

PEPFAR Burundi

Country Operational Plan (COP) 2017

Strategic Direction Summary

April 29, 2017



Table of Contents

1.0 Goal Statement

2.0 Epidemic, Response, and Program Context

- 2.1 Summary statistics, disease burden and epidemic profile
- 2.2 Investment profile
- 2.3 Sustainability Profile
- 2.4 Alignment of PEPFAR investments geographically to burden of disease
- 2.5 Stakeholder engagement

3.0 Geographic and population prioritization

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

- 4.1 Targets for scale-up locations and populations
- 4.2 Priority population prevention
- 4.3 Preventing mother-to-child transmission (PMTCT)
- 4.4 HIV testing and counseling (HTC)
- 4.5 Facility and community-based care and support
- 4.6 TB/HIV
- 4.7 Adult treatment
- 4.8 Pediatric Treatment
- 4.9 TB/HIV
- 4.10 Addressing COP17 Technical Considerations
- 4.11 Commodities
- 4.12 Collaboration, Integration and Monitoring

5.0 Program Activities in Attained and Sustained Locations and Populations

(Note: In COP 2017, Burundi does not have attained or sustained SNUs)

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

- 6.1 Critical systems investments for achieving key programmatic gaps
- 6.2 Critical systems investments for achieving priority policies
- 6.3 Proposed system investments outside of programmatic gaps and priority policies

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

Appendix A - Prioritization

Appendix B - Budget Profile and Resource Projections

Appendix C - Tables and Systems Investments for Section 6.0

Acronym List

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavior Change Communication
CAGs	Community ART Groups
CAMEBU	National Drug Store
CBIS	Computer technology-based interventions
CBO	Community-Based Organization
CCM	Country Coordinating Mechanism
CHW	Community Health Worker
CLHIV	Children Living with HIV
CNLS	National AIDS Council
COP	Country Operating Plan
CSO	Civil Society Organization
CSW	Commercial Sex Workers
CTX	Cotrimoxazole
DBS	Dried Blood Spot
DHIS ₂	District Health Information System
DHS	Demographic and Health Survey
DOD	United States Department of Defense
DSD	Direct Service Delivery
EA	Expenditure Analysis
EID	Early Infant Diagnosis
EMR	Electronic Medical Record System
FBO	Faith-Based Organizations
FP	Family Planning
FY	Fiscal Year
GBV	Gender-based Violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOB	Government of Burundi
HEI	HIV Exposed Infant
HIV	Human Immunodeficiency Virus
HIVST	HIV Self-Testing
HQ	Headquarters
HR	Human Resources
HRH	Human Resources for Health
HSS	Health Systems Strengthening

HTC	HIV Testing and Counseling
HTS	HIV Testing Services
IBBSS	Integrated Biological and Behavioural Surveillance Survey
IDP	Internally Displaced Person
INH	Isoniazid
IP	Implementing Partner
IPT	Isoniazid Preventive Therapy
KP	Key Population
LGBTI	Lesbian, Gay, Bisexual, and Transgender Individuals
LMIS	Logistic Management Information System
LPV/r	Lopinavir/ritonavir
LTFU	Lost to Follow-Up
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MMP	Multi-Month Prescribing
MSM	Men Who Have Sex with Men
MSPLS	Ministry of Public Health and Fight against AIDS
NGO	Non-Governmental Organization
NHDP	National Health Development Plan
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PBAC	PEPFAR Budget Allocation Calculator
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PITC	Provider-initiated Testing and Counseling
PLACE	Priorities for Local AIDS Control Efforts
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-To-Child Transmission
PNLS	National AIDS Program
POART	PEPFAR Oversight and Accountability Response Team
POC	Point of Care
PWID	People Who use Injectable Drugs
PrEP	Pre-Exposure Prophylaxis
QA/QI	Quality Assurance/Quality Improvement
RHIS	Regional Health Information System
RTK	Rapid Test Kit
SCMS	Supply Chain Management System
SDS	Strategic Direction Summary
SI	Strategic Information
SID	Sustainability Index and Dashboard
SIMS	Site Improvement through Monitoring System
SNU	Sub National Unit
STI	Sexually Transmitted Infections

SV	Sexual Violence
SW	Sex Workers
TA	Technical Assistance
TAT	Turn Around Time
TB	Tuberculosis
TBBAT	Target Based Budgeting Allocation Tool
TPT	TB Preventive Therapy
UE	Unit Expenditure
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
USAID	United States Agency for International Development
USG	United States Government
VL	Viral Load
WHO	World Health Organization

1.0 Goal Statement

PEPFAR Burundi's Country Operational Plan for FY 2018 (COP17) builds on the current implementation of Test and Start (Treat All) to rapidly increase national antiretroviral therapy (ART) coverage, and accelerate progress towards sustained epidemic control. In Burundi, the HIV/AIDS program (PNLS) is implemented under the leadership of the Ministry of Public Health and Fight against AIDS (MSPLS) and the National AIDS Council (CNLS), with human resources for health (HRH) and infrastructure mostly provided by the MSPLS. The PEPFAR program has leveraged this capacity with above-site and site-level support, including training, mentoring, HRH for lab, and key commodities. This support has resulted in the successful scale up to approximately 66% national ART coverage by end 2016.

In FY 2018, PEPFAR Burundi will build on geographic prioritization developed in COP 2015 and COP 2016 to reach HIV epidemic control by the end of FY19 in five high-prevalence provinces, Bujumbura Mairie, Bujumbura Rural, Ngozi, Kayanza and Kirundo, which collectively account for 52% of the burden of HIV/AIDS nationally. The GOB, with principal support from the GFATM, will cover the remaining 48% of geographic burden, but PEPFAR will continue to work closely with the PNLS to ensure that best practices and lessons learned in PEPFAR-supported sites are shared and scaled-up nationally.

The PEPFAR program will support the MSPLS to aggressively scale up a comprehensive package of prevention, care and treatment activities in three provinces designated as scale up aggressive. These provinces: Bujumbura Rural, Ngozi, and Kayanza are expected to reach 81%, 70% & 75% coverage respectively, by FY 2019. The remaining two PEPFAR supported provinces are designated as scale up saturation. These provinces: Bujumbura Mairie and Kirundo are expected to reach over 100% saturation by end FY 17 (215% & 145% respectively). This is due to a large number of individuals from surrounding provinces accessing services in these SNUs. For example, a file review conducted in 2016 indicated that almost 11% of individuals on ART in Bujumbura Mairie are from Bujumbura Rurale. PEPFAR program will implement different strategies across the five provinces in response to the differing service delivery and access gaps in the various provinces.

The PEPFAR program will focus on high-yield testing strategies to identify HIV positives in order to reach the first 90, through index patient testing, HIV self-testing (HIVST), and testing in high yield entry points to services. The PEPFAR program will tailor strategies to reach, test and link youth 15-24 years old and men. Pediatric case finding will be strengthened through innovations including reaching children of female sex workers (FSW). PEPFAR will also support the PNLS in implementing combination prevention approaches, including pre-exposure prophylaxis (PrEP) for high risk individuals.

To reach the second 90, PEPFAR will support the full implementation of Test and Start, which includes same-day ART initiation and differentiated models of care such as multi-month prescribing. A 90% linkage rate will be reached through strategies including mobile referrals. The PEPFAR program will also aim to maintain or increase the high 12 month retention rate (87%) through the national network of people living with HIV (RBP+), and community adherence groups (CAGs). To assess progress towards the third 90, PEPFAR will support patient access to routine viral load monitoring to reach 70% test coverage and 90% viral load suppression in

PEPFAR provinces by FY18.

In COP 2017, the PEPFAR program will narrow its population focus considerably to those individuals driving the epidemic. Specifically, preventive and clinical services will be scaled up to target key populations such as female sex workers (FSW) and men who have sex with men (MSM), priority populations such as youth, and military service members and their families. In FY18, PEPFAR programs will incorporate community-level activities for adolescent girls and young women (AGYW) and orphans and vulnerable children (OVC), including social asset building, caregiver education, and community mobilization. In FY18, gender-based violence (GBV) prevention programs will incorporate psychosocial support components and Men as Partners (MAP) trainings to shift norms around GBV.

As in previous years, PEPFAR will continue to support antiretrovirals (ARVs) for pregnant and breastfeeding women covered under Option B+, rapid test kits (RTKs), and other lab commodities, but will not be purchasing ARVs for treatment. The GFATM will be supporting ARVs for all eligible PLHIV. PEPFAR will continue to provide support to the PNLs and its quantification committee to forecast ARVs for Test and Start. Further, PEPFAR will continue to work closely with the GFATM's Country Coordinating Mechanism (CCM) to ensure alignment of programming during the GFATM's next funding cycle (2018-2020).

PEPFAR Burundi is committed to attaining the 90-90-90 goals outlined by UNAIDS and will continue to use regular partner meetings, quarterly PEPFAR Oversight and Accountability Response Team (POART) reviews, and the Site Improvement through Monitoring System (SIMS) findings to assess performance and further tailor strategies and approaches to most efficiently deliver expected results.

2.0 Epidemic, Response, and Program Context

2.1 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 2016 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 March 13, 2017, UNHCR and IOM estimates that there are 57,926 internally displaced persons and 412,185 refugees that have fled Burundi for neighboring countries since the beginning of the political crisis. Although true PLHIV estimates are difficult to obtain, data in 2016 estimated that there were as many as 3,000 PLHIV among the refugees. Complex health challenges impacting the HIV response include a malaria epidemic and chronic malnutrition rates of nearly 50% in children.

Burundi has a population of 11,215,024 and is considered to have a low-prevalence mixed HIV epidemic. As of 2015, the most recent year for which an estimate is available, 1.0% (1.3% women and 0.8% men) were living with HIV, with approximately 3,000 annual deaths attributed to AIDS.¹ According to SPECTRUM estimates compiled by UNAIDS and the National AIDS Council (CNLS), approximately 77,000 individuals are living with HIV.² 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 4.8% among men having sex with men.³

With support from PEPFAR and the GFATM, the GOB has strategically scaled up HIV/AIDS interventions and has worked towards developing a more sustainable model. The effectiveness of the response to the epidemic has been evidenced by a decline in HIV prevalence from 2.9% in 2001 to 1.3% in 2014. Burundi experiences extremely high adherence to ART, 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 The PMTCT program is strong, with 90% pregnant HIV-positive women accessing ARVs to prevent mother-to-child-transmission (PMTCT) of HIV, with a rate of 7% MTCT.

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: 1) low pediatric care and treatment coverage, 2) weak male participation in PMTCT, 3) high level of stigma and legal discrimination against MSM, and 4) weak laboratory capacity for EID and Viral Load monitoring.

HIV prevalence in the general population:

According to the 2015 United Nations Joint Programme on HIV/AIDS (UNAIDS) report on Burundi, the HIV prevalence rate among adults age 15-49 years is 1.0%. However, the National

¹UNAIDS."Burundi." Accessed March 26, 2016.<http://www.unaids.org/en/regionscountries/countries/burundi>.

²UNAIDS."Burundi." Accessed March 26, 2016. <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

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. As outlined in Section 4.11, PEPFAR Burundi will implement specific interventions in COP17 to address each age band.

Available data show a feminization of the HIV epidemic regardless of age. The Burundi 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 2015 estimates show 1,200 new HIV infections: 675 cases in women and 525 in men, 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%); FSW clients (23.52%) and their partners (6.15%).

New data from both the DHS III and SPECTRUM are expected by end FY17, and will allow further refinement of HIV prevalence rate and PLHIV estimations in Burundi.

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 prevalence data is unavailable for military personnel, 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 FY 2017 Integrated Biological and Behavioural Surveillance Survey (IBBSS) studies of FSW, MSM and people who inject drugs with GFATM support and the Military with PEPFAR support 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 five PEPFAR-supported provinces cover 52% of the national burden of PLHIV.

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 prevalence rates at 6.8%, while rates were 7.4% in PIZ of provincial towns and 3.6% in PIZ located in rural areas.

