PEPFAR Burundi

Country Operational Plan

(COP) 2018

Strategic Direction Summary

March 22, 2018

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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
DHIS2	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
FAST	Funding Allocation Strategic Tool
FSW	Female Sex Workers
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 Behavioral 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 Program 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

The PEPFAR/Burundi vision for the Country Operational Plan 2018 (FY19) is accelerated case-finding for key and hard-to-reach populations, mainly adolescents and men, and to rapidly increase national antiretroviral therapy (ART) coverage, retention, and viral load suppression by applying population and age specific solutions to accelerate progress towards reaching the 95-95-95 goals in PEPFAR-supported SNUs. 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). The PEPFAR program will continue to work with the Government of Burundi (GOB), the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), and other stakeholders to leverage above-site investments (lab, supply chain, HRH, information systems) and site-level support to ensure successful scale up of ART coverage at a national level.

In FY19, PEPFAR/Burundi will utilize the latest DHS (2016) and SPECTRUM (2016) data to adjust the geographic prioritization developed in COP16 and COP17 in order to reach HIV epidemic control in PEPFAR-supported areas by the end of FY19. Geographic adjustments include combining Bujumbura Mairie and Bujumbura Rural into one sub-national unit (SNU) - Bujumbura, with a reduction in the number of PEPFAR-supported sites (from 33 to 9) in Bujumbura Rural; the addition of 11 sites, as well as community level (key population targeted) interventions, in the province of Gitega; and continued support for passive testing and sustained treatment, in addition to active key population (key populations), priority population (adolescents and men) and pediatric case-findings in all PEPFAR-supported sites. PEPFAR/Burundi will continue to review available national and program data to refine the epidemiological profile and adapt geographic strategies aligning interventions to high-burden and low coverage areas. PEPFAR/Burundi will provide targeted technical assistance (TA) and support implementing partners (IPs) to increase case-finding and accelerate coverage in all high-yield sites. The GOB, with principal support from the GFATM, will continue to implement services for people living with HIV (PLHIV) at all non-PEPFAR-supported sites. PEPFAR/Burundi will continue to work in close collaboration with the PNLS to ensure that best practices and lessons learned in the PEPFAR program are shared and scaled-up nationally.

To support achievement of the first 95, the PEPFAR/Burundi program plans to optimize testing strategies that increase case-finding, maximize yield, and improve same-day linkage-to-treatment rates. PEPFAR/Burundi will support the PNLS to scale-up case-finding aggressively for key and hard-to-reach priority populations, and to introduce customized, targeted, and proven interventions that are age, sex, and population specific. The program will phase-out low-yield sites, minimize general population testing and inappropriate re-testing, and increase case-finding using strategies that will be tailored to reach, test, and link to treatment positive 15-19 year old women, adult men, key populations and their sexual networks, and young children (<15 year olds) by focusing on index testing and partner notification, key populations testing, and screening and testing of high risk children. The program will also continue to scale-up HIV self-testing (HIVST) for key populations: Negative clients will be referred for appropriate prevention services. The PEPFAR/Burundi program will complete a mapping exercise to identify high burden SNUs with low pediatric testing and treatment coverage and realign programming to reach children and their families. Pediatric case-finding will be further strengthened through the implementation of

a pediatric screening tool, optimization of the OVC program to reach adolescent girls and boys, and reaching children of female sex workers (FSW).

To support achievement of the second 95, PEPFAR/Burundi will continue improving access to ART with support of full scale implementation of Test-and-Start, scaling up same-day ART initiation and strengthening differentiated models of care (DMOC). A 95 percent linkage-to-treatment rate will be reached by addressing the factors that have been shown to negatively affect linkage and retention to treatment, and adopting population and age-specific strategies that will optimize linkage and treatment retention: interventions will include: deploying well trained linkage-to-care health mediators for both intra- and inter-facility referrals to ensure complete linkage via direct client escort and mobile tracking respectively; mentor mothering for women; men-friendly services at times convenient for men; and offering children and adolescents non biomedical, socio-economic OVC interventions. Furthermore, the PEPFAR/Burundi program will maintain and even increase early (12-month) retention rate to $\geq$ 89 percent, and increase the longer term ($\geq$24-month) retention rate working in close collaboration with the national network of people living with HIV (RBP+), and strategic integration of community-based ART distribution groups - which were initiated in 2017-2018 in 27 select sites - to track and re-engage clients who miss appointments using a problem solving approach and referral to additional supportive services as needed, combined with intensified adherence counselling. Multi-month prescribing and dispensing, and/or community dispensing of ARVs for stable clients will be scaled-up to further support ART adherence and to optimize retention. The program will ensure routine site specific data analysis to identify, track and proactively link to treatment positive clients not yet linked or those who default treatment. In addition to further ensure data quality, PEPFAR/Burundi will also ensure practices are in place to appropriately capture information on clients who transfer from one site (transfer out) to another (transfer in). This will help address the issue of double counting when they test (verification in the case of known positives) or are re-enrolled onto treatment (for those who have already initiated ART) and ensure accurate reporting, as IPs have repeatedly reported this as an issue during supportive supervision.

To maintain progress towards achieving the third 95, PEPFAR/Burundi will increase access to viral load testing through continued support to lab strengthening and patient access to routine viral load monitoring. PEPFAR/Burundi will coordinate with the GFATM to plan for rapid expansion of VL across Burundi, to increase testing coverage and virologic suppression not just in PEPFAR sites but nationally, by FY19. The laboratory mapping exercise performed as part of COP18 planning will be used in a lab network optimization exercise among all stakeholders, to inform placement of viral load platforms, and to optimize the sample referral network. The viral load supply chain will be strengthened through enhanced coordination of all stakeholders at the national level (PNLS, INSP, CAMEBU, DPML, UNDP, ANSS/OPP-ERA) to support VL reagents monitoring and delivering to end users, sample collection and transportation to labs, and timely results returned to beneficiaries. PEPFAR will work closely with the MSPLS and the GFATM as part of the National Laboratory Strategy Committee to update the 2014-2017 national laboratory strategic plans under the leadership of the PNLS.

In COP18, further refinement of evidence-based key populations interventions targeting female sex workers (FSW), men who have sex with men (MSM), and transgender individuals (TG) will occur by enhancing community based organizations (CBOs) targeted outreach strategies. Activities will be directed to high risk key populations (via social and sexual networks) for testing and linkage-to-treatment, scale-up of HIV self and index testing (including a focus on

children of key populations), and ensuring a safe and enabling environment for key populations. The expansion into Gitega province will select high-yield sites near key populations hotspots along major transport routes. Further expansion into other geographic areas will be based on triangulation of DHS, Spectrum, and key populations hot-spot size estimate mapping, to determine sites for greatest impact.

Continued emphasis on reaching adolescents (girls/boys), young women (AGYW) and OVC through site strategy refinement will be implemented, adapting lessons learned from Kayanza and Gatara communes in Kayanza province in intensive case management, mentorship for girls, and HIV prevention and life skills to apply across sites and populations. In FY19, PEPFAR/Burundi programs will continue to work towards increasing known status of AGYW/OVC and linking to ART and providing support services for families to improve health status and food security and decrease GBV and child abuse and neglect. In FY 19, PEPFAR/Burundi will continue to work with the Burundi National Defense Force (BNDF) in the military HIV Prevention, Care and Treatment program and increase the BDNF's capacity to deliver comprehensive and quality HIV treatment and prevention in a sustainable and cost effective way.

The GFATM will continue to support procurement of antiretrovirals (ARVs) for all eligible PLHIV in FY19. PEPFAR/Burundi will complement this support by procuring ARVs for pregnant and breastfeeding women, rapid test kits (RTKs), HIV self-test (HIVST) kits, commodities for VL and early infant diagnosis (EID), and drugs for the management of opportunistic infections (OIs). In addition, PEPFAR/Burundi will increase emphasis on collaboration with the GOB and GFATM on commodity procurement for the successful transition to tenofovir-lamivudine-dolutegravir (TLD) as the primary first line ARV. PEPFAR/Burundi will also continue to support the PNLS and its quantification committee for the accurate forecasting and quantification of commodities, timely arrival of shipments, stock management, and commodities distribution to peripheral sites.

Ongoing rigorous partner management through monthly one-on-one meetings to analyze program results, including site-level results will be coupled with quarterly plenary meetings to share high-level results, lessons learned, best practices, and strategic/policy discussions. This approach to partner management will allow real-time shifts as evidenced by data. Additional meetings and data analyses will be called as needed to continue addressing gaps/barriers and follow-up on implementation. Quarterly PEPFAR Oversight and Accountability Response Team (POART) reviews, and the Site Improvement through Monitoring System (SIMS) findings will continue to be additional methods used to assess performance and further tailor strategies and approaches to most efficiently deliver expected results. Additionally, PEPFAR/Burundi engages with GOB stakeholders, bilateral, multilateral, and Civil Society Organizations (CSOs) on a quarterly basis to review program strategy, progress, and results. PEPFAR/Burundi conducts focused CSO sessions, including those directly representing PLHIV and key populations, to collect feedback on program successes and challenges, and to ensure that implementation addresses the expressed needs of the networks of PLHIV and key populations.

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 $770 per capita and remains one of the poorest countries in the world, ranked 184 out of 188 countries, on the 2016 UNDP Human Development Index.[1,2] Important gains have been realized in the health sector over the past ten years, but they remain fragile and may be at risk due the ongoing crisis following contested elections in 2015. Burundi is a challenging operating environment for implementation of USG-funded programs due to low local capacity, and security and travel restrictions for USG personnel and IPs. As of March 2018, UNHCR estimates that there are 175,936 internally displaced persons and 428,351 refugees that have fled Burundi for neighboring countries since 2015.[3] 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 (March 2017-December 2018, with continued high caseloads) and chronic malnutrition rates of nearly 50 percent in children. Non-health factors impacting the HIV response include extreme poverty, food insecurity, unemployment, overall security, and high mobility of persons within the country. As one of the most densely populated countries in Africa, Burundi continues to experience population pressures on its limited resources. Poverty serves as a motivating reason for people to seek income from different occupational activities in different parts of the country.

Burundi has a growing population of 11.7 million, total fertility rate of 5.5, life expectancy at birth is 57.1 years[4]; and is considered to have a low-prevalence, mixed HIV epidemic.[5] According to the 2016 DHS, 1 percent (1.2 percent women and 0.8 percent men) were living with HIV, with approximately 2,900 annual deaths attributed to AIDS.[6] According to SPECTRUM 2016 estimates compiled by UNAIDS and the PNLS, 82,363 adults and children are living with HIV. Furthermore, it is estimated that the prevalence of HIV among key populations is significantly higher, with a prevalence of 21.3 percent among female sex workers and 4.8 percent among men having sex with men, with no data available on transgender populations. The prevalence data for key populations is outdated (2013). An integrated bio-behavioral survey (IBBS) was planned in 2017, but was not approved at the national level. Stakeholders in Burundi are optimistic that the IBBS can take place in FY18/19 and that new data will support more accurate prevalence data and size estimation for key populations.

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. Between 2001 and 2014, the national HIV prevalence dropped from 2.9 percent to 1.3 percent. The prevention of mother to child transmission (PMTCT) program has made significant strides at the national level: 84 percent of pregnant HIV-positive women accessed ARVs in 2016, and the estimated mother to

[1] World Bank: Burundi Country Profile. Accessed March 8, 2018. http://databank.worldbank.org/data/views/reports/reportwidget.aspx?Report_Name=CountryProfile&Id=b450fd57&tbar=y&dd=y&inf=n&zm=n&country=BDI
[2] UNDP Human Development Report - Burundi 2016. Accessed March 12, 2018. http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/BDI.pdf
[3] UNHCR Burundi Situation Report. Accessed March 9, 2018. http://www.unhcr.org/59244aa77.pdf
[4] UNDP Human Development Report - Burundi 2016. Accessed March 9, 2018. http://hdr.undp.org/en/countries/profiles/BDI
[5] Institute Statistics And Studies Economic Du Burundi (ISTEEBU), 2017.
[6] UNAIDS Country factsheets: Burundi 2016. Accessed March 7, 2018. http://www.unaids.org/en/regionscountries/countries/burundi

child transmission rate of 2.2 percent at twelve months of age in 2015.[7]

Since 2002, Burundi has revised the National HIV Strategic Plans (NSPs) three times with the objective of defining clear principles that coordinate the interventions of various stakeholders and changing priorities. In COP18, PEPFAR/Burundi in coordination with key stakeholders, will support and advocate for policy changes including updates to the National Testing Strategy to optimize case-finding and prioritize index testing, reducing the overall number of tests performed nationally; ensuring a safe and enabling environment for key populations, especially MSM; accelerating Test & Start scale-up nationally; accelerate task-shifting for pediatric treatment services; and supporting the inclusion of a mature minor close of health services within the National Strategic Plan.

HIV prevalence in the general population:

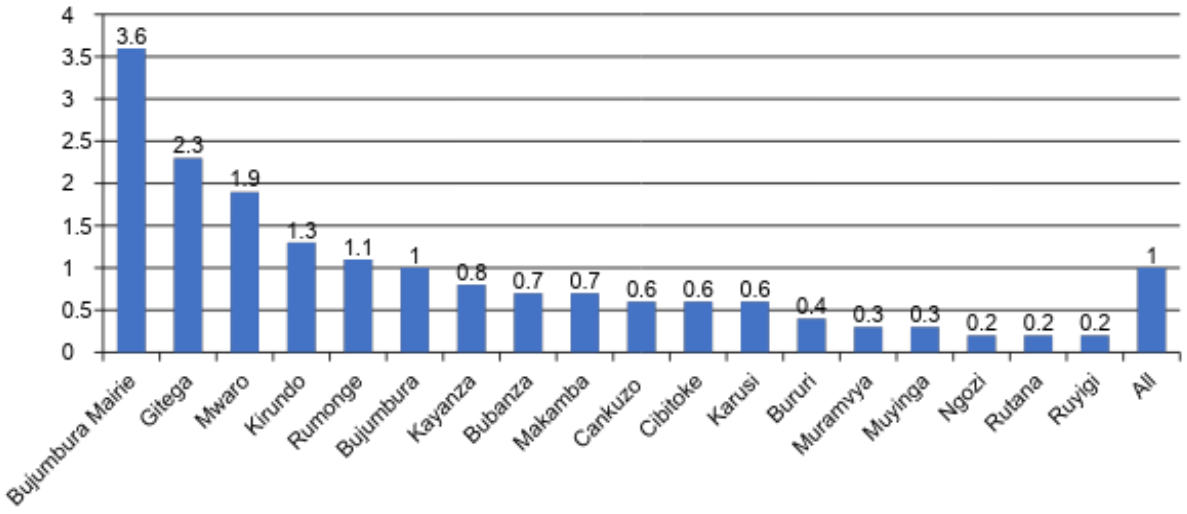
According to the 2016 United Nations Joint Program on HIV/AIDS (UNAIDS) report on Burundi, the HIV prevalence rate among adults age 15-49 years is 1 percent. However, the 2016 DHS notes that the prevalence rate varies according to age group. The most affected age groups are 35-39 year olds and 45-49 year olds among both males and females; each of these age groups has a prevalence rate of 1.9 percent. Comparatively, those between 40 and 44 years have a prevalence of 1.5 percent, and 30-34 year olds a prevalence of 1.4 percent. PEPFAR/Burundi will implement interventions in COP18 that target each age band respectively.

