

PEPFAR Burundi

Country Operational Plan (COP) 2016

Strategic Direction Summary

June 14, 2016

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Goal Statement

In FY17, PEPFAR Burundi will continue its ambitious effort to achieve HIV epidemic control by the end of FY18 in five high-prevalence provinces, Bujumbura Mairie, Bujumbura Rural, Ngozi, Kayanza and Kirundo, which collectively account for 55% of the burden of HIV/AIDS nationally. The Government of Burundi (GOB), with principle support from the Global Fund for AIDS, Tuberculosis and Malaria (GFATM), will cover the remaining 45% of geographic burden but PEPFAR will continue to work closely with the National HIV/AIDS Program (PNLS) to ensure that best practices and lessons learned in PEPFAR-supported sites are shared and scaled-up nationally. PEPFAR will also support the PNLS in the revision and implementation of national treatment guidelines to reflect 2015 World Health Organization (WHO) recommendations on Test and Start and new service delivery models. This effort is underway and it expected that the new guidelines will be adopted and implementation will begin by the end of FY16.

In terms of timeline, PEPFAR Burundi will aim to reach half of those people living with HIV (PLHIV) needed to reach saturation by the end of FY17 and the other half in FY18. Following a major geographic pivot in COP15 and continued rigorous analysis of burden by province as well as individual site yields for HIV Testing and Counselling (HTC) and Prevention of Mother to Child Transmission (PMTCT), PEPFAR Burundi will not be making significant changes to its geographic footprint in FY17. Rather, based on a detailed review of expenditure analysis and annual performance report (APR) data, PEPFAR Burundi will be narrowing its population focus considerably to focus on those individuals driving the epidemic. Specifically, this will include more targeted testing and service delivery to key populations such as female sex workers (FSW) and men who have sex with men (MSM) and priority populations such as military service members and their families and vulnerable adolescent girls and young women (AGYW).

As in previous years, PEPFAR will continue to support antiretrovirals (ARVs) for pregnant and breastfeeding women covered under Option B+, rapid test kits for diagnosis of HIV, and other lab commodities but will not be purchasing ARVs for treatment. As part of the conventions signed for its latest round of funding, the GFATM will be supporting antiretroviral treatment (ART) for all eligible PLHIV. The proposed transition to Test and Start was taken into account in the drafting of the concept note for this round of funding but PEPFAR will continue to provide support to the PNLS and its quantification committee to ensure that any gaps created by expanded treatment eligibility criteria will be met. In addition to this support, PEPFAR Burundi will be providing site-level technical assistance aimed at targeted high yield testing of key and priority populations (first 90), strong linkages to care and treatment for those testing positive (second 90), reinforcement of high adherence rates and rapid scale-up of viral load testing (third 90).

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden, and country profile

Burundi is a low-income country with GNI of 758 USD per capita (PPP adjusted) and remains one of the poorest countries in the world, ranked 184 out of 188 countries on the 2015 UNDP Human Development Index. Important gains have been realized in the health sector over the past ten years but they remain fragile and may be at risk due to the ongoing political and economic crisis following contested elections in 2015. As of the submission of this COP, over 250,000 refugees have fled Burundi for neighboring countries and it is estimated that there may be 3,000 or more PLHIV among them.

Burundi has a population of 10,395,931 and is considered to have a low-prevalence mixed HIV epidemic. As of 2014, the most recent year for which an estimate is available, 1.3% of the population was living with HIV with approximately 4,700 annual deaths attributed to AIDS¹. According to SPECTRUM estimates compiled by UNAIDS and the National AIDS Council (CNLS), approximately 84,000 individuals are living with HIV². Furthermore, it is estimated that the prevalence of HIV among key populations is significantly higher, with a prevalence of 21.3% among female sex workers and a 4.8% among men having sex with men³.

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: 90.1% 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.

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>.

³ Priorities for Local AIDS Control Efforts (PLACE) Study, 2013

⁴ Global AIDS Response Progress Reporting 2013

HIV prevalence in the general population:

According to the 2014 United Nations Joint Programme on HIV/AIDS (UNAIDS) report on Burundi, the HIV prevalence rate among adults age 15-49 years is 1.3%. However, the National Strategic Plan against AIDS 2014-2017 notes that the prevalence rate varies according to age group. 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.

Available data show a steady feminization of the HIV epidemic regardless of age. 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% among women of childbearing age, 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. 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%).

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. Planned IBBSS studies of FSW, MSM and people who inject drugs with GFATM support and Military with PEPFAR support, during FY16 will make more accurate data available.

Geographic Distribution of HIV Burden:

Prevalence is unevenly distributed nationally with 80% 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 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.

Standard Table 1.1.1

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) ⁵
HIV Prevalence (%)		1.3%									UNAIDS Burundi SNU estimates 2014
AIDS Deaths (per year)	3900		n/a		n/a		n/a		n/a		http://www.unaids.org/en/regions/countries/countries/burundi
# PLHIV	84,000		7,140		6,860		42,000		28,000		http://www.unaids.org/en/regions/countries/countries/burundi . For children, census proportion (51% for women and 49% for males)
Incidence Rate (Yr)											
New Infections (Yr)	3765										NSP 2014-2017 page 28
Annual births	420,626	n/a									Population projections 2008-2030, ISTEUBU, June 2014
% of Pregnant Women with at least one 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

⁵ 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.

Pregnant women needing ARVs	5,895	100%									NSP 2014-2017 page 82 (It is generated from other data)
Orphans (maternal, paternal, double)	793,269										CNLS estimates 2015
Notified TB cases (Yr)	7,309										WHO/ Report 2015 (Annex 4 page 35)
% of TB cases that are HIV infected		14%									WHO/ Report 2015 (Page 80)
% of Males Circumcised		33%									DHS2010
Estimated Population Size of MSM*	9,346										PLACE 2013
MSM HIV Prevalence		4.8%									PLACE 2013
Estimated Population Size of FSW	51,482										PLACE 2013
FSW HIV Prevalence		21.3%									PLACE 2013
Military	100,000										Department of Defense Burundi 2014
Military HIV prevalence		1.3%									Department of Defense Burundi 2014
<i>*If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.</i>											

Table 1.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (12 months)

Table 1.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (12 months)									
				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	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%	84,000	42,169	34,743	Data Not available	1,234,683	15,464	7,134
Population less than 15 years	4,746,738	Not available	14,000	2,654	2,496	Data not available	33,512	587	311
Pregnant Women	464,257	1.7%	5,895	3,885	3391	Data not available	433,305	3078	2242
MSM	9,346	4.8%	449	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
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
Military	100,000	1.3% military 1.9% dependents	1,450 (475 military) (975 dependents)	877	178	122	17,653	303	189

1.2 Investment Profile

The HIV response in Burundi is funded primarily by two sources, PEPFAR and the GFATM. For the period of 2016-2017, the GFATM will contribute 56% of the national HIV response while PEPFAR will contribute 37%. The national government's contribution for the same period is estimated to be around 5 % while other donors will contribute 3%. The national government had been steadily increasing its contribution to the response over the last five years and had also taken internal steps to address the epidemic, including waiving all taxes on HIV/AIDS medications and commodities and declaring all HIV/AIDS services free of charge to the patient. However, there is considerable uncertainty about the government's capacity to increase or even maintain current funding in light of the current political and economic crisis.

PEPFAR support had been maintained at a similar funding level of \$ 18,860,000 from FY11 to FY14, but declined to \$17,360,000 in FY2015. For FY17, PEPFAR funding will remain constant at \$17,360,000. 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 GFATM Country Coordinating Mechanism (CCM) submitted a concept note on January 30, 2015, based on the UNAIDS costed and prioritized National Strategic Plan to access funds under the GFATM New Funding Model (NFM) allocation for the period of 2015-2017. The concept note was approved for a two year funding period (2016-2017) of \$46,603,032. These funds will be divided into a community component (\$11,297,390) managed by the Burundi Red Cross and a clinical component (\$35,305,642) managed by the National HIV/AIDS Program (PNLS).

