Burundi

Country Operational Plan

(COP) 2020

Strategic Direction Summary

19 May, 2020

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Acronym List

AGYW	Adolescent girls and young women
AIDS	Acquired immunodeficiency syndrome
ALHIV	Adolescents living with HIV
ANC	Antenatal care
ART	Antiretroviral therapy
ARV	Antiretroviral
CAGs	Community ART groups
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
CTX	Cotrimoxazole
DBS	Dried blood spot
DHIS2	District health information system
DHT	District health team
DHS	Demographic and Health Survey
DOD	Department of Defense
DSD	Differentiated service delivery
DTG	Dolutegravir
EID	Early infant diagnosis
EMR	Electronic medical record system
EPOA	Enhanced peer outreach approach
ER	Expenditure reporting
FAST	Funding Allocation Strategic Tool
FBO	Faith-based organizations
FP	Family Planning
FSW	Female sex workers
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
HRH	Human resources for health
HSS	Health systems strengthening
HTS	HIV testing services
INH	Isoniazid
IP	Implementing partner
IPV	Intimate partner violence
KP	Key population
LGBTI	Lesbian, gay, bisexual, and transgender individuals
LPV/r	Lopinavir/ritonavir
LTFU	Lost to follow-up
M&E	Monitoring and evaluation
MCH	Maternal and child health
MMD	Multi-month dispensing
MMS	Multi-month scripting
MSM	Men who have sex with men
MSPLS	Ministry of Public Health and the Fight against AIDS
NACP	National AIDS Control Program
NGO	Non-governmental organization
OI	Opportunistic infections
OVC	Orphans and vulnerable children
PBF	Performance-based financing
PEPFAR	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
POART	PEPFAR Oversight and Accountability Response Team
POC	Point of care
PLL	Planning level letter
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
QA/QI	Quality assurance/quality improvement
RTK	Rapid test kit
SCMS	Supply chain management system
SDS	Strategic direction summary

S/GAC	U.S. Global AIDS Coordinator and Health Diplomacy, Department of State
SI	Strategic information
SID	Sustainability index and dashboard
SIMS	Site improvement through monitoring system
SNU	Sub-national unit
STI	Sexually transmitted infections
TB	Tuberculosis
TG	Transgender individuals
TPT	TB preventive treatment
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNHCR	United Nations High Commissioner for Refugees
USAID	United States Agency for International Development
USG	United States Government
U=U	Undetectable = Untransmissible
VL	Viral load
WHO	World Health Organization

1.0 Goal Statement

Burundi has made remarkable progress in its HIV response over the past five years, and the country is poised to achieve sustained epidemic control in fiscal years 2020-2021. In full partnership with the National AIDS Control Program (NACP), and aligned with planned investments from the Ministry of Public Health and the Fight Against AIDS (MSPLS) and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), the President's Emergency Plan for AIDS Relief (PEPFAR) program's 2020 Country Operational Plan (COP20) for Burundi will focus on building on the solid achievements made to date and closing known gaps in the epidemic response. The COP20 plan aims to set a nationwide standard for access to quality HIV services for all those at risk for HIV infection or living with HIV. The vision will ensure that those currently left behind - principally children, young people and men - are reached; that the quality of HIV and tuberculosis (TB) services is raised across all provinces using the best antiretroviral therapy (ART) regimens and drug dispensing methods; that partnering with communities is increased and used to provide quality services; and that investments in electronic medical record systems improve the patient experience and produce high quality program data.

During FY21, PEPFAR Burundi program will support four pillars:

- Pillar 1: Geographic investment prioritization
- Pillar 2: Client-centered approaches to HIV services
- Pillar 3: Decentralized service and commodity systems
- Pillar 4: Integrated health information system

Pillar 1: Geographic investment prioritization

In COP20, the PEPFAR Burundi program will continue to build on its ambitious geographic expansion in COP19 through targeted and tailored technical assistance that focuses on rapidly transferring best practices to District Health Teams (DHTs). PEPFAR Burundi's geographic approach will continue to tailor the intensity and level of support in each province to current progress toward achievement of the three 95 goals for epidemic control. In each province, PEPFAR programming will prioritize technical assistance to districts with the highest burden and need, and support sites with substantial retention gaps and/or large ART cohorts, particularly district hospitals, sites associated with large key population (KP) hotspots, and TB reference facilities, with the aim of directly assisting sites that collectively serve 80 percent of all ART patients in each province. At the same time, the DHTs will receive targeted technical assistance to ensure that they are reaching the remainder of sites.