Geographic Distribution of HIV Burden

Geographically, prevalence is unevenly distributed nationally. Urban provinces have an average prevalence of almost five times that of rural provinces: 3.3 percent compared to 0.7 percent. Bujumbura Mairie and Gitega account for the highest prevalence across the country, at 3.6 percent and 2.3 percent, respectively (ref. Fig. 2.1.1). This is reflected in the national burden of PLHIV; SPECTRUM 2016 data estimates that the five COP17 PEPFAR provinces -Bujumbura (composed of Bujumbura Mairie and Rural), Gitega, Ngozi, Kayanza, and Kirundo -account for almost 59 percent of the national burden of PLHIV. Job seeking behavior results movement of people around the country, as they seek income from different occupational activities. The migratory patterns are attributable to agricultural migration, labor migration, or rural-urban migration, and are at times aggravated by the political climate. This migratory pattern across different regions of the country has an effect on both short and longer term retention rates as well as prevalence data. Anecdotal reports suggest that as many as 3,000 HIV clients have been displaced, and could be a major factor contributing the to the lower > 24 months retention rates.

[7] UNAIDS Report for Burundi, GARPR 2015. Accessed March 13, 2018.

Figure 2.1.1 HIV Prevalence and Geographic Burden (Data source: DHS 2016)



Geographic analysis of the DHS 2016 data shows higher prevalence in provinces traversed by major international transport routes and with large key populations hotspots. This suggests a key populations-driven epidemic and the need to target key populations, their social and sexual networks, as well as other vulnerable and hard-to-reach populations, including men with mobile professions, clients of key populations, children of key populations, and vulnerable adolescents and children. PEPFAR/Burundi will instruct IPs to align their programs to respond to the epidemic with targeted and customized interventions to maximize impact within these populations.

HIV prevalence in key and priority populations

The 2013 PLACE Study estimated that there are 51,482 FSW in Burundi with a prevalence rate of 21.3 percent. The study estimated a 3.8 percent prevalence rate among their clients and 5.2 percent for their partners. The same study estimated 9,346 MSM with an HIV prevalence rate of 4.8 percent. Transgender women were not specifically included in the study. The Integrated Biological and Behavioral Surveillance Survey (IBBS) study planned to take place in FY 17 with GFATM has been postponed, based on concerns by the Ministry of Planning. Renewed commitment by the MSPLS, UNAIDS, UNDP, and civil society representatives at the Regional Planning Meeting (RPM) to conduct the IBBS of FSW, MSM and people who inject drugs with GFATM support in COP17-18 will allow for more accurate data on key populations. Continued discussions with the GOB on the approval, planning and implementation of the IBBS will be needed going forward and UNAIDS will lead the facilitation of these discussions.

The National Defense Force is also a priority population due to known high-risk behavior among military personnel. Preliminary results from the SABERS study conducted in 2017 estimated a 1.8 percent HIV prevalence rate among military personnel, almost two times the national prevalence rate. Tables 2.1.1, 2.12 and figure 2.1.2 below summarizes this prevalence data:

Table 2.1.1 Host Country Government Results (Data Source: DHS 2016)															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	11,722,595	100	2,622,792	22	2,517,262	21	1,315,800	11	1,223,744	*10*	1,969,333	17	2,073,664	18	ISTEEBU, 2017
HIV Prevalence (percent)		1						0.3		0.9		1.8		0.8	DHS 206-17
AIDS Deaths (per year/2017)	2,322		297		303		94		100		453		1.075		SPECTRUM 2017/ME/PNLS
# PLHIV	82,363		5,399		5,440		4,391		2,911		34,653		29,569		SPECTRUM 2017/ME/PNLS
Incidence Rate (Yr)		0.33		0.13		0.13		0.7		0.29		0.3		0.34	SPECTRUM 2017/ME/PNLS
New Infections (Yr)	2,108														SPECTRUM 2017/ME/PNLS
Annual births	511,512														SPECTRUM 2017/ME/PNLS
percent of Pregnant Women with at least one ANC visit	442,072	75	252	0.1			193,652	43.8			248,168	56.1			DSNIS (ANC) DHIS2

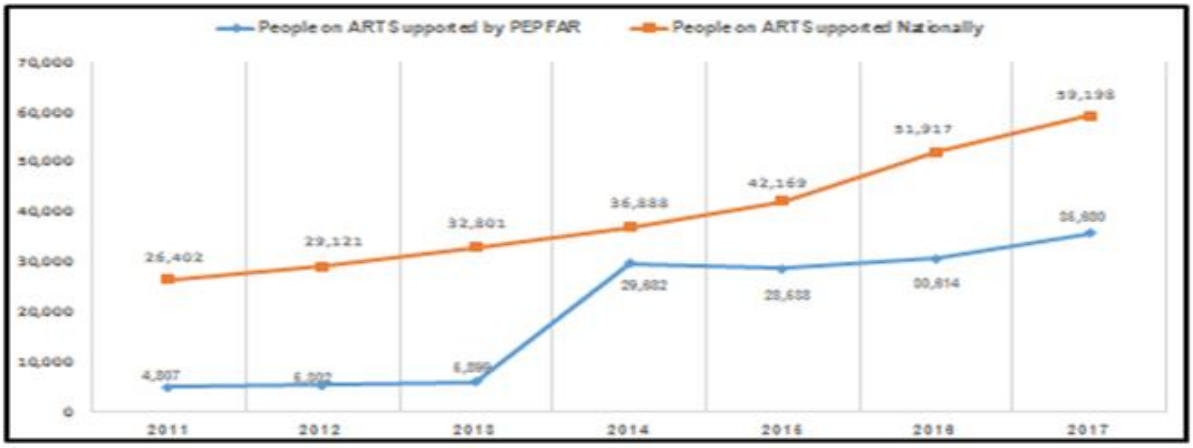
Pregnant women needing ARVs	4,858														SPECTRUM 2017/ME/PNLS
Orphans (maternal, paternal, double)	23,880														
Notified TB cases (Yr)	7,862														
percent of TB cases that are HIV infected	887	11													
percent of Males Circumcised	N/A														
Estimated Population Size of MSM*	9,346														PLACE 2013
MSM HIV Prevalence	4.8														PLACE 2013
Estimated Population Size of FSW	51,484														PLACE 2013
FSW HIV Prevalence	21.3														PLACE 2013
Estimated Population Size of PWID	N/A														

PWID HIV Prevalence	N/A														
Estimated Size of Priority Populations Military**	100,000														BNDF
Estimated Size of Priority Populations Prevalence (specify)	1.8														SABERS 2017
	If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.* * Military include military personnel and their family members*														

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (Data Source: DHS 2016)										
Epidemiologic Data					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	11,722,595	1	82,363	62,471	59,198	72	90	1,577,499	14,586	11,890
Population <15 years	5,140,054	NA	10,839	3,701	3,303	30	73	77,768	852	889
Men 15-24 years	1,223,744	0.9	2,911	1,804	1,686	58	83	178,278	806	787
Men 25+ years	2,073,664	0.8	29,569	17,480	16,540	56	85	325,768	4,084	3,310
Women 15-24 years	1,315,800	0.3	4,991	4,729	4,391	88	87	430,657	3,032	1,836
Women 25+ years	1,969,333	1.8	34,653	34,495	32,940	95	93	565,028	5,812	5,068

MSM	9,346	4.8	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
FSW	51,484	21.3	N/A	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
Priority Pop (specify)Military	100,000	1.8 military 1 dependents	1 1,200(450 military) 750 dependents)	1,363	1,363		7,795	26,612	396	431

Figure 2.1.3 National and PEPFAR Trend for Individuals currently on Treatment



2.2 Investment Profile

The HIV response in Burundi is funded primarily through PEPFAR and the GFATM. For the period of 2017-2019 the Global Fund designated $29,916,039 for the HIV program. For the same period (COP 16, 17, 18) PEPFAR's total contribution amounts to $49,720,000. The GOB has 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. A combination of recent political instability and evolving economic challenges have created a complex environment for all programming in Burundi, with an 87 percent decline in external resources leading to a 54 percent decrease in available funding for health.

The two main external funding sources for health in Burundi are also declining. PEPFAR COP18 (FY19) planning level figures indicate a decrease from COP17 (FY18) funding levels from $17,360,000 to $15,000,000 in COP18 (FY19), representing a 14.9 percent decrease from the previous year. The uncertain political and financial landscape in Burundi has also resulted in changes in GFATM support: the GFATM granted Burundi a total of $29.9 million for HIV and $5.7 million for TB for 2017-2019, which is a decrease over the previous allocation period.

Although the government provided formal co-financing commitments of $16.8 million, satisfying GFATM requirements to access the co-financing incentive, ongoing political uncertainty led to a change in implementation arrangements of the Principal Recipient (PR) from the GOB to the United Nations Development Program (UNDP) and a streamlining of grants from five to two. Key high-level priorities for the GFATM in the current funding cycle include the prioritization and mobilization of domestic resources for health by the GOB, with a particular focus on increasing the GOB contribution to procure HIV/TB drugs. Technical priorities for the grant period include four key areas:

1. Development of a national viral load strategy, including for the implementation of viral load scale-up;
2. Improved access to and coverage of virological testing among infants born to HIV-positive mothers (early infant diagnosis);

3. Ensuring the quality of interventions for key populations, including linkages of prevention activities with HIV testing and treatment services; and
4. A comprehensive supply chain management plan for the country, including warehousing and distribution until the last mile.

Close alignment of technical priorities between PEPFAR and the GFATM necessitate seamless collaborative planning between the GFATM, GOB, and PEPFAR to ensure coordination on key program areas (ref. Table 2.2.1 below). The GFATM continues to be the largest procurer of HIV-related commodities (83 percent) and the PEPFAR program will continue to work closely with the country coordinating mechanism (CCM) and the GFATM to ensure alignment of all programming areas, but most notably in commodity planning and procurement, and the transition of Efavirenz-based regimens to TLD regimens, which will need to be adequately coordinated among stakeholders ensure a smooth transition to the new regimen and avoid stock-out and wastage, while also considering the global demand for the new formulation (ref. Table 2.2.2-4 below).

Table 2.2.1 Annual Investment Profile by Program Area[1]

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

[1] GRP, National AIDS Spending Assessment, 2012 (most recent complete assessment available, all amounts in USD)

Table 2.2.2 Annual Procurement Profile for Key Commodities

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	$13,485,224	5.4	85.56	8.7	0
Rapid test kits	$2,534,379	16.2	78.87	0	5
Other drugs	$986,746	15.3	60.39	24.3	0
Lab reagents	$811,970	12.6	87.42	0	0
Condoms	$1,174,523	0	76	8	16
Viral Load commodities	$1,078,646	20.5	79.53	0	0
VMMC kits	0	0	0	0	0
MAT	0	0	0	0	0
Other commodities	0	0	0	0	0
Total	**$20,071,488**	**8.03**	**82.67**	**7.48**	**1.82**

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: $1,190,227	1	IHP: $2,185,522	
USAID Malaria	$9,000,000	MEASURE Evaluation: $100,000 PSM: $6,470,750 Assessing Lab Quality: $50,250 IHPB: $1,030,000	2	MEASURE Evaluation: $600,000 PSM: $2,805,329	PSM: Technical assistance to build supply chain management capacity
Family Planning	$3,000,000	RAFG: $769,142 BRAVI: $400,000 PSM: $400,000 Youth Power: $311,638 Gender-Based Violence Analysis: $100,000	4	RAFG: $5,415,631 BRAVI: $800,000 PSM: $2,805,329 Youth Power: $1,220,000	RAFG: Integrated service delivery for HIV, MCH, Malaria and FP to improve ART coverage for PLHIV and achieve epidemic control 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
Total	**$14,500,000**	**$10,321,007**	**6**	**$10,840,963**	

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
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

PEPFAR/Burundi, in collaboration with UNAIDS Burundi, convened a one-day multi-stakeholder workshop with participants from the National AIDS Control Council (CNLS), PNLS, GFATM grants PRs, UN agencies, representatives of civil society, faith based organizations, public sector representatives, and the National Network of PLHIV (RBP+). The workshop collaboratively developed the Sustainability Index Dashboard (SID) 3.0. The sustainability profile in Burundi remains mostly the same as last year; however, the economic situation is 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 COP17 SID:

Sustainability Strengths:

- **Planning and Coordination (9.0, 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.

- **Performance data (7.52, light green):** The GOB routinely collects, analyzes, and makes available HIV/AIDS service delivery data to track program performance. It also leads routine data review meetings at national and sub-national levels to review data quality issues and outline improvement plans. However, both the national monitoring and evaluation plan and the procedures manual need to be updated.
- **Public Access to Information (7.00, light green):** The GOB 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 that 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.
- **Domestic Resource Mobilization (6.94, light green):** The GOB increased its commitment to contribute to the national response with up to 12.3 percent of its national budget allocated to health, including HIV/AIDS. However, the budget execution reports are not available timely enough to confirm if those funds have been utilized for their intended purpose.
- **Civil Society Engagement (6.96, yellow):** In Burundi, there is active civil society engagement in HIV/AIDS advocacy, decision-making processes, and service delivery in the national HIV/AIDS response. However, there is a need to continue supporting CSOs for capacity building in project development and program management.