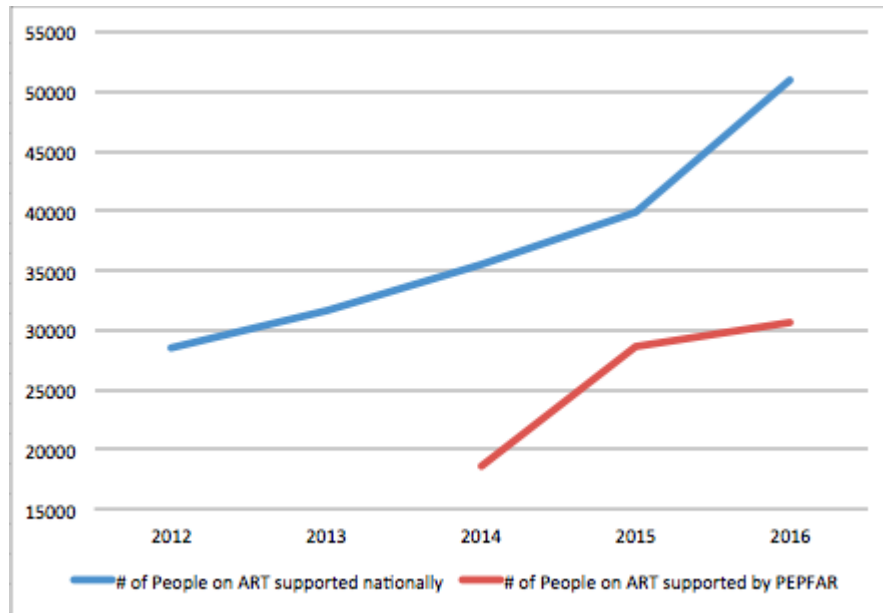
Table 2.1.1 Key National Demographic and Epidemiological Data											
	Total		<15				15+				Source, Year
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
Total Population	11,215,024	100 %	2,547,418	22.71%	2,573,530	22.95%	3,089,039	27.54%	3,005,037	26.79%	UNFPA 2017
HIV Prevalence (%)		1.3 %									UNAIDS Burundi SNU estimates 2014
AIDS Deaths (per year)	3,000		n/a		n/a		n/a		n/a		UNAIDS 2015
# PLHIV	77,000		4,641		4,459		41,000		27,000		UNAIDS 2015
Incidence Rate (Yr)		0.02 %									
New Infections (Yr)	1,200										UNAIDS 2015
Annual births	560,751	n/a									UNFPA 2017
% of Pregnant Women with at least one ANC visit	555,144	99%	n/a				n/a				UNFPA,PNLS 2017
Pregnant women needing ARVs	5,5562	100%									National Strategic Plan 2014-2017 (page 82)
Orphans (maternal,	69,000										UNAIDS 2015

paternal, double)											
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

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 Within the Last Year		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	11,215,024	1.3%	77,000	61,306	50,964	66%	90%	1,234,683	15,464	7,134
Population less than 15 years	5,120,948	n/a	9,100	4,499	3,086	34%	90%	33,512	587	311

15-24 year olds	2,109,305	0.3%	6,400	n/a	3,384	n/a	n/a	n/a	n/a	n/a
25+ year olds	n/a	1.3%	n/a	n/a	27849	n/a	n/a	n/a	n/a	n/a
MSM	9,346	4.8%	449	n/a	n/a	n/a	n/a	n/a	n/a	n/a
FSW	51,482	21.3%	10,966	n/a	n/a	n/a	n/a	n/a	n/a	n/a
PWID	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Military	100,000	1.9% military 1.3% dependents	1,450 (475 military) (975 dependents)	1,122	1,120	77%	122	17,653	303	189

Figure 2.1.3 National and PEPFAR Trend for Individuals currently on Treatment



Note: # People on ART supported nationally is for all provinces. PEPFAR program started reporting on TX_CURR in 2014. SNU re-prioritization led to reduction in SNUs supported by PEPFAR in FY 15 from 8 to 5.

2.2 Investment Profile

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 FY15 to FY17. For FY18, 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 HIV response in Burundi is funded primarily by two sources, PEPFAR and the GFATM. For the period of 2017-2018 the GFATM will contribute 53% of the national HIV response while PEPFAR will contribute 40% (Table 2.2.1). 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.

The GFATM Country Coordinating Mechanism (CCM) has submitted a funding request for 2018-2020, with a proposed budget of \$29,916,039, a reduction from the previous Concept Note of \$46,602,041. The PEPFAR program will continue to work closely with the CCM and the GFATM to ensure alignment of programming, given that the GFATM is the largest procurer of HIV-related commodities (84%, Table 2.2.2).

The PEPFAR program also leverages funding from other non-PEPFAR sources in order to improve overall health outcomes and to maximize investments. In COP17, major investments as described in Table 2.2.2 will ensure integration of HIV with maternal and child health (MCH), malaria, and family planning. In FY18, PEPFAR will not have any non-COP resources, such as central initiatives or PPP.

Table 2.2.1 Investment Profile by Program Area ⁵

Program Area	Total Expenditure	% PEPFAR	% GF	% GoB	% 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

* Other donors include UNICEF, French and Belgian Cooperation, and WHO.

Table 2.2.2 Annual Procurement Profile for Key Commodities

Commodity Category	Total Expenditure	% PEPFAR	% GF	% GoB	% Other*
ARVs	\$7,395,271	3.06	84.60	11.27	1.07

⁵ (GRP, National AIDS Spending Assessment, 2012), all amounts in 2012 USD

Rapid test kits	\$3,133,197	13.07	86.93	0	0
Other drugs	\$943,728	11.39	63.15	25.46	0
Lab reagents	\$7,365,605	4.18	95.82	0	0
Condoms	\$1,090,809	0	100	0	0
Viral Load commodities	\$465,582	45.17	54.83	0	0
Other commodities	\$23,616	35.97	64.03	0	0
Total	\$14,101,029	7.82	84.81	7.25	0.11

* Other donors include UNICEF, French and Belgian Cooperation, and WHO.

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	\$2,000,000	IHP: \$1,290,227	1	IHP:\$2,185,522	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	MEASURE Evaluation: \$200,000 PSM: \$6,799,750 Assessing Lab Quality: \$50,250	3	MEASURE Evaluation: \$600,000 PSM: \$2,353,388 Assessing Lab Quality: \$174,625	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 Assessing Lab Quality: An external quality assurance (EQA) evaluator will assess lab service availability and quality.
Family Planning	\$3,000,000	IHP: \$769,142 BRAVI: \$500,000 PSM: \$400,000 Youth Power: \$211,638 Gender-Based Violence Analysis: \$100,000	5	IHP: \$2,185,522 BRAVI: \$750,000 PSM: \$2,353,388 Youth Power: \$922,017 Gender-Based Violence Evaluation: \$150,000	IHP: Integrated service delivery for HIV, MCH, Malaria and FP to improve quality of care and capitalize on synergies and cost efficiencies. BRAVI: Integration of FP and GBV services. Youth Power: Provide high impact services to vulnerable AGYW aimed at preventing new HIV infections and unintended pregnancies. PSM: Technical assistance to build supply chain management capacity GBV Evaluation: Assess quality and effectiveness of GBV programming.
Total	\$14,500,000	\$10,321,007	8	\$7,335,552	

Table 2.2.4 Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP

Funding Source	Total PEPFAR Non-COP Resources	Total Non-PEPFAR Resources	Total Non-COP Co-funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
DREAMS Innovation	n/a	n/a	n/a	n/a	n/a	n/a
VMMC – Central Funds	n/a	n/a	n/a	n/a	n/a	n/a
LCI	n/a	n/a	n/a	n/a	n/a	n/a
Other PEPFAR Central Initiatives	n/a	n/a	n/a	n/a	n/a	n/a
Other Public Private Partnership	n/a	n/a	n/a	n/a	n/a	n/a
Total	n/a	n/a	n/a	n/a	n/a	n/a

2.3 National Sustainability Profile Update

Sustainability Index and Dashboard (SID) Update: The sustainability profile in Burundi remains mostly the same as last year; however the economic situation remains tenuous, and could potentially impact the GOB's ability to finance the HIV/AIDS response. Funding commitments from PEPFAR and the GFATM mean that needed commodities are likely to be fully covered by external donors over the next few years.

Updates on the COP 2016 SID:

Sustainability Strengths:

- **Planning and Coordination (10.0, dark green):** With the support of donors, the host country develops, implements, and oversees a costed multi-year national strategic plan and serves as the preeminent convener of a coordinated HIV/AIDS response in the country through the PNLS. The PNLS is leading implementation of the new Test and Start strategy.
- **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) was identified as one of the sustainability vulnerabilities in COP16. Several strategies have been implemented to address this weakness including: Test and Start implementation from FY 2016 Q4, active tracing and enrollment of pre-ART clients onto ART, and development of an SMS messaging referral system to ensure 90% of those identifying positive initiate ART.
- **Epidemiological and Health data (5.65, yellow):** Lack of data on HIV incidence and limited capacity at national level for analysis of data and evidenced-based decision making were highlighted in COP 16 as a sustainability vulnerability. To remedy this situation the following actions have been implemented in 2016-2017: design and adoption of new RHIS and CBIS data collection tools for HIV, and training of providers aiming to extend DHIS-2 to all health districts. With support from PEPFAR and other stakeholders, routine data are available and used for programming. Burundi has also resumed ANC

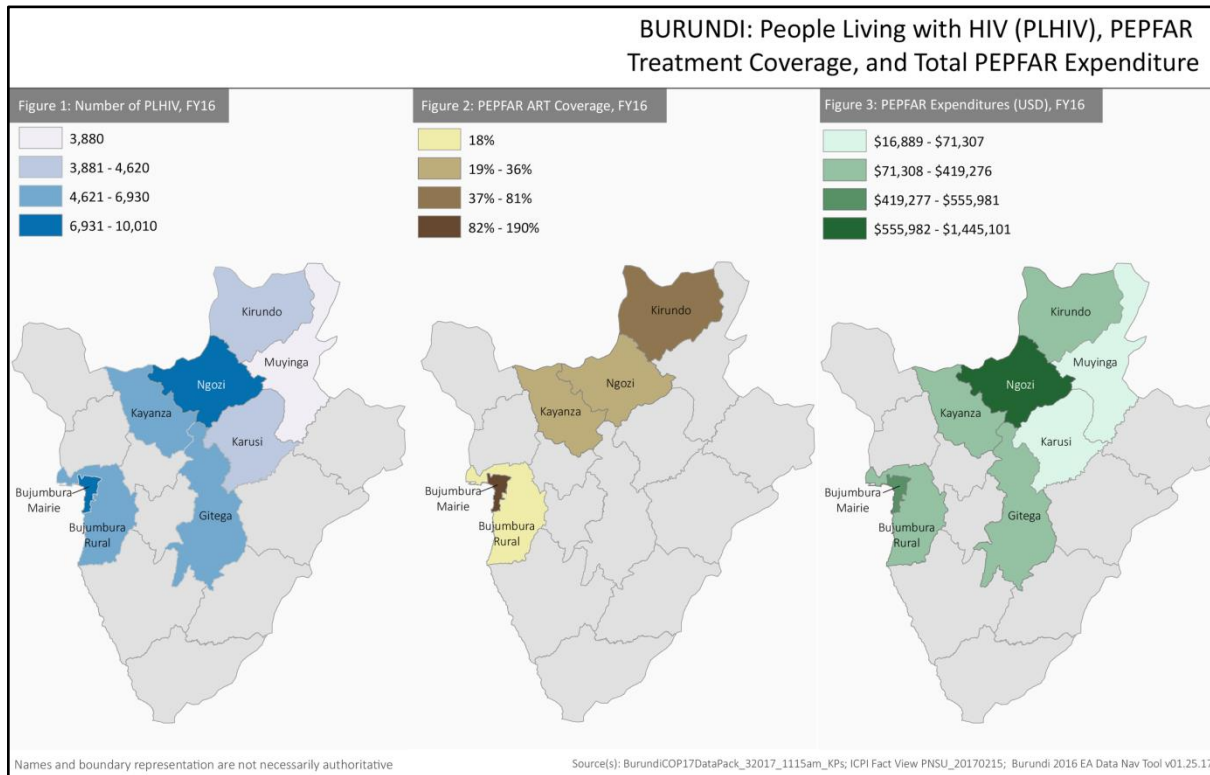
sentinel surveillance during the fiscal year 2016-2017. In addition, new DHS III and SPECTRUM data will be available end FY 2017 to inform program planning.