This COP20 proposal has benefited substantially from ongoing consultations with the NACP, with bilateral, multilateral, and implementing partners, with civil society organizations (CSOs) and with the GFATM. In particular, the period of COP20 planning coincided with the development of the 2021-2023 GFATM Concept Note. The joint planning, activity mapping and alignment exercises that resulted from these two processes, under the leadership of the NACP, has resulted in a common vision for this final COP20 proposal and a set of national priorities that are aligned

along the funding streams. This shared commitment will contribute substantially to the successful implementation of COP20.

Pillar 2: Client-centered approaches to HIV services

PEPFAR Burundi will continue to adapt and implement solutions that are population-, age-, and gender-specific with the goal of targeting case-finding, strengthening retention nationally, and closing the viral load (VL) access and suppression gaps. Interventions will target the continuum of the HIV patient's journey, between the facility and the community, to ensure high-quality services throughout the patient's experience and to meet the needs of all populations, but with specific focus on populations where treatment gaps continue to exist - in key populations (KPs), in children and young people and in adult men.

In particular, ART patient retention will be the key focus in COP20, ensuring that facility- and community-based programs are designed and implemented to respond to the needs of patients who must remain on ART for a lifetime. In addition to continued acceleration of same-day test-and-start treatment initiation, this will require accelerated progress to implement the national directives on multi-month scripting (MMS) and multi-month dispensing (MMD) for ART patients who are stable and ensuring that all people living with HIV (PLHIV) are able to access optimized ART regimens. Critical to these investments, PEPFAR Burundi will refocus efforts to work with CSOs and support approaches that empower community health agents (through GFATM, MSPLS and other investments) to support patient access to and retention in quality services. COP20 investments include a new funding mechanism to provide small grants to CSOs to monitor and help improve the quality of services for PLHIV by strengthening community/facility linkages and communication pathways. These investments are designed to prevent patients from defaulting from care, and to identify and bring back into care those who have stopped receiving ART. Segmented retention strategies that build on available evidence to tailor interventions effectively will be applied to address age-, gender-, and population-specific barriers, especially for children, young people, and adult men.

HIV case-finding efforts will be increasingly targeted in COP20 and will focus on children, young people, and adult men - all populations in which case-identification gaps are still notable in Burundi. PEPFAR Burundi will continue to optimize index testing for these populations, including through self-testing approaches, through population-specific strategies that leverage existing program platforms (e.g., PMTCT and OVC programs), and strong evidence from other countries (e.g. MenStar approaches for case-finding among men).

In COP20, the OVC programs will evolve and focus more on the key challenges for children in the Burundi epidemic, in particular the pediatric treatment gap, the risk of sexual violence against adolescent girls, and the risk to children posed by poor adult treatment retention and viral suppression rates.

PEPFAR Burundi will successfully transition its OVC and GBV investments to local partners in COP19 and will continue to expand local partner investments in COP20. To ensure the success of these transitions, PEPFAR Burundi will leverage technical assistance from central mechanisms

and from high-performing local sub-partners to mitigate fiduciary and programmatic risks. PEPFAR Burundi is particularly excited to launch a new small grants program for CSOs to support community-led monitoring of ART services.

To improve patient experience, PEPFAR Burundi will also support integration of family planning and HIV services. This integration will allow for one-stop, comprehensive health services where clients, in particular women on ART, can receive family planning services at the same place where they access HIV services.

Pillar 3: Decentralized service and commodity services

From a policy perspective, the PEPFAR Burundi program will continue to support the NACP, together with the World Health Organization (WHO), to adapt and implement national guidelines based on the best available evidence and in compliance with WHO guidance and PEPFAR standards. In particular, PEPFAR Burundi will prioritize support for the rapid scale-up of MMD according to its implementation plan and for full access to TLD, which together are expected to improve patient retention significantly. Through Ambition Funding, COP20 also proposes to support the introduction of optimized TB preventive treatment (TPT).

Complementing retention efforts, PEPFAR Burundi will build on the important progress made in COP18 and COP19 to accelerate access to VL testing to ensure both the quality of programs and high levels of community VL suppression. PEPFAR Burundi will continue to focus on demand creation and results uptake, and on strengthening VL testing capacity at all levels of the system. In FY20, PEPFAR Burundi, in collaboration with the GFATM and the NACP, plans to expand access to VL in all provinces. Current VL coverage and suppression gaps are particularly acute among KPs, children and young people, and adult men. PEPFAR Burundi will implement differentiated strategies that target age-, gender-, and population-specific barriers to VL access and site-level strategies to improve clinical patient monitoring and use of patient VL data.