Sustainability Vulnerabilities:

- **Epidemiological and Health data (6.04, yellow):** No available data on HIV incidence. Limited capacity at national level for analysis of data and evidence-based decision making. To remedy this situation, PEPFAR/Burundi supported (COP17) the production of annual national-level Epi reports and capacity building of the national program to make decisions based on this report.
- **Service Delivery (5.46, yellow):** The national health authorities have the capacity to effectively plan and manage HIV services. HIV/AIDS services are accessible to poor and vulnerable populations at risk of infection. However, GOB provides minimal financing for HIV/AIDS service delivery. Moreover, performance is weak in the areas of targeted HTC services, linkage-to-treatment rates, systematic approach linkage, and finding those lost to follow-up (LTFU). Several strategies have been implemented to address these weaknesses including: Test and Start implementation from FY 2016 Q4 in some provinces, active tracing and enrollment of pre-ART clients to ART, and development of an SMS messaging referral system to ensure 90 percent of those identifying positive initiate ART. PEPFAR will continue to support implementation of all these strategies.
- **Quality management (5.00, yellow):** The GOB does not have an adequate quality management (QM)/quality improvement (QI) system with dedicated leadership, nor a current QM/QI plan for HIV care and treatment. PEPFAR will support a functional QM/QI committee which regularly convenes and routinely reviews performance data and system-and patient-level outcomes, helping facilities identify and address areas for improvement.
- **Laboratory (4.75, red):** There is a national laboratory strategic plan for 2014-2017 and an adequate number of qualified laboratory personnel (but not specialized lab technicians for viral load machines) in the public sector to sustain key functions to meet the needs of PLHIV for diagnosis, monitoring treatment, and viral load (VL) suppression. However,

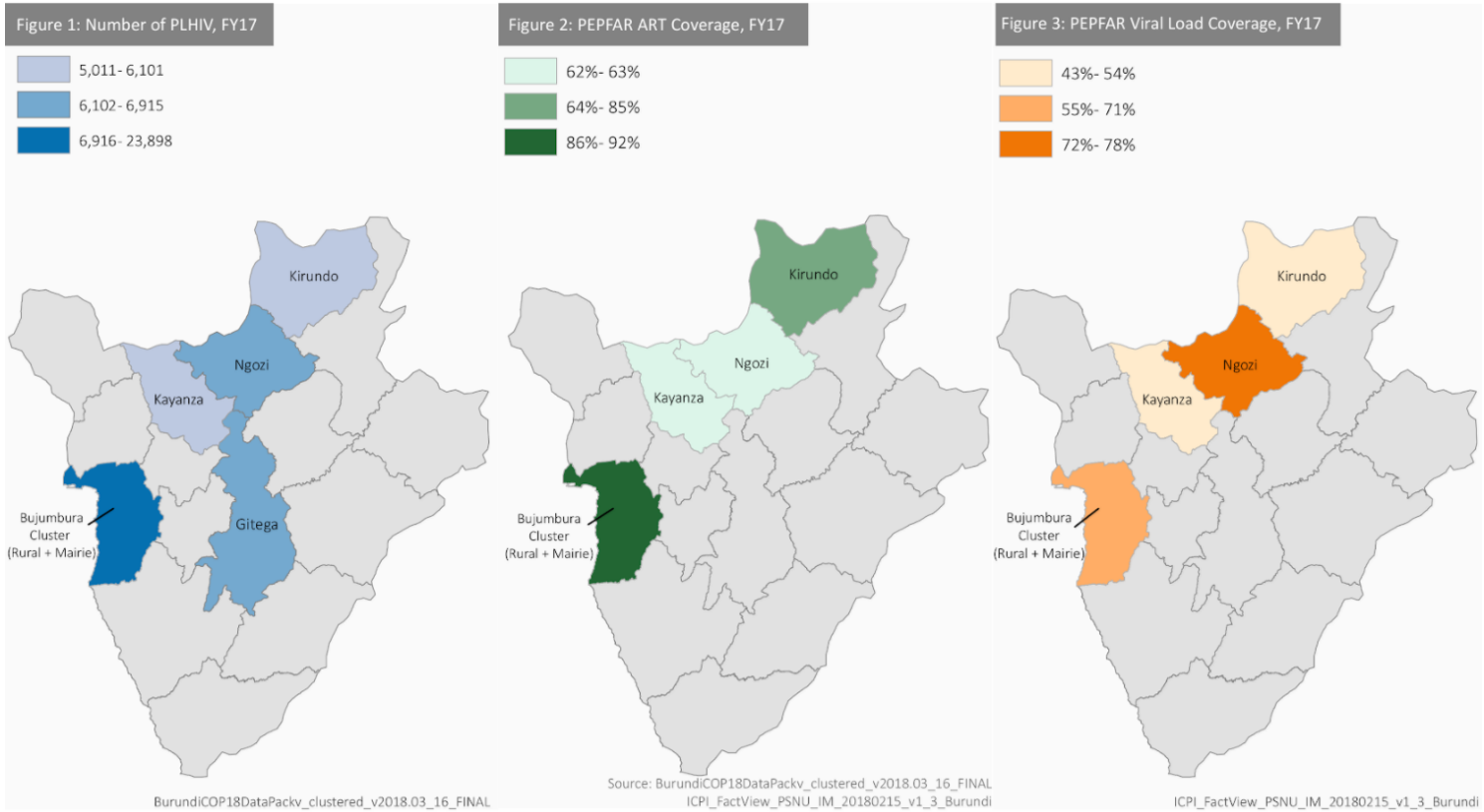
there is lack of adequate and consistent capacity to perform timely DNA PCR and viral load testing at a large scale.

- There are 3 public VL functional platforms, and 4 machines from OPP-ERA (of which 3 in procurement phase at the time of COP18 development). Two of the OPP-ERA platforms will be located in PEPFAR-supported provinces, and one will be located in Muyinga province (next to Kirundo).
- The main challenges remain: weak national ownership of the VL strategy, recurrent reagent stocks out and/ or expiry, maintenance issues, few qualified lab technicians, and a weak sample transportation system. PEPFAR/Burundi, with critical support and coordination leadership from the GFATM, will support the development of a National Viral Load Strategy under the umbrella leadership of the MSPLS.
- Although stock challenges for lab commodities still exist, this may relate to the current ordering processes in country, whereby GFATM commits to most HIV commodity orders directly after the annual quantification. Thereby, PEPFAR/Burundi will aim to space its HIV commodity orders to occur several months after the GFATM large annual order, as this will allow for PEPFAR procured commodities to compensate and fill-in for commodity concerns, as stock levels, patient targets, and consumption fluctuates after the quantification is completed. Further, in order to prevent new stock outs, PEPFAR/Burundi will reinforce the technical assistance to the Ministry of Health and to 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 corrective actions are taken in a timely manner.

2.4 Alignment of PEPFAR investments geographically to disease burden

The trend in past FYs of increased yield and higher than expected performance in Bujumbura Mairie, in contrast to lower performance in neighboring Bujumbura Rural necessitated the commission of an assessment of health seeking behavior and quality of HIV services in COP17. The "*Rapid Assessment on seeking care and HIV services in Bujumbura Mairie and Rural"* detailed a number of recommendations that will be implemented in COP18. The program will shift out of 22 of the lowest yield sites in Bujumbura Rural and transfer management of these sites to the GOB/GFATM for continued support. The remaining 11 sites with greater than 50 patients currently on treatment and demonstrating greater than 10 newly identified positive patients in the last year will be retained under the PEPFAR portfolio. These 11 sites accommodate 1177 patients currently on treatment and are within close proximity to key population hot spots, allowing key populations access to services in a familiar environment, and reducing risk of exposure to stigma and discrimination associated with seeking treatment in key populations-specific facilities. Beginning in COP18, PEPFAR/Burundi will combine Bujumbura Mairie and Bujumbura Rural into one geographical SNU: Bujumbura. Geographic prioritization and transition plans are expanded upon in Section 3.0

Figure 2.4.1 percent PLHIV by SNU, total PLHIV by SNU, coverage of total PLHIV with ART, and viral load coverage by SNU



2.5 Stakeholder Engagement

The PEPFAR/Burundi team consulted with key stakeholders including the MSPLS, UNAIDS, WHO, the CNLS, the PNLS, and civil society on the PEPFAR planned Strategic Direction for FY18-19. Consultations included presentations and exchanges on accelerating Burundi's progress towards achieving HIV/AIDS 95-95-95 goals towards epidemic control, and policy dialogue sessions that reflect the diversity of CSO concerns in Burundi. Consultations focused on the following:

1. Update on PEPFAR's new policy directives and technical approaches towards reaching the 95-95-95 goals toward epidemic control through prioritization of high burden geographic areas and hotspots, with a focus on key and priority populations including men and adolescent girls and young women (AGYW);
2. Collaborative exercises to identify the best testing strategies to increase testing in high-yield entry points to service; including index testing and TB clinics, and a reduction in support to sites with low positive yield;
3. Discussion on the approach PEPFAR/Burundi will use to transition out of low performing sites in Bujumbura Rural and supporting high burden sites/hotspots in Gitega;
4. Sharing data analysis and decision-making resulting from site yield analysis and geographic coverage to realign the approach PEPFAR/Burundi is using to saturate areas of high HIV burden and prevalence with combination prevention and treatment activities;

A one-day workshop with key stakeholders was convened on Feb. 1, 2018, where participants were updated on progress of the PEPFAR-supported strategy which began in COP17. The stakeholders recognized the high quality of PEPFAR interventions and appreciated the goal of reaching epidemic control by realizing efficiencies, with a focus on targeted testing in priority and key populations in specific geographic areas. However, as during previous COP planning meetings, stakeholders raised the weakness of interventions in non-PEPFAR-supported high-burden areas and expressed their uncertainty regarding transitioning out of sites in PEPFAR-supported SNUs. CSOs also expressed their concern about the political environment with regard to key populations, and the fact that CSOs have limited access to direct USG financing. CSOs present included non-governmental organizations, community groups, faith-based organizations, professional associations, and other not-for-profit organizations.

Recommendations that were suggested by stakeholders included:

1. The need to reduce low-yield testing under the existing "test-all approach" and identify and optimize testing strategies that will increase HIV positive case-finding, targeting key and priority populations, including AGYW and men;
2. The identification of other "hotspots" and higher burden locations where the program should focus in PEPFAR-supported regions and Gitega;
3. The scaling up of Test and Start in the non-PEPFAR-supported regions, support for retention in care especially after 12 months on ART, adoption of strategies to promote EID and scaling up of viral load monitoring;
4. Strengthening of CSOs' institutional capacity to support scale up of targeted prevention, testing and long term retention on ART interventions.

These recommendations have been streamlined and integrated into the COP, and PEPFAR/Burundi will continue to work in partnership with stakeholders and GOB to align with

PEPFAR's new policy directives and technical approaches towards reaching epidemic control. PEPFAR/Burundi plans to continue quarterly coordination meetings with the GFATM, MSPLS, civil society, and other stakeholders to review data, to ensure that implementation plans are prepared and well-executed, and to ensure implementing partners continue to respond effectively and efficiently to the epidemic.

3.0 Geographic and Population Prioritization

Leading up to and during the RPMs, programmatic results and newly released DHS 2016 data were used to prioritize geographies for COP18. SNU site performance was assessed, with recommendations to transition out of low-yield sites and retain high-yield sites, with expansion into new geographic areas based on the new DHS data presented.

At the RPM in coordination with GOB, GFATM and other stakeholders, USAID/Burundi decided to maintain efforts in all PEPFAR COP17 supported provinces: Bujumbura Mairie, Bujumbura Rural, Kirundo, Kayanza and Ngozi. In COP18, Bujumbura Mairie and Bujumbura Rural will be combined to track progress. In addition, 9 of 33 sites in current Bujumbura Rural will be retained for support, with an additional 11 sites in Gitega province being added to the portfolio in COP18 (ref. figure 3.1.1). These decisions were made based on several factors including:

1. 9 sites to be retained in Bujumbura Rural have TX_CURR >50 and HTS_POS >10, with a significant number of key populations hotspots located in close proximity.
2. DHS 2016 results showing a significant HIV prevalence shift in Gitega from 0.8 percent in 2010 to 2.3 percent in 2016, becoming second most burdened province (est. 6,915 PLHIVs).
3. 11 sites selected in Gitega were chosen based on proximity to key populations hotspots along major international transport corridors.

At the time of writing of the COP18 Strategic Direction Summary, the PEPFAR/Burundi team, in collaboration with the Inter-Agency Collaborative for Program Improvement (ICPI), was conducting an analysis and triangulation of DHS 2016, Spectrum, and annual program results (APR) 2017 to determine the burden of PLHIV per province, as well as current ART coverage. PEPFAR/Burundi will continue to shift program focus towards active case-finding, and linkage to treatment prioritizing high burden and low coverage areas, while continuing to support PEPFAR sites to sustain treatment quality with lower intensity technical assistance and resources. In addition, PEPFAR/Burundi will adjust the program based on DHS data to ensure that the approach to key populations programming is in line with the current epidemic, continuing with the approach adopted for Gitega - where selection of sites is based on proximity to key populations hotspots. The program will also ensure seamless integration with community-level outreach services for targeted case-finding, and ensure client linkage to treatment, while also enhancing capacity of sites to provide high-quality treatment, retention, and adherence services to key populations, and other priority and vulnerable populations using age and gender-synchronized approaches.

Figure 3.1.1 Bujumbura (left) and Gitega Sites (right)

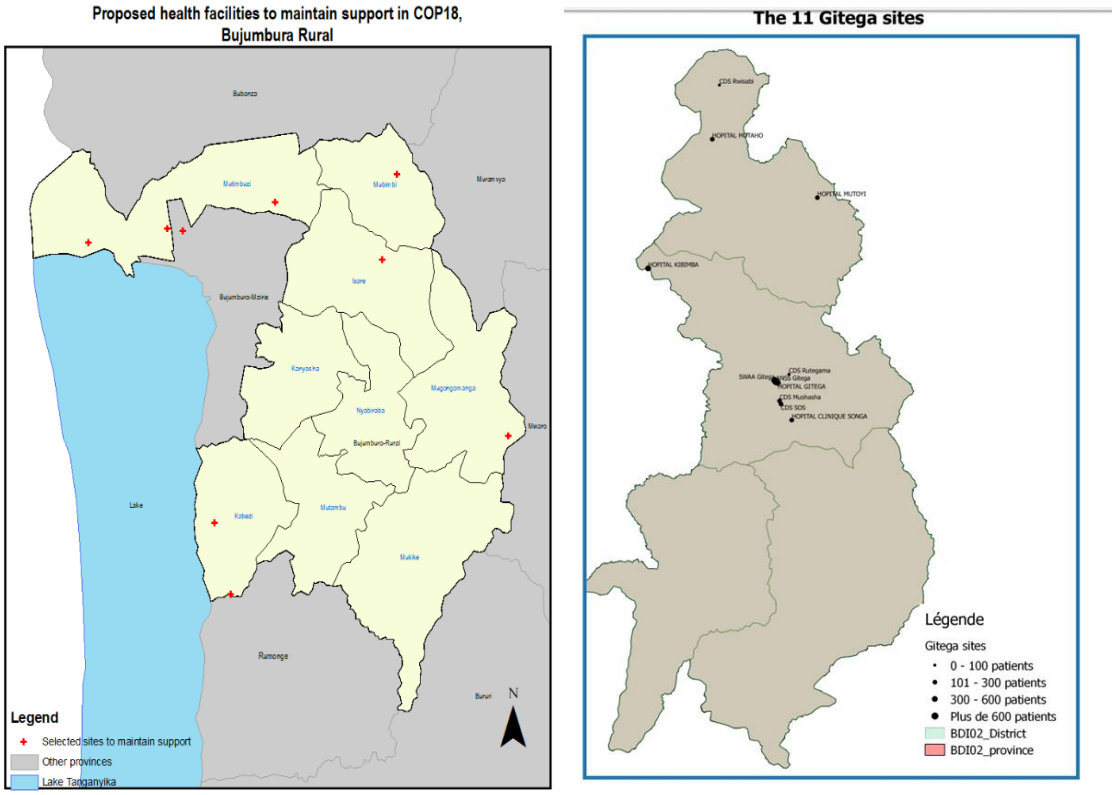


Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/ % of all PLHIV for COP18**	**# Current on ART (FY17)**	**# of SNU COP17 (FY18)**	**# of SNU COP18 (FY19)**
Attained	N/A	N/A	N/A	N/A
Scale-up Saturation	36,176	29,116	2	3
Scale-up Aggressive	13,153	6,564	3	2
Sustained	N/A	N/A	N/A	N/A
Central Support	N/A	N/A	N/A	N/A