Table 1.2.1 Investment Profile by Program Area ⁶					
Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
Clinical care, treatment and support	\$18,261,427	34%	55%	8%	3%
Community-based care, treatment, and support	\$1,119,373	0	90%	10%	0
PMTCT	\$2,464,911	65%	30%	5%	0
HTS	\$6,295,664	43%	57%	0	0
Priority population prevention	\$3,568,614	33%	50%	1%	16%
Key population prevention	\$2,347,890	38%	62%	0	0
OVC	\$1,214,517	66%	44%	0	0
Laboratory	\$500,000	100%	Included in HSS	0	0
SI, Surveys and Surveillance	\$2,756,160	30%	70%	0	0
HSS	\$3,082,614	53%	43%	3%	1%
Total	\$41,611,170	40%	53%	4%	3%

⁶ (GRP, National AIDS Spending Assessment , 2012), all amounts in 2012 USD

Table 1.2.2 Procurement Profile for Key Commodities					
Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	\$7,207,977	3.14%	86.80%	9.84%	-
Rapid test kits	\$2,095,245	20.32%	79.68%	-	3.24%
Other drugs	\$1,051,841	13.63%	56.66%	29.71%	-
Lab reagents	\$2,165,689	4.10%	95.90%	0%	-
Condoms	\$1,090,809	-	100%	-	-
Viral Load commodities	\$465,582	45.17%	54.83%	0%	-
VMMC kits	-	-	-	-	-
MAT	-	-	-	-	-
Other commodities	\$23,616	35.97%	64.03%	-	-
Total	\$14,101,029	7.82%	84.81%	7.25%	0.11%

Table 1.2.3 USG Non-PEPFAR Funded Investments and Integration					
Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	\$2,000,000	\$2,000,000	1	\$2,640,157.50	IHP: Integrated service delivery for HIV, MCH, Malaria and FP to improve quality of care and capitalize on synergies and cost efficiencies.
USAID Malaria	\$9,500,000	IHP: \$450,000 PSM: \$778,411	2	IHP: As above PSM: \$1,250,000	IHP: Integrated service delivery for HIV, MCH, Malaria and FP to improve quality of care and capitalize on synergies and cost efficiencies. PSM: Technical assistance to build supply chain management capacity
Family Planning	\$3,000,000	IHP: \$2,000,000* Youth Power: \$100,000* BRAVI: \$250,000* PSM: \$650,000* *estimated	4	IHP: As above Youth Power: \$799,517 BRAVI: \$750,000 PSM: As above	IHP: Integrated service delivery for HIV, MCH, Malaria and FP to improve quality of care and capitalize on synergies and cost efficiencies. Youth Power: Provide high impact services to vulnerable AGYW aimed at preventing both new HIV infections and unintended pregnancies. BRAVI: Integration of FP and GBV services. PSM: Technical assistance to build supply chain management capacity
Total	\$14,500,000	\$6,228,441	4	\$4,641,473.50	

1.3 National Sustainability Profile

On February 4, 2016, the Burundi PEPFAR team, in collaboration with UNAIDS, convened a one-day multi-stakeholder Sustainability Index and Dashboard (SID) workshop with participants from the National AIDS Council, National AIDS Program, Global Fund Principal Recipients, UN agencies, National Reproductive Health Program, representatives of civil society and faith based organizations, and the National Network of PLHIV (RBP+). The workshop was hosted by UNAIDS. After an introduction of the SID tool and highlights on the notable updates that have been made to SID 2.0, participants broke into four domain subgroups to discuss and complete the SID questionnaire based on available public data and information assembled. The full group then reconvened at the end of the day to review the completed tool, discuss the findings, and identify priorities. UNAIDS' hosting of the multi-stakeholder meeting highlights longstanding collaboration with PEPFAR.

The following SID elements were identified as sustainability strengths:

Sustainability Strengths:

- **Planning and Coordination (10.0, dark green):** With the support of donors, the host country develops, implements, and oversees a costed multiyear national strategic plan and serves as the preeminent convener of a coordinated HIV/AIDS response in the country.
- **Public Access to Information (9.00, dark green):** The Government of Burundi widely disseminates reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets. Efforts are made to ensure the public has access to data through reports, websites, radio or other methods of disseminating information. However promptness and accuracy of data are areas in need of improvement.
- **Civil Society Engagement (7.17, light green):** In Burundi, there is active civil society engagement in HIV/AIDS advocacy, decision-making and service delivery in the national HIV/AIDS response. However there is a need for capacity building in project development and management.

Sustainability Vulnerabilities:

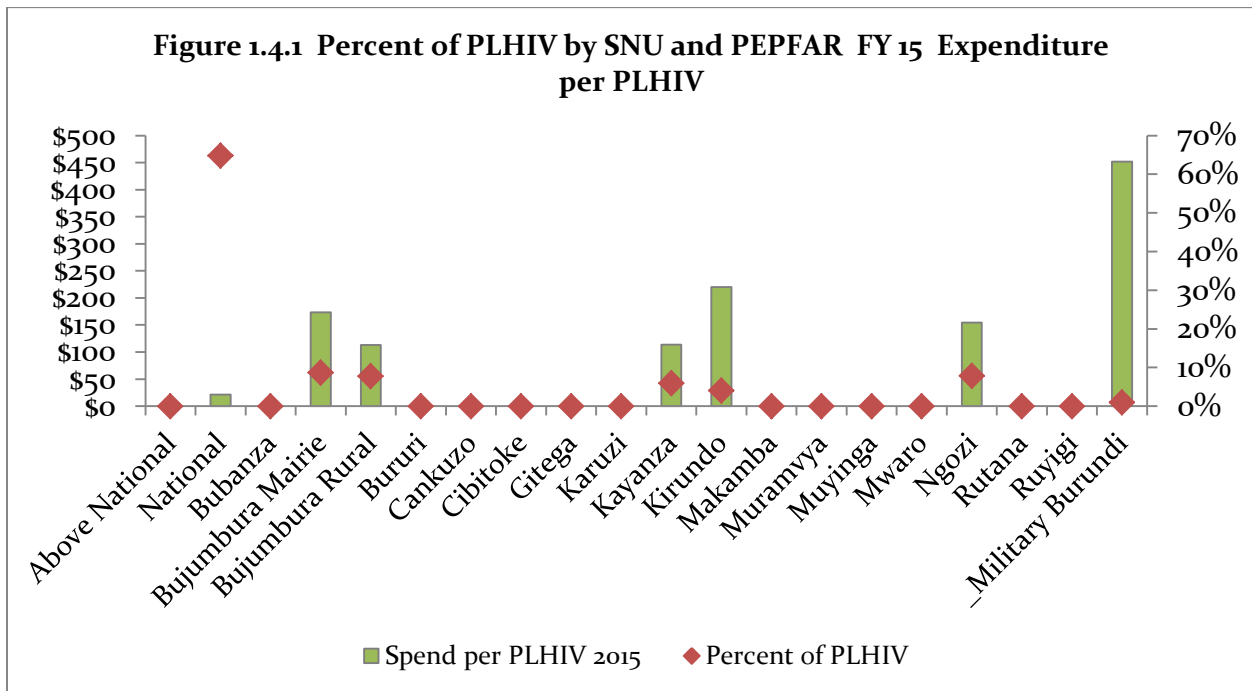
- **Service Delivery (5.46, yellow):** Weakness in HTC linkages to treatment and care, lack of systematic approach linkage from testing to services and loss to follow-up (LTFU). As a solution an SMS messaging system to identify patients who do not present at treatment site will be established in FY17.
- **Epidemiological and Health data (5.65, yellow):** No available data on HIV incidence. Limited capacity at national level for analysis of data and evidenced-based decision making. To remedy this situation the following actions will be taken: ANC Sentinel Surveillance will be made operational in 20 sites, production of annual national-level Epi

report and capacity building of the national program to make decisions based on this report.

- Laboratory (3.43, red): Lack of adequate and consistent capacity to perform timely DNA PCR and Viral Load testing. The only PCR/Viral load machine located in Bujumbura was inoperable for most of FY15. Only 68 PCR tests were performed in FY15 (2% of target). A second machine, located in Ngozi Province (purchased by GFATM) will be made operational in Q3 of FY16 and PEPFAR will secure maintenance contracts to ensure that both machines are repaired promptly in the future. PEPFAR will also work closely with the GFATM and the PNLs to explore the possibility of leveraging GenExpert machines originally intended for diagnosis of tuberculosis.

1.4 Alignment of PEPFAR investments geographically to disease burden

PEPFAR Burundi investments are strongly aligned to the disease burden by covering five provinces which collectively account for 55% of the total national disease burden, Bujumbura Mairie (14%), Bujumbura Rural (12%), Ngozi (13%), Kayanza (9%), and Kirundo (7%). While on paper, coverage levels in Bujumbura Mairie (142% as of December 2015) have exceeded the threshold for epidemic control, continued high testing yields in both HTC and PMTCT, as well as analysis documenting that patients from outside Bujumbura Mairie continue to seek care there, provide ample justification for continued investment in this SNU. Per patient costs are relatively similar across the five SNUs with a somewhat higher than average spend in Kirundo which is unsurprising given that it is the farthest distance from the capital, Bujumbura.



1.5 Stakeholder Engagement

PEPFAR Burundi has consulted with key stakeholders including the Ministry of Public Health (MSPLS), UNAIDS, WHO, the National AIDS Council (CNLS), the National AIDS Program (PNLS), and civil society on how to continue aligning PEPFAR Burundi's work to the new PEPFAR global strategy. Consultations have included: (1) Update and exchanges on the PEPFAR 3.0 strategy to reach epidemic control through prioritization of high burden geographic areas, focus on women of childbearing age, adolescent girls as well as key and priority populations; (2) collaborative exercises to update the sustainability index and dashboard; (3) sharing the data analysis and decision-making resulting from the site yield and geographic coverage analysis; (4) discussion on the approach PEPFAR Burundi is using to scale-up to saturation in Bujumbura Marie and aggressive scale-up for the other areas of high HIV burden and prevalence (Bujumbura Rural, Kayanza, Kirundo and Ngozi); and (5) continuing discussions on implementation of transition plans for sites from which PEPFAR exited in COP15.