- **Laboratory (3.43, red):** Identified as one of the weakest domain of the health system in COP16. In 2016-2017, significant progresses was and will be made on the following SIMS CEEs:
 - **Laboratory QMS program (10.2):** Burundi participated in a lab quality improvement program (SLIPTA), and the PEPFAR program will support the PNLs to start a Continuous Quality Improvement/Quality Management System (CQI/QMS) approach in 2017.
 - **Laboratory Workforce (10.3):** IPs will train additional lab technicians and lab managers on VL techniques, and health care providers on VL test interpretation and strategies to manage unsuppressed patients.
 - **VL Infrastructure (10.4):** Viral load monitoring is routine in Burundi in alignment with new guidelines and scale up has been successful in FY16. Test coverage was 46% in FY16, with 20,000 VL tests performed (of these 15,000 in PEPFAR supported provinces), which represents a 900% increase from FY15. Factors that will further improve scale up in FY18 include:
 - Four VL/EID platforms are currently functioning and have maintenance contracts, with an estimated capacity of 136,752 tests per year, while estimated needs for the country are 77,000 annual tests.
 - Three new platforms have been purchased by UNITAID via OPP-ERA project and will double the current VL capacity. Two will be located in PEPFAR-supported provinces, and one will be located in Muyinga province (near Kirundo).
 - PEPFAR will continue to work closely with the GFATM and the PNLs to conduct a rapid VL/EID instruments mapping to ensure that any new investment in VL/EID platforms is done in the most rational way, and that any gains from improving VL program also strengthen the EID and TB lab system.

2.4 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 52% of the total national disease burden, Bujumbura Mairie (14%), Bujumbura Rural (12%), Ngozi (13%), Kayanza (9%), and Kirundo (7%), as shown in the maps in Figure 2.4.1. While on paper, coverage levels in Bujumbura Mairie (202% as of APR16) 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 justification for continued investment in this SNU.

Figure 2.4.1: Number of PLHIV by SNU (UNAIDS 2015); PEPFAR ART coverage (APR16); PEPFAR Expenditures (USD, APR16).



2.5 Stakeholder Engagement

Engagement with Government of Burundi and Multilateral Organizations

Building a more sustainable response to fighting HIV in Burundi is a fundamental priority for the PEPFAR program. In COP17, PEPFAR Burundi plans to continue regular quarterly coordination meetings with all stakeholders to discuss strategies and review available data to ensure a coordinated and effective response.

PEPFAR Burundi supports the GOB in coordination of the national HIV/AIDS response, such as:

- 1) Development of multi-year national strategic plans;
- 2) 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;
- 3) Using a data-driven approach to determine priorities;
- 4) Establishing policies and guidelines that direct HIV/AIDS service delivery;
- 5) Joint supervisions to oversee field interventions

Key stakeholders, including the Ministry of Public Health (MSPLS), UNAIDS, WHO, the National AIDS Council (CNLS), the National AIDS Program (PNLS), and civil society, are regularly involved in collaborative discussions on how to continue aligning the PEPFAR program with the UNAIDS 90-90-90 global strategy. Regular consultations have included:

- (1) Briefings and awareness on the priorities, strategies and tools to reach epidemic control through prioritization of the five high-burden geographic areas, with a focus on key and priority populations;
- (2) Successful collaborative exercises on the adaptation of the WHO new guidelines to the national context including Test and Start, PrEP, HIVST and multi month prescriptions (validated in September 2016), and the design of the implementation plan for the new guidelines (also validated in December 2016);
- (3) Sharing data analysis and decision-making resulting from quarterly POART data reviews;
- (4) Discussion on scale-up to saturation in Bujumbura Mairie and Kirundo, and aggressive scale-up for the remaining provinces (Bujumbura Rural, Kayanza, and Ngozi);
- (5) Sustainable Financing discussions including GOB indirect support of NGOs/CSOs.
- (6) Continuing discussions on implementation of transition plans for sites from which PEPFAR exited in COP 2015 and COP 2016.

Engagement with CSOs

The PEPFAR program consults regularly with CSOs, and a one-day workshop was organized in

the preparation of the COP with representatives from local non-governmental organizations, networks/coalitions, activist and advocacy groups, groups representing key and highly-affected populations, national networks of PLHIV, LGBT/gender and sexual minorities, sex worker organizations, women and young girl groups, youth-led organizations, faith-based organizations, professional and private organizations, groups led by people living with disabilities, organizations led by PWID, and PEPFAR program beneficiaries.

At these consultations, the PEPFAR program received feedback on implementation of the new guidelines; the startup and scale up of KP programming in all five PEPFAR supported provinces; the implementation of the EID sample referral strategy at a private lab in FY16, which improved the number of HIV-exposed children tested and linked to treatment. CSOs also recognized 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. In these consultations, the language barrier is the major factor that limits feedback as all the COP 2016 SDS documents were in English.

Recommendations were made to the PEPFAR Burundi team including;

- 1) Consider conducting annual mappings to identify new hotspots and populations at high risk;
- 2) Support legal interventions for people living with HIV and key populations;
- 3) Utilize social networks to access key populations;
- 4) Consider programming in KP hotspots in non-PEPFAR provinces;
- 5) Consider PWID as a new target for KP program;
- 6) Strengthening of CSOs institutional capacity and their promotion to prime implementing partners;
- 7) Support capacity building for peer navigators and educators to reach youth.

To access youth, CSOs suggested a less formal approach; for example peers of young boys where they meet for games, sex workers and MSM where they wait for clients (at their hotspots); greater focus on adolescents in and out of school; sensitization of communities on the availability of clinical services at sites (GBV, HIV testing, and other services).

3.0 Geographic and Population Prioritization

3.1 Geographic Prioritization

Sub-national epidemiologic estimates used for geographic prioritization were drawn from UNAIDS data for 2014, the most recent year available, and applied proportionally to the UNAIDS 2015 national PLHIV estimate of 77,000. According to 2016 data from the CNLS, 50,964 people were on treatment at the end of FY 2016 representing 66% of PLHIV, leaving an ART gap of 34%. 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 lack of updated data on prevalence by province, no major changes will be made to geographic prioritization by province this year; however, further refinement of site specific support will be done based on a detailed yield analysis. PEPFAR will continue to work in five provinces in COP17; two of which will be prioritized as scale up saturation to enroll 22,422 PLHIV on ART, and three of which will be prioritized as scale up aggressive to enroll 20,061 PLHIV on ART by the end of FY18 (Table 3.1). Results from updated prevalence estimates are expected at the end of FY17, and will be used for COP18 planning.

Table 3.1 Current Status of ART saturation

Prioritization Area	Total PLHIV/% of all PLHIV for COP17	# Current on ART (FY16)	# of SNU COP16 (FY17)	# of SNU COP17 (FY18)
Scale-up Saturation	10,010 (26%)	20,249	17,947	22,422
Scale-up Aggressive	27,720 (74%)	11,882	22,096	20,061
TOTAL	37,730	32,131	40,043	42,483

3.2 Geographic-Specific Activities

After a thorough review of data from FY16 and Q1 FY17, PEPFAR Burundi will utilize additional geographic-specific approaches in COP17 to close gaps in service delivery. The different strategies are summarized in Table 3.2, and the specific technical information is summarized in Section 4.

Table 3.2 Geographic-Specific Approaches

SNU	Approaches
Bujumbura Mairie	Index testing; targeted facility-based testing; high volume facility efficiencies
Bujumbura Rural	Focus on high volume sites; assess service utilization (Section 3.3)
Kayanza	Index testing; increase facility-based testing; increase linkages to treatment
Kirundo	Index testing; targeted facility-based testing; strengthen pediatric and KP services
Ngozi	Increase facility-based testing; scale up comprehensive treatment strategies ; utilize strength of CSOs for case-finding and linkages to treatment

3.3 Assessment of Service Utilization in Bujumbura Rural and Mairie

A file review conducted in PEPFAR sites indicates that about 11% of patients seeking services in Bujumbura Mairie originate from Bujumbura Rural, while a further 6% of clients are from nearby provinces, most notably Bubanza, Bururi, and Muramvya. The mobility of clients from Bujumbura Rural into urban Bujumbura Mairie will be explored in COP17 to inform

investments in order to provide the highest quality care where people wish to access it. In COP17, PEPFAR Burundi will conduct several activities to ascertain the health-seeking behavior, site capacity, and quality of care as follows:

- 1) **Survey to better understand the reason for clients from Bujumbura Rurale choosing to obtain HIV care and treatment in Bujumbura Mairie.** Surveys will be adapted from existing validated surveys on quality improvement, satisfaction with healthcare in LMIC settings, and others.
- 2) **Quality assurance and improvement activities to ascertain availability of and enhancement of services at community and facility levels in Bujumbura Rural.** Activities will include: continued SIMS visits, participative data quality assessments, expansion of civil society organizations to Bujumbura Rural, and provision of focused TA to improve the quality of services in Bujumbura Rural at nine high-volume sites with the highest yield and number of positive cases.
- 3) **Ascertain the capacity of Bujumbura Mairie sites to absorb new patients and provide high quality of HIV care and treatment.** Select high volume sites in Bujumbura Mairie will be assessed to ascertain their capacity using existing tools, such as the Service Provision Assessment (SPA) or Service Availability Readiness Assessment (SARA).
- 4) **A rigorous site yield analysis was conducted to identify specific sites that yielded <5 positives to further refine geographic prioritization.** After cross-checking data on both HTC and PMTCT total and percentage yields, 29 sites with fewer than five new positives were identified and will be transitioned to passive testing. No targeted testing will be pursued in these sites, with minor exceptions based on lack of trend data and contextual information. It is anticipated with these cuts, that more efficiency gains and targeted testing will increase HTC yield.

3.4 Populations

PEPFAR Burundi will also make important changes to the population groups targeted by PEPFAR support. Historically, Burundi was a PMTCT focus country for PEPFAR, however since the development of COP15, PEPFAR Burundi has aimed to build on successes in PMTCT. Approaches have focused on reaching 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 FY18, PEPFAR Burundi will scale up the key populations activity to reach 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

The COP 2017 target-setting process took place with the revised 2015 UNAIDS PLHIV estimates of 77,000, decreased from 84,000 in COP 2016. In addition, data was provided from Bujumbura Mairie and Kirundo highlighting population mobility to seek services in these provinces. Together, this new information drove the target-setting process in COP 2017 in the absence of updated subnational estimates (DHS III and SPECTRUM updates are estimated end FY 2017). The ART coverage in the five PEPFAR supported provinces ranged from 18% to 190% at the end of FY 16. This information is skewed due to the high mobility of patients into Bujumbura Mairie and Kirundo. In FY18, PEPFAR Burundi intends to aggressively scale up ART services in three of the current five provinces—Bujumbura Rural, Ngozi, and Kayanza. The expected ART coverage at the end of FY 18 is expected to be between 35% to 224%. Coverage adjusted for mobility between Bujumbura Rurale and Mairie only will lead to coverage range between 60% to 213%.

While Bujumbura Mairie and Kirundo are 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. Kirundo will have also reached saturation by end FY17, due in part to the strong network of CSOs, rather than population mobility (96% of clients visiting sites in Kirundo are from Kirundo province). Due to challenges in pediatric ART coverage and reaching key populations with services in Kirundo, this province will be classified as scale-up saturation in COP17.