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

4.1 – 4.3 COP18 Programmatic Priorities for Epidemic Control

4.1 Finding the missing, getting them on treatment, and retaining them

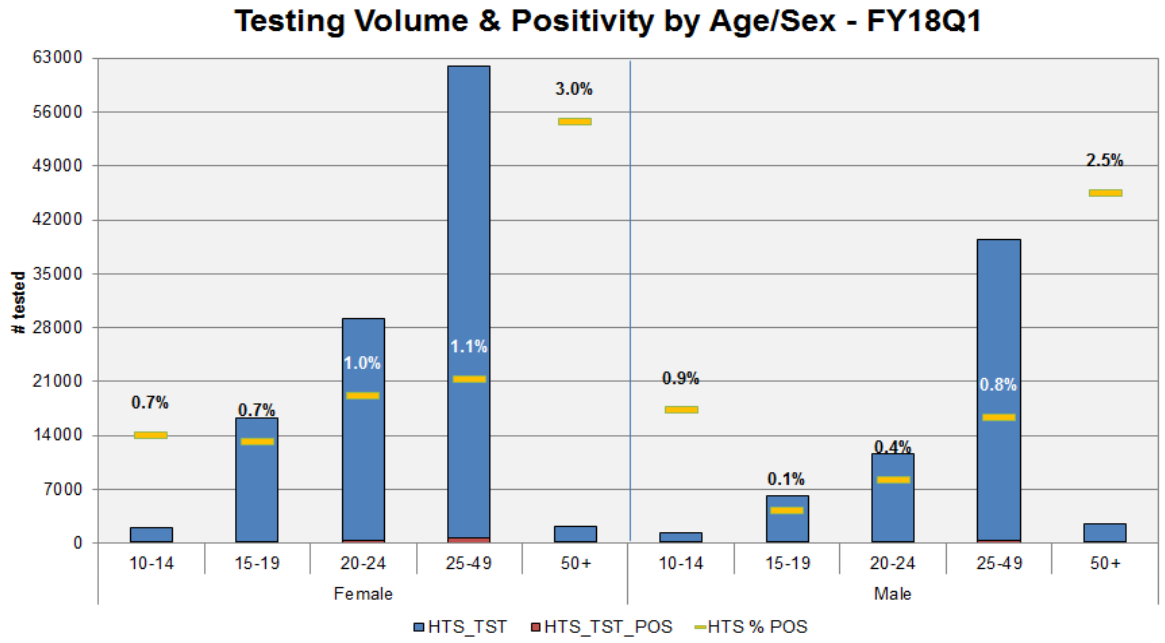
In COP18, PEPFAR/Burundi will work with the IPs and ensure collaboration with all stakeholders including the MOH, the GFATM PR (UNDP), and increase involvement of civil society organizations to strengthen case-finding, linkage-to and retention on ART, and access to viral load services to ensure achievement of the 95-95-95 goals in all PEPFAR-supported sites. Current systems gaps and barriers to achieving epidemic control include: 1) low case-finding attributed to lack of a National Testing Strategy that emphasizes case-finding and high-yield especially with finding men, adolescents and pediatrics; 2) less than optimal linkage to treatment rates; 3) poor viral load suppression rates due to weak laboratory capacity for EID and VL monitoring, including sample transfer networks and results communications system. 4) High level of stigma, legal discrimination, and violence against FSWs, MSM, and TG. These challenges have affected treatment coverage, and have also had an impact on both short term (12 months) and long term (≥ 24 months) retention rates. These challenges are exacerbated by religious leaders who convince clients that they may be cured of HIV through religious intervention; and the uncertain political landscape and economic hardship resulting in clients moving from one area to another in search of employment opportunities, and/or internal/external displacement for clients seeking political stability.

Reaching Epidemic Control among Males Aged 15+ years old

The program recognizes the challenges with reaching targets related to finding and retaining men on ART. Anecdotal evidence suggests that in addition to general challenges highlighted above, this could be due to the following: generally Burundian men do not seek healthcare services unless severely ill; health facilities are not favorable environments for men as most of the health providers are female and sites are often overwhelmed with female patients seeking ANC/PNC or medical care for themselves and/or their children; and conflicting work schedule and clinic hours.

1st 95: In FY17 PEPFAR/Burundi reached 119 percent of the tested positive targets (HTS_TST_POS). Only 36 percent of all positive diagnosed in 2017 ages 15-49 were men, and yet data shows that males 15-49 years account for the highest unmet need among adults PLHIV with unknown status. The graph in figure 4.1.1 below illustrates the difference in tested (HTS_TST) and HTS_TST_POS between male and female across different age bands at FY18Q1:

Figure 4.1.1: Graph illustrating testing volume and positivity by age and sex (Data Source: ICPI)



Data source: ICPI FactView_PSNUxIM_20180215

To accelerate case-finding among adult men in COP18, PEPFAR/Burundi will maximize testing modalities that have demonstrated high-yield in the identification of positive men. In FY17, index testing was the highest-yield strategy for finding men: Through index testing, sexual partners of positives were identified at all sites: 88 percent of the partners identified were reached and 68 percent tested, with a resultant average sero-positivity among men aged 25-49 of 10 percent; TB clinics were the second-highest yielding point of entry, with an average sero-positivity of 2 percent. Case-finding among key populations was also relatively high, with 4.01 percent sero-positivity rate.

In FY19, PEPFAR/Burundi will continue to prioritize and scale up index testing of sexual partners of positive women who are newly diagnosed or already enrolled in HIV treatment services. Adolescent and adult male conducive waiting and counseling areas will be established in health facilities during times that are convenient for them. Health care providers and peer educators identified as Male Experts will be well trained to counsel high risk males to test. Health providers and peer educators will invite partners of all HIV+ pregnant women to be tested for HIV and encourage them to accompany their wife to ANC consultations and/or to get tested if their partner is found HIV positive through appropriate partner notification services.

Targeted outreach strategies to reach key and priority men will be established with the guidance of focus groups - hotspots will be targeted, using trained providers to reach men at high risk of HIV infection, including partners of FSW and MSW, and men with mobile professions (truckers, mine workers, fishermen, military and other uniformed professions) with male friendly mobile-testing services. Men will be screened using a risk assessment questionnaire to reduce over-testing and positive clients linked to HTS appropriately. Self-testing will be offered to clients of

FSWs, MSM, and transgender: HIVST is expected to increase case-finding in key and hard-to-reach populations, including men, as it reduces some of the systemic barriers by "de-medicalizing" the testing process.

Improved data collection tools will be used to identify gaps in finding men and linking men, and to assist in the real time modification of the testing and linkage strategies being applied. The following program indicators will be used to track men engagement: the number of partners of HIV+ pregnant women tested, the number of partners of HIV+ pregnant women tested HIV+, the number of partners of HIV+ pregnant women tested HIV+ linked to ART services, the number of partners tested in other services, the number of partners tested HIV+ in other services and linked on ART.

2nd 95: Linking men to treatment and retention of adolescent and adult males also remains a challenge and will require innovative programming. In FY 17 Burundi achieved 88 percent of the new on treatment target (Tx_NEW); ~31.3 percent were men; and out of 87 percent of the current on treatment target (Tx_CURR) that were achieved, ~32.1 percent were men.

To increase linkage to and retention in treatment in FY19, PEPFAR Burundi will invest in scaling up same-day ART initiation for newly diagnosed positive men, and follow up non-initiated HIV+ men to ensure initiation on treatment. Health care providers and peer will be trained to reduce stigma and discrimination, and ensure implementation of quality services. The role of well-trained male-friendly health providers, peer navigators and counsellors, health mediators and peer adherence support groups will be strengthened to provide guidance and support ART adherence and long term retention in care. To ensure long term retention, HIV+ men will be encouraged to join a PLHIV network for emotional and treatment adherence support, and be nurtured so that they remain engaged in care, even beyond the first two years of treatment initiation. The program will also engage with other community members, including traditional and religious leaders, providing them with appropriate training and recommendations to efficiently and effectively counsel clients on prevention of HIV transmission as well provide linkage and retention in ART support.

Successful innovations aimed at initiating and retaining clients initiated on ART in COP17 that will be enhanced in COP18 will include:

1. To increase ART coverage to 90 percent and retention to 95 percent among adult men living with HIV in COP18, active linkage to same-day ART will be promoted whereby a newly diagnosed client is escorted to the ART clinic. Appointments reminders will be sent using SMS messaging, and men who miss appointments will be actively tracked (by phone and then in-person by male-expert peer within one week), and followed up to ensure ART initiation and clinical monitoring at facility level.
2. Differentiated models of care (DMOC), including multi month prescription and dispensing, and community distribution of ART - already introduced in COP17 -will be scaled-up to support adherence and retention on treatment, especially for stable clients.
3. Treatment literacy is a challenge in initiation and retention of male clients, and will be a focus of intervention; this will be reinforced with BCC materials designed for and made accessible to men with the help of the network of male-friendly CSOs.
4. Alternative facility hours (i.e. evenings/weekends and "male-only" hours) will be considered at health facilities. The program will monitor the impact of the expanded

facility hours on ART initiation and retention to inform scaling up of these targeted services. This will be coupled with multi-disease screening offered in male conducive environments, to further encourage long term retention (> 12 months).

5. Standardize SOPs and tools used for monitoring and tracking and linking of clients, and will strengthen the completeness of data collection tools, both paper based registers and electronic (SIDA-INFO) in order to better track clients identified in HTS and enrollment in ART clinics.

3rd 95: To improve viral load coverage to 90 percent and viral load suppression rate to 95 percent amongst men over the age of 15, a number of measures will be put in place to identify and target men for VL services. Viral load focal persons will be identified at sites to ensure eligible men are tested and results returned and clients informed in a timely manner. Standard operating procedures for routine and targeted VL will be developed. Male-friendly community support groups and peer/adherence clubs will be utilized for VL literacy and demand creation. Careful monitoring of sites will be carried out and sites with low VL coverage will implement measures to increase VL access among men. Patients with detectable VL will be assessed for clinical monitoring.

Reaching Epidemic Control among Females Aged 15+ years old

In FY17, PEPFAR/Burundi had OU-level successes in reaching adult women over 15. Adult women tested at a 1.8-fold higher rate than men (likely due to ANC); once diagnosed, the linkage rate to ART was 102 percent; retention on ART was 90 percent; VL suppression was 91 percent, and access to VL testing was 70 percent. However, gaps in reaching at-risk women in specific age bands and in geographic locations were identified in FY17 that could challenge attainment of 95-95-95 at the national level. Specifically, challenges were identified in case-finding, ART enrollment, and access to VL testing in younger women (ages 15-24), and in Kirundo across age bands. Strategic shifts in the OVC/AGYW program to high-burden areas will reach younger adult women (ages 15-24) to coordinate clinical care, and family support for families of HIV-positive young women, recognizing the potential overlap for AGYW and FSW.

1st 95: To accelerate case-finding among at-risk adult women in COP18, PEPFAR/Burundi will continue to scale up index testing of sexual partners and partner notification for every newly identified positive or known positive. In Kirundo, a site assessment will identify poor-performing sites across the adult female testing and treatment cascade in order to provide targeted TA to improve case-finding performance. Younger adult women (ages 15-24) had the highest HIV prevalence in all age bands in FY17 (6.4 percent), and will be targeted for HTS at the facility level through a revised risk screening tool. Those young women reached in the OVC/AGYW program who do not know their status will also be screened for HIV risk, and linked to HTS as appropriate.

HIV+ women will be counseled and strongly encouraged to invite their partners to be tested. Partners testing HIV+ will be counseled by male-friendly health providers and enrolled on ART. They will also be encouraged to fight stigma and discrimination with the support of well-trained CHW, health mediators and the PLHIV networks.

2nd 95: To increase ART coverage to 90 percent and retention to 95 percent among adult women living with HIV in COP18, active linkages to same-day ART will be promoted whereby a newly diagnosed client is escorted to the ART clinic. Tracing of clients who do not return for ART

initiation within one week will be carried out through a new SMS reminder system. Community-facility linkages to increase retention and adherence among adult women will be implemented in COP18. Each newly diagnosed PLHIV will be connected with Burundi's strong network of CSOs to support adherence, and OVC/AGYW will be actively linked with age-appropriate support groups and household support services to improve retention of each age group. Differentiated models of care, including newly launched community ART distribution groups (PODIs) and MMP, have been successful in enrolling women living with HIV stable on ART, and will aim to reach and enroll younger adult women (ages 15-24) in COP18.

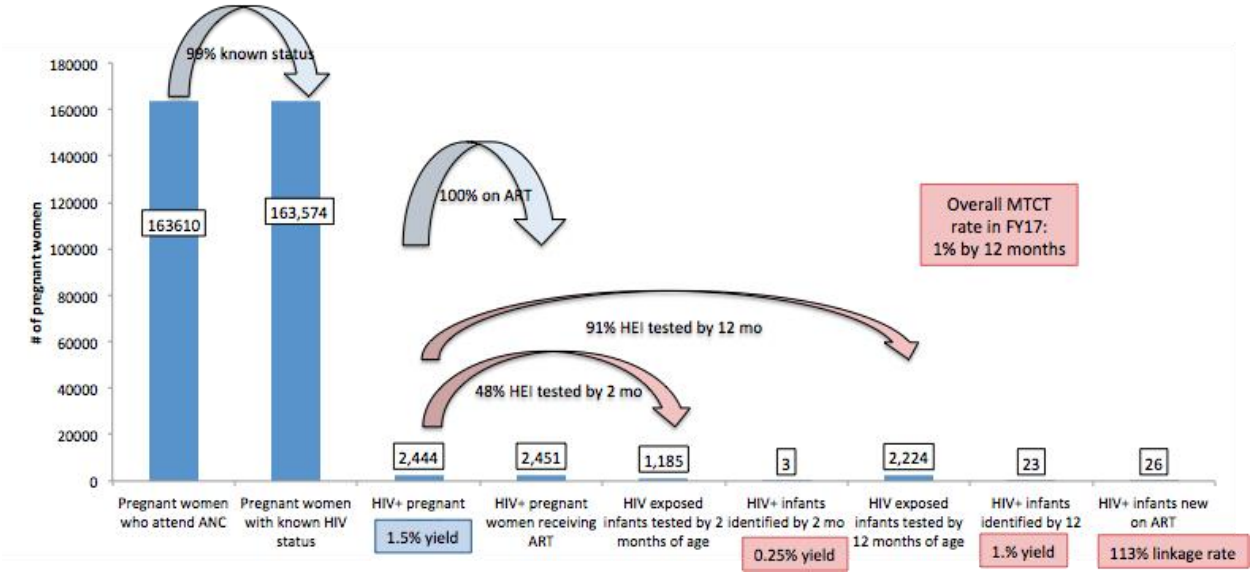
3rd 95: To improve viral load coverage to 90 percent and suppression to 95 percent for women over 15 years in COP18, PEPFAR/Burundi will increase testing uptake for AGYW and pregnant and breastfeeding women through lab strengthening activities and HCW capacity building, ensuring that they are prioritized for viral load monitoring.