In COP20, optimized alignment of KP investments among GFATM and PEPFAR Burundi will improve programmatic reach and population saturation for female sex workers (FSW), men who have sex with men (MSM), and transgender individuals (TG). PEPFAR Burundi will work in close collaboration with GFATM to ensure that GFATM prevention investments will complement and contribute to the success of PEPFAR investments to support KP with HIV in treatment, through a range of community- and peer-engagement strategies, patient navigation approaches, and improved coordination among implementing partners (IPs).

Consistent with the planned introduction of HIV pre-exposure prophylaxis (PrEP) in Burundi through the 2021-2023 GFATM Concept Note, COP20 funding will introduce PrEP into KP programs, and into targeted programs for other serodiscordant couples, with a target of providing sustained PrEP to 2,000 seronegative individuals.

Building on the substantial successes in COP18 and COP19, the PEPFAR program will continue to support the optimization of integrated TB/HIV services, including TB screening of all ART clients and expansion of TPT for all TB-negative ART clients, including introduction of optimized regimens.

Above-site investments will continue to be aligned with site-level objectives, focusing on strengthening supply chain systems from central to site levels, optimizing lab networks and functionality, and expanding health information systems to serve the needs of a sustained epidemic control program. In close complementarity with the GFATM, PEPFAR will continue to procure ARV drugs and other essential commodities (including TPT, test kits and self-test kits, VL test reagents, TB screening, and EID testing commodities) to maintain the provision of high-quality HIV services and to meet expanding needs in COP20.

PEPFAR Burundi will continue to strengthen its partner management framework to ensure efficient implementation of quality interventions and adjustments in real-time and to optimize the use of granular site- and patient-level data. High-frequency reporting, which proved exceedingly valuable to monitoring and managing roll-out of index testing, will be continued and tailored to retention efforts as needed in COP20.

Pillar 4: Integrated Health Information Systems

During FY21, PEPFAR Burundi will invest in an integrated information system to ensure availability and use of high-quality and timely information critical to reaching and sustaining epidemic control. The investment will support an interoperable health information system crucial for program planning and sustained national commitment and accountability. PEPFAR will support system governance and workforce capacity to optimize supply chain logistics and laboratory utilization based on strong programmatic data from the site and district levels.

Burundi is transitioning to treatment optimization and national scale-up of key testing and care strategies including index testing, self-testing, multi-month dispensing, community ART distribution, TPT, and use of GeneXpert for early infant diagnosis (EID) and TB diagnostics. COP20 investments will support an accurate patient-level information system throughout the HIV cascade, crucial to ensuring patient monitoring and continuity of services between community and facility, and to guiding program-level monitoring and decision-making.

In COP20 PEPFAR Burundi will also invest in improved surveillance systems to enable tracking of all newly diagnosed individuals (and prioritize them for index testing and partner notification, with an expectation of increased yield). This system will feed real-time data to the dashboard for monitoring newly diagnosed cases, recent infections, ART coverage, VL suppression, and drug resistance. Ability to monitor the status of these indicators and to respond quickly constitutes a key foundation of epidemic control in Burundi. Recency testing, introduced in COP19, will be expanded to inform targeted HIV prevention interventions, to monitor the trajectory of the epidemic and epidemic control, and to provide real-time information for HIV estimates in the country. These efforts will be complemented by a population-based HIV impact assessment (PHIA) that uses cutting-edge technologies to directly measure HIV incidence, HIV prevalence, and HIV VL suppression.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden, and country profile

Program Context: The Republic of Burundi is a small, landlocked country in the African Great Lakes region bordering Lake Tanganyika. The country shares borders with Rwanda, Tanzania, and the Democratic Republic of the Congo. With an estimated population of 11.6 million in 2019,[1] Burundi is the second most densely populated country in Africa, with about 435 inhabitants per square kilometer, as of 2018.[2] Burundi's total fertility rate of 5.5 children per woman,[3] is one of the highest in the world. Burundi faces a large youth bulge, with almost half of the population below the age of 15.