Across all five provinces, PEPFAR Burundi aims to enroll 8,122 additional PLHIV (adults and

children) with the goal of achieving a total of 44,223 current on ART in PEPFAR-supported SNU by the end of FY 18. This represents an increase in coverage from 67% to 101% for adults (Table 4.1.1). The implementation of the Test and Start policy started in September 2016, and should be completed by end FY17; as such, COP 2017 planning contains no assumptions pertaining to a pre-ART population. Both adult and pediatric treatment and testing targets are based upon a projected linkage rate of 90%.

KEY AND PRIORITY POPULATIONS: In order to achieve epidemic control, PEPFAR Burundi will 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 1,932 newly initiated on ART in FY18.

PMTCT: Activities will focus on the diagnosis of HIV and initiation of ART for HIV-positive pregnant women, as well their sexual 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 1,469 newly initiated clients by end of FY18. 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 39%, scale-up to saturation may be more gradual for children. In aggressive scale up SNU, PEPFAR Burundi will aim to achieve 55% pediatric ART coverage by FY18 and 61% by the end of FY19, with 85% and 91% in FY18 and FY19 respectively, in saturation provinces. This will be achieved through active case finding of untested children of known HIV-positive adults; routine PITC in pediatric hospitalization, TB, under-5 clinics, and malnutrition services; case finding for children of key populations; and scale-up of OVC activities. PEPFAR program will also leverage gains made from VL scale up to strengthen the EID laboratory network.

OVC: PEPFAR Burundi reoriented its OVC activities toward a strategic focus on vulnerable adolescent girls and young women (AGYW) and commenced implementation of a new OVC program in early FY17 in Kayanza, which has an estimated 55,000 OVC, of which 11,000 are AGYW ages 10-18 (Table 4.1.3). In COP17, 8,000 AGYW and their caregivers will be targeted to link them to HIV prevention and treatment, as well as education and household economic strengthening.

TB/HIV: Through routine testing of all people living with TB, PEPFAR Burundi expects to enroll 341 new TB/HIV patients on ART in FY17. PEPFAR Burundi will work with the national TB program to ensure molecular testing using the new GeneXpert platforms for rapid and accurate diagnosis.

Consistent with past programming, PEPFAR Burundi will not procure ARVs for treatment, but will provide technical assistance for site-level activities to strengthen treatment services. The program will continue to procure ARVs for PMTCT clients only in PEPFAR supported PMTCT

sites.

As with COP 2016, facility- and community-testing and treatment targets were costed on a per person reached basis, based upon expenditure analysis (EA) data from COP 2015. Where such data were not yet available (as from new initiatives begun in COP 2016/FY 2017), unit expenditure (UE) assumptions from COP 2016 were maintained. For follow-on activities proposed in COP 2017, estimates were generated from projected months operational based on current targets and average UEs for similar program activities.

Table 4.1.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts

Entry Streams for ART Enrollment	Tested for HIV (APR FY18) HTS TST	Newly Identified Positive (APR FY18) HTS TST POS	Newly initiated on ART (APR FY 18) TX_NEW
Adults			
TB Patients	3,044	341	341
Pregnant Women	162,245	1,495	1,469
Key populations	13,925	2,460	1,932
Priority Populations	19,326	509	509
Other Testing	136,737	4,227	4,015
Previously diagnosed and/or in care*	-	-	-
Total Adults	335,267	9,032	8,266
Pediatrics (<15)			
HIV Exposed Infants	2,380	47	34
Other pediatric testing	64,150	1,090	1,125
Previously diagnosed and/or in care*	-	-	-
Total Pediatrics	66,530	1,137	1,159
TOTAL	401,797	10,169	9,425

*Due to Test and Start implementation in FY17, PEPFAR estimates no “pre-ART” patients in FY18.

Table 4.1.2 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations *	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY17)	FY18 Target
Key Populations	27,911		
Bujumbura Mairie FSW	7,281	60%	61%
Bujumbura Mairie MSM	2,692	60%	74%
Bujumbura Rural FSW	4,042	80%	61%
Bujumbura Rural MSM	679	80%	77%
Kayanza FSW	4,343	80%	61%
Kayanza MSM	648	80%	77%
Kirundo FSW	2,265	75%	61%
Kirundo MSM	349	75%	75%
Ngozi FSW	4,855	80%	61%
Ngozi MSM	757	80%	40%
Priority	100,000		
Military**	100,000	22%	20%

*PEPFAR will only be supporting prevention services for KPs and military.

** Includes military and their family members.

Table 4.1.3 Targets for OVC and Linkages to HIV Services

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY18 Target) OVC_SERV
Kayanza	55,000 total (of which 11,000 AGYW ages 10-18)	8,000
TOTAL	55,000	8,000

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 estimated

prevalence 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. Data on transgender (TG) individuals and persons who inject drugs (PWID) is not available in Burundi, although a GFATM-supported study for PWID is underway.

PEPFAR Burundi will continue to support high-impact core interventions in COP17 for key and priority populations, listed in Table 4.2. 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.

Table 4.2 Key and Priority Population Interventions

<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • Promotion of sexual education in schools, with an emphasis on HIV prevention practices and gender norms in relationships that affect HIV and GBV
<ul style="list-style-type: none"> • Targeted peer-led HIV education through social media approaches 	<ul style="list-style-type: none"> • STI testing and treatment services
<ul style="list-style-type: none"> • Improved linkages to combination prevention services including PrEP 	<ul style="list-style-type: none"> • PMTCT for FSWs and the military and their partners
<ul style="list-style-type: none"> • Condom/lubricant promotion and distribution 	<ul style="list-style-type: none"> • PEP and linkage to clinical care services for victims of sexual violence (SV) and GBV
<ul style="list-style-type: none"> • Strengthened referral networks 	<ul style="list-style-type: none"> • Linkages to same-day enrollment on ART

4.2.1 Key Populations

Based on the PLACE study mapping of MSM and FSW hotspots, the LINKAGES activity began working in Q4 of FY16 in Bujumbura Mairie and Kirundo provinces and scaled up in Q1 FY17 to cover hotspots in all five PEPFAR supported provinces. The hotspots and needs for prevention, care and treatment among FSW and MSM were identified through a mapping activity. LINKAGES will reach KP and link to HTS, GBV and clinical services, and will aim to facilitate HIV testing for 80% of those reached. Specific focus will be given to Kirundo, based on hotspot mapping.

In COP17, PEPFAR will implement three new approaches and will engage KP-led CSOs in their development:

- 1) **HIV self-testing pilot:** A pilot program to assess the feasibility and efficacy of reaching MSM will guided self-testing will be implemented, where peer educator/navigators assist a peer in conducting their own self-test, and then provide support for follow-up and referral to treatment services ,as needed.
- 2) **Reaching children of FSW:** Given the high prevalence in female sex workers and the high total fertility rate in Burundi, PEPFAR Burundi will focus on reaching the children of FSW,testing and linking them to care as needed.
- 3) **Capacitation of public sector clinics to be “KP Friendly”:** Stigma and

discrimination trainings for healthcare providers will ensure that public sector clinics provide services for KPs who may not always self-identify.

There remain significant above-site challenges to reaching key populations, including limited data to inform programming decisions, national laws and policies that marginalize and criminalize certain populations (e.g. MSM), and a lack of recognition of the role that GBV and SV play in perpetuating the HIV epidemic in Burundi. At the national level in COP17, PEPFAR will support the development of a KP technical working group. At the local level, the LINKAGES activity will work with local civil society organizations and other key stakeholders to assess the situation and proceed with care and confidentiality to ensure clients are protected.

4.2.2 Military Populations

The Military are at higher risk for HIV as most are highly mobile within and outside of the country. 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. PEPFAR Burundi will also target military personnel, their dependents, and neighboring communities through focused interventions, such as targeted HTC, and condom promotion and distribution.

4.3 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 FY16 and 90% of those testing positive or previously known HIV-positive received ARVs to prevent the transmission of HIV to their infants. 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 COP16 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 FY18 is on scaling up the implementation of the highly successful index patient model originally piloted by the PEPFAR-supported PMTCT AP activity to ensure systematic testing of male partners and children born prior to PMTCT enrollment. Focus will also be placed on increasing access to EID testing, as detailed in the

section on pediatric treatment below.

4.4 HIV testing and counseling (HTC)

HTC activities supported by PEPFAR Burundi are consistent with WHO standards and target communities and individuals with an emphasis on key and priority populations. HTC services will continue to be provided towards the goal of identifying 90% of PLHIV in PEPFAR-supported provinces. In the preparation of COP17, PEPFAR Burundi carried out a HTC efficiency analysis. Based on this, two new approaches will be taken for FY18: 1) Geographic strategies prioritized by province, and 2) Targeted HTC to those in high-risk populations (such as index patient and KPs).

4.4.1 Efficiency Analysis

In preparation for COP17, PEPFAR Burundi carried out an efficiency analysis to focus efforts on the sites finding >5 positives in FY16, and to review all high volume testing sites with low positivity yields. PEPFAR supported HTC at 231 sites in FY16. Analysis of testing yields at these sites in Chart 1 below indicates that 80% of HIV positive individuals were identified at 35% of sites in FY16 and 27% of sites during Q1 FY17. These sites will continue to be a priority focus to generate new positives.

Twenty-nine sites were identified to decrease active HTC services (Table 4.4.1). Low volume sites that offer HTC and treatment referral will begin to transition from HTC in FY17, and will fully discontinue active testing by Q1 FY18. For sites that offer more comprehensive ART services, patients that present symptoms consistent with HIV or request an HIV test will be offered a test but there will be no active outreach or routine testing done at this site. The PEPFAR program would continue to support ART for patients identified at this site. Partners will be directed to use this strategy and analyze program data by HTC entry point to continually modify the testing strategy to maximize yield and efficiency gains.

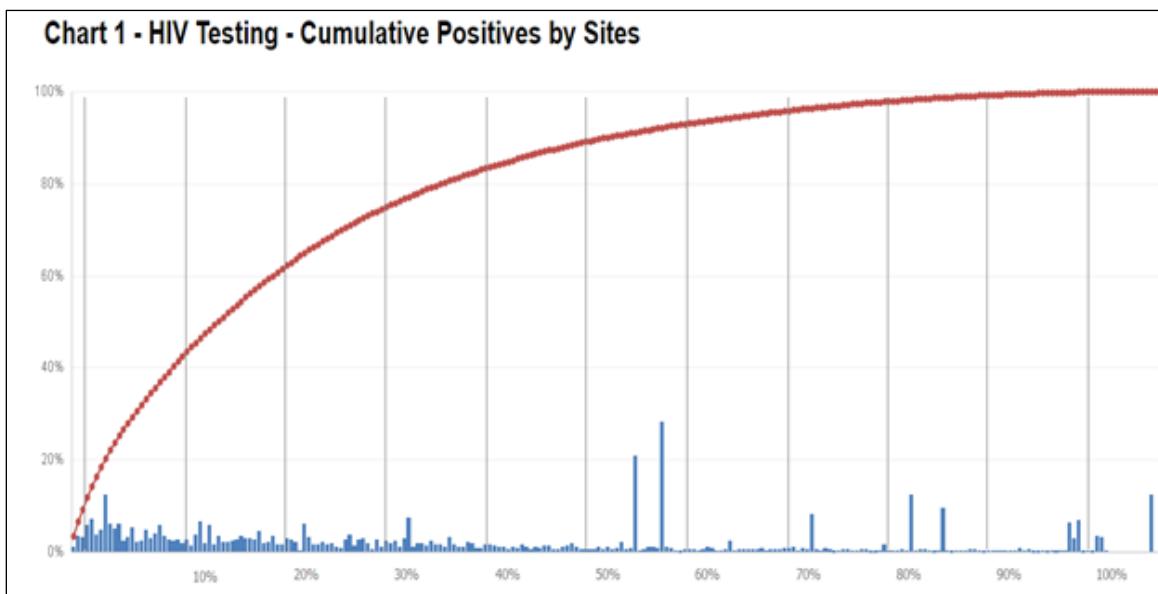


Table 4.4.1 Number of sites removed from active HTC support

Province	# sites removed
Bujumbura Mairie	0
Bujumbura Rural	18
Ngozi	4
Kayanza	6
Kirundo	1
Total	29

4.4.2 Geographically Focused Testing Strategies

Based on review of FY16 and Q1 FY17 data disaggregated by age, sex, and testing entry point, PEPFAR will expand index patient testing to all provinces to 100% of new clients and 50% of existing clients. To improve data collection, HTC registers will be updated to include fields to track clients entering through index patient testing, and the electronic medical record system will be modified to record partners and children of PLHIV to allow review of index patient testing at each clinic visit. Given the increased vulnerability to HIV infection of women of childbearing 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 of other family members.