Preventing Mother-to-Child Transmission (PMTCT)

As one of the prioritized Global Plan countries, investment in Burundi's PMTCT program by PEPFAR and other donors drove a significant reduction in the number of new child infections from 1800 per year in 2010 to <500 per year in 2016.[8,9] PEPFAR data for the PMTCT and EID cascade, illustrated in figure 4.1.3, shows an 0.25 percent mother to child transmission (MTCT) rate at 2 months, with 46 percent of infants tested; by 12 months, the MTCT rate is 1.1 percent with 85 percent coverage of the EID test. By 18 months, about half (46 percent) of the HIV-exposed infant cohort has a final HIV status outcome and the MTCT rate is 1.5 percent. In other non-PEPFAR provinces in Burundi, data quality is generally poor and only available for the 12 month EID test. Available data from two provinces indicates that the MTCT rate is 2.6 percent and EID test coverage is 5.5 percent at 12 months, significantly lower than the coverage rate of 85 percent in the PEPFAR provinces (Table 4.1.1).

[8] Progress Report on the Global Plan, UNAIDS 2015. Accessed March 12, 2018. http://www.unaids.org/sites/default/files/media_asset/JC2774_2015ProgressReport_GlobalPlan_en.pdf
[9] UNAIDS Data Book, 2017. Accessed March 15, 2018. http://www.unaids.org/sites/default/files/media_asset/20170720_Data_book_2017_en.pdf

Figure 4.1.3 PMTCT and EID Cascade



In COP18, the PEPFAR/Burundi program will address the remaining gaps in PMTCT programming to move the country towards elimination of MTCT (eMTCT), including:

1. Strengthening prevention services for AGYW in Kirundo where the highest proportion of new positives at ANC were identified in the 15-24 age band in FY17;
2. Employing Mentor Mothers for PMTCT clients to strengthen service access and uptake, especially in Kirundo, who will:
    a. Serve as peer counselors providing guidance and support in keeping appointments, and tracking of clients who miss appointments. Appointments reminders will be sent using SMS messaging, and women who miss appointments will be actively tracked and followed up to ensure long term retention on ART.
    b. Promote ART adherence and retention among pregnant and breastfeeding women,
    c. Support mothers to bring infants to clinic for HIV-exposed infant (HEI) services, including the 6 week EID test, regular nutritional monitoring, ARV prophylaxis and final outcome diagnostics post-breastfeeding
    d. Ensuring pregnant and breast feeding (PBF) women are prioritized for VL monitoring and clinicians supported for management of high VL in PBF women, especially in Bujumbura where rates of MTCT are highest.
3. Improving mother-infant cohort monitoring at site level to allow accurate completion of definitive diagnosis of the exposed infant (PMTCT_FO) indicator and estimation of MTCT rate.
4. The program will standardize tools used for monitoring and tracking of clients, and will strengthen the completeness of data collection tools, both paper based registers and electronic (SIDA-INFO) in order to better track of clients identified and enrolled on ART.

Table 4.1.1 PMTCT and EID Cascade and 4.4 Proxy MTCT Rate at 12 mo. by Province, FY17

	PMTCT_STAT _POS 2017	PMTCT_EID and (and EID coverage = PMTCT_EID/ PMTCT_STAT_ POS) 2017	PMTCT_HEI _POS @ 2mo 2017	Proxy MTCT rate @ 2 mo (PMTCT_HEI_ POS/ PMTCT_EID) - %	PMTCT_ EID by 12 mo 2017 (PMTCT_ EID @ 2mo + @ 2-12 mo)	PMTC T_ HEI_P OS @12 month s 2017	EID yield at 12 mo (proxy MTCT rate) HEI_POS/ EID 2017 - %	% HEI tested by 12 mo (PMTCT_E ID /PMTCT_S TAT _POS)
Bujumb ura Mairie	1,389	608 (44%)	0	0	1,020	14	1.4	73
Bujumb ura Rural	158	58 (37 %)	2	3.40	121	2	1.7	77
Kayanza	168	123 (73 %)	1	0	187	1	0.5	111
Kirundo	564	234 (41 %)	0	0.85	602	6	1.0	107
Ngozi	286	162 (57 %)	0	0	263	1	0.4	92
PEPFA R SNUs	***2,565***	***1,185 (46 %)***	***3***	***0.25***	***2,193***	***24***	***1.1***	***86***
Gitega	434	n/a	n/a	n/a	15	0	0.0	4
Muying a	278	n/a	n/a	n/a	24	1	4.2	9
NON PEPFA R SNUs	***712***	n/a	n/a	n/a	***39***	***1***	***2.6***	***6***
ALL SNU	**4,101**	n/a	n/a	n/a	**2,232**	**25**	**1.1**	**54**

Reaching Epidemic Control among Children

In PEPFAR/Burundi provinces in FY17, ART coverage for children living with HIV (CLHIV) was at 47 percent. Among newly diagnosed CLHIV, 84 percent were initiated on ART; 57 percent received a viral load test, with 70 percent having a suppressed viral load (Figure 4.1.1). In COP18, the program will aim to close the gap in ART coverage and VL suppression for CLHIV through aggressive case identification, ART initiation, and tailored retention and adherence strategies.

1st 95: To increase case-finding of CLHIV, PEPFAR/Burundi will undergo a mapping exercise to identify high burden sites with low pediatric testing coverage and work through the index testing platform to ensure all children of index clients receive HTS. "Know your family's HIV status" events on weekends and school holidays will take place to promote increased uptake of family-based index testing. Additionally, the program will employ an outpatient HIV risk screening tool for CLHIV to identify those children most at risk and actively link them to HTS services. In the PMTCT program, Mentor Mothers will be utilized in the prenatal period to sensitize expectant mothers on the importance of EID and then in the post-natal period to work with these mothers to ensure uptake of the HIV-exposed infant services, including the 6-8 week EID test and through to definitive diagnosis of the exposed infant (PMTCT_FO). PEPFAR/Burundi will also advocate for development of a national pediatric HIV disclosure strategy and a mature minor clause that

allows adolescents to give consent for HIV testing without parental notification. The OVC program will aggressively roll out its HIV risk screening tool and ensure that all OVC enrolled in the OVC program have either a definitive HIV status or screening results indicate the OVC are at a low risk of HIV infection. Those found HIV positive will be linked to treatment.

PEPFAR/Burundi will also continue its synergizing effort of index testing with the children of female sex workers living with HIV. For COP 18, LINKAGES will begin offering non-biomedical socio-economic support to the children of key populations (particularly the children of FSWs) through targeted OVC interventions.

2nd 95: To scale up ART initiation and adherence among children in COP18, PEPFAR/Burundi will develop strategies to adapt DMOC for children, including children in boarding schools, children of parents in CAGs/PODIs, or those parents receiving MMPs. All CLHIV will be linked to OVC/AGYW programming or, in areas where PEPFAR OVC programs are not currently available, to other CSOs offering non biomedical services to provide adherence and long term retention support.

PEPFAR/Burundi will also support health system strengthening through trainings to enhance provider's capacity and skills in managing pediatric patients. Additionally, to increase the comfort level of providers, PEPFAR/Burundi will assure that, at regular intervals, a pediatrician specializing in pediatric ART will attend the various clinics supported by PEPFAR and work with the providers that care for CLHIV at these facilities. PEPFAR/Burundi will also closely monitor supply chain plans for pediatric ARVs, including new formulations such as LPV/r pellets.

3rd 95: To enhance viral load suppression and retention on ART among children, PEPFAR/Burundi will continue to implement the recommendations from the *"Rapid Assessment for Factors Impacting High Viral Load among Children"* report commissioned in FY17. Specifically, children will benefit from family-centered services in COP18, where parents/caregivers and children receive ART appointments on the same day. PEPFAR/Burundi will also ensure that children and adolescents on ART are actively targeted in appointment registers and prioritized for VL monitoring. PEPFAR also plans a loss analysis in COP18 to identify reasons for LTFU among children and to identify strategies to address gaps in retention.

Reaching Epidemic Control among Key Populations

Recognizing the deficit in reaching targets related to HTS_TST_POS for key populations (e.g. Female Sex Workers/FSW, MSM and TG), PEPFAR/Burundi will double down on evidence-based strategies to reduce testing and increase yield, as well as seek further information on the actual HIV burden in key populations. USAID/Burundi will work in coalition with other development partners, MoH and civil society representatives to ensure the key populations-specific IBBS will be approved for FY18/19. With such outdated data on the HIV epidemic among key populations, it is challenging to formulate effective strategies. Available LINKAGES program data from recent key populations mapping exercises show a concentration of key populations hotspots in urban areas of Burundi (for both MSM and FSW), with notably larger hotspots in large urban areas along major transport routes. The PEPFAR/Burundi program will therefore realign its key populations program to larger urban areas to increase case-finding within key populations, as well as within their sexual networks and their children. The LINKAGES activities and interventions in urban communities will complement RAFG's facility-based interventions to ensure access to key

populations competent treatment services. In addition to expanding services for key populations in Gitega, LINKAGES will continue to strengthen and coordinate existing interventions in large urban areas such as Bujumbura Mairie, Kayanza, Ngozi, and Kirundo, to optimize impact across the cascade.

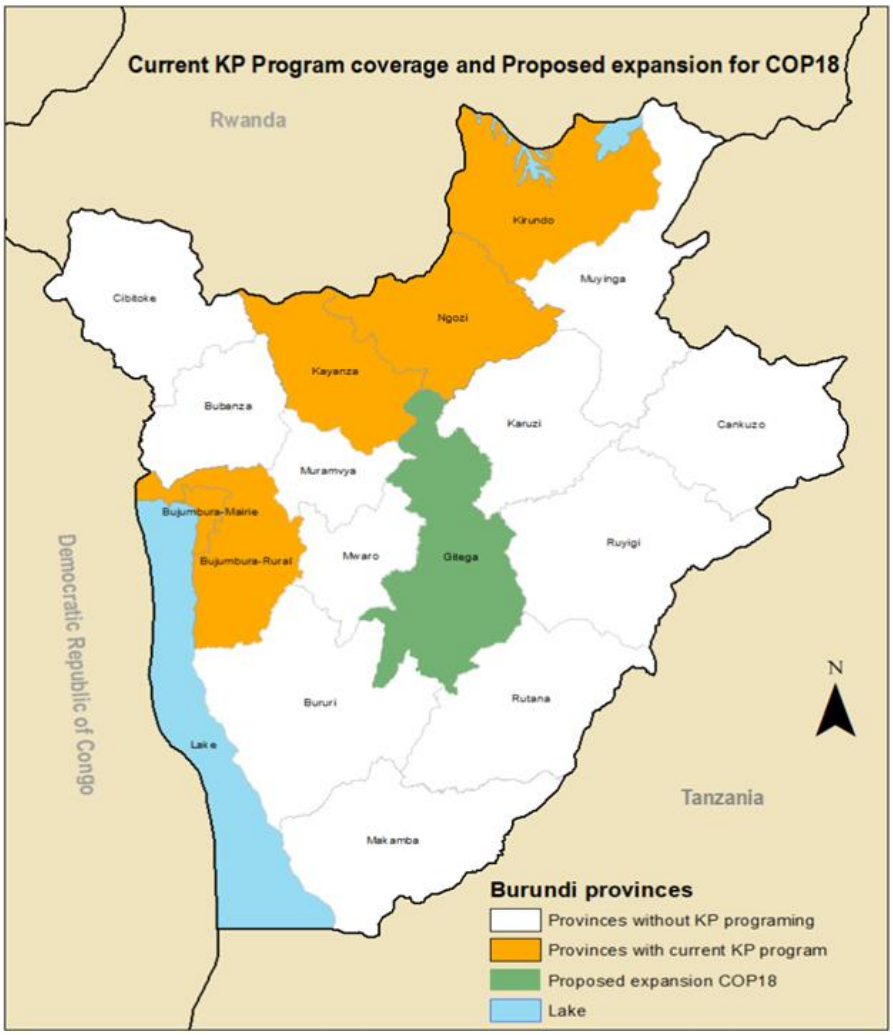
1st 95: For COP18, PEPFAR/Burundi will continue evidence-based solutions based on LINKAGES successes in past years. In FY18 Q1, HTS_POS targets related to MSM were finally achieved; hence, lessons learned from activities will be applied across the key populations portfolio. LINKAGES will continue to scale and enhance strategies for the 1st 95, including Enhanced Peer Outreach Approach (EPOA); self-testing utilizing sexual networks for FSW, MSM and TG; Index testing among children and regular partners of FSWs and stable partners of MSM and TG; use of information communication technology (ICT) including social media to reach hard-to-reach MSM and TG; and continued key populations competency training for healthcare worker in public sector clinics.

With the geographic shift to Gitega, and the realignment to urban areas, LINKAGES will work to ensure RAFG-supported clinical sites are able to meet the needs of key populations beneficiaries being referred for services. In terms of COP18 new strategies, LINKAGES will introduce a revised risk screening tool to increase testing of higher risk key populations, as well as work to mitigate HIV-related stigma and discrimination among key populations through a behavior change communication (BCC) campaign utilizing the Undetectable = Untransmittable (U=U) framework.

2nd 95: FY17/18 POART data has consistently shown that PEPFAR/Burundi's efforts to enroll HIV+ key populations into treatment has remained strong, thus nearing achievement of the 2nd 95. Hence, LINKAGES will scale up and enhanced its evidence-based strategies including peer navigation, which is linked to adherence counseling by peer navigators and support groups; key populations competency training with public sector health care workers; and the SMS[2] reporting system which allows beneficiaries to report incidents of stigma and discrimination in healthcare settings and see issues addressed by LINKAGES staff. In terms of COP18 new strategies, LINKAGES will work with MSM and TG community-led organizations and other stakeholder to secure a more discreet public and/or private clinic to serve as a MSM and TG competent clinic for more hidden MSM and TG beneficiaries to utilize. LINKAGES will integrate OVC providers into key populations competency trainings; strengthen their abilities to take a family approach to treatment for both FSWs and their children.

3rd 95: Similar strategies from the 2nd 90 will be used to scale up and enhance interventions to maintain key populations on treatment and attain viral suppression, including peer navigation; key populations competency trainings, the SMS[2] stigma mitigation system and a discrete clinic for MSM and TG.

Figure 4.1.4 Current key populations Program Coverage and Proposed COP 18 Expansion



4.2 Prevention in Priority Programming:

4.2.1 AGYW/OVC and Children of FSWs

Leveraging the OVC platform to close gaps along the clinical cascade for children and adolescents

The current OVC program in Burundi, Youth Power Action, was originally designed as an HIV prevention program intended to mitigate the risk of HIV infection, unintended pregnancies, transactional sex, and gender-based violence among vulnerable adolescent girls (aged 10-18) in Kayanza province - an area of the country believed to have a high HIV burden at the time of the project design. By September 2017, the program had enrolled approximately 5,500 adolescent girls and provided comprehensive services intended to increase access to high-quality HIV and family planning services, improve human and economic assets, and enhance family support and social assets for vulnerable adolescent girls and young women. However, as of Q1 of this year, 49 percent of the girls enrolled in the OVC program did not yet know their HIV status. Because the

program was primarily focused on preventing HIV infection, the program had enrolled very few HIV+ OVC. Furthermore, more recent HIV data revealed the Kayanza province to have a relatively lower HIV burden than other areas of the country.