The PNLS and CNLS were updated on progress of the new strategy which began COP15. PEPFAR Burundi plans to continue regular quarterly coordination meetings with the GFATM, MSPLS, and civil society to revisit and review data, as it is available, to ensure we continue to respond effectively and efficiently in the right places at the right time.

A one-day workshop for consultations with civil society organizations was jointly organized with UNAIDS on March 9, 2016. Participants reiterated recognition of the high quality of PEPFAR interventions and appreciated the goal of reaching epidemic control by focusing on targeted geographic areas and key and priority populations. They also appreciated news of the imminent startup of the LINKAGES project specific to key populations as this will contribute to a substantial reduction in new infections. However, as they did during the COP15, they raised the weakness of interventions in non-PEPFAR high-burden areas and expressed their uncertainty regarding taking responsibility for quality service delivery in areas where PEPFAR is transitioning.

Recommendations were made to the PEPFAR Burundi team and to the GOB, including: the need to accelerate the updating of the national treatment protocol (2014) to include Test and Start; the strengthening of CSOs institutional capacity and their promotion to prime implementing partners; adoption of private sector strategies to promote Early Infant Diagnosis (EID); creation of friendly settings for testing of men and youth; increasing funding for community activities including tracking lost to follow-up in order to improve the retention rate; and increasing the implication and participation of men in PMTCT and other activities. These recommendations were analyzed, discussed, and many were integrated into the COP. These include: the acceleration of the adoption of new WHO guidelines; the identification of additional "hotspot" and higher burden locations where the LINKAGES program should focus; private sector strategies for EID, and opening the opportunity for CSOs to achieve 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. In addition, the USG team and GOB are continuously engaged in coordination of the national HIV/AIDS response including (i) development of multiyear national strategic plans; (ii) tracking and mapping all HIV/AIDS activities in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners, in order to avoid duplication and gaps; (iii) using a data-driven approach to determine priorities; and (IV) establishing policies and guidelines that direct HIV/AIDS service delivery. 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 actively participating in the oversight committee.

2.0 Core, Near-Core and Non-Core Activities

The PEPFAR Burundi program is relatively small in budget, and the core, near-core, non-core exercise conducted for COP15 revealed that the program is predominantly focused where the disease burden is highest. There were, however, some activities that were deemed not critical to scaling-up treatment and reducing new infections, and these have been transitioned to GOB or other partners over the course of FY16. Overall, the majority of the remaining “core” activities are in Care and Treatment, PMTCT, and key populations while most of the “near-core” activities identified are in Program/System Support, particularly Strategic Information (SI).

While the PEPFAR program intends to continue its high-impact activities (e.g. PMTCT and key populations) in five provinces with high burden of the epidemic, there was recognition that there may be scope for expansion to support national 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 so that successful approaches and lessons learned in PEPFAR-supported sites can be effectively shared and 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 and using PMTCT as a platform for finding men and children through the index patient approach, finding and linking key populations to services and reaching women and key populations through the Integrated Health Project (IHP), PMTCT Acceleration, DOD PMTCT, and LINKAGES mechanisms. IHP, PMTCT AP, and DOD PMTCT mechanisms will continue to provide long-term, integrated health services for women, their partners and their children. Supported sites will also target access to other priority populations, such as military personnel who are highly mobile and may engage in high-risk behaviors which can expose family members.

These services aim to reach as many individuals as possible by being strategically located in the provinces that comprise 55% of the disease burden in Burundi against 35% of the national population. Recent data show that PEPFAR-supported sites have achieved 91% coverage for PMTCT services while the national rate is only 65.9%. 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 HTC and ART services provided to key and priority populations, PEPFAR will continue to support targeted prevention including condom distribution, post-exposure prophylaxis (PEP), sexually-transmitted infection (STI) and opportunistic infection (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 for PMTCT in PEPFAR-supported sites. However, PEPFAR will continue to procure rapid test kits (RTKs), Cotrimoxazole, PEP, CD4 and viral load commodities, among other key commodities essential to PEPFAR activities. In addition, through the new Global Health Supply Chain-Procurement and Supply Management (PSM) mechanism, PEPFAR will continue its 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 PSM package of services, is fundamental to ensuring the smooth provision of PEPFAR-supported services. Based on the political situation prevailing in Burundi as of April 2016, the DHS and LMIS which were planned in COP15 as core activities have been delayed but will be implemented later this year.

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 COP15 review, PEPFAR Burundi designed a new OVC project using its OVC funding, coupled with additional Family Planning funds. Through an existing task order of the Youth Power mechanism, PEPFAR has designed a new OVC project focused on improving outcomes for vulnerable adolescent girls and young women. While Burundi is not a DREAMS Initiative country, the design of the new mechanism is largely based on DREAMS guidance. The project will target girls and young women ages 10 to 18, both in and out of school with a comprehensive package including HIV testing and counseling, referrals for continuum of care and treatment, 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 fundamental to the success of “core” activity implementation. These include countering 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/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. Significant investments in SI capacity, including a new initiative to establish ARV drug resistance surveillance are needed. These efforts will directly impact on the success of core PEPFAR activities by providing the data necessary to validate or refine current PEPFAR strategies, particularly those focusing on key and priority populations.

The Non-Core: Activities to be transitioned

Given the very rigorous core, near-core and non-core exercise conducted in COP15, no additional non-core activities were identified for transition in COP16.

3.0 Geographic and Population Prioritization

Subnational epidemiologic estimates used for geographic prioritization were drawn from UNAIDS data for 2014, the most recent year available. According to 2015 data from the CNLS, 42,169 people were on treatment at the end of FY 2015 representing 55% of PLHIV leaving a gap of 45%. According to the NSP, a total of \$250,127,490 would be needed over four years to reach epidemic control (80% coverage of all PLHIV) nationally by the end of 2017.

Given the significant geographic pivot undertaken by PEPFAR Burundi in COP 15, and the lack of any new data on prevalence or burden by province, no major changes will be made to geographic prioritization this year. That said, rigorous site yield analysis was conducted to identify specific sites with no or very few new positives. After cross-checking data on both HTC and PMTCT total and percentage yields, 31 sites with fewer than five new positives and less than 1% positivity were identified and slated for transition in late FY 2016 or early FY 2017. All of these sites have been supported by PEPFAR for at least one full year, offering sufficient data to determine that either they are located in areas with little to no HIV, or do not attract a client population likely to be infected. As with similar sites transitioned in FY15/FY16, patients on treatment, including pregnant women on Option B+ will continue to receive GFATM-supported ART but PEPFAR-supported technical assistance will be discontinued.

While geographic coverage will remain largely unchanged in FY17, PEPFAR Burundi will make important changes to the population groups targeted by PEPFAR support. Historically, Burundi was a PMTCT focus country for PEPFAR but since the development of COP15, PEPFAR Burundi has aimed to build on successes in PMTCT by broadening efforts to reach partners and children of women identified as HIV+ through the index patient approach, by more targeted application of provider initiated testing, and by more targeted efforts to reach key and priority populations most

affected by HIV. These include FSW, MSM, military service members and their families, and AGYW. In FY17, PEPFAR Burundi will significantly increase funding for its LINKAGES activity which targets FSW and MSM in order to expand geographic coverage to additional hotspots in all PEPFAR-supported provinces. For military service members and their families, the Department of Defense (DOD) will continue its scale up of military prevention and PMTCT activities while AGYW will be reached through the USAID-funded Youth Power mechanism, using a combined OVC and family planning package aimed at empowering young women to remain in school and to make and execute healthy decisions to prevent HIV and unintended pregnancy.

It is expected that more targeted testing, both through the successful index patient approach pioneered in PMTCT services and the increased outreach to key and priority populations, will result in significantly higher testing yields, increasing the number of PLHIV identified while lowering costs relative to a general population testing approach. Additional focus on linkage to treatment for those testing positive will drive efforts to achieve epidemic control.

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

4.1 Targets for scale-up locations and populations

Using a cascade approach, PEPFAR Burundi has calculated the required number of additional PLHIV that need to be identified in order to reach 80% ART coverage by the end of FY18. The five provinces which PEPFAR currently supports for ART have an average coverage of 53% (APR 2015). In FY17, PEPFAR Burundi intends to aggressively scale up ART services in four of the current five provinces—Bujumbura Rural, Ngozi, Kirundo and Kayanza. While Bujumbura Mairie is in principle, already at or above saturation, sites there continue to generate high yields of new positives. Analysis of available site level data indicates that at least 17% of patients on treatment in Bujumbura Mairie are resident in other provinces, with 11% coming from Bujumbura Rural. For these reasons, Bujumbura Mairie will continue to be classified as a scale-up to saturation province but in recognition of the high level of saturation, negligible transport costs and economies of scale, significantly lower UEs were applied for target-based budgeting in this SNU.