While index patient testing will be employed across Burundi in COP17, analysis of APR16 and Q1 FY17 data has revealed the need for differentiated geographic strategies to ensure optimal focusing of HTC resources, as indicated in Table 3.2. In Ngozi and Kayanza, HTC in inpatient and outpatient settings will be reinforced in order to expand access to testing and to maximize case finding. In Bujumbura Mairie and Kirundo, HTC in inpatient and outpatient settings will be scaled down, and screening tools for adults and children will be employed to ensure resources are focused to those at high risk of HIV infection.

To access populations that are difficult to reach, such as men, KPs and youth, different strategies will be developed. For KPs, a guided self-testing pilot will be implemented (please see Key Population section 4.3 for more information). 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.

PEPFAR Burundi will focus on high yield index patient-partner and patient-family testing and

mobile testing in hotspot locations for the military, their families, and surrounding communities, an estimated 100,000 people. In addition, active linkage to prevention, care and treatment services will be ensured.

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 from 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.

4.5 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 identified in COP16 and continued in COP17 include: STI and OI/TB 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 and FY16, versus 8% in previous years. In COP17, PEPFAR Burundi will support the development and implementation of new service delivery models aimed at decongesting health facilities and improving patient care and retention. These models include multi-month prescribing of ARVs in line with the new national guidelines, community-based ART distribution groups, and community adherence groups to increase retention on treatment. For community groups, healthcare providers will also provide supportive services such as TB/OI and STI screening, and referrals where indicated.

Additional effort will also be placed on strengthening facility and community-based care and support for children and adolescents, ensuring that all HIV-exposed infants and OVCs have known HIV status and are linked to not only needed clinical services, but also psychosocial services. For additional information on children, adolescents and OVC, please refer to the relevant sections.

Specific geographic focus will be applied to different regions as indicated in Table 3.2. In Kayanza, Ngozi and Bujumbura Rural, CSOs should share best practices in case-finding and linkages. In Bujumbura Rural, CSOs can:

1. Promote/encourage the extension to Bujumbura Rural of HIV services offered by

experienced civil society organizations, such as local offices with similar services at headquarters.

2. To sensitize the PLHIV originating from Bujumbura Rural in the Bujumbura Mairie health facilities by “groupe de parole” on the availability of HIV services in their home province
3. Involve Bujumbura Rural volunteer network of PLHIV living positively (RBP+) to sensitize peers through testimony sessions
4. Organize community sensitization on stigma/index patient testing (combined community actors, religious leaders and health providers in Bujumbura Rural)

4.6 TB/HIV

TB is the most common OI among PLHIV in Burundi. In 2015, the WHO estimated the incidence of HIV co-infection in TB patients at 14%, ranking Burundi among the 41 countries where the burden of coinfection is heaviest. The estimated incidence rate of TB (including HIV-positive TB patients) is 122 per 100,000, with 51% of those cases being notified to the National TB Program in 2015 (6,892 new and relapse cases in total). Of the estimated 6,892 cases, 12% were among children under 15 years of age, and the incidence among males was almost double that of females. Multidrug resistant TB (MDR-TB) is also a concern in Burundi, with estimated incidence of 3.2% among new TB cases, and 14% among retreatment cases in 2015. Only 22% of the 190 patients notified for MDR-TB started treatment in 2015.

Among TB patients, HIV incidence is 14%. There is no data available for the rate of diagnosis of HIV in TB patients, but once patients became aware of their HIV status, 87% were initiated on ART in 2016 in PEPFAR provinces.

TB activities in Burundi are almost completely supported by the GFATM and include: HIV testing of TB patients and surveillance of HIV prevalence; early ART initiation; integration of HIV prevention messages in TB care; and capacity building of TB centers to provide quality services. While PEPFAR does not procure TB medicines, it complements the above-described activities in supported provinces with the goal of achieving 90-90-90 for PLHIV with confirmed or suspect TB.

In FY18, PEPFAR Burundi will continue to support TB/HIV co-infection management, with an expected 341 new TB/HIV patients to be enrolled in the five priority provinces and the military. PEPFAR will aim to reach test 100% of clients with diagnosed or presumptive TB at supported sites, and will explore other high-yield interventions such as offering TB symptom screening to household members of PLHIV, and HIV testing to contacts of people with TB. PEPFAR will ensure ART initiation among all co-infected patients within 2-8 weeks of initiating TB treatment, in line with the national algorithm.

For prevention in PLHIV without active TB, PEPFAR will scale up isoniazid preventive therapy (IPT) as an integral part of the clinical care package in line with the national guidelines, and will support data collection efforts. TB prevention and infection control interventions in PEPFAR-supported facility and community-based settings will also be implemented in COP17. The IPT

implementation began slowly in 2016 in 3 sites. Scaling it up will face some challenges such as the reluctance of healthcare workers to implement the program, lack of the predictability of the availability of INH commodities, and the unknown adherence of PLHIV on IPT.

PEPFAR will work with the National TB Program (PNILT) and GFATM to ensure systematic TB screening among HIV-positive people and to reinforce the referral systems between HIV/AIDS and TB services wherever indicated. Individuals who are TB symptomatic in PEPFAR sites will continue to be referred to TB settings for diagnosis. To accelerate case finding and TB treatment initiation for PLHIV in COP17, PEPFAR will work with the PNILT and GFATM to refer sputum samples for molecular diagnostic testing using the new GeneXpert MTB/RIF platforms.

Several larger sites conduct TB diagnosis, but to ensure access to TB diagnosis at HIV testing sites that do not offer TB diagnoses, the PNILT has set up a system for collecting and transporting sputum. In COP17, PEPFAR will also strengthen the sample transport network to ensure timely results return to clients. The same SMS tracking system described for HTC will be used to ensure that referrals for TB diagnosis or treatment are completed.

4.7 Adult treatment

Burundi's current national treatment directives, adopted in September 2016, are in line with the WHO "Test and Start" recommendations issued in 2015 where ART is provided for all PLHIV. The implementation plan of the new guidelines was developed in early 2017, and a training of trainers on the new guidelines was held in March 2017.

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. Two provinces, Bujumbura Mairie and Kirundo, will be considered scale-up to saturation due to population mobility, with expected coverage of 224% and 167% respectively by the end of FY18. All other sites will be considered aggressive scale-up with FY18 targets as follows: Military settings: 80%, Bujumbura Rural 35% (due to service uptake in Bujumbura Rural), Ngozi 60% and Kayanza 65%. Supplemental focused activities will be applied to different provinces as indicated in Table 3.2.

In order to achieve these ambitious targets, the COP16 package of services for all scale-up SNUs will be continued in COP17, to include: targeted HTC; active linkage to services; ART initiation and follow up; active loss to follow-up tracing; routine viral load monitoring; 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.

A site analysis for linkages to ART revealed many sites with <75% linkage rate. To increase

linkages to treatment, PEPFAR will provide TA to ensure that individuals testing positive are initiated on ART within 1 week of testing positive, in line with new national guidelines. If ART sites are not co-located with testing sites, physical linkages from the test site to the ART site will be facilitated by healthcare workers and/or peer navigators. PEPFAR will explore innovative strategies to ensure effective linkages.

Components of the package of services new in COP17 are IPT provision for all PLHIV, and PrEP for high risk clients or serodiscordant couples. In addition, new service delivery modalities will be offered to stable clients to improve access to ART through multi-month prescribing and community-based ART groups.

Implementing partners will also place emphasis on clinical management through scale up of routine viral load monitoring. Under the current Concept Note from 2014-2017, the GFATM procures PCR and viral load diagnostic commodities and PEPFAR other laboratory commodities in the target provinces. In FY 2018, PEPFAR intends to support maintenance of the PCR machines located in national laboratories in Bujumbura Mairie and Ngozi. PEPFAR will also work with the GFATM and PNILT to ensure sputum samples from PEPFAR-supported sites are tested for TB using molecular diagnostic platforms.

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.

4.8 Pediatric Treatment

At the national level, Burundi has reached 41% ART coverage for children under 15 (PNLS, December 2016). 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 seropositive 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 FY18, 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.

During development of COP17, SNU data on pediatric ART coverage was reviewed along with feedback from stakeholders to identify the need for capacity building in pediatric treatment, especially in provinces with low pediatric ART coverage like Kirundo. In COP17, PEPFAR Burundi will implement a mobile pediatric attachment TA approach at facilities demonstrating low pediatric coverage to increase the comfort of healthcare providers in managing pediatric clients and to build capacity of lower-cadre healthcare providers to support taskshifting. Best practices in pediatric treatment will also be shared through an IPs workshop.

Across PEPFAR-supported sites, PEPFAR Burundi will support all aspects of the pediatric care and treatment continuum through technical assistance in COP17:

- **Improvement of case finding of infants, children and adolescents exposed to or infected with HIV by:**
 - (i) setting aggressive pediatric HIV testing targets to motivate implementing partners to improve pediatric case finding;
 - (ii) tracking all eligible children in PEPFAR-supported PMTCT services and ensuring that they are referred to facilities that provide ART services;
 - (iii) scaling-up EID systems to provide HIV virological testing at six weeks of age, minimize delays in return of results for HIV-exposed infants, and strengthen linkages;
 - (iv) 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;
 - (v) implementing and monitoring family-centered or index patient approaches to HIV testing in adult ART, OVC, MNCH, school health, social services, and malaria programs;
 - (vi) ensuring adequate and consistent supply chain for EID and PITC commodities.

- **Implementation of Test and Treat for all children by:**
 - (i) setting aggressive numeric disaggregated treatment and viral load targets;
 - (ii) 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;
 - (iii) supporting the PNLs to expand existing task shifting policies to include pediatric treatment;
 - (iv) supporting the national supply chain system to ensure reliable supply of efficacious, easy to use pediatric formulations (Lopinavir/Ritonavir oral 40mg/10mg pellets).

- **Retention and linkage of infants, children and adolescents in life-long care and treatment through:**
 - (i) implementing quality improvement (QI) 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 pediatric ART services.

In FY16, EID targets significantly improved over FY15 due to engagement with a private sector lab to process samples from PEPFAR supported sites, and the installation of a second PCR machine in Ngozi province. However, stock outs for EID and VL reagents were experienced due to a delayed delivery. COP17 strategies to ensure EID tests for all HIV-exposed infants will include: sensitization of providers and mothers on the 6 week EID test; strengthening the entire lab network and sample transport system; and through securing maintenance contracts for the two

existing PCR machines to ensure that they remain operational. Improvements made to the overall laboratory system from VL investments will also be leveraged by the EID program to reduce lab and HR capacity and results turnaround time (TAT).

4.9 OVC

Based on feedback received during the development of COP15, PEPFAR Burundi reoriented its OVC activities toward a strategic focus on vulnerable adolescent girls and young women (AGYW) and commenced implementation of a new OVC program in early FY17. Multiple social, cultural and demographic factors put AGYW 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, the AGYW/OVC program started in Q1 FY17 uses both PEPFAR and Family Planning funds to focus on four areas of intervention: Education, Service Delivery, Household Economic Strengthening, and Capacity Building. The target population is AGYW 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 HTC 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 operating in Kayanza province, which has a lower concentration of other OVC services than other PEPFAR-supported provinces, low ART coverage (38%) and a lower than average contraceptive prevalence rate (31.1%). In FY18, it is expected that 8,000 AGYW and their caregivers will be served. The following high-level outcomes are expected:

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

4.10 Addressing COP17 Technical Considerations

The following section addresses the PEPFAR program's implementation, and improved impact, in the adoption of the key technical issues included in the COP17 Technical Considerations. Below are details regarding the current status of implementing the key interventions for each key technical issue area, as relative to each programmatic area, and across the clinical cascade.