Over the next years, the OVC program in Burundi will take steps to transition from a primarily prevention program, to programming that will more effectively contribute to case-finding, linkage, retention and viral suppression goals in Burundi - as well as prevention goals. In addition, the program will take steps to achieve geographic alignment with the rest of the PEPFAR portfolio in high burden provinces. In order to minimize service disruption for OVC currently enrolled in the program, the transition will be gradual - beginning in COP18 but continuing in subsequent COP years. Interventions listed below describe transition benchmarks for COP18 and further transition opportunities for COP19 when a new OVC program will be launched through a new central mechanism.

In COP18, the OVC program will accelerate efforts to support pediatric case-finding and work toward closing the ART coverage gap among adolescents, by ensuring that all 3924 AGYW/OVC with unknown HIV status in the OVC program are screened for HIV risk. Of those determined to be at a high risk for HIV, 100 percent will be escorted to facilities for HIV testing. Of those who test HIV+, 100 percent will be linked to ART services and HIV community support services. In addition, the OVC program will aggressively recruit HIV+ adolescents to the OVC program and ensure that the siblings and caregivers of these adolescents are screened for HIV risk, referred for testing and linked to treatment where necessary. In subsequent years, as the OVC program becomes more established in provinces with a high HIV burden, the OVC program will also seek to enroll the children of HIV+ caregivers into the OVC program and support efforts to identify and test other family members while offering family-based OVC services to HIV affected households.

In addition, in COP18, the OVC program will focus on improving HIV treatment retention and viral suppression among HIV+ adolescents - providing targeted support to adolescents transitioning to adult treatment so as to prevent LFTU at this critical time. The OVC program will work closely with health facilities and RAFG to support interventions to improve adherence among adolescents - including interventions intended to (1) support disclosure, (2) improve relationships between adolescents and their caregivers so that caregivers can, in turn, better support adolescents to take responsibility for their treatment, (3) increase economic resources available to support costs associated with treatment (e.g. transport costs, costs associated with purchasing nutritional food or medications to treat HIV associated and other illnesses), (4) support OVC and caregivers to advocate for viral load testing and other treatment needs (demand creation), and (5) engage in regular case conferencing with health service providers to actively track adolescents LTFU, support them to re-engage in care at health facility, and provide swift referral for those adolescents found to be ill and non-adherent to ART (with suspected treatment failure). In subsequent years, the OVC program will extend HIV treatment support to younger HIV+ children as well as adolescents.

Initial testing results indicated that the children of key populations are a high-yield pediatric population and would benefit from additional OVC interventions to prevent HIV infection among HIV- children and improve treatment outcomes for HIV+ children. Specifically, in COP18 LINKAGES will provide limited group based parent education and support programming and group based economic strengthening interventions to FSWs with children to enable them to more effectively care for their children. By layering these OVC interventions on top of existing HIV

services, key populations will be more inclined to bring their children when they access services and LINKAGES will be better positioned to encourage testing among the children of key populations, and link and retain HIV+ children to treatment. In subsequent years, the OVC program will enroll the children of key populations in more comprehensive household-based OVC programming.

While making these shifts, the OVC program will be careful to maintain the high quality prevention interventions currently offered through Youth Action Power. As adolescent girls in Kayanza complete program interventions, the OVC program will gradually shift to additional high HIV burden provinces - beginning with one of the following in COP18: Bujumbura, Gitega, or Kirundo. By COP19, the OVC program will withdraw completely from Kayanza and cover all three high burden provinces. In COP18, PEPFAR/Burundi will work with OVC partners to identify targets for OVC sub-populations to ensure a balanced OVC caseload and identify benchmarks for graduation in an effort to better guide OVC programming and monitor progress toward clear, measurable, OVC outcomes.

4.2.2 Gender Based Violence

The GBV data from the DHS 2016 and PEPFAR program FY17 and FY18 Q1 data show a high prevalence of GBV in many parts of the country and that the demand for services is increasing. As demand increases, all partners will ensure access to high quality of care for survivors of violence - either through direct service provision or referrals to services - in particular ensuring that services are appropriately tailored for children and adolescents in and out of school. This will be achieved through a variety of interventions including but not limited to: the review of facility protocols such as SOPs, monitoring availability of commodities, feedback on service quality to clients, and strengthening referrals to non-clinical services such as psychosocial care and legal support. PEPFAR will continue to increase the awareness of health providers and survivors for follow up visits to ensure continued provision of services.

PEPFAR will continue to strengthen relationships between health facilities and communities. Community leaders and health providers will meet at the facility to discuss barriers for GBV survivors to access services and propose together possible solutions. In addition, this increases community leaders' awareness of existing SBGV services in health facilities close to the community. This approach allows strengthening a sort of accountability on both sides for health providers and community leaders in regards to the GBV services.

4.2.3 Priority Populations (Military)

Military personnel contribute to the burden of new HIV infections with estimated prevalence of 1.8 percent. PEPFAR/Burundi will continue to support high impact interventions for high-risk sub-populations within military and other priority populations such as AGYW near FSW hotspots and military bases. The intervention package for adults will include the following:

1. Promotion of relevant prevention and clinical services, and demand creation to increase awareness, acceptability and uptake of these services.
2. Information, education, and skill development to reduce HIV risk and vulnerability; correctly identify HIV prevention methods; adopt and sustain positive behavior change; and promote gender equity and supportive norms and stigma reduction.

3. Referral to or provision of HIV testing; facilitated linkage to care and prevention services; and /or support services to promote use of, retention in, and adherence to care
4. Condom and lubricant (where feasible) promotion, skills building, and facilitated access to condoms and lubricant (where feasible) through direct provision or linkages to social marketing and /or other service outlets.

4.3 Additional Country-Specific Priorities

4.3.1. Programmatic Data Alignment

A comprehensive gap analysis of ART need by province is being done through an analysis of emerging data from DHS 2016 and other data sources. The outcome of this analysis will determine the geographical prioritization and approach to move to passive treatment in sites that have greater than 85 percent coverage by the end of FY18. Quality improvement in all sites remains a priority for GOB and PEPFAR and PEPFAR/Burundi will continue to work with the GOB, GFATM, and other stakeholders to realign the program consistent with sustained epidemic control while providing technical support to large treatment sites not supported through PEPFAR funding.

4.3.2 National Testing Strategy

The current National Testing Strategy implements a "Test All" approach which lends itself to overtesting with low-yields in ANC, VCT, and other modalities. The PEPFAR/Burundi program, in coordination with key stakeholders, will work with the GOB to revise the current strategy for a more targeted approach focusing on case-finding and higher yields across testing entry points. The revision of the strategy will also focus on refining strategies for hard-to-reach AGYW/OVC and key populations and their sexual partners.

In line with revising the national testing guidelines, IPs will monitor site-by-site testing data on a monthly basis. Analysis done in FY18Q1 revealed that sites have incorrectly reported testing data as VCT rather than as PITC or index testing. IPs will be required to flag sites with high VCT and low index testing and provide TA to align testing strategies with high-yield modalities. The program will continue to transition out of generalized testing to only index testing, key population testing, and testing of high risk children.

4.3.3 Policy and Practice on key populations (FSWs, MSM and TG)

Currently, Burundi is witnessing an increase in stigma, discrimination, and violence against FSWs, MSM, and TG. In FY17, several incidents of LINKAGES staff being harassed and detained occurred, as well as clients harassed for utilizing key populations drop-in-centers. In September 2017, the harassment culminated in a three-week detention for four MSM peer educators in Bujumbura. In addition, there also has been a ban on the importation of lubricant. The delay of the IBBS also affected the program's ability to collect accurate data for program implementation. With identification of HIV+ key populations already challenged, these issues have affected the program's ability to implement case-finding of key populations and providing access to quality HIV services which has been evident in Q1 data demonstrating a drop in beneficiaries reached, as well as continued low rates of HTS_TST_POS among key populations.

Based on COP16/17 and POART findings to date, additional strategies for innovative key populations programming is proposed for COP 18; however, support from GOB will be vital for success.

During the RPMs, the PNLS representative, UNAIDS, WHO, GFATM, and civil society representatives all agreed to advocate for key populations programming in Burundi, specifically linked to a timeline for re-application for the IBBS approval, and the reauthorization of lubricant for importation. Innovative strategies for key populations programming COP 18 are proposed, including scaling up a HTS risk screening tool, securing a more discreet clinic for harder to reach MSM, and launching an anti-stigma campaign based on "Undetectable = Untransmittable (U=U)." PEPFAR/Burundi will continue to realign the key population program to urban areas and ensure index testing as well as peer outreach along with OVC services to all children of key population members. The program will also ensure that key populations programs work in close collaboration with facilities to ensure that health providers are well trained in stigma and discrimination, and offer key populations- friendly services. Positive clients will be actively linked to treatment services and monitored with the support of key populations peer networks, to ensure retention in care.

4.4 Commodities

The GFATM is the largest donor for HIV commodities in Burundi. In FY17, the GFATM procured 83 percent of all HIV commodities, including ARVs, RTKs, VL reagents, and other essential drugs.

In FY19, the GFATM will continue to cover most of the HIV commodity needs for Burundi. PEPFAR/Burundi's commodity procurement support will continue to focus on ARVs for PMTCT treatment in PEPFAR-supported sites. PEPFAR/Burundi will also continue the procurement of RTKs, Cotrimoxazole (to prevent opportunistic infections), VL and EID reagents, and dry blood spot (DBS) kits for EID in PEPFAR-supported sites. PEPFAR/Burundi will also support the collection and transportation VL samples for supported sites. Additionally, UNITAID will fund commodities for VL through the OPERA project until June, 2019.

In late-2017, the GFATM shifted its principle recipient from GOB to UNDP. Overall, this is a good opportunity to continue efforts in supply chain coordination between the GFATM, GOB, and PEPFAR/Burundi, particularly with regards to regularity in the analysis of supply chain performance, and completing subsequent informed decision-making regarding commodity needs.

In the current grant for HIV, the GFATM will cover 55,500 PLHIV on treatment, requesting other donors, along with the GOB, to cover the remaining 4,618 PLHIV. In COP17 and COP18, the GFATM showed openness to reallocating funds to ensure sufficient ARVs for the growing cohort, especially if there is a national move to Test & Treat. Close monitoring of HIV donors and Government commitments, as well as early advocacy will have to be developed by the in-country donor partners.

Despite the TA provided by PEPFAR/Burundi to support the supply chain in Burundi, stock outs continue to be a challenge: six key commodity items have been reported in stock out at the national warehouse in FY16, and eight in FY17. Other commodities have been reported at risk of stock-out but coordinated PEPFAR/GFATM actions allowed for the procurement and delivery of needed commodities to avoid stock-outs at site level.

The following are key supply chain solutions for Burundi:

1. **Harmonizing Order Cycle:** compared to the GFATM, PEPFAR/Burundi contributes a smaller percentage of total commodity procurement in Burundi. Given PEPFAR/Burundi's role to help fill-in the commodity procurement gap, PEPFAR/Burundi can choose
   to:
   a. work with UNDP to disaggregate large annual orders into smaller orders completed through the year, and adjusted per review of the quarterly supply plan, and considering changes to treatment and testing targets;
      and/or
   b. Complete its HIV commodity order six months after the GFATM order. This would allow further analysis of subsequent supply plans, changes to targets, and status of GFATM orders, and thereby allow the PEPFAR/Burundi HIV commodity order to fill-in any gaps or needs for various commodity orders not fully covered by the GFATM order.

2. **Creating Greater Stock Visibility:** PEPFAR/Burundi will introduce the use of the Procurement Planning and Monitoring Report HIV tool (PPMR-HIV), which is already in use in 4 PEPFAR countries (Cameroon, Tanzania, Zambia, and Ghana), to create greater stock visibility. The tool brings together data from logistics management information systems (LMIS), warehouse inventory management systems, donor orders, and quantifications/supply plans, to provide a visual representation of current stock-status, and forecasts of future stock status. The tool can then be used for determining the placement of future orders and their quantities, to assure appropriate stock levels. The PPMR-HIV has been vetted, presented, and discussed extensively with the GFATM, who is highly supportive of its roll-out. PPMR-HIV costs are limited to data entry; as maintenance and administration are centrally funded. Since the PPMR-HIV is a web-based platform, other donors, government staff, and other partners can be provided access to look at stock analysis.

3. **Network Optimization Study and Design**: similar to PEPFAR-funded studies in Lesotho and Ethiopia, the study will examine GPS data for actual routes driven by supply chain transport vehicles (traveling to and from CAMEBU, district store rooms, and service delivery points), issuance data from store rooms, frequency of orders, stock levels at store rooms, and the number of vehicles that are available and utilized for supply chain transport. The study will provide recommendations for improved supply chain transport routes (based on cost-efficiency, volume of stock to be delivered, etc.), and suggestions for improved fleet management to assure appropriate maintenance and usage of vehicles. USAID, along with its implementing partner Global Health Supply Chain (GHSC-PSM), will establish regular supply chain meetings with UNDP/Global Fund, CAMEBU, DPML, PNLS, etc. to discuss: 1) current stock-levels for HIV commodities nationally; 2) updates to quantification/supply plans; 3) updates on the status of current and future HIV commodity orders (highlighting any orders that may be late); and 4) Deciding on any mitigation actions to be taken for any in-country-, or external global-supply chain issues that may affect HIV programming in Burundi. This will also be a good meeting to review data noted in the PPMR-HIV. It will be useful for donors and GOB to share stock and order data before the meeting, to allow for in-kind analysis and development of questions before the meeting.

PEPFAR/Burundi will coordinate with the GFATM and stakeholders to develop short-term measures to optimize distribution.

4. "**Manage-Up" and Coordination with UNDP/GFATM:** USAID, along with its implementing partner GHSC-PSM, will establish regular supply chain meetings with UNDP/GFATM, CAMEBU, DPML, PNLS, etc. to discuss: 1) current stock-levels for HIV commodities nationally; 2) updates to quantification/supply plans; 3) updates on the status of current and future HIV commodity orders (highlighting any orders that may be late); and 4) Deciding on any mitigation actions to be taken for any in-country-, or external global-supply chain issues that may affect HIV programming in Burundi. This will also be a good meeting to review data noted in the PPMR-HIV. It will be useful for donors and GOB to share stock and order data before the meeting, to allow for in-kind analysis and development of questions before the meeting. PEPFAR/Burundi will coordinate with the GFATM and stakeholders to develop an operational plan for supply chain management strengthening and capacity building to monitor progress and benchmarks.

5. **LMIS:** Commodity data continues to be a key factor for forecast and supply planning accuracy. PEPFAR/Burundi will continue to conduct supportive supervision for 22 health facilities to improve their LMIS reporting. PEPFAR/Burundi will also incentivize LMIS by providing incentives to push for higher LMIS reporting. A pilot eLMIS will be introduced to sites that are consistent LMIS reporters.