Across all five provinces, PEPFAR Burundi aims to enroll 10,553 additional patients (adults and children) with the goal of achieving a total of 41,111 current on ART in PEPFAR-supported SNUs by the end of FY 17. This represents an increase in coverage from 53% to 86% 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 70% coverage in FY17 and the remaining gap in FY18. PLHIV will be identified and linked to care and treatment services via provider-initiated, voluntary, and targeted mobile counseling and testing services, using evidence-based best practices to inform service delivery models.

KEY POPULATIONS: In order to achieve epidemic control, PEPFAR Burundi will move away from a general population focus in order to prioritize key and priority populations and increase testing

yields to efficiently identify HIV-positive clients and effectively link them to care and treatment in a timely manner (Table 4.1.2). These groups include FSW and their clients, MSM, and military service members and their families. These groups are expected to yield an estimated 7,878 newly initiated on ART in FY17.

PMTCT: Activities will focus on the diagnosis of HIV and initiation of ART for HIV-positive pregnant women, as well their partners and children through scale-up of the successful index patient approach. PEPFAR Burundi aims to test 95% of pregnant women in the scale-up provinces and enroll 95% of those testing HIV-positive into ART. This is expected to yield 1,886 newly initiated clients by end of FY17. In line with national guidelines, 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.

PEDIATRICS: Given the currently relatively low pediatric ART coverage of 25%, scale-up to saturation may be more gradual for children. PEPFAR Burundi will aim to achieve 60% pediatric ART coverage by FY17 and 80% by the end of FY18. This will be achieved through active case finding of untested children of known HIV-positive adults, routine PITC in pediatric hospitalization and malnutrition services, and scale-up of OVC activities.

TB/HIV: Through routine testing of all people living with TB, PEPFAR Burundi expects to enroll 478 new TB/HIV patients on ART in FY17.

Consistent with past programming, PEPFAR Burundi will not procure ARVs for treatment, but will contribute to coverage results by providing technical assistance to improve 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 Scale-up Sub-national Units for Epidemic Control

SNU	Total PLHIV	Expected current on ART (APR FY 16)	Additional patients required for 80% ART coverage	Target current on ART (APR FY17) TX_CURR	Newly initiated (APR FY 17) TX_NEW	ART Coverage (APR 17)
Bujumbura Mairie	11,667	17,947		17,947	1817	142%
Bujumbura Rural	10,476	3,775	4,137	6,216	2,818	70%
Kayanza	7,976	4,016	2,766	5,426	1,812	70%
Kirundo	5,476	3,184	1,525	3,768	913	70%
Ngozi	10,595	4,217	4,224	6,685	2,890	70%
Military	1,450	951	283	1,068	283	80%
Total	47,640	34,090	12,935	4,111	10,553	86%

Table 4.1.2 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts

Entry Streams for ART Enrollment	Tested for HIV (APR FY17)	Identified Positive (APR FY17)	Newly initiated (APR FY 17) TX_NEW
Adults			
Clinical care patients not on ART			
HIV+ TB Patients not on ART	2926	503	478
HIV-positive Pregnant Women	160,665	1,986	1,886
Other priority and key populations	275,713	6,238	7,878
Pediatrics			
Clinical care pediatrics not on ART			
HIV Exposed Infants	1,848	91	82
Orphans and Vulnerable Children Provider Initiated Testing	8,674	229	229
Total	449, 826	9,047	10,553

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (priority SNU)	Coverage Goal (in FY17)	FY17 Target**
Bujumbura Mairie FSW	7,281	60%	4,369
Bujumbura Mairie MSM	2,692	60%	1,615
Bujumbura Rural FSW	4,042	80%	3,233
Bujumbura Rural MSM	679	80%	543
Kayanza FSW	4,343	80%	3,474
Kayanza MSM	648	80%	518
Kirundo FSW	2,265	75%	1,699
Kirundo MSM	349	75%	262
Ngozi FSW	4,855	80%	3,884
Ngozi MSM	757	80%	606
Military	*100,000 (national)	22%	22,572
Total	127,911	32%	42,775

* 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 Linkages to HIV Services			
	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY17 Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY17 Target) OVC_KNOWNSTAT*
Kayanza	55,000 total 11,000 AGYW ages 10-18	5,500	4,950
TOTAL	55,000	5,500	4,950

4.2 Key and Priority population prevention

Although the majority of HIV infections in Burundi occur in the general population, recent surveys have shown that key and priority populations, such as FSW (and their clients), MSM, and military personnel, contribute significantly to the burden of new HIV infections with prevalence rates of 21.3%, 4.8%, and 1.3%, respectively. The PEPFAR program will continue to focus its efforts to target these groups both from a geographical and technical standpoint to help reach epidemic control.

Women 15–24 years of age are particularly vulnerable to acquiring HIV, owing to high rates of GBV in the school environment. It is estimated that 13.7% of young girls are victims of sexual violence. This population group also has limited access to information about HIV prevention and health services. Men are the ones who make family planning decisions and agree to the use of a condom during intercourse. FSWs do not have much power to negotiate with their clients over condom use.

PEPFAR Burundi will support high-impact core interventions in COP16 for key and priority populations. These include: targeted sensitization 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, PEP and linkage to clinical care services for victims of sexual and gender-based violence, promotion of community-based HIV-testing approaches to reach people who do not usually attend health services (men, youth, MSM, sex workers and their clients), promotion of sexual education in schools with an emphasis on HIV prevention practices and gender norms in relationships that affect HIV and GBV.

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.

Based on the PLACE study mapping, the LINKAGES project will begin working in FY16 in Bujumbura Mairie and Kirundo provinces but is expected to scale-up to cover hotspots in all five PEPFAR supported provinces in FY17.

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.

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. 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 Preventing mother-to-child transmission (PMTCT)

Burundi has been implementing Option B+ for all HIV-positive pregnant women since 2014 so no guideline changes were made this year, nor are any expected in the near future. ANC attendance is estimated at over 90% nationally in Burundi and in PEPFAR-supported sites, 91% of women attending ANC had known HIV status in FY15 and 90% of those testing positive or previously known HIV-positive received ARVs to prevent the transmission of HIV to their babies. While there remains room for improvement to reach the targets of 95% of women attending ANC with known status and 95% of those testing positive receiving ART, PEPFAR Burundi believes it is on the right track and does not plan significant changes to its PMTCT strategy.

The package of services will thus remain largely unchanged from COP15 with systematic HIV testing of all pregnant women who present at ANC and prompt enrollment on ART of all HIV-positive pregnant women regardless of CD4, clinical staging, age of gestation or other criteria. PEPFAR will continue to procure ARVs for pregnant and breastfeeding women for a period of not more than two years, depending on the age of gestation at which treatment began. Once a woman has completed the cycle of PMTCT she will continue to receive her ARVs on-site and experience no change in services, but the drugs will be paid for by the GFATM.

Where additional emphasis will be placed in FY17, is on scaling up the implementation of the highly successful index patient model originally piloted by the PEPFAR-supported PMTCT AP to ensure systematic testing of male partners and children born prior to PMTCT enrollment and resolving challenges to EID as detailed in the section on pediatric treatment below.

4.5 HIV testing and counseling (HTS)

HTC activities supported by the PEPFAR Burundi are consistent with WHO minimum standards and target communities and individuals with an emphasis on key and priority populations. In FY17, HTC services will continue to be provided in 200 health facilities with the goal of identifying 90% of PLHIV in PEPFAR-supported provinces. In order to achieve this, testing will be far more targeted to those most likely to be living with HIV, than in previous years when a broader, general population-focused approach was applied.