According to the International Office for Migration and the United Nations High Commissioner for Refugees (UNHCR), Burundi has witnessed substantial civil conflicts that have resulted in internal mass displacements and large migration flows. Internally displaced persons were settled in sites established for them, while other people fled to neighboring countries and were mainly settled in refugee camps. While Tanzania hosted the majority of refugees, Rwanda and the Democratic Republic of the Congo were also the destinations of Burundians seeking international protection. As of February 2020, UNHCR estimates that there are 336,980 refugees that have fled Burundi for neighboring countries, most since 2015.[4] Natural hazards, limited access to land, and food insecurity are three critical issues faced by Burundi's displaced population. In general, job-seeking behavior results in the movement of people around the country, as individuals seek income from different occupational activities. The migratory patterns are attributable to agricultural migration, labor migration, or rural-urban migration, and are at times intensified by the political climate.

Burundi is a low-income country with Gross National Income of $662 per capita[5] and remains one of the poorest countries in the world: 71.8 percent of Burundi's population lives with less than $1.90 a day. Burundi is in the bottom five of the low-income categories of countries (185 of 189 countries) on the 2017 United Nations Development Programme (UNDP) Human Development Index.[6] The economy is predominantly agricultural, with a 92 percent employment rate (share of total employment that is employed in agriculture) in 2019.[7] Burundi remains a challenging operating environment for implementation of U.S. government (USG)-funded programs due to its fragility, its low local capacity, and security and travel restrictions for USG personnel and IPs.

[1] https://www.unfpa.org/data/world-population/BI

[2] https://data.worldbank.org/indicator/en.pop.dnst

[3] Idem

[4] UNHCR Regional Update. Burundi Situation February 2020. Updated 29 Feb 2020; accessed 12 Mar 2020. https://data2.unhcr.org/en/situations/burundi

[5] https://data.worldbank.org/indicator/NY.GNP.PCAP.PP.CD?locations=BI

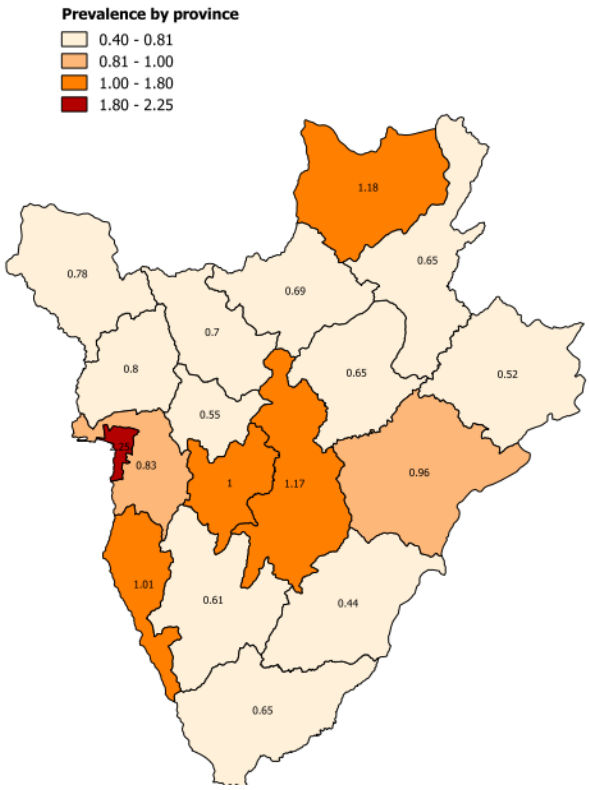
[6] http://hdr.undp.org/en/composite/HDI

[7] https://data.worldbank.org/indicator/SL.AGR.EMPL.ZS?locations=BI

HIV Prevalence: According to 2020 Spectrum modeling, Burundi's HIV prevalence is 0.7 percent. Among adults over age 15, prevalence is 1.3 percent. Prevalence varies according to age group. The most affected age group is 40-49 years old among both males and females (3.0 percent). Comparatively, prevalence for those 30-39 years is 1.4 percent, and for those 20-29 years is 0.5 percent. Overall, there is a trend toward urbanization (2.2 percent in Bujumbura Mairie versus 0.8 percent in Bujumbura Rural) and feminization of the epidemic (1.1 percent in women versus 0.8 percent in men) among those in the age range 15-49 years.