6. **Completing Local Procurement for Lab Consumables**: GHSC-PSM is looking to prequalify vendors in Burundi that can provide various lab consumables. This will allow for local procurement of lab consumables, and assure greater access to lab consumables in a much quicker timeframe.

4.4.1 TLD Transition

A consensus was met at the COP18 RPM in Johannesburg in presence of the GOB representative and key stakeholders to transition all eligible patients, including pregnant women and co-infected HIV/TB patients to TLD by November 2019. A modeled 8-month transition to TLD (March, 2019-November, 2019) was adopted. The transition will assure legacy ARV stock levels will be drawn down to a minimum to prevent wastage. Stakeholders offered to support the GOB to revise the national guidelines to include TLD and to provide needed TA for the implementation, including training material development, provider training, and supply chain related activities. At the RPM, PEPFAR/Burundi, GOB, and stakeholders agreed on the timeline and roles and responsibilities: in order to have the first PLHIV transitioned to TLD in March 2019, orders will be placed at the latest in June 2018, and the product will arrive in country in January 2019. GFATM/UNDP and PEPFAR/Burundi accepted to procure the product as soon as the revised guidelines are completed. The quantification of HIV commodities, which is scheduled in early April 2018, will take into account the transition plan.

PEPFAR/Burundi is not procuring VMMC commodities.

4.5 Collaboration, Integration and Monitoring

During FY19, PEPFAR/Burundi will continue to collaborate closely with GOB through the MOH structures, UNDP as the Principal Recipient for the GFATM HIV grants, UNAIDS, WHO and Civil Society Organizations including key populations civil society representatives.

PEPFAR/Burundi collaborates closely with the GFATM and the CCM, as well as with the Fund Portfolio Manager, to ensure information sharing on planning, strategic direction, and program implementation. PEPFAR/Burundi is engaged in grant proposal development and review and in supporting shifting priorities throughout program implementation.

Collaboration between partners on supply chain management, and particularly VL supply chain, is critical to achieving the 95-95-95 goals and ensuring commodity security. Partners meet regularly to coordinate procurement schedules, distribution, and systems strengthening activities. Collaboration of all stakeholders at the national level (PNLS, INSP, CAMEBU, DPML, UNDP, ANSS/OPP-ERA and the GFATM) will be enhanced specifically to support TLD transition and VL scale-up including laboratory strengthening activities, reagents monitoring and delivering to end users, sample collection and transportation to labs, and timely results return to clients.

Stakeholders will continue to work collaboratively to review data and make programmatic shifts to increase new HIV case-finding and decrease over testing, increase linkage of positives to ART services through implementation of Test and Start, retain all PLHIV on treatment, and secure access to quality viral load monitoring.

Partner Performance and Monitoring

Implementing partner management and monitoring will be enhanced through monthly one-on-one meetings, and more regular site level monitoring for more efficient and timely partner management and course correction. Meetings will analyze program data, including SIMS, to share high level results, lessons learned, best practices, and strategic/policy discussions. Site level challenges that require an above site level intervention will be quickly identified and addressed such as testing strategies, commodity distribution and management, lab infrastructure and support and key populations access to services. Innovative strategies and scale up of efficacious proven strategies across all provinces will include the "Test less, yield more" strategy, scale-up of HIV self-testing in key populations in all provinces, patient escorting efforts, scale up of multi month prescribing and dispensing and ARV community distribution, linkages between health services and communities including PLHIV networks to strengthen adherence to treatment and quality follow up.

4.6 Targets for scale-up locations and populations

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts			
Entry Streams for ART Enrollment	**Tested for HIV (APR FY19) *HTS_TST***	**Newly Identified Positive (APR FY19) *HTS_TST_POS***	**Newly Initiated on ART (APR FY 19) *TX_NEW***
Total Men	**Data not available at the time of this writing.**		
Total Women			
Total Children (<15)	**16,970**	**203**	**182**
Adults			
TB Patients (TB_STAT/ART)	***2,518***	**163**	**157**
Pregnant Women (PMTCT_STAT/ART)	***183,291***	**1,239**	**1,103**
VMMC clients	**N/A**	**N/A**	**N/A**
Key populations	***19,762***	--	--
Priority Populations	***N/A***	**N/A**	**N/A**
Other Testing	***277,403***	**8,432**	--
Previously diagnosed and/or in care	***358***	--	--
Pediatrics (<15)			
HIV Exposed Infants	***2,473***	**27**	**26**
Other pediatric testing	***N/A***	**N/A**	**N/A**

Previously diagnosed and/or in care	***N/A***	**N/A**	**N/A**

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	**Population Size Estimate** (scale-up **SNUs**)	**Coverage Goal (in FY18)**	**FY19 Target**
<u>Key Populations</u>			
Bujumbura Mairie FSW	9,547	72%	5,480
Bujumbura Mairie MSM	2,343	80%	1,317
Kayanza FSW	5,587	47%	2,402
Kayanza MSM	701	71%	302
Kirundo FSW	4,998	27%	2,649
Kirundo MSM	169	80%	90
Ngozi FSW	5,400	55%	1,782
Ngozi MSM	393	76%	130
Gitega FSW	3,500	N/A	2,100
Gitega MSM	218	N/A	130
<u>Priority</u>			
Military**	100,000	20%	19%

Table 4.6.4 Targets for OVC and Linkages to HIV Services			
SNU	**Estimated # of Orphans and Vulnerable Children**	**Target # of active OVC (FY19Target) OVC_SERV**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY19 Target)**
Kayanza	50,000	10,000	8,700
TOTAL	**50,000**	**10,000**	**8,700**

5.0 Program Activities for Epidemic Control in Attained and Sustained Locations and Populations

PEPFAR Burundi will not have any sustained or attained support locations in FY18.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

Above site investments in COP18 will continue to leverage systems investments by the GOB and GFATM to strengthen site level impact and address the main challenges identified in the SID and throughout program implementation. The main areas of focus in COP18 will be:

Lab support and supply chain management
Laboratory capacity was identified as the only "red" category in the SID, citing the lack of adequate and consistent capacity to perform timely DNA PCR and VL testing at a large scale. Above site investments in the laboratory and supply chain management systems are critical to ensuring viral load and commodity distribution at the site level. Working collaboratively to leverage resources of the GFATM and MoH, lab services will be supported in order to increase VL and EID, DNA-PCR coverage and support completion and implementation of the national Viral Load strategy. Support will also be given to the national AIDS Program to develop an adequate and functional QM/QI system to scale up lab services, including VL/EID scale up. Technical assistance will include TA for VL/EID transport and review and revision of HTC/TX/ANC/VL stock registers. National supply chain management support will be provided in forecasting, quantification, warehouse and stock management, and SI systems.

Information Systems
Information systems was highlighted as "yellow" in the SID due to the lack of an adequate quality management (QM)/quality improvement (QI) system with dedicated leadership, or a current QM/QI plan for HIV care and treatment and the limited capacity at national level for analysis of data and evidence-based decision making. To address this, COP18 will prioritize capacity building in the utilization of data systems and incorporation of new data into decision making through technical support to PNLS for HMIS, facility data collection systems, QM/QI systems at service delivery points, and DHIS2 use (including integrating HIV indicators in DHIS2). Support will be provided for a needs assessment for the development of an Electronic Medical Record (EMR) System.

Above site activities for information systems will focus on leveraging resources of other donors to strengthening the National AIDS Control Program's capacity to collect, analyze, and disseminate program data for implementation and quality improvement. Coordination with World Bank will continue in COP18 on database development to ensure data from other key ministries, especially Ministry of Health and Ministry of Justice, are integrated. Capacity building activities will include using data on testing yields to identify the highest yield entry points and reviewing and revising HTS/TX/ANC/VL/STOCK registers at the site level and in the SIDAInfo to reflect entry points for priority testing locations and to record index patient testing.

Policy, Governance, Technical Guidance and Support
Advocacy on the national level for policies and guidelines that support the implementation of Test and Start will remain a priority. Key policies such as the National Testing Strategy revision for more focused testing at facility level, Differentiated Models of Services Delivery, and Multi month prescribing and dispensing, will all support 95-95-95 goals. With recent increased violence against MSM, advocacy for a safe policy environment is needed to ensure access to quality HIV

services in all priority geographical areas. Policy development and strategic planning in supply chain forecasting and planning will support improved stock management and TLD transition. PEPFAR/Burundi will also work to initiate and build capacity in technical working groups such as a national lab and pediatrics TWG and the SGBV TWG and CDCF interventions.

Human Resources for Health: Workforce Development and Training

A strong well qualified workforce is the cornerstone of providing high quality HIV services to patients. Military officers from the Military School of nurses (Ecole Paramédicale Militaire) will be trained to enhance capacity in providing HIV high quality services. Technical assistance and training to national, province, and district SI staff in facilities will be given on collection, analysis, and interpretation of data.

The Table 6 Excel workbook is attached in Appendix C.

7.0 Staffing Plan

The existing staffing pattern of PEPFAR Burundi is sufficient to achieve program goals if fully staffed. USAID/Burundi completed the recruitment of a U.S. Personal Services Contractor Health Team Leader, a third-country-national PMTCT/MCH Advisor, and a FSN third-country-national Senior Clinical Officer in FY18. The Senior Clinical Officer position replaces the Prevention Officer vacant position. The realignment of the vacancy was done in order to meet PEPFAR requirements and program priorities in Burundi. With these recruitments completed, the technical staff are able to focus their time on their respective technical areas, enhanced partner management, and technical assistance to the GOB. USAID/Burundi also completed the recruitment for a third party contractor for SIMS in FY18.

No additional posts will be proposed this fiscal year, and therefore PEPFAR Burundi's CODB for FY19 will remain consistent with the FY18 staffing composition.

APPENDIX A -- PRIORITIZATION

SNU Prioritization

Table A.1 SNU Prioritization

Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY 18)**	**Additional patients required for 80 percent ART coverage**	**Target current on ART (APR FY19) *TX_CURR***	**Newly initiated (APR FY 19) *TX_NEW***	**ART Coverage (APR 19)**
Attained	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Scale-Up Saturation	**36,176**	**32,670**	**N/A**	**37,365**	**6,797**	**103 percent**
Scale-Up Aggressive	**15,233**	**10,532**	**N/A**	**13,944**	**2,428**	**92 percent**
Sustained	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Central Support	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Commodities (if not included in previous categories)	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Total						

APPENDIX B – Budget Profile and Resource Projections

B1. COP 18 Planned Spending

Table B.1.1 COP18 Budget by Approach and Program Area

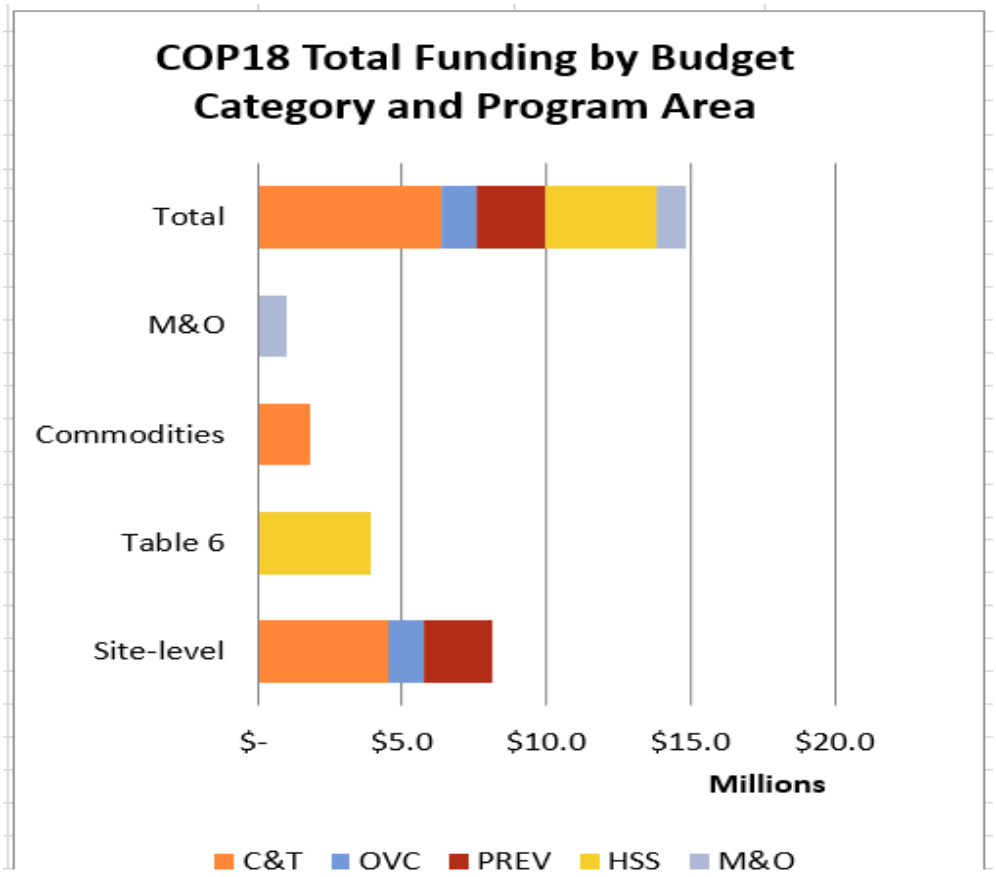


Table B.1.2 COP 18 Total Planning Level

Applied Pipeline	New Funding	Total Spend
$160,237	$14,839,763	$15,000,000

*Data included in Table B.1.2 should match FACTS Info records, and can be double-checked by running the "Summary of Planned Funding by Agency" report.

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	$733,963
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	$0
HVOP	Other Sexual Prevention	$1,661,083
IDUP	Injecting and Non-Injecting Drug Use	$0
HMBL	Blood Safety	$0
HMIN	Injection Safety	$0
CIRC	Male Circumcision	$0
HVCT	Counseling and Testing	$1,864,663
HBHC	Adult Care and Support	$309,801
PDCS	Pediatric Care and Support	$182,762
HKID	Orphans and Vulnerable Children	$1,220,000
HTXS	Adult Treatment	$2,668,024
HTXD	ARV Drugs	$715,195
PDTX	Pediatric Treatment	$425,482
HVTB	TB/HIV Care	$205,953
HLAB	Lab	$2,012,543
HVSI	Strategic Information	$350,000
OHSS	Health Systems Strengthening	$1,502,420
HVMS	Management and Operations	$987,874
TOTAL		**$14,839,763**

B.2 Resource Projections

While the resource envelope declined in COP18 when compared to the COP17 envelope, the PEPFAR/Burundi team applied pipeline amount also declined resulting in more new funds are available for programming. The COP18 Care & Treatment budget is $6,371,880, which represents nearly 43 percent of total OU's budget. Additionally the Prevention, Health Systems Strengthening, and OVC budgets have also increased in COP18 when compared to COP17. Of the total OU budget 90 percent of the funding is allocated to USAID, with the remaining 10 percent to DOD.