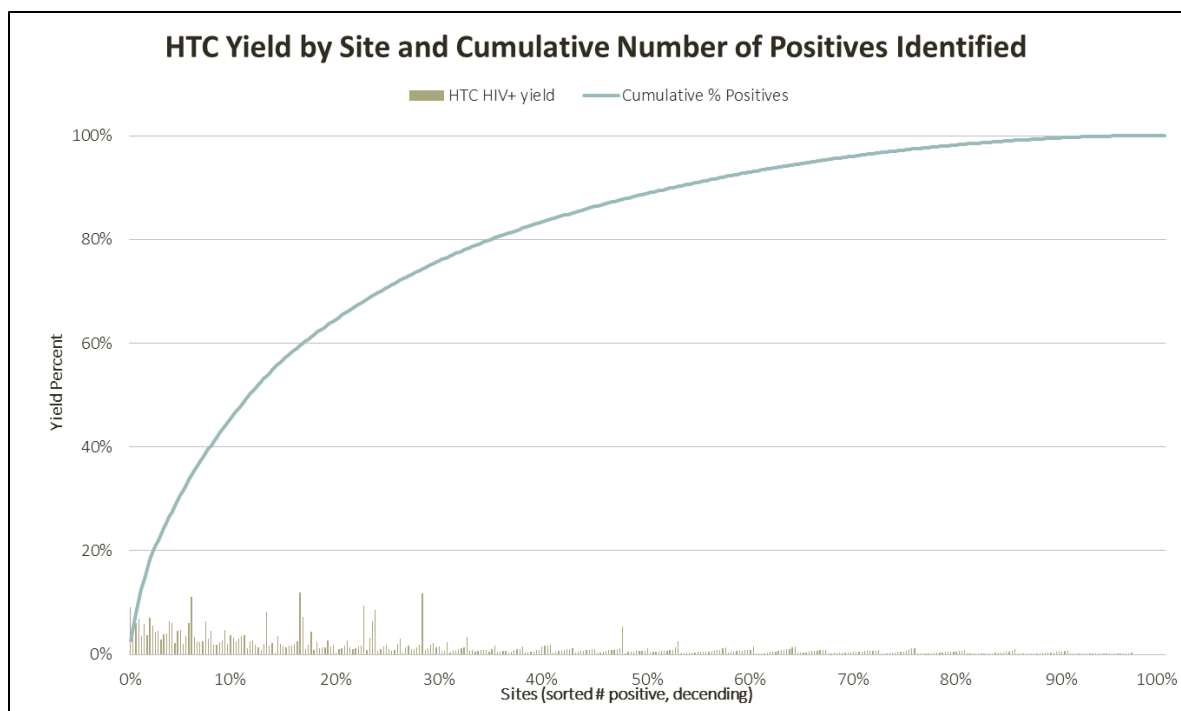
Given the increased vulnerability to HIV infection of women of child-bearing age and the high levels of ANC attendance in Burundi, ANC and PMTCT services will continue to be a key entry point for family-focused HTC but additional strategies will also be deployed. These include increasing provider initiated counseling and testing (PITC) in inpatient and outpatient services besides ANC such as TB, STI and malnutrition, targeted community-based outreach key and priority populations, and youth and LGBTQ-friendly comprehensive clinical services.

PEPFAR will also continue to identify innovative ways to encourage men to access HTC, but the demand for voluntary testing is still suboptimal. Renewed focus will be placed on increasing men's knowledge of HIV prevention and treatment, reducing stigma and GBV, and exploring positive incentives to encourage men's participation.

The DOD will support, testing and counseling services for the military, their families, and surrounding communities, an estimated 100,000 people.

To ensure that all individuals testing positive for HIV are directly linked to care and treatment services, PEPFAR Burundi will implement a new SMS messaging system to ensure linkages in sites which offer testing but not treatment. Under this system, contact will be established between nurses at referring and receiving sites and airtime will be provided to ensure that the receiving nurse texts the referring nurse to confirm receipt of a newly referred patient. If the referring nurse does not receive timely confirmation that the patient has been received at the referral site, he or she will deploy a community health worker or other cadre to trace the patient.

Efficiency Analysis



PEPFAR supported HTC at 234 sites in FY15. Analysis of testing yields at these sites indicates that 80% of HIV positive individuals were identified at 35% of sites. These sites will continue to be a priority focus to generate new positives.

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 routine TB screening and referral for diagnosis and treatment. The core and near-core activities include: STI and OI screening and treatment, Cotrimoxazole, condom distribution and other prevention activities, integration with nutrition, malaria and family planning services and PHDP. 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 and rapidly scaling up Test and Start for all PLHIV. Retention of patients in care will remain a high priority, especially in this period of political crisis when loss to follow-up increased to 13% in FY15, versus 8% in previous years. PEPFAR Burundi will also be launching the EQUIP mechanism to explore and implement new service delivery models aimed at improving patient care and retention.

Additional focus will also be placed on children and adolescents, ensuring that all HIV-exposed infants and OVCs have known HIV status and are able to access not only the clinical, but also psychosocial services they need.

4.7 TB/HIV

TB is the most common OI among PLHIV in Burundi. In 2015, the WHO estimated the incidence of TB/HIV co-infection at 14%, ranking Burundi among the 41 countries where the burden of co-infection is heaviest. TB activities in Burundi are almost completely supported by the GFATM and include: (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.

While PEPFAR doesn't procure TB drugs, it complements the above-described activities in target provinces by working the GOB/GFATM, 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 settings for diagnosis. Follow-up to ensure that patients completed the referral is easier as most large HIV testing sites also conduct TB diagnosis. 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. For patients who are referred for TB diagnosis or treatment, the same SMS tracking system described for HTC will be used to ensure that referrals are completed.

In FY17, PEPFAR Burundi will continue to support TB/HIV co-infection management, with an expected 478 new TB/HIV patients to be enrolled in the five priority provinces. In COP 2016, 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. As INH prophylaxis is still in the pilot phase in Burundi, PEPFAR will support eventual scale-up as indicated by national guidelines.

4.8 Adult treatment

Burundi's current national treatment directives, adopted in 2014, are based on the WHO's 2013 guidelines. ART is provided for PLHIV with CD4 less than 500, and test and treat is applied to HIV-positive partners in sero-discordant couples, to all HIV-positive FSW and MSM, to all HIV/TB and HIV/HEP-C co-infected patients, all HIV-infected children under 5 years old, and all HIV-positive pregnant or breast-feeding women (Option B+). As of March 2016, Burundi has begun the process of revising its national guidelines in line with the WHO recommendations issued in 2015.

As part of this process the following actions have been taken or are planned: (i) on March 5, 2016, the MOH convened a national workshop, attended by 67 participants from government, civil society, donors and partners and representatives of PLHIV networks, to disseminate the 2015

WHO guidelines; (ii) a national steering committee to pilot the guideline revision has been appointed by the MOH with 2 PEPFAR staff as members; (iii) the steering committee will make a rapid assessment of the implementation of the 2013 Guidelines that were adopted in 2014; (iv) the steering committee will then review and adapt the 2015 WHO guidelines to national context including consideration of test and, Pre-exposure prophylaxis (PrEP), and new service delivery models including multi-month and community distribution; (v) and finally the elaboration of revised guidelines and an Implementation Plan with TA from WHO Regional Office. This process is expected to be completed by June or July 2016, at which time PEPFAR expects to rapidly train staff and begin implementing the new guidelines before the end of FY16.

While the GFATM procures ARVs for treatment nationally, PEPFAR will contribute to achieving epidemic control in target provinces through ongoing technical assistance to ART sites. TA will be focused on active case finding through targeted HTC and rapid linkage to treatment for those testing positive. One province, Bujumbura Mairie, will be considered scale-up to saturation with expected coverage of 142% by the end of FY17. All other sites will be considered aggressive scale-up with FY17 targets as follows: Military settings: 80%, Bujumbura Rural 70%, Kirundo 70%, Ngozi 70% and Kayanza 70%.

In order to achieve these ambitious targets, the package of services for all scale-up SNU will include: targeted testing (in-patient, TB, malnutrition, index client, OVC, targeted PITC in outpatient departments; active linkage to services; ART initiation and follow up; active loss to follow-up tracing; routine viral load testing; other laboratory services (CD4 hematology and chemistry at ART initiation), lab specimen transport, CTX provision, routine TB, OI and STI screening; PHDP and support groups using CHW and the National Network of PLHIV (RBP+); ongoing in service training, mentoring and supportive supervision; testing demand creation; quality improvement; support to health districts for data collection and analysis; PEP; and GBV services.

Implementing partners will also put emphasis on clinical monitoring through viral load testing scale up. 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 support maintenance of the national PCR/viral load machines located in Bujumbura Mairie and Ngozi provinces. PEPFAR will also work with the GFATM and PNILT to explore the possibility of leveraging GenExpert machines purchased (or planned) for TB diagnosis for viral load and EID.

In terms of above site level activities which directly support efforts to achieve treatment saturation, PEPFAR Burundi will continue to provide strategic planning support for the national supply chain system and for CAMEBU, the central medical store, including the warehousing and distribution of HIV commodities. In addition, PEPFAR Burundi will introduce a new SI activity aimed at establishing HIV drug resistance (HIVDR) surveillance. Given the traditionally high adherence rates in Burundi, resistance had not historically been a major concern however the

large scale displacement, of both refugees and IDPs, has raised concerns about treatment interruptions and the risk for development of drug resistance.

4.9 Pediatric Treatment

At the national level, Burundi has only achieved 24.5% ART coverage for children under 15 (CNLS, December 2015). In its 2014-2017 NSP, the GOB outlined specific and ambitious targets on pediatric HIV: 54% of eligible HIV-positive children receive ARV treatment by 2017; 90% of orphans and children attending clinics who have been or may have been exposed to HIV are tested; and 55% of infants born to sero-positive mothers receive their first PCR test by two months of age by the end of 2017. PEPFAR Burundi aims to exceed these targets in supported scale-up provinces to ensure that in FY17, 60% of HIV-positive children receive ART, 90% of enrolled OVCs have known HIV status, and 95% of HIV-exposed infants receive their first PCR test by two months of age.