HIV prevalence also varies by province. Among adults 15-49 years, the highest prevalence is documented in Bujumbura Mairie (2.3 percent), Kirundo and Gitega (1.2 percent each), and the lowest in Rutana (0.4 percent), Cankuzo (0.5 percent) and Muramvya (0.5 percent) (Figure 2.1.1). Geographic analysis of Spectrum data shows a higher prevalence in 1) provinces traversed by major international transport routes and 2) provinces with large KP hotspots. This suggests the need to 1) target populations with higher mobility (e.g. truck and motorbike drivers), and 2) target KPs and their social and sexual networks with HIV prevention, care and treatment services.. Migratory patterns across different regions of the country have an effect on both short- and long-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 to lower retention rates in some provinces.

Figure 2.1.1: HIV prevalence by province, 15-49 years



Source: Spectrum 2020 (Naomi subnational file)

Key Populations: No recent information is available on population size and HIV prevalence for FSW, MSM, and TG. The Integrated Biological and Behavioral Surveillance Survey will be implemented this year and taken into account for COP implementation as soon as results are available. The 2013 Priorities for Local AIDS Control Efforts (PLACE) Study estimated that there are 51,482 FSW in Burundi, with a prevalence of 21.3 percent. These estimates indicated geographic variation in FSW population size, with 13,385 (26 percent) of the FSWs in Bujumbura Mairie, 12,356 (24 percent) in other urban areas, and 12,741 (25 percent) in rural areas. The 2013 PLACE study estimated HIV prevalence of 3.8 percent among clients of FSW, and 5.2 percent among sexual partners of FSW. The same study estimated a population of 9,346 MSM in Burundi, with an HIV prevalence 4.8 percent. Nearly 75 percent of MSM (6,916) are estimated to live in Bujumbura Mairie, with 13 percent (1,215) in other urban areas, and 13 percent (1,215) in rural areas. Transgender people were not specifically included in the study. A 2017 study[8] of injection drug users (IDUs) in Bujumbura Mairie (funded by the GFATM) indicated a prevalence of 10.2 percent in a population of 127 IDU survey participants; 9.4 percent of the IDUs were infected with hepatitis B virus, and 5.5 percent with hepatitis C.

Military Populations: The Burundian National Defense Force is also a priority population due to known high-risk behavior among military personnel. Results from the Seroprevalence and Behavioral Epidemiology Risk Survey conducted in 2017 estimated a 1.8 percent HIV prevalence rate among military personnel, twice the national prevalence rate. The survey highlighted several areas that need further attention, including condom use and HIV testing services. Other programs that would benefit the Burundian National Defense Force include alcohol prevention and GBV awareness.

HIV Treatment Program: PEPFAR Burundi provides direct support to a subset of facilities implementing the national HIV treatment program. As of December 2019, there were 71,743 PLHIV on ART in Burundi, of which 61,224 were receiving ART in facilities directly supported by PEPFAR (Figure 2.1.2).

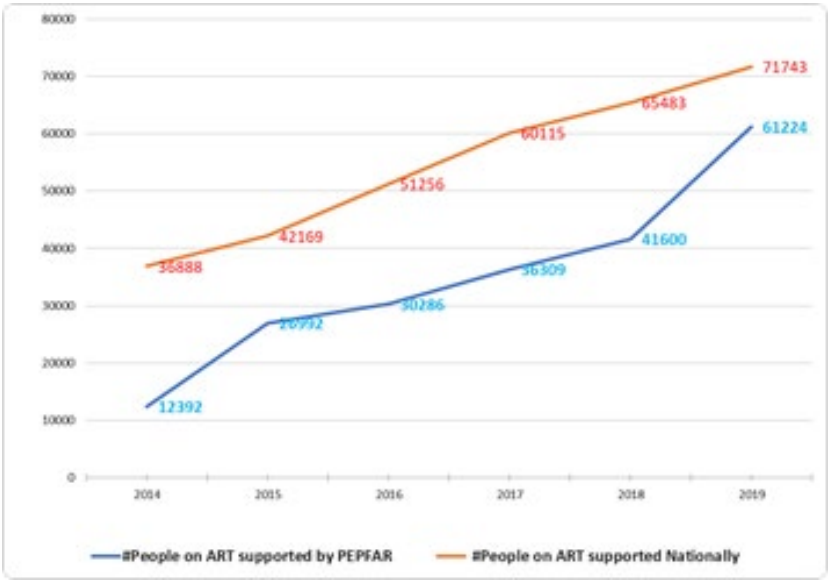
Burundi has accelerated progress toward HIV epidemic control (Figure 2.1.3). PEPFAR defines national HIV epidemic control as "the point at which the total number of new infections falls below the total number of deaths from all causes among HIV-infected individuals, with both declining."