4.10.1 Increased focus on prevention and care services for individuals under 30 years old

From the 2015 revision of Burundi's population pyramid by the UN, the majority (72%) of Burundians are under 30. The available age-disaggregated data reveals that the HIV/AIDS epidemic is increasingly focused on youth, highlighting the importance of integration of youth-friendly services into programming. Data from the 2010 DHS indicates that a younger sexual debut in girls correlates with increasing HIV prevalence (2.9% for 17 and under, vs 1.9% for 18 and older). In addition, girls are infected earlier than men, with higher prevalence (1.5% vs 0.2%) seen in the 20-24 year old age group. AGYW 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, and men are the ones who make family planning decisions and agree to the use of a condom during intercourse.

4.10.2 Increased testing yield and improving testing modalities

One challenge identified in the preparation of COP17 was low testing yields. To focus resources to find PLHIV who do not know their status, PEPFAR Burundi will implement: 1) a renewed focus on index patient strategies, 2) geographic-specific strategies, and 3) review of HTC sites with low yields and <5 positives. For specific information, refer to Section 4.5.

The collection and use of data on testing entry point is limited due to inadequate data collection systems. In COP17, PEPFAR Burundi will provide TA to improve data collection, including: HTC registers updated to include fields to track clients entering through index patient testing; the EMR will be modified to record partners and children of PLHIV to allow review of index patient testing at each clinic visit; a SMS system will be developed to strengthening referrals to treatment.

4.10.3 Improved retention and viral suppression

PEPFAR Burundi aims to enroll 8,122 additional PLHIV patients (adults and children) with the goal of achieving a total of 44,223 current on ART in PEPFAR-supported SNUs by the end of FY 18. In order to accommodate this gain from Test and Start, EQUIP will support the GOB in implementing differentiated models of care per geographic region and population. These models include multi-month prescribing of ARVs in line with the new national guidelines, community-based ART distribution groups, and community adherence groups to increase retention on treatment.

The added focus on retention of patients in care will remain a high priority, especially in the period of crisis when loss to follow-up increased to 13% in FY15 and FY16, versus 8% in previous years. As of March, 2017, there were 61,782 IDPs in Burundi due to several factors, including the crisis and food shortages. IDPs have a heightened risk of HIV acquisition, a far greater risk of gaps in ART coverage, and increased risk for drug resistance, which could potentially have significant implications for the gains made in the HIV epidemic in Burundi.

Barriers to scaling-up viral load testing will be addressed through TA for viral load testing, sample collection, results return, and clinical management through coordination across multiple IPs. This effort will be coordinated through PSM and EQUIP and utilized to sustain and supplement the 900% increase in VL coverage already attained by PEPFAR Burundi in FY16.

4.10.4 Support a sustainable, quality service delivery model.

Building on the activities described above, in COP17 PEPFAR Burundi will develop and implement new service delivery models aimed at decongesting health facilities and improving patient care and retention through EQUIP. Currently, patients on ART can only access drugs at the facility level. EQUIP will provide TA to identify possible models for scale up, accelerated treatment services, and decentralized drug distribution in the community. For community groups, healthcare providers will also provide supportive services such as TB/OI and STI screening, and referrals where indicated. Facility assessments and patient surveys at PEPFAR Burundi sites will be completed in FY17 in order to better understand facility capacity and patient perception (as described in Section 2.4). This assessment is prioritized for facilities located in Bujumbura Rural, where up to 11% of patients access treatment services in neighboring Bujumbura Mairie. Identifying what service models are effective for which provinces or sites, and addressing appropriate shifts in service delivery, will be prioritized in FY17 and FY18.

To strengthen laboratories, TA for CQI and QMS will be provided for existing and future labs in COP17 by EQUIP, PSM, and other implementing partners. Sufficient staffing, accurate interpretation of results, and results management will be addressed.

4.11 Commodities

The GFATM and PEPFAR will continue to be the most important donors for HIV commodities procurement to support the Test and Treat strategy. GFATM covers all the needs of ARVs for the whole country, except for PMTCT in PEPFAR-supported provinces which are covered by PEPFAR. PEPFAR will continue to complement the GFATM by procuring RTKs, Cotrimoxazole to prevent OIs, CD4 reagents, and DBS kits for viral load and EID sample transportation, in the supported provinces. In order to ensure there is no VL/EID testing interruption, PEPFAR will procure a small quantity of VL and EID reagents which will serve as a backup.

The GFATM's 2018-2020 proposed budget is \$29,916,039, a reduction from the previous Concept Note of \$46,602,041. This budget reduction will certainly impact on the coverage of commodity needs. PEPFAR will coordinate with GFATM, the GOB and other key stakeholders to make sure the potential gaps and additional funding sources are identified. Also, despite the Technical Assistance provided by PEPFAR to support the supply chain in Burundi, stock outs remain a major concern. In fact, the country has experienced some stock outs in 2016, due to delayed delivery of ABC/3TC 600/300 tab, LPV/r 200/50 tab, and HIV Determine test kits. In order to

prevent new stock outs, PEPFAR will reinforce the TA provided to the MOH and other national counterparts through the Global Health Supply Chain-Procurement and Supply Management (GHSC-PSM) mechanism. GHSC-PSM will work closely with the GFATM to ensure any risk of stock out or expiry is anticipated and adequate actions are taken in a timely manner.

Regarding laboratory systems strengthening, significant improvement was made in VL/EID testing scale-up in FY16. In COP17, GHSC-PSM and clinical partners will continue to support supply chain for laboratory, which is fundamental to reach the first and third 90 goals.

4.12 Collaboration, Integration and Monitoring

As described in earlier narratives, the PEPFAR program collaborates closely with the GFATM, GOB, multilateral donors and civil society. Harmonization with GF on commodities is crucial for RTKs, EID and VL reagents, and ARVs. In addition, implementation of strategies such as sample transport, HIV/TB prevention, and diagnosis and treatment relies on this harmonized relationship. As mentioned, the PEPFAR program is a member of the CCM and is participating in the funding application development for the 2018-2020 Global Fund allocation.

PEPFAR Burundi is committed to program quality across the clinical cascade through regularly monitoring the performance of partner achievements towards targets. PEPFAR Burundi has institutionalized a quarterly meeting with its implementing partners (IPs) and will move to a monthly meeting in FY18. The goal of these meetings is to follow up the implementation of different projects by the IPs, to identify timely corrective actions/strategies for addressing any gaps, and to improve progress towards performance indicators. The purposes of this meeting are to analyze the IP results, adopt strategies to address challenges identified during the previous quarter; improve underperforming indicators; and to follow up the previous recommendations.

During FY18, PEPFAR Burundi will continue to organize the monthly IP meeting and will invite key stakeholders to debate challenges to be addressed especially the AIDS National Program (PNLS) and National Laboratory (INSP) for HTC yield, sample transportation for EID and VL test, maintenance of lab equipment, as well as registers and data collection tools (both registers and software). PEPFAR Burundi will also engage CSOs during the implementation of index patient strategy, outreach to KPs, and to improve pediatric case finding and treatment coverage.

The PEPFAR Burundi team developed a monthly partner management tool which will be further refined during COP17. With that tool, indicators are categorized in 3 types: Indicators with high performance (green when achievement rate is over 90%), those with moderate performance (yellow between 60-89%) and those with low performance (in red under 60%). Graphs are automatically calculated, and IPs can review the data and write strategies to be adopted to address the underperforming indicators. In addition, PEPFAR Burundi will use established tools including SIMS and MER, and develop new ones to track progress against indicators and the above site annual benchmarks outlined in Table 6.

Human resources capacity building across the health system is a cross-cutting area for PEPFAR Burundi. In COP17, implementing partners will provide site-level TA to healthcare providers and to lay cadres (including peer navigators) to build their capacity to implement the new ARV guidelines. PEPFAR will also provide above-site level TA to MOH, as well as district health staff and lab managers, for example on SI activities including DHIS2 implementation.

In COP 2017, the PEPFAR program will work to improve efficiencies of service delivery through differentiated models of care. Currently, patients can only access treatment services at the facility, despite this, the 12-month ART retention rate in PEPFAR-supported provinces is 87%. In order to create efficiencies, activities under EQUIP will assist IPs on the roll-out of facility and community ART distribution models to improve patient outcomes. These models include multi-month prescribing of ARVs in line with the new national guidelines, community-based ART distribution groups, and community adherence groups to increase retention on treatment. One activity will identify optimal models of care and complete cost outcomes. Central to this activity will be multi-month scripting (2, 3 or 6 months depending on category) and advocacy for the use of community-based drug distribution for stable patients. Value chain analyses will also be performed to assess cost savings due to these new models of care. The decongestion of facilities will provide further efficiencies in VL monitoring.

PEPFAR Burundi recognizes the critical importance of strengthening the diagnostic laboratory network to provide timely, quality results. In COP17, PEPFAR will provide TA at site and above-site levels to strengthen all components of the laboratory cascade, from client demand generation, to education of healthcare providers, to sample transport, results return, and client case management.

5.0 Program Activities in Sustained and Attained Support Locations and Populations

Having completed a significant geographic pivot in FY16, PEPFAR Burundi will not have any sustained or attained support locations in FY18.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

In order to reach the ambitious ART coverage goals of 117% in PEPFAR supported provinces by end of FY18, it is estimated that 7,613 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 39% of proposed FY17 budget resources, will be devoted to target-based activities, 21% of the budget will be used for activities that play a key role in addressing bottlenecks and programmatic gaps that hamper efforts to achieve treatment saturation.

In COP16, the top three key programmatic gaps identified in the clinical cascade were low adult ARV coverage, low pediatric ARV coverage and low number of key populations identified and linked to services. SI activities are seen as cross-cutting in order to improve the quality of available data and promote a culture of evidence-based decision making. In the development of COP17 the PEPFAR team revalidated these systems barriers, and revisited the activities developed in COP16 to assess areas of significant and limited progress. Feasibility of the benchmarks set for activities was also assessed, and the need for additional activities was also assessed.

Activities that will be continued from COP16 for Adult ART coverage (6.1.1) include improvements to the HTC strategy; increasing SI capacity to collect and use data; and strengthening viral load monitoring. For Pediatric ART coverage (6.1.2), approaches to case finding including index testing and accurate data collection; capacity building of providers; EID sample transport and lab HR capacity building will be continued in COP17.

Below is a summary of any modifications made to Table 6.1 during the revalidation exercise:

Achieved Activities

The following activities were achieved in COP17 due to the successful adoption of the new national ARV guidelines, including Test and Start, by the GOB:

1. 6.1.1, 3.1 *Support the MoH to review and adapt the new WHO guidelines including community involvement in linkage, adherence, and retention*
2. 6.1.1, 3.2 *Support the MoH to elaborate an implementation plan for Test and Start*
3. 6.1.1, 3.4 *Support dissemination and training on new guidelines to service providers*

Modified Activities

The National AIDS Program does not have an adequate quality management (QM)/quality improvement (QI) system with dedicated leadership and a current QM/QI plan for care and

treatment. In COP17, the team modified a site level activity (budgeted at the site level in FY17) to an above site level activity (Activity 6.1.1, #3). The goal to overcome this barrier is that by FY18, a functional QM/QI committee will exist which regularly convenes and routinely reviews performance data and system- and patient-level outcomes, helping facilities identify and address areas for improvement.

New Activities

For key populations, stigmatization of KP has increased during the crisis, yet the GOB has included strategies to address HIV in KPs in the new guidelines. In COP16, the PEPFAR program supported the MOH in the development of these guidelines. To further address the key systems barrier of KP stigmatization in COP17, the PEPFAR program will facilitate the formation of a Key Population TWG at the national level to provide guidance and advocacy on KP-friendly policies.