While PEPFAR will not purchase ARVs for pediatric treatment it will support all other aspects of the pediatric care and treatment continuum through technical assistance. This will include training and mentoring of healthcare providers in pediatric treatment and dosing, support for laboratory services, age-adapted PHDP, and OVC services. In order to expand infant, pediatric and adolescent treatment, PEPFAR Burundi will implement the following strategies in COP16:

- Improvement of case finding of infants, children and adolescents exposed to or infected with HIV by: (i) tracking all eligible children in PEPFAR-supported PMTCT services and ensuring that they are referred to facilities that provide ART services; (ii) scaling-up early infant diagnosis (EID) systems to provide HIV virological testing at six weeks of age, minimize delays in return of results for HIV-exposed infants, and strengthen linkage to care; (iii) ensuring pediatric testing beyond EID, through policies that promote routine PITC, especially in inpatient pediatric wards, malnutrition clinics, TB clinics, OVC programs and other outpatient settings with increased HIV prevalence; (iv) implementing and monitoring family-centered or index patient approaches to HIV testing in adult ART, OVC, MNCH, school health, social services, and malaria programs; (v) setting aggressive numeric pediatric HIV testing targets to motivate implementing partners to improve pediatric case finding; and (vi) ensuring adequate and consistent supply chain for EID and PITC commodities.
- Implementation of 2015 WHO treatment guidelines for all children by: (i) ensuring implementation of universal and immediate ART initiation for all HIV-infected children, regardless of CD4 count or percentage or clinical staging; (ii) setting aggressive numeric disaggregated treatment targets; (iii) ensuring that pediatric HIV services are decentralized along with adult HIV services and made available at the lowest-level possible with skilled health care providers; (iv) supporting the PNLs to expand existing task shifting policies to include pediatric treatment; (v) supporting the national supply chain system to ensure reliable supply of efficacious, easy to use pediatric formulations.

- Retention and linkage of infants, children and adolescents in life-long care and treatment by: (i) implementing quality improvement activities that address the challenges of following mother-infant pairs and loss to follow-up of children and adolescents; (ii) working with CHWs of RBP+ to reinforce linkages and retention in treatment of children and adolescents; (iii) using age disaggregation data to improve program planning and identification of gaps in children ART services.

In COP15, EID targets were not met due to maintenance challenges with the single PCR machine available to the public sector. Only 68 PCR tests were performed in FY15 representing 2% of the target. PEPFAR Burundi is continuing to work with the GOB to ensure that this situation is not repeated. Interim strategies already underway in FY16 include engagement with a private sector lab to process samples from PEPFAR supported sites, the installation of a second PCR machine in Ngozi province, and technical support for procurement and supply chain management to ensure that DBS and test kits and PCR reagents are consistently available. Longer term strategies for implementation in FY17 will include securing maintenance contracts for the two existing PCR machines to ensure that they remain operational and exploring the possibility of leveraging GenExpert machines purchased by the Global Fund for TB diagnosis to also perform EID.

4.10 OVC

Based on feedback received during the elaboration of COP15, PEPFAR Burundi has reoriented its OVC activities toward a strategic focus on vulnerable adolescent girls and young women. 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. Educating girls helps improve gender equity by increasing agency and empowering girls to engage in decision-making that affects their families and the development of their communities.

To appropriately address the needs of this population, PEPFAR Burundi will use a combination of PEPFAR and Family Planning funds in order to focus on four areas of intervention: Education, Service Delivery, Household Economic Strengthening, and Capacity Building. The target population is 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. Adolescent boys and young men may be included in HIV counseling and testing and some education and sensitization activities, especially those aimed at building awareness of family planning and HIV prevention, but will not receive direct financial support.

The project is still in the final stages of procurement but will be operating in Kayanza province which has a lower concentration of other OVC services than other PEPFAR-supported provinces, low treatment coverage (23.7%) and a lower than average contraceptive prevalence rate (31.1%). The following high-level outcomes are expected:

1. High-quality HIV and Family Planning services available to and accessed by vulnerable adolescent girls and young women (AGYW).
2. Increased education and empowerment for vulnerable adolescent girls and young women.
3. Enhanced family support for vulnerable adolescent girls and young women.
4. Increased capacity of local governments and communities to protect and provide for their most vulnerable populations.

5.0 Program Activities in Sustained Support Locations and Populations

5.1 Package of services in sustained support locations and populations

Having completed a significant geographic pivot in FY16, involving transition of three provinces and additional low-yield sites, PEPFAR Burundi will not have any sustained support locations in FY17 as all remaining SNU's will be considered scale-up.

5.2 Transition plans for redirecting PEPFAR support to scale-up locations and populations

As detailed above, PEPFAR Burundi will not be transitioning additional SNU's in FY17. For the 31 low-yield sites identified by the site yield analysis, transition will follow the successful model implemented for low yield sites within scale-up SNU's in FY16. Like last year, PEPFAR implementing partners will work with the PNLs as the GFATM Principle Recipient (PR) and the relevant district medical officials to ensure that there are no interruptions to treatment for patients already enrolled. As PEPFAR was not paying for ART in these sites, patients on treatment will continue to receive ARVs funded by the GFATM and pregnant women who had been receiving ARVs funded by PEPFAR will be transitioned to GFATM-procured drugs. This should not involve any significant change in care as all services are already integrated regardless of funding source.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

In order to reach 80% ART coverage in PEPFAR supported provinces by end of FY18, it is estimated that 24,147 additional patients will need to be supported with ART services. This will require identifying PLHIV through targeted HTC, PMTCT and interventions targeting key populations. While the majority of PEPFAR Burundi's efforts, and 73% of proposed FY17 budget resources, will be devoted to site level activities, above site-level activities, comprising 17% of the budget, will play a key role in addressing bottlenecks and programmatic gaps that hamper efforts to achieve treatment saturation.

The top three key programmatic gaps identified in the clinical cascade are low adult ARV coverage, low pediatric ARV coverage and low number of key populations identified and linked to services.

Adult ARV coverage is hampered by suboptimal HTC strategies, lack of SI capacity at the PNLs to monitor trends in the epidemic, higher loss to follow-up for pre-ART patients than for those on treatment, and weaknesses in linkages from HTC to care and treatment.

Weaknesses in pediatric coverage are similar to those for adults but also include inadequate and inconsistent capacity to perform timely DNA PCR testing, inadequate testing and linkage to care of OVC, and reticence of providers to treat children with HIV.

For key populations, stigmatization of KP leads to unwillingness to self-identify which makes them difficult to track in PEPFAR programs leading to low rates of identification, testing, and linkage to services.

The principal cross-cutting issue underlying these three gaps, and therefore the largest recipient of above site-level budget, is strategic information. SI activities, implemented by MEASURE Evaluation, will include revision of registers and other tools and mentoring and capacity building at site, district and national levels to improve the quality of available data and promote a culture of evidence-based decision making.

Table 6.1.1 Key Programmatic Gap #1: Low Adult ART coverage						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Sub-optimal HTC strategy	1. Testing yields at all sites are greater or equal to prevalence (Year 1: 1.2 % Year 2: 1.3 % Year 3: 1.3)	Activity 1: Strengthening the national HIV/AIDS program capacity, to collect and analyze data on testing yields to identify the highest yield entry points.	HVSI	\$100,000	MEASURE	15. Performance Data
	1. Improve targeted testing to identify 90 % of PLHIV in PEPFAR-supported provinces by FY 17 2.	Activity 2: Review and revise HTC registers to reflect entry points for priority testing locations.	HVSI	\$100,000	MEASURE	15. Performance Data
Lack of SI capacity at the National HIV program to monitor trends in the epidemic	1. ANC Sentinel Surveillance is operational in 20 sites by FY 17	Activity 1: Improve the tools used for collection of data, and implement annual ANC Sentinel Surveillance in 20 sites.	HVSI	\$100,000	MEASURE	15. Performance Data
	2. Production of annual national-level Epidemiological report	Activity 2: Train and provide TA to national, provincial, and district SI staff on collection, analysis, and interpretation of program data.	HVSI	\$175,000	MEASURE	15. Performance Data
	3. National program making decisions based on annual Epi report	Activity 3: Support integration of HIV data into national electronic data collection system from the site to the national level	HVSI	\$25,000	MEASURE	15. Performance Data
Higher Loss to Follow-up for pre-ART patients than for those on treatment	1. National adoption of Test and Start by FY 17 2. Percentage of adult patients in care but not on ART reduced to 10 % or less by FY17	Activity 1: Support the MoH to review and adapt the new WHO guidelines, including community involvement in linkage, adherence, and retention.	OHSS	TA Only	N/A	2. Policies and Governance
		Activity 2: Support the MoH to elaborate an implementation plan for Test and Start.	OHSS	TA Only	N/A	2. Policies and Governance
		Activity 3: Support the MoH national program to adjust forecast for drugs and commodities in line with new guidelines	OHSS	TA Only	N/A	2. Policies and Governance
		Activity 4: Support dissemination and training on new guidelines to service providers.	OHSS	Included at site level	IHP, PMTCT AP, Military PMTCT	2. Policies and Governance
TOTAL				\$500,000		