PEPFAR Burundi investments focus on optimizing the programs and systems that support, achieve, and sustain epidemic control. PEPFAR Burundi works closely with the Government of Burundi (GOB) to support the NACP's efforts to adopt practices and policies based on the best available evidence. The GOB has adopted new international guidelines and best practices, including updates to the National Testing Strategy to optimize case-finding and prioritize index testing and self-testing, reducing the overall number of tests performed nationally. Performance-based financing (PBF) indicators have also been aligned with the new testing strategies. Burundi

[8] Nkurunziza M. HIV and harm reduction for drug users. *Alliance Burundaise Contre le SIDA et pour la promotion de la Santé*, NACP, Kenya AIDS NGOs consortium. June 2017

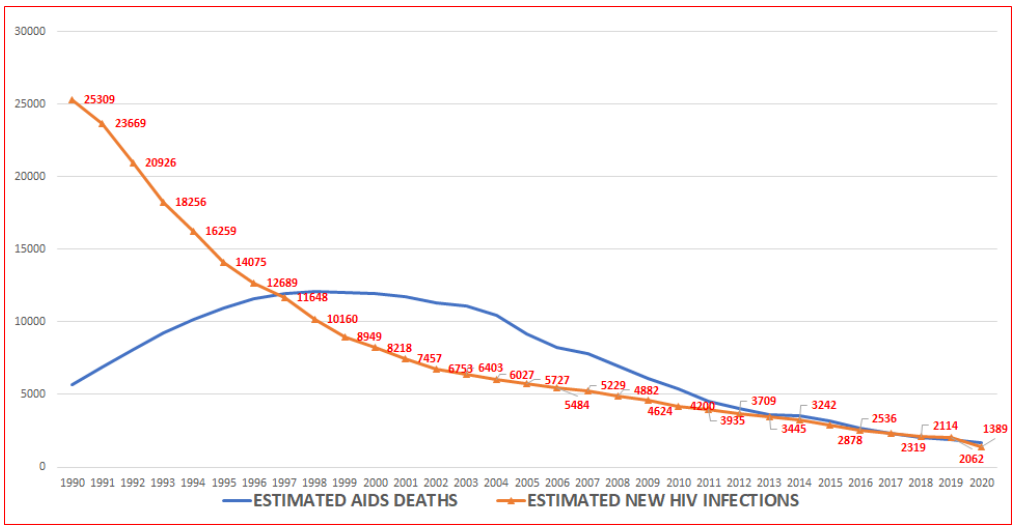
has already made significant progress in scaling up targeted case-finding strategies, and nevirapine (NVP) recall. Additionally, PEPFAR is supporting the NACP to operationalize and fully scale MMD and to complete the full transition to tenofovir-lamivudine-dolutegravir (TLD).

Figure 2.1.2: Individuals currently on ART in Burundi - all patients and sub-set receiving direct PEPFAR support



Source: DHIS2 and PEPFAR Program Reporting (FHI360 and RISE Reports December 2019)

