Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support?	○ A. No, there are no such laws or policies ◉ B. Yes, there are such laws, regulations or policies. Check all that apply (each check box reduces score): ☑ Criminalization of HIV transmission ☑ HIV testing disclosure policies or age requirements ☐ Non-disclosure of HIV status laws ☑ Anti-homosexuality laws ☑ Anti-prostitution legislation ☑ Laws that criminalize drug use, methadone use or needle exchange	Q1 Score: 1.0	2005 HIV/AIDS Law Policies; Penal Code of the Republic of Burundi (566 is the homosexuality code)	
Q2. Access protection: Is there a National HIV/AIDS Policy or set of policies and laws that creates a legal and policy environment that ensures non-discriminatory and safe access to HIV/AIDS services, providing social and legal protection where those rights are violated? (note: full score of six points possible without checking all boxes)	○ A. No, there are no such policies or laws ◉ B. Yes, there are such policies and laws. Check all that apply: ☑ For people living with HIV ☐ For men who have sex with men ☐ For transgendered persons ☐ For sex workers ☐ For people who inject drugs	Q2 Score: 3.0	There are no laws for young girls, LGBTI, drug users, survivors Gender-based Violence (GBV). HIV/AIDS Law section 32. 2009 GBV Strategy - the policy is being updated and is not yet complete or validated.	

	☑ For children orphaned or affected by HIV/AIDS ☐ For young girls and women vulnerable to HIV ☑ For survivors of gender-based violence			
Q3. Civil society sustainability: Does the legislative and regulatory framework make special provisions for the needs of Civil Society Organizations (CSOs) or give not-for-profit organizations special advantages?	○ A. No, there are no special provisions or advantages for CSOs ◉ B. Yes, there are special provisions and advantages for CSOs. Check all that apply: ☐ Significant tax deductions for business or individual contributions to not-for-profit CSOs ☑ Significant tax exemptions for not-for-profit CSOs ☑ Open competition among CSOs to provide government-funded services ☑ Freedom for CSOs to advocate for policy, legal and programmatic change	Q3 Score: 3.0	1992 Law related to non-profits; Article 4 National Policy and Law on HIV/AIDS - special status.	
Q4. Enabling legislation: Are there policies or legislation that govern HIV/AIDS service delivery?	○ A. No ◉ B. Yes, there are. Check all below that are included: ☑ A national public health services act that includes the control of HIV ☑ A task-shifting policy that allows mid-level providers to provide key HIV/AIDS services	Q4 Score: 4.0	Task shifting policy/ Minister of Health Order July 2012; National Health Policy; Law of 12 May 2005 judicial protection of PLHIV;	
	Policies, Laws, and Regulations Score:	**11**		

15. **Planning and Coordination:** Senior policy makers prioritize health and the HIV/AIDS response. Host country develops, implements, and oversees a multiyear national strategy and serves as the preeminent architect and convener of a coordinated HIV/AIDS response in the country across all levels of government and key stakeholders, civil society and the private sector. National plans are aligned to national priorities to achieve planned targets and results, with full costing estimates and plans incorporated.		**Source of data**	**Notes/Comments**
	○ A. No, there is no national strategy for HIV/AIDS	Q1 Score: 4.0	National Strategic Plan for HIV/AIDS	

Q1. National Strategy: Does the country have a multi-year, costed national strategy to respond to HIV?	◉ B. Yes, there is a national strategy. Check all that apply: ☑ It is multiyear ☑ It is costed ☑ Its development was led by the host country government ☑ Civil society actively participated in the development of the strategy		2014-2017	
Q2. Data driven prioritization: Did the host country government develop the strategy using a data-driven prioritization approach, which coordinates the investment of multiple sources of funding, i.e. Investment Case?	○ A. No data-driven prioritization approach was used ◉ B. Yes, a data-driven prioritization approach was used but it did not coordinate the investment of multiple funding sources ○ C. Yes, a data-driven prioritization approach was used that coordinated the investments of multiple funding sources	Q2 Score: 2	GFATM Concept Note 2015 and the National Strategic Plan for HIV/AIDS 2014 - 2017	
Q3. CCM criteria: Has the country met the minimum criteria that all CCMs must meet in order to be eligible for funding by the Global Fund?	○ A. No or there is no CCM ○ B. Yes, with conditions ◉ C. Yes	Q3 Score: 2	Global Fund Eligibility List 2014; USAID-supported GMS continues to provide CCM support 2014 - 2015 trip reports and visit/ meeting documents	
Q4. Coordination of national response: Does the host country government coordinate (track and map) all HIV/AIDS activities in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners, to avoid duplication and gaps?	○ A. No, it does not track or map all HIV/AIDS activities ◉ B. the host country government coordinates all HIV/AIDS activities. Check all that apply: ☑ Of Civil Society Organizations ☐ Of private sector ☑ Of donor implementing partners ☑ Activities are tracked or mapped ☐ Duplications and gaps are addressed	Q4 Score: 3.0	Mapping activity notes and outcomes of HIV/AIDS between GFATM and PEPFAR; annual and quarterly reports submitted to National AIDS Program; Coordination is the responsibility of CNLS	

	☐ Joint operational plans are developed that include key activities of all implementing agencies			
Q5. Civil society engagement: Is there active engagement of diverse non-governmental organizations in HIV/AIDS advocacy, decision-making and service delivery in the national HIV/AIDS response?	○ A. No ◉ B. Yes, civil society (such as community-based organizations, non-governmental organizations and faith-based organizations, local leaders, and/or networks representing affected populations) are actively engaged. Check all that apply: ☑ In advocacy ☑ In programmatic decision-making ☑ In technical decision-making ☑ In service delivery	Q5 Score: 4.0	Joint Annual Review; National Strategic Plan 2014 - 2017; GFATM Concept Note development 2015; CCM participation and voting membership	
		Planning and Coordination Score:	**15**	

THIS CONCLUDES THE SET OF QUESTIONS ON THE ENABLING ENVIRONMENT DOMAIN