Table 6.1.2 Key Programmatic Gap #2: Low Pediatric ART coverage						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score
EID-lack of adequate and consistent capacity to perform timely DNA PCR testing	<ol style="list-style-type: none"> At least 2 PCR machines are installed and functional in publicly accessible facilities by FY17 Maintenance contracts secured to ensure that machines are repaired promptly by FY17 95 % of HIV exposed infants in PEPFAR-supported facilities are tested for HIV by 2 months of age by FY 17 	Activity 1: Training and accompaniment of medical providers.	MTCT	Included at Site Level	IHP, PMTCT AP, Military PMTCT	10. Laboratory
		Activity 2: Reinforcement of sample transport and result pick-up procedures	LAB	Included at Site Level	IHP, PMTCT AP, Military PMTCT	10. Laboratory
		Activity 3: Contract for equipment maintenance	LAB	\$100,000	PSM	10. Laboratory
TOTAL				\$100,000		

Table 6.1.3 Key Programmatic Gap #3: Low # of Key Populations identified and linked to services						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score
Stigmatization of KP leads to unwillingness to self-identify which makes them difficult to track in PEPFAR programs	<ol style="list-style-type: none"> Disaggregated data on testing yields among key populations is available and used to further enhance targeting by FY 17 Targeted prevention services are reaching KP via peer networks in all PEPFAR supported SNU's and other identified hotspots : FY 17:75%,FY 18:80%,FY19:90% 	Activity 1: Provide training to healthcare providers to decrease stigmatization in healthcare settings and provide KP-friendly services.	HBHC	\$600,000	LINKAGES	6. Service Delivery
		Activity 2: Support the MOH to develop guidelines addressing stigma with regards to KP	OHSS	TA Only	LINKAGES	6. Service Delivery

Low rates of identification , testing, and linkage to services for KPs	1. 90% of identified KPs know their HIV status by FY 19 (by FY 17:60%,by FY18:80%,)	Activity 1: Mobilize community and peer networks to sensitize KPs to available KP-friendly services	HBHC HVCT HTXS HVOP	\$480,000	LINKAGES	6. Service Delivery
	2. 90 % of identified KPs testing positive for HIV are on ART (by FY 17:80%, by FY18:90%)	Activity 2: Deploy SMS and other media to relay health information to KPs.	OHSS	\$120,000	LINKAGES	6. Service Delivery
TOTAL				\$1,200,000		

6.2 Critical Systems Investments for Achieving Priority Policies

As Burundi is already in the process of adoption of Test and Start and as this strategy was taken into account in the GFATM concept note, there are no major barriers but rather steps that need to be taken in order to move toward implementation.

In terms of new and efficient service delivery models, increasing LTFU, likely related to the current political/security situation, and lack of MOH/PNLS capacity to incorporate multiple changes at once (especially given current political/economic crisis) need to be addressed in order to facilitate widespread adoption and uptake.

Table 6.2.1 Test and Start						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score
Concerns about resource constraints including ARVs, commodities and human resources for Test and Start	1. Credible accurate data is available for planning and budgeting resources for test and start by FY 17	Activity 1: Activity 1: Support the MoH national program to adjust forecast for drugs and commodities in line with new guidelines	OHSS	\$400,000	PSM	2. Policies and Governance
	2. National task-shifting policy is implemented in 100% of PEPFAR supported facilities by FY 17	Activity 2: Support the MOH to ensure that national task-shifting policy is updated to allow nurses to initiate ART in all HIV-positive patients	OHSS	TA Only	N/A	2. Policies and Governance
TOTAL				\$400,000		

Table 6.2.2 New and efficient service delivery models						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score
Lack of MOH/PNLS capacity to design and implement new service delivery models to support the full implementation of Test and Start strategy.	<ol style="list-style-type: none"> 3. Patients are moved to multi-month scripting gradually as follows: Year 1: 50 % Year 2: 65 % Year 3: 80% 4. Community ARV dispensation model is implemented by FY17 	<p>Support the design and implementation of advancing innovative solutions to the following areas of HIV care and treatment:</p> <ol style="list-style-type: none"> 1. Alternative modes of ART delivery (including community based drug distribution and multi-month ART dispensing) 2. Approaches to support viral load scale-up (including viral load network optimization, specimen transport, facility level data management and centralized viral load data collection and management) 3. Strategies and technologies for more effective linkage to ART (including implementation supported related to differentiated models of care and treatment) 4. Approaches responding to the needs of key populations (including PrEP scenario planning/demonstration project TA and key populations treatment service support) 	OHSS	\$400,000	EQUIP	6. Service Delivery
TOTAL				\$400,000		

6.3 Proposed system investments outside of programmatic gaps and priority policies.

In addition to the Systems Investments for Achieving Key Programmatic Gaps and Priority Policies, PEPFAR will continue to invest in other key activities that are essential in reaching the 90/90/90 targets.

All the proposed activities are related to the following categories: HRH - Systems/Institutional Investments, Institutional & Organizational Development, Laboratory, Strategic Information and Systems Development. Finance and Governance activities are no longer included as these were deemed non-core and transitioned in COP15.

Table 6.3 below shows the proposed investments by systems category, which of the three 90s they address, the outcomes expected after 3 years of investment, the allocated budget amount, the budget code(s), the associated Implementing Mechanism ID and the relevant SID Element score.

Table 6.3 Other Proposed Systems Investments							
Systems Category	Activity	1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control	Outcomes expected after 3 years of investment	Budget Amount	Budget Code(s)	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Laboratory							
Lab	Support the MoH in the roll-out of the national laboratory strategy.	Second and Third 90	National Laboratory Strategy is rolled out at district and facility levels by FY 17	\$100,000	HLAB	PSM	10. Laboratory
Lab	Support the Burundi Ministry of defense(MOD) in the implementation of the national laboratory strategy at military health centers	Second and Third 90	National Laboratory Strategy is implemented at military health centers by FY 17	\$150,000	HLAB	PSI BURUNDI	10. Laboratory
Lab	Technical Assistance for Lab Strengthening	Second and Third 90		\$150,000	HLAB	PSM	10. Laboratory
Strategic Information							
SI	Strengthening the national HIV/AIDS program capacity to collect and analyze data on testing yields to identify the highest yield entry points.	First 90	Improved National HIV/AIDS program capacity to collect and analyze data on testing yields by FY 17	\$ 100,000	HVSI	MEASURE	15. Performance Data
SI	Review and revise HTC registers to reflect entry points for priority testing locations.	First 90	Revised HTC registers are available and used by the HTC sites by FY 17	\$ 100,000	HVSI	MEASURE	15. Performance Data
SI	Improve the tools used for collection of data, and implement an annual ANC Sentinel Surveillance in 20 sites.	First 90	Improved data collection in 20 ANC Sentinel Surveillance sites by FY 17	\$ 100,000	HVSI	MEASURE	15. Performance Data

SI	Train and provide TA to national, provincial, and district SI staff on collection, analysis, and interpretation of program data.	First 90; Second 90 and Third 90.	Improved capacity of national, provincial, and district SI staff on collection, analysis, and interpretation of program data by FY 17	\$175,000	HVSI	MEASURE	15. Performance Data
SI	Support integration of HIV data into national electronic data collection system from the site to the national level.	First 90; Second 90 and Third 90.	Improved integration of HIV data into the national data collection system by FY 17	\$25,000	HVSI	MEASURE	15. Performance Data
SI	Contribute to the establishment of ARV Drug Resistance Surveillance System	Third 90; Sustained Epidemic Control	A Drug Resistance Surveillance System is in place and functional by FY 17	\$300,000	HVSI	MEASURE	15. Performance Data
SI	Develop a military electronic health information network	First, second and third 90	A military electronic health information network is in place and functional by FY 17	\$150,000	HVSI	DOD Mech Burundi(NHRC)	15. Performance Data
SI	Support the completion of the HIV Prevalence study in the military(SABERS)	First 90	Survey completed with MOD and MOH and results available at the national and sub-national levels by FY 17	\$150,000	HVSI	Metabiota Burundi	15. Performance Data
Systems Development							
HSS	Support the government in strategy planning and coordination for supply chain related activities.	First 90; Second 90 and Third 90.	A National Supply Chain Master Plan is in place and supply chain activities are coordinated by FY 17	\$ 250,000	OHSS	PSM	1. Planning and Coordination
HSS	Support the MoH in the roll-out of the national logistic management information systems (LMIS).	First 90; Second 90 and Third 90.	<ol style="list-style-type: none"> 1. Integrated LMIS tools and SOPs effectively utilized and adhered to by districts and health facilities by FY 17 2. Supply chain skills are enhanced at district and facility levels by FY 17 3. No stock-outs of HIV commodity in 	\$ 400,000	OHSS	PSM	8. Commodity Security and Supply Chain

			PEPFAR supported facilities/districts by FY17				
TOTAL				\$1,800,000			

7.0 Staffing Plan

The PEPFAR Burundi team believes that the existing staffing pattern is sufficient to achieve program goals if fully staffed. With both a Health Team Leader and PEPFAR Team Leader in place, technical staff would be freed up to focus their time on their respective technical areas, supervision and monitoring of implementing partners including SIMS visits, and technical assistance to the GOB as appropriate.