Figure 2.1.3: Trend of new infections and all-cause mortality among PLHIV

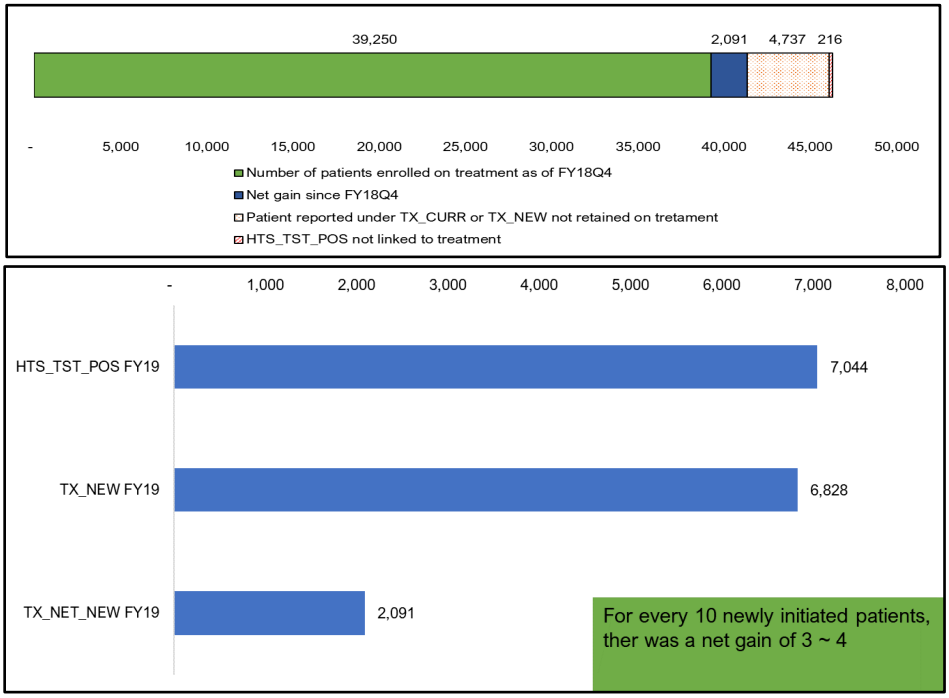


Source: Spectrum 2020

Following the expansion of PEPFAR Burundi activities into 12 new provinces, there was an initial drop in retention rates, which the IP has worked hard to resolve. There has been visible progress

over the past three quarters, but there is still work to do (Figure 2.1.4), and continued improvements are anticipated during the remainder of COP19 into COP20.

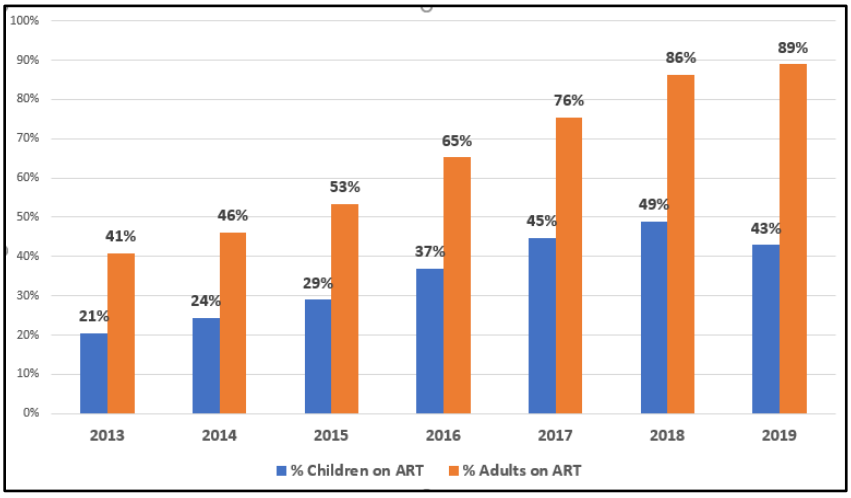
Figure 2.1.4: Proportion of clients lost from ART 2018 Q4 to 2019 Q4



Source: RAFG Program data FY2018 Q4 - FY2019 Q4

Burundi has made substantial progress in enrolling patients on ART. At the end of 2019, according to DHIS2 data, 71,743 (85 percent) of the estimated 84,702 PLHIV in Burundi were on ART (Table 2.1.2). However, treatment coverage is substantially lower among children than among adults (Figure 2.1.5).

Figure 2.1.5: Trends in ART coverage, adults (15+) and children (<15)



Source: DHIS2

VL testing is still not widely available in Burundi, and VL coverage is particularly low in some provinces (Figure 2.5.1). VL access and VL suppression is also lowest among children and adolescents. Achieving VL suppression at the population level is critical for epidemic control, and PEPFAR investments will continue to work to close the gap in VL access in Burundi.

Tuberculosis and Hepatitis: In Burundi, tuberculosis affects all segments of the population. TB incidence was estimated at 12,000 (range: 8,000-18,000) in 2018, including HIV-coinfected populations, with a rate of 111 per 100,000 population. Among HIV-positive populations, TB incidence was estimated at 1,300 (range: 850-1,800), with a rate of 12 per 100,000 population. A total of 7,202 TB cases were notified in 2018, of which 98 percent had a known HIV status. Among the 7,202 notified cases, 61 percent were among men, 33 percent among women, and 6 percent among children 0-14 years.[9]

A 2019 external review of the National TB Control Program found that TB screening remains passive in the country, and is likely to miss an estimated 47 percent of TB cases,[10] although this is likely to vary by province, based on the level of community involvement (including contact tracing) and the adequacy of the screening platforms.