Each mechanism was costed out in the FAST by reviewing strategic objectives, deliverables, and budgets in the FY17 work-plans. Activity managers revised strategic objectives for COP18 for additional detail or clarity, and a systematic review of the most appropriate approaches were identified for each objective of each implementing mechanism. The process of costing out each mechanism's budget was a collaborative process that involved discussions with the implementing partner, who provided the USG team with detailed work-plan budgets. In the FAST budgets were carried forward by using FY17 as a baseline and then adjusted by approach based on discussions with partners given the funding level proposed for COP18. The PEPFAR/Burundi team studied the analysis tabs of the FAST tool to ensure budgets were aligned in accordance with targets set in the data pack and according to the overall programmatic strategies for COP18.

APPENDIX C – Tables and Systems Investments for Section 6.0

See supplemental Table 6 Attachment.

Table 6 Attachment

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)
1	DOD	<Placeholder - 70018 Burundi DOD>	HSS	Organize a comprehensive training program for HIV curriculum targeting military officers from the MDNAC "Ecole Paramédicale Militaire".	Workforce development, pre-service training	Train military officers from Military School of Nurses (Ecole Paramédicale Militaire) to enhence their capacity in providing HIV high quality services once they are hired.
2	DOD	<Placeholder - 70018 Burundi DOD>	HSS	Support needs assessment and development of military Eletronic Medical Record (EMR) System.	Information systems	Assessment of needs and development of EMR system.
3	DOD	<Placeholder - 70018 Burundi DOD>	HSS	Support lab services in order to increase VL and EID, DNA-PCR coverage	Laboratory sample referral/ transportation systems	TA to support the VL/EID sample collection, transportation and results return.
4	USAID	BRAVI	HSS	Support Ministry of Gender through TWG and CDFCs to advocate and coordinate SGBV interventions at central, provincial and communal level and strengthen referral networking	Technical area guidelines and tools	Provide capacity building for the SGBV TWG and CDFCs to advocate at all levels and to strengthen the referral networking
5	USAID	BRAVI	HSS	Coordinate with World Bank on database development and ensure data from other key ministries, especially Ministry of Health and Ministry of Justice, are integrated in the database	Information systems	Coordinate with World Bank to develop a national integrated database for SGBV data collection, analysis and reporting.
6	USAID	Reaching an AIDS Free Generation (RAFG)	HSS	Support the national AIDS Program to develop an adequate and functional QM/QI system for care and treatment services	Technical area guidelines and tools	Provide TA to support the National AIDS Program to develop an adequate and functional QM/QI system for care and treatment services
7	USAID	Reaching an AIDS Free Generation (RAFG) (Previously an EQUIP Strategic Objective)	C&T	Strenthening differentiated models of ART delivery, including multi-month prescribing	Technical area guidelines and tools	Provide TA support to scale-up the implementation of differentiated models of ART delivery, including multi-month prescribing, and full implementation of the Test and Start strategy in non-PEPFAR provinces.
8	USAID	Reaching an AIDS Free Generation (RAFG) (Previously an EQUIP Strategic Objective)	HSS	Stengthen laboratory systems in support of VL scale up	Laboratory quality improvement and accreditation	Provide TA to support VL lab optimization, including QM/QI, in coordination with other key stakeholders.
9	USAID	Reaching an AIDS Free Generation (RAFG) (Previously an EQUIP Strategic Objective)	HSS	Support the national AIDS Program to develop an adequate and functional QM/QI system to scale up lab services, including VL/EID scale up	Laboratory quality improvement and accreditation	Provide Support to the National AIDS Program to develop an adequate and functional QM/QI system to scale up lab services, including VL/EID scale up
10	USAID	MEASURE Evaluation Phase IV	HSS	Support the National AIDS Control Program in improving data quality through data collection, analysis, and utilization processes and integration of HIV data into national electronic data collection system from the site to the national level	Information systems	Train and provide TA to national, provincial, and district SI staff on collection, analysis, and interpretation of program data.

Row	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool
1	Insufficient qualified human resources to provide HIV services in military settings	7. Human Resources for Health	5.76	100% military health centers have at least 3 personnel trained on HIV services delivery	1 year	Number of student nurses trained
2	Poor record keeping in military settings and access to data systems	13. Epidemiological and Health Data	6.04	A military electronic health information network is in place and functional	1 year	Implement health information network
3	VL/EID sample referral/ transportation systems not optimal.	10. Laboratory	4.75	The VL/EID sample referral/ transportation systems in military settings are optimal	1 year	Percentage of PLHIV on treatment receiving VL testing in military; Percentage of HIV exposed infants receiving test for HIV by 2 months of age in military
4	Low capacity of the Ministry of Gender to coordinate SGBV interventions and the referral network.	2. Policies and Governance	6.51	GBV TWG and CDFCs strengthened to advocate at all levels and to strengthen the referral networking	1 year	Number of meetings held to support SGBV TWG and CDFCs
5	Weak national system for SGBV data collection, analysis and reporting.	1. Planning and Coordination	9	A national integrated database for SGBV data collection, analysis and reporting is developed and operational.	2 years	Functional database
6	Low institutional capacity for developing, implementing, and monitoring an adequate and functional QM/QI system for care and treatment services.	2. Policies and Governance	6.51	The National AIDS Program capacity to developing, implementing, and monitoring an adequate and functional QM/QI system for care and treatment services is increased.	3 years	Existence of adequate and functional QM/QI system for care and treatment services is developed, approved, and adopted by at least 80% of sites providing C&T services.
7	Lack of institutional capacity to implement and scale-up of new service delivery models, incuding multi-month prescribing, and to support the full implementation of Test and Start strategy in non-PEPFAR provinces.	2. Policies and Governance	6.51	MOH/PNLS capacity to implement and scale-up of new service delivery models, incuding multi-month prescribing, and to support the full implementation of Test and Start strategy in non-PEPFAR provinces increased	1 year	Number of facilities implementing new model of services
8	Low capacity for viral load testing scale-up and lack of lab QM/QI system.	10. Laboratory	4.75	VL lab QM/QI system is in place and VL and lab are optimized for scale up	2 years	VL lab QM/QI system is operational
9	Low institutional capacity and lack of a operational QM/QI system to scale up the VL/EID services and other ab services.	10. Laboratory	4.75	A QM/QI system is set up and fully rolled out rolled out	2 years	VL lab QM/QI system is operational
10	Lack of SI capacity at the National AIDS Program to monitor epidemic trends and program outcomes.	7. Human Resources for Health	5.76	National, provincial, and district SI staff trained on collection, analysis, and interpretation of epidemiological and program data.	2 years	Number of SI staff trained

Row	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and Q4 results will be included here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be included here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be included here for monitoring.
1	31 student nurses at miltary school trained on HIV/AIDS service delivery	30 student nurses at miltary school to be trained on HIV/AIDS service delivery					
2	Military Health information system	complete needs assessment and develop a military Eletronic Medical Record (EMR) System.					
3	66%of PLHIV received VL test in FY17: 47%of HIV exposed infants received test for HIV by 2 months of age in FY17	80% of PLHIV receive VL test; 70% of HIV exposed infants receiving test for HIV by 2 months of age					
4	Quarterly meetings	1.) A functional referral neteworking for access to comprehensive SGBV services at provincial level. 2 Gender units put in place in different Ministries and strengthened for					
5	NA	1) National SGBV indicators defined. 2) Capacity of CDFC staff strengthened on the data collection mecanism including data collection tools.		SGBV data collected			
6	0%	50%		70%		90%	
7	20	100					
8	A draft is available	70% VL Lab are implementing the QM/QI system		100% VL Lab are implementing the QM/QI system			
9	A draft is available	70% VL Lab are implementing the QM/QI system		100% VL Lab are implementing the QM/QI system			
10	NA	80% of SI staff at national, provincial, and district levels are trained.		90% of SI staff at national, provincial, and district levels are trained and/or retrained.		100% of SI staff at national, provincial, and district levels are trained and/or retrained.	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)
11	USAID	MEASURE Evaluation Phase IV	HSS	Strengthen the National AIDS Control Program's capacity to collect, analyze, and disseminate data on testing yields to identify the highest yield entry points. Organize trainings and integrate HIV indicators into DHIS2. Contribute to the multiplication of registers for adults and children (copies)	Information systems	1. Provide TA to strengthen the national HIV/AIDS program capacity, to collect, analyze and disseminate data on testing yields to identify the highest yield entry points. 2. Organize training and integrate HIV indicators in DHIS2. 3. Contribute to the multiplication of registers (copies).
12	USAID	MEASURE Evaluation Phase IV	HSS	Review and revise HTS/TX/ANC/VL/STOCK registers at the site level and in the SIDAInfo to reflect entry points for priority testing locations and to record index patient testing. Integrate SIDAINFO into DHIS2	Information systems	1. TA to review and revise HTC/TX/ANC/VL/STOCK registers in fields and in SIDAInfo to identify priority testing locations and high yield entry points and to record index patient testing. 2. Integrate SIDAINFO to DHIS2
13	USAID	MEASURE Evaluation Phase IV	HSS	Train and provide TA to national, provincial, and district SI staff on collection, analysis, and interpretation of program data.	Workforce development, pre-service training	Training and TA to national, provincial, and district SI staff on collection, analysis, and interpretation of program data.
14	USAID	PSM-GHSC	HSS	TA to support Supply Chain and Lab Sytems.	Supply chain systems	I) Provide TA to support policy development and strategic planning in supply chain, forecasting and supply planning, quality assurance, warehousing and inventory management, and commodity transportation and distribution. II) Increase supervision and monitoring at the health district level to ensure increased usage and coordination of LMIS for reporting to inform the central level with adequate, complete, and accurate information for decision-making
15	USAID	Reaching an AIDS Free Generation (RAFG)	HSS	Support lab services in order to increase VL and EID, DNA-PCR coverage and support completion and implementation of the national Viral Load strategy.	Laboratory sample referral/ transportation systems	TA to support the VL/EID sample collection, transportation and results return.

Row	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool
11	Low capacity of the National AIDS Program to collect and analyze data on testing yields to identify the highest yield entry points.	13. Epidemiological and Health Data	6.04	Data on the highest yield testing point and modalities are available (including finite disaggregates) and utilized to improve program performance and determine strategic direction	2 years	Quarterly reports
12	Inadequate capacity to review existing tools to identify priority testing locations and high yield entry points and to record index patient testing and to integrate SIDAInfo in DHS2.	13. Epidemiological and Health Data	6.04	Data on the highest yield entry point are available and utilized to improve program performance and determine strategic direction	2 years	Percentage of tools revised and harmonized
13	Inadequate capacity of SI staff to collect, analyse, and interpret program data.	7. Human Resources for Health	5.76	Quality disaggregate are complete and available timely at the national level	2 years	Percentage of health districts report timely and accurate data
14	Low capacity of the MOH in strategic planning and coordination for supply chain related activities and low capacity to roll-out the national logistic management information system	8. Commodity Security and Supply Chain	2.79	Increased capacity of the MOH in strategic planning and coordination for supply chain and LMIS related activities.	3 years	I) Number of strategic planning and coordination meetings supported; II) Percentage of HIV commodities distributed according to the National supply chain master plan III) Percentage of the health districts implementing the LMIS.
15	VL/EID sample referral/ transportation systems not optimal.	10. Laboratory	4.75	The TAT is reduced under 2 weeks	1 year	I)Percentage of PLHIV receiving VL test. II)Percentage of HIV exposed infants receiving test for HIV by 2 months of age III) TAT time

Row	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and Q4 results will be included here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be included here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be included here for monitoring.
11	Annual report	Quarterly national-level report (40 days after end of quarter).		Quarterly national-level report (40 days after end of quarter) is produced and disseminated for use in decision making..		Quarterly national-level report (35 days after end of quarter) is produced and disseminated for use in decision making..	
12	70% of tools are harmonized	90% of tools are revised and harmonized.		95% of tools are revised and harmonized (to meet actual needs related to epidemiological changes) 95% of Health Facilities are using correctely using newly revised tools for reporting in HMIS.		100% of tools are revised and harmonized (to meet actual needs related to epidemiological changes) 100% of Health Facilities are using correctely using newly revised tools for reporting in HMIS.	
13	70%	90% of health districts reports are complete		95% of health districts reports are complete 95% of health districts are transmeting timely their reports at national level		100% of health districts reports are complete 100% of health districts are transmeting timely their reports at national level	
14	I) Quarterly meetings; II) 70% III) 50% of health districts roll-out and implement LMIS	I) 80% of HIV commodities are distributed according to the National Supply Chain Master Plan II) 100% of coordination meetings are supported III) 70% health districts roll-out and implement LMIS.		I) 90% of HIV commodities are distributed according to the National Supply Chain Master Plan II) 100% of coordination meetings are supported III) 80% of health districts roll-out and implement LMIS"		I) 95% of HIV commodities are distributed according to the National Supply Chain Master Plan II) 100% of coordination meetings are supported III) 100% of health districts roll-out and implement LMIS"	
15	I) 67% II) 28% III) TAT: 4 weeks	I) 80% of PLHIV on ART receive viral load test. II) 90 % of HIV exposed infants in PEPFAR-supported facilities are tested for HIV by 2 months of age; III) VL/EID test turnaround time (TAT) is reduced to < 2 weeks					

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)
16	USAID	Reaching an AIDS Free Generation (RAFG)	HSS	Advocate for (and continue dialog) with GoB for adapting testing policy and guidelines to ensure more efficient and effective approaches to testing in line with international stands	Technical area guidelines and tools	Advocate with GoB for adapting testing policy and guidelines to ensure more efficient approaches to testing in line with international standards
17	USAID	Strengthening services for key populations/LINKAGES	HSS	Conduct advocacy activities for enabling environment for KPs, Engage CSO/Government to monitor and support policy development/security for KP programs	Policy and governance	Conduct advocacy to improve the national environment in favor of comprehensives HIV services to KP

Row	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool
16	Sub-optimal HTS strategy with a "test-all" approach.	2. Policies and Governance	6.51	HTS strategy which includes index testing, screening tool to reduce number of tests and increase yield, and prioritization of high-yield testing modalities approach is fully implemented at all sites and the testing yield is improved to higher than the HIV prevalence	1 year	Revised National HTS Strategy in place.
17	The political and legal environment is a barrier to full access to services to KP	2. Policies and Governance	6.51	Comprehensive HIV services are fully available to KP	2 years	Number meetings with the CSOs and the Government.

Row	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and Q4 results will be included here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be included here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be included here for monitoring.
16	NA	Revised HTS National Strategy is in place and fully implemented at all sites.					
17	Quarterly for Government and monthly for CSOs	I) at least 50% of the local admiration and the the law reinforcement agents (police and justice) are favorable to the program implementation in all the 6 provinces with significant reduction of KPs and staff harassment . II) 50% of the government Sites and 70% of CSOs sites are providing high quality, stigma, and discrimination free services to KPs (monitored through SMS2-service quality monitoring system via SMS) .		I) At least 80% of the local admiration and the the law reinforcement agents (police and justice) are favorable to the program implementation in all the 6 provinces with significant reduction of KPs and staff harassment II) 80% of the government Sites and 100% of CSOs sites are providing high quality, stigma, and discrimination free services to KPs (monitored through SMS2-service quality monitoring system via SMS) .			