The major challenge to achieving full staffing in FY 2016 has been hiring delays related to the ordered departures following the failed May 13, 2015 coup d'état and the resulting uncertainty about post status with regard to dependents. Since a determination was made in March 2016 to permit adult EFMs only when employed at the Embassy, hiring has recommenced and all current vacancies are expected to be filled by Q1 of FY 2017. No additional posts will be proposed this fiscal year.

PEPFAR Burundi's CODB decreased significantly this year compared to the amount requested in COP15. The transition in financial management from the USAID Regional Mission in Kenya to USAID Rwanda has resulted in greater transparency and ownership of financial processes by the Burundi team. This has enabled the team to establish a more realistic CODB in line with what is actually spent and eliminate PEPFAR contributions towards regional positions. DOD's CODB has remained constant.

APPENDIX A REQUIRED

Level of Implementation	Core Activities	Near-core Activities
Site level	<ul style="list-style-type: none"> • 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 sites • 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 • Support integrated PMTCT 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 	<ul style="list-style-type: none"> • In-service training and mentoring for clinicians and other providers to provide adult care and treatment, PMTCT, pediatric care and treatment • 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 • Implement MAP programs to prevent GBV in community • Gender-based violence(training, male-involvement (PMTCT, PEP • Quality improvement activities: (e.g. data collection for results monitoring) in PMTCT sites • Training and coaching of HCWs in targeted facilities (PMTCT) • Supervision in PMTCT sites

	<p>treatment services into MCH platforms</p> <ul style="list-style-type: none"> • 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) • Comprehensive services to vulnerable adolescent girls and young women 	
Sub-national level	<ul style="list-style-type: none"> • Training of community health workers in OVC services 	<ul style="list-style-type: none"> • 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 review meetings • Support implementation and scale-up of Men as partner 's programs (MAP)in healthcare facilities
National level	<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • Research and studies (MOT, ANC surveillance, Military IBBSS, IBBSS for key pops follow up and analysis, HMIS, surveillance of drug resistance) • 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

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 16

Level of Implementation	Core Activities	Near-core Activities
HTS	<ul style="list-style-type: none"> • HTC - entry point to prevention, care, treatment, and support, linkage to care • 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) 	<ul style="list-style-type: none"> • Clinical youth- and family-friendly comprehensive services (training and supervision)
Care and Treatment	<ul style="list-style-type: none"> • 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+ • 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 	<ul style="list-style-type: none"> • In-service training and mentoring of 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

	<p>technical support to the site</p> <ul style="list-style-type: none"> • Test and treat for Key pops • PHDP package implementation and integration 	
Prevention	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • GBV prevention, and health response for SV survivors
OVC	<ul style="list-style-type: none"> • Provide very young adolescents aged 10-14 with information about sexuality, FP, GBV dynamics. • Ensure linkages to HIV counseling and testing, care and treatment, long-acting and reversible contraceptive methods for young people, STI diagnosis and treatment, and other services as appropriate • Adolescent friendly contraceptive and reproductive health service delivery • Provide in-kind support, such as the provision of school materials and uniforms, for girl students aged 10-14. • Provide financial support, such as payment of school fees and/or book fees, for girl students aged 10-14. • Prioritize interventions to support completion of school, including innovative strategies to address barriers for female students and reduce school drop outs • Work with local authorities, government agencies at the local level, civil society, and religious groups on promotion of family planning use and advocacy for reproductive health rights that support HIV prevention in adolescents, particularly in high-risk groups. • Support formal and informal community-based organizations and structures in their efforts to provide and coordinate critical high-quality services for HIV + AGYW • Strengthen the technical quality of community services and support to improve and expand community assistance for increased access to, retention, progression, and completion of educational programs among vulnerable children, AGYW • Support policies and programs that 	<ul style="list-style-type: none"> • Assist civil society, community organizations, and local multi-sectoral committees. involved in social welfare to collaborate regularly to ensure smooth and effective referrals between providers • Prepare vulnerable adolescent girls for work readiness by building skills in entrepreneurship, money management, and workplace skills. • Prepare young women for tertiary or vocational education. • Facilitate group-based interventions to educate and support parents, including interventions based on culturally appropriate, evidence-based adult learning curricula or training materials to improve relationships within families (e.g. parent-child communication and interactions, positive discipline, child protection, and partner communication.) • Design specific interventions, as needed, for families with special needs. E.g. families with very young or old caregivers, those caring for children with disabilities or HIV, HIV + caregivers, single parents, and/or the caregivers of children at risk of becoming street children, etc... • Facilitate savings and credit opportunities for caregivers of all targeted children and young women. • Provide complementary money management education and counseling.

	<p>prevent all forms of GBV, including early/child marriage and mitigate its effect on the wellbeing of adolescent girls and young women.</p> <ul style="list-style-type: none"> Engage with the GOB and civil society to explore ways of expanding the professional work force that addresses the social welfare needs of vulnerable children and families 	
<p>Program/system support</p>	<ul style="list-style-type: none"> HIV commodities Quantification and Supply planning Warehousing & Distribution National Supply Chain technical support Training at national and sub national levels Lab system strengthening SIMS 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) 	<ul style="list-style-type: none"> 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 (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 (MOT, ANC surveillance) IBBS key pops IBBS military follow up and analysis HMIS Surveillance for drug resistance

APPENDIX B REQUIRED

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level		
Applied Pipeline	New Funding	Total Spend
\$US \$1,691,138	\$US 15,668,862	\$US \$17,360,000

Table B.1.2 Resource Allocation by PEPFAR Budget Code		
PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	\$ 1,598,167
HVAB	Abstinence/Be Faithful Prevention	0
HVOP	Other Sexual Prevention	\$1,188,315
IDUP	Injecting and Non-Injecting Drug Use	0
HMBL	Blood Safety	0
HMIN	Injection Safety	0
CIRC	Male Circumcision	0
HVCT	Counseling and Testing	\$ 2,944,782
HBHC	Adult Care and Support	\$666,664
PDCS	Pediatric Care and Support	\$193,757
HKID	Orphans and Vulnerable Children	\$799,517
HTXS	Adult Treatment	\$4,448,540
HTXD	ARV Drugs	0
PDTX	Pediatric Treatment	\$539,368
HVTB	TB/HIV Care	\$191,263
HLAB	Lab	\$350,000
HVSI	Strategic Information	\$1,135,000
OHSS	Health Systems Strengthening	\$1,613,489
HVMS	Management and Operations	\$1,691,138
TOTAL		\$17,360,000

B.2 Resource Projections

While the resource envelope remained constant from FY16, targets set, especially for treatment, are far more ambitious this COP. Because PEPFAR/Burundi had historically been a PMTCT-focused program, no budget was specifically allocated to treatment (HTXS) in COP15 while this year's HTXS budget was increased to \$4,415,544 to reflect the programmatic shift toward achieving epidemic control in PEPFAR-supported provinces. A portion of this difference came from shifts in target-based budgeting, a portion resulting from the dividends of the pivot

undertaken in COP15, and the remainder from savings generated in Management and Operations (M&O).

Just over half (53%) of the proposed FY17 budget was determined through target-based budgeting using the PBAC tool. Unit Expenditures (UEs) were adjusted in many cases to better align with program priorities or geographic disparities. For example, the UE for PMTCT was decreased given the successfully completed scale-up of Option B+ during FY15 and FY16 while UEs for treatment were increased to reflect the additional efforts which will need to be made to achieve saturation. This resulted in an overall decrease in budget for PMTCT from \$4,054,741 in COP15 to \$1,565,618 this year, the balance of which was reallocated to treatment consistent with targeting.

While PEPFAR Burundi transitioned out of three provinces and eliminated a number of non-core health systems strengthening activities in COP15, this had only minimal impact on that year's budget due to the costs associated with transition. By COP16 however, this generated considerable savings, applied here to treatment and other core activities. In addition to the three provinces transitioned in COP15, UEs for Bujumbura Mairie across all technical areas were cut by half this year to reflect the fact that the province is already at saturation and benefits from economies of scale.

Finally, M&O costs declined significantly from COP15 due to both lower overall costs and increased transparency into financial management resulting from the transition of administrative support for USAID Burundi from the East Africa Regional Mission to USAID Rwanda.

The remaining budget consists of above-site level activities (37%) and M&O (10%). For ongoing above-site level activities, resource needs were calculated based on historical performance but also took into account evolving strategies. For example, the lump sum amount allocated to SI activities was increased significantly to fund the establishment of ARV drug resistance surveillance.

While additional resources could well be used to assist Burundi in achieving epidemic control nationally by increasing PEPFAR's geographic coverage, the PEPFAR Burundi team is confident that the current allocation, as budgeted, is sufficient to meet the targets set in this COP.