In Burundi, there is little data on the epidemiology of hepatitis. Some studies with limited scope and power show that the prevalence of hepatitis B is between 5 and 10 percent and that hepatitis C is closer to 10 percent and increases with age. The National Viral Hepatitis Strategic Plan 2018 - 2022 has identified PLHIV and KPs (MSMs and IDUs) as priority populations.

[9] Global Tuberculosis Report, 2019. World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/329368/9789241565714-eng.pdf?ua=1 accessed March 22, 2020.
[10] Rapport de la revue externe du PNILT, December 2019. *Referenced in Burundi's HIV/TB Concept Note (2021-2023) submitted to GFATM, March 2020.*

Table 2.1.1: Host country government results

	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	11,971,975	100	2,713,288	23	2,729,482	23	1,127,811	9.0	1,097,102	9	2,236,332	19	2,067,960	17.0	Spectrum 2020
HIV Prevalence (%)		1		0.2		0.2		0.3		0.2		1.2		0.8	Spectrum 2020
AIDS Deaths (per year)	1,697		276		283		88		100		434		516		Spectrum 2020
# PLHIV	84,702		4,218		4,259		3,053		1,922		42,888		28,362		Spectrum 2020
Incidence Rate (Yr)		0.1													Spectrum 2020
New Infections (Yr)	1,389														Spectrum 2020
Annual births	473,197	4.2													Spectrum 2020
% of Pregnant Women with at least one ANC visit	455,172	100	210	0.05			190,682	41.9			264,281	58.1			SNIS DHIS2 2018
Pregnant women needing ARVs	5,316														Spectrum 2020
Orphans (maternal, paternal, double)	636,362														Spectrum 2020
Notified TB cases (Yr)	7,202														PNILT
% of TB cases that are HIV infected		10.6													PNILT
% of Males Circumcised	Not available														
Estimated Population Size of MSM*	9,346														PLACE Study, 2013
MSM HIV Prevalence		4.8													PLACE Study, 2013
Estimated Population Size of FSW	51,482														PLACE Study, 2013
FSW HIV Prevalence		21.3													PLACE Study, 2013
Estimated Population Size of PWID	Not available														
PWID HIV Prevalence		10.2													Ref. 7
Estimated Size of Priority Populations (Military)	100,000														
Priority Population Prevalence (Military)	1.8%														

If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.

1 Both sexes combined; 2 Ages 15+

Table 2.1.2: 90-90-90 cascade - HIV diagnosis, treatment and viral suppression*											
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 (#)	1st 90 (known positives %)	2nd 90 (on ART %)	3rd 90 (Viral Suppression %)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	11,971,975	1.0	84,702	72,150	71,743	85.1	99.4	90	1,029,490	16,413	18,246
Population <15 years	5,442,770	0.2	8,477	3,762	3,622	44.4	96.3	70	64,240	742	785
Men 15-24 years	1,097,102	0.4	1,922	2,335	2,328	121.5	99.7	79	72,237	754	697
Men 25+ years	2,081,363	1.1	28,362	21,015	20,899	74.1	99.4	93	185,780	4,615	5721
Women 15-24 years	1,127,811	0.6	3,053	5,792	5,753	189.7	99.3	82	262,419	3,077	2,686
Women 25+ years	2,236,333	1.7	42,888	39,246	39,141	91.5	99.7	92	444,814	7,225	8,357
MSM**	9,346	4.8	448	425	416	94.9	97.9	91	2,374	177	171
FSW**	51,482	21.3	10,965	5,295	5,189	48.3	98.0	89	11,654	1,503	1,478

*National data (DHIS2 as of December 2019); Spectrum 2020
**Linkages Program data (APR 2019), PLACE Study 2013

2.2 New Activities and Areas of Focus for COP20, Including Focus on Client Retention

The COP20 Vision, as presented at the COP20 Regional Planning Meeting in March 2020 and described in Figure 2.2.1, focuses efforts on:

- Reaching those left behind by ensuring that children, young people and men are diagnosed, enrolled on optimized ARVs, and retained in care;
- Raising the bar to ensure that at the national level the program will support the standardization of quality services and the scale-up of MMD, TPT and optimized ART regimens;
- Partnering with community to ensure an effective platform for community leadership and engagement across the clinical cascade and a greater community role in monitoring HIV services;
- Investing in data systems to ensure the availability and use of high-quality and timely information, critical to reaching and sustaining epidemic control.