Transitioned Activities

In early FY17, the Global Fund secured a maintenance contract to cover lab equipment, completing 6.1.2, Activity 3, *Contract for equipment maintenance*. PEPFAR will continue to work with the GF and other donors to ensure that new platforms entering Burundi have maintenance included through bundling or a reagent rental agreement.

Given the scale up of the KP program, the following activities were moved to the site level in FY18:

1. 6.1.3, Activity 1, *Provide training to healthcare providers to decrease stigmatization in healthcare settings and provide KP-friendly services*
2. 6.1.3, Activity 2, *Support the MOH to develop guidelines addressing stigma with regards to KP*
3. 6.1.3, Activity 1, *Mobilize community and peer networks to sensitize KPs to available KP-friendly services*
4. 6.1.3, Activity 2, *Deploy SMS and other media to relay health information to KPs*
5. In COP17, *Technical assistance for lab strengthening* was moved from Table 6.3 and will be continued under new VL scale-up and EID services represented in table 6.1.

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, the recent increase in loss to follow up will also need to be addressed in order to facilitate widespread adoption and uptake.

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: Laboratory, Strategic Information, Systems Development, and HRH - Systems/Institutional Investments.

In COP17, PEPFAR will continue to provide TA to the GoB and the Ministry of Defense to implement the national laboratory strategy at facilities. PEPFAR will also continue SI-related activities to strengthen data collection in military facilities, and to understand HIV prevalence in the military for improved target-setting. Supply chain management will be supported through the roll-out of the logistics management system, and through the implementation of the National Supply Chain Master Plan. Activities that will be modified or transitioned are described below.

Modified

A new activity under *HRH - Systems/Institutional Investments* was added, as the team identified that there are insufficient qualified human resources to provide HIV services in military settings. The goal of this activity is to increase the number of trained nurses in HIV at military health centers in order to increase the sustainability of the national response.

Transitioned

Funding for the following SI activity 6.3, *Contribute to the establishment of an ARV drug resistance surveillance system*, will be discontinued in COP17 as the initial funding was provided in COP16.

Funding for the following SI activity, 6.3 *Improve the tools used for collection of data, and implement an annual ANC Sentinel Surveillance*, will be discontinued in COP17 as support will be transitioned to the GFATM and GOB. PEPFAR Burundi will provide TA for this activity as needed.

7.0 Staffing Plan

The existing staffing pattern of PEPFAR Burundi is sufficient to achieve program goals if fully staffed. With the recruitment of both a Health Team Leader and PMTCT/MCH Advisor, currently underway, 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. There is a need for a third party contractor to meet all SIMS Action Planner requirements. Funding for a third party contractor was approved in COP16 and recruitment is underway.

No additional posts will be proposed this fiscal year, and therefore PEPFAR Burundi's CODB for FY18 will remain consistent with the FY17 staffing composition.

APPENDIX A

Table A.1 SNU Prioritization

SNU	COP15 Prioritization	APR16 Achievement	COP16 Prioritization	Expected Achievement by APR17	COP17 Prioritization	COP17 Target (APR18)
Bujumbura Mairie	ScaleUp: Saturation	190%	ScaleUp: Saturation	215%	ScaleUp: Saturation	224%
Bujumbura Rural	ScaleUp: Aggressive	18%	ScaleUp: Aggressive	26%	ScaleUp: Aggressive	35%
Ngozi	ScaleUp: Aggressive	33%	ScaleUp: Aggressive	54%	ScaleUp: Aggressive	60%
Kayanza	ScaleUp: Aggressive	36%	ScaleUp: Aggressive	60%	ScaleUp: Aggressive	65%
Kirundo	ScaleUp: Aggressive	81%	ScaleUp: Aggressive	145%	ScaleUp: Saturation	167%

Table A.2 ART Targets by Prioritization for Epidemic Control

Prioritization Area	Total PLHIV	Expected current on ART (APR FY 17)	Additional patients required for 80% ART coverage	Target current on ART (APR FY18) <i>TX_CURR</i>	Newly initiated (APR FY 18) <i>TX_NEW</i>	ART Coverage (APR 18)
Scale-Up Saturation	14,630	28,249	0	30,138	4,976	206%
Scale-Up Aggressive	23,100	10,993	7,487	12,346	2,637	53%
Total	37,730	39,242	7,487	42,484	7,613	117%

APPENDIX B

Table B.1.1 Planned Spending in FY 2018

Table B.1.1 Total Funding Level		
Applied Pipeline	New Funding	Total Spend
US \$6,260,537	US \$11,099,463	US \$17,360,000

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
CIRC	Male Circumcision	\$0
HBHC	Adult Care and Support	\$379,357
HKID	Orphans and Vulnerable Children	\$1,314,720
HLAB	Lab	\$401,800
HTXS	Adult Treatment	\$4,717,148
HTXD	ARV Drugs	\$0
HVCT	Counseling and Testing	\$2,717,179
HVMS	Management & Operations	\$1,703,415
HVOP	Other Sexual Prevention	\$1,184,849
HVSI	Strategic Information	\$900,000
HVTB	TB/HIV Care	\$289,779
IDUP	Injecting and Non-Injecting Drug Use	\$0
MTCT	Mother to Child Transmission	\$1,506,244
OHSS	Health Systems Strengthening	\$1,368,119
PDCS	Pediatric Care and Support	\$482,410
PDTX	Pediatric Treatment	\$394,979
HMBL	Blood Safety	\$0
HMIN	Injection Safety	\$0
HVAB	Abstinence/Be Faithful	\$0
TOTAL		\$17,360,000

B.2 Resource Projections

While the resource envelope remained constant from FY17, targets set, especially for treatment, are more ambitious this COP. This year's HTXS budget was increased to \$4,717,148 to reflect the programmatic shift toward achieving epidemic control in PEPFAR-supported provinces through Test and Start implementation. The majority of this difference came from shifts in target-based budgeting.

Thirty-eight percent of the proposed FY17 budget was determined through target-based budgeting using the PBAC tool. Resource projections were made for each implementing mechanism by reviewing Expenditure Analysis 16 Unit Expenditures (UEs) and applying final agreed-upon unit budgets (UB) for all agencies for a target-based approach.

Expenditures analysis (EA) data and the UEs in the data navigation tool formed the starting point for the target-based budgeting approach and a separate allocation tool (TBATT) was used for the target-based budget for each mechanism operating in Burundi. The team jointly reviewed the UEs that were reported for each mechanism from FY2016 EA, reviewed each cost category, and made adjustments based on the package of services planned for COP17. Some fixed costs were held constant, while other cost categories that are directly related to the number of beneficiaries were left to multiply by the COP17 targets. Those adjusted costs were divided by nominal targets set for each respective program area in COP17, which then resulted in the applied UBs that were entered into an IM allocation tool for calculation and then ultimately the PBAC. The cost categories for commodities, Program Management (PM), and Strategic Information (SI) were excluded from the UB's and budgeted separately in the PBAC.

Due to data completeness and the general continuation of programming, all implementing mechanisms relied on the COP16 unit expenditures as the basis for the target-based budget and adjusted accordingly based on expected resource needs for COP17. The PMTCT-AP mechanism reduced costs for in-service training and personnel for all program areas due to a reduction in activities before closing out. The following describes the cost category adjustments made to each of Burundi's COP17 applied UBs:

- Adult ART – There were slight increases in in-service training, personnel and travel costs to account for inflation and rising fuel costs.
- Pediatric ART - The same cost is anticipated for Pediatric ART as for Adult ART.
- Pregnant women tested and receiving results – The USAID mechanisms used the COP17 UB for budgeting while DoD used the UB's as reported by the implementing partner for EA16 (FY16 expenditures and results). Travel costs increased due to the rising fuel prices in Burundi.
- Women receiving ARV prophylaxis – The team used the Adult ART UB as due to no considerable variation in the package of services. The PMTCT/DoD Mechanism budgeted extra for in-service training, personnel, and travel.
- PMTCT Infants on Care: The COP16 national UB was used for all implementing mechanisms.
- PMTCT EID - The COP16 national UB was used for all implementing mechanisms.
- VCT clients – The COP16 national UB was used for all implementing mechanisms.
- PITC clients – The COP16 national UB was used for all implementing mechanisms.
- CBTC clients –The COP16 national UB was used for the LINKAGES mechanism while DoD used their unit expenditure from EA16 as their applied unit budget for COP17.
- OVC - As OVC programming is new in Burundi, the COP17 applied UB was calculated based on the planned budget and expected number of beneficiaries.

- PP-PREV –The EA16 unit expenditure was applied as the unit budget, with a slight increase in personnel as it was not reported to EA16 but should still be budgeted.
- Female sex workers reached – The LINKAGES UE as reported to EA16 was used as the basis for budgeting. Adjustments were made as the program begins to mature to decrease program management, increase travel, in-service training, and personnel.
- MSM reached - The KP-FSW UB was applied for KP-MSM/TG as the best estimate of costs. FSWs and MSMs will both be targeted under the same program, with similar packages of services.

The remaining budget consists of the activity-based budget (21%), PM and SI (19%), commodities (11%) and M&O (10%). 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.

APPENDIX C

Section 6.o Tables: Program Support Necessary to Achieve Sustained Epidemic Control

Table 6.1.1 Key Programmatic Gap #1: Low Adult ART coverage									
Key Systems Barrier	Outcomes expected after 3 years of investment	Year One (COP/ROP16) Annual Benchmark	Year Two (COP/ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score (if applicable)
1. Sub-optimal HTC strategy	The national HIV/AIDS program has the adequate capacity to collect and analyze data on testing yields to identify the highest yield entry points.	Testing yields at all sites are greater or equal to prevalence	Testing yields at all sites are greater or equal to prevalence	HTC_TST; HTC_TST_POS; Site yield analysis	Activity 1.1: Strengthening the national HIV/AIDS program capacity, to collect and analyze and disseminate data on testing yields to identify the highest yield entry points. Organize training, Integrate HIV indicators in DHIS2. Contribute to the	HVSI	\$ 150,000.00	MEASURE	15. Performance Data

					multiplication of registers (copies).				
	Improve targeted testing to identify 90 % of PLHIV in PEPFAR-supported provinces	85% of PLHIV are identified in PEPFAR-supported provinces	90 % of PLHIV in PEPFAR-supported provinces	HTC_TS T; HTC_TS T_POS; Proportion of PLHIV identified relative to subnational estimates	Activity 1.2: Review and revise HTC/TX/ANC/VL/STOCK registers in fields and in SIDAInfo to reflect entry points for priority testing locations and to record index patient testing. Integrate SIDAINFO to DHIS2	HV SI	\$ 125,000.00	MEASURE	15. Performance Data
2. Lack of SI capacity at the National HIV program to monitor trends in the epidemic	Built capacity of national, provincial and district SI staff to produce annual	An annual national-level Epi. report is produced (40 days after	Production of quarterly national-level report (40 days after year)	A quarterly report is available (40 days after each quarter)	Activity 2.1: Train and provide TA to national, provincial, and district SI staff on collection, analysis, and interpretation	HV SI	\$ 200,000.00	MEASURE	15. Performance Data

	national-level Epidemiological Report	year)			of program data.				
	National program making decisions based on Epi report	National program making decisions based on annual Epi report submitted 40 days after year end	National program making decisions based on quarterly Epi report	Epidemiological report.	Activity 2.2: Support integration of HIV data into national electronic data collection system from the site to the national level	HV SI	\$ 125,000.00	MEASURE	15. Performance Data
3. Higher Loss to Follow up for pre-ART patients than for those on treatment	National adoption of Test and Start	Completed—T&S has been adopted & implementation has started.	-	-	Activity 3.1: Support the MoH to review and adapt the new WHO guidelines, including community involvement in linkage, adherence, and retention.	OH SS	TA only	N/A	2. Policies and Governance

	National adoption of Test and Start	Completed—T&S has been adopted ; implementation has started.	-	-	Activity 3.2: Support the MoH to elaborate an implementation plan for Test and Start.	OH SS	TA only	N/A	2. Policies and Governance
	Percentage of adult patients in care but not on ART reduced to 10% or less	Completed—T&S has been adopted ; implementation has started.	-	-	Activity 3.4: Support dissemination and training on new guidelines to service providers.	OH SS	TA only	N/A	2. Policies and Governance

<p>3. The National AIDS Program does not have an adequate quality management (QM)/quality improvement (QI) system with dedicated leadership and a current QM/QI plan for care and treatment</p>	<p>A QA/QI system for care and treatment is in place at national program level with a dedicated leadership and current QM/QI plan</p>	<p>A current QA/QI plan is developed</p>	<p>A functional QM/QI committee/team exist which regularly convenes (quarterly) and routinely reviews performance data and system- and patient-level outcomes, helping local facilities identify and address areas for improvement</p>	<p>Documentation of systematic monitoring of completed/ongoing QI projects with results across all health facilities</p>	<p>Activity 1: Support the national AIDS Program to develop an adequate and functional QM/QI system for care and treatment services</p>	<p>HT XS</p>	<p>\$ 50,000.00</p>	<p>ASSIST</p>	<p>15. Performance Data</p>
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4. Low capacity for viral load monitoring.	90% of PLHIV on ART receive viral load test.	50% of PLHIV on ART receive viral load test.	70% of PLHIV on ART receive viral load test.	TX_PVLS	<p>Activity 1: Assure the completion and implementation of the national Viral Load strategy.</p> <p>Activity 2: Coordinate with Global Fund, GOB, and national counterparts to map the capacity of the viral load network and to inform decision making on procurement of viral load platforms and reagents.</p>	HL AB	\$ 250,000.00	GHSC- PSM	10. Laboratory
	VL testing turnaround time is reduced to less than 2 weeks	VL turnaround time is reduced to less than 4 weeks	VL turnaround time is reduced to less than 3 weeks	Register tool in clinic; tracking tool in lab	<p>Activity 1: Develop clinic and lab quality improvement approaches to support scale up, including: network optimization, specimen transport,</p>	HL AB		GHSC- PSM	10. Laboratory

					facility level data management and centralized viral load data collection and management.					
TOTAL							\$	900,000.00		

Table 6.1.2 Key Programmatic Gap #2: Low Pediatric ART coverage

Key Systems Barrier	Outcomes expected after 3 years of investment	Year One (COP/ROP16) Annual Benchmark	Year Two (COP/ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score (if applicable)
1. Low rate of pediatric case identification and linkages to treatment	Children living with HIV are identified by index patient testing and through high yield entry points	50% of all children of PLHIV are tested	90% of all children of PLHIV are tested	HTC_TS T <15: register and SIDAInfo data	Activity 1: Linked with Adult Treatment effort to create fields in registers and SIDAInfo to document entry points and to document testing of children of	PD CS	\$ 150,000.00	IHP, PMTCT AP, Military PMTCT	15. Performance Data

					PLHIV				
2. EID-lack of adequate and consistent capacity to perform timely DNA PCR testing	95 % of HIV exposed infants in PEPFAR-supported facilities are tested for HIV by 2 months of age	62 % of HIV exposed infants in PEPFAR-supported facilities are tested for HIV by 2 months of age	80 % of HIV exposed infants in PEPFAR-supported facilities are tested for HIV by 2 months of age	PMTCT_EID disaggregated by <2 mo	Activity 1: Training and accompaniment of medical providers.	MT CT	Included at Site Level	IHP, PMTCT AP, Military PMTCT	15. Performance Data
	EID test turnaround time (TAT) is reduced to < 2 weeks	EID test TAT is reduced to < 4 weeks	EID test TAT is reduced to < 3 weeks	Register tool in clinic; tracking tool in lab	Activity 1: Reinforcement of sample transport and result pick-up procedures Activity 2: Training of lab staff to increase lab efficiencies (e.g. run samples when received rather than when machine is	HL AB	Included at Site Level	PSM, EQUIP	10. Laboratory

					full)				
	3. Maintenance contracts secured to ensure that machines are repaired promptly by FY17	-	-	-	Activity 3: Contract for equipment maintenance	HL AB	Included at Site Level	PSM	40. Laboratory
TOTAL							\$ 150,000.00		

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	Year One (COP/ROP16) Annual Benchmark	Year Two (COP/ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score (if applicable)
1. Inadequate / weak political advocacy and policies for GBV Prevention and Key populations	Key Population TWG is formed at national level to provide guidance	The KP TWG is formed; the KP TWG meets on quarterly	The strategic guidance/propositions for KP access to services are	Meeting reports; Number of partners participating in the KP TWG	Activity 1: Establish relevant sub-working groups ; Activity 2: Develop KP SBCC tools;	N/A	TA Only	LINKAGES	1. Policies and Governance

	and advocacy on policies supporting KPs	y basis	decided/proposed in the KP TWG meetings	meetings	Activity 3: Conduct Advocacy activities for enabling environment for KPs				
	GBV TWG strengthened and supported to provide guidance and advocacy on policies preventing GBV	New activity for COP17 . The national strategy on GBV is updated and the 2017-2021 implementation plan developed	The implementation of the 2017-2021 plan is evaluated and monitored ; a Gender data base including GBV data is developed	The updated national strategy and implementation plan validated	Activity 1: Technical meeting to identify key indicators; Activity 2: Meeting to analyze the quality of the data base to insure data from other key ministries, especially Ministry of Health and Ministry of Justice, are integrated in the data base	N/A	TA Only	EngenderHealth	Policies and Governance
Stigmatization of KP leads to unwillingness to self-identify which makes them difficult to track in PEPFAR programs	1. Disaggregated data on testing yields among key populations is	-	-	-	Activity 1: Provide training to healthcare providers to decrease stigmatization in healthcare	HB HC	Included at Site Level	LINKA GES	6. Service Delivery

	available and used to further enhance targeting by FY 17				settings and provide KP-friendly services.				
	2. Targeted prevention services are reaching KP via peer networks in all PEPFAR supported SNUs and other identified hotspots: FY 17:75%, FY 18:80%, FY 19:90%	-	-	-	Activity 2: Support the MOH to develop guidelines addressing stigma with regards to KP	OH SS	Included at Site Level	LINKA GES	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 FY 18:80%, by FY 19:90%)	-	-	-	Activity 1: Mobilize community and peer networks to sensitize KPs to available KP-friendly services	HB HC HV CT HT XS HV OP	Included at Site Level	LINKA GES	6. Service Delivery

	2. 90% of identified KPs testing positive for HIV are on ART (by FY17:80%, by FY18:90%)	-	-	-	Activity 2: Deploy SMS and other media to relay health information to KPs.	OH SS	Included at Site Level	LINKAGES	6. Service Delivery
TOTAL							\$ -		

Table 6.2.1: Test and Start									
Key Systems Barrier	Outcomes expected after 3 years of investment	Year One (COP/ROP16) Annual Benchmark	Year Two (COP/ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score (if applicable)
Concerns about resource constraints including ARVs, commodities and human resources for Test and Start	Data is available for continuous planning and budgeting of resources for Test and Start policy	All data is available to forecast the number of new patients to start ART, according	All data is available to forecast the number of new patients to start ART, according to new policy, for use in	SCH data collection system	Activity 1: Support the national HIV/AIDS program to adjust forecast for drugs and commodities in line with new guidelines	OH SS	\$ 250,000.00	GHSC-PSM	2. Policies and Governance

		ng to new policy, for use in national annual quantification exercise.	national annual quantification exercise.						
	National task-shifting policy is implemented in 100% of PEPFAR supported facilities	90% of PEPFAR supported facilities implement task-shifting	100% of PEPFAR supported facilities implement task-shifting	PNLS training data	Activity 1.2: 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								\$ 250,000.00	

Table 6.2.2: New and efficient service delivery models									
Key Systems Barrier	Outcomes expected after 3 years of investment	Year One (COP/ROP16) Annual Benchmark	Year Two (COP/ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score (if applicable)

1. Lack of MOH/PNLS capacity to design and implement new service delivery models to support the full implementation of Test and Start strategy.	Community ARV dispensation model (CAG) is implemented	Sites are identified for community ARV dispensation model and policy is finalized	Community ARV dispensation model is implemented in 80% of identified sites	Program data	Activity 1.1 Community ARV dispensation model (CAG) is implemented	OH SS	\$ 400,000.00	EQUIP	6. Service Delivery	
	Multimonth prescribing (MMP) policy is developed to decongest clinics and to increase retention on ART.	MMP policy is finalized; sites are identified for implementation; healthcare providers are trained on MMP.	MMP is implemented in 80% of identified sites.	Program data	Activity 1.2. Strategies and technologies developed for effective linkage to and retention on ART					
TOTAL								\$ 400,000.00		

Table 6.3 Other Proposed Systems Investments

Activity	For each activity, indicate which of the following the activity addresses : 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control. (Teams may select more than one.)	Outcomes expected after 3 years of investment	Year One (COP/RO P16) Annual Benchmark	Year Two (COP/RO P17) Annual Benchmark	Relevant Indicator or Measurement Tool	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Laboratory									
Support the Government of Burundi in the roll-out of the national laboratory strategy.	Second and Third 90	National laboratory strategy is implemented at district and facility levels.	None	Quality assessment of key lab completed and priorities for improvement set; locus of leadership within the GoB established	None	N/A	TA Only	PSM	10. Laboratory

				ed and functioning					
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	None	Two sites with functional equipment and SOPs in place.	None	N/A	TA Only	PSI Burundi	10. Laboratory
Technical Assistance for Lab Strengthening	-	-	-	-	-	HL AB		PSM	10. Laboratory
Strategic Information									
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.	-	-	-	HV SI		MEASURE	15. Performance Data

Lack of current and reliable HIV prevalence data among military	First 90; Sustained Epidemic Control	Reliable survey based HIV prevalence data among military are available	Survey completed with MOD and MoH and results available at the national and sub-national levels by FY 17	Complete dissemination and publishing of survey results	Number of dissemination meetings; Number of publication	HV SI	\$ 150,000.00	Metabio ta	15. Performance Data
Contribute to the establishment of ARV Drug Resistance Surveillance System	First 90; Second 90 and Third 90.	A Drug Resistance Surveillance System is in place and functional	A Drug Resistance Surveillance System is in place and functional	The scope of work is available included the protocol with steering committee	Establishment of ARV drug resistance surveillance system	N/A	TA Only	MEASURE	15. Performance Data
Poor record keeping in military settings and access to data systems	Sustained Epidemic Control	EMR with quality data available	A military electronic health information network is in place and functional	Complete planning	Implement health information network	HV SI	\$ 150,000.00	DoD Department of Defense Naval Health Research Center	15. Performance Data
Systems Development									
Low capacity of the MOH to roll-out of the national logistic management information systems (LMIS).	Sustained Epidemic Control	100% health districts roll-out and implement	50% of health districts roll-out and implement LMIS.	100% of health districts roll-out and implement LMIS.	LMIS tools and SOPs;	OH SS	\$ 150,000.00	GHSC-PSM	8. Commodity Security and Supply Chain

		L MIS							
Low capacity of the MOH in strategy planning and coordination for supply chain related activities.	Sustained Epidemic Control	The National Supply Chain Master Plan is available and coordination meetings are organized.	70% of HIV commodities are distributed according to the National Supply Chain Master Plan; and 100% of coordination meetings are supported.	100% of HIV commodities are distributed according to the National Supply Chain Master Plan; and 100% of coordination meetings are supported.	Supply Chain Master Plan; Number of coordination meetings;	OH SS	\$ 250,000.00	GHSC- PSM	8. Commodity Security and Supply Chain
HRH - Systems/Institutional Investments									
Insufficient qualified human resources to provide HIV services in military settings	Sustained Epidemic Control	100% military health centers have at least 3 personnel trained on HIV services deliver	New activity for COP17	31 student nurses at military school to be trained on HIV/AIDS service delivery	Number of student nurses trained	OH SS	\$ 70,000.00	Military Prevention Activity	6. Service Delivery

TOTAL								\$		
								770,000.00		

All Tables Total								\$		
								2,470,000.0		
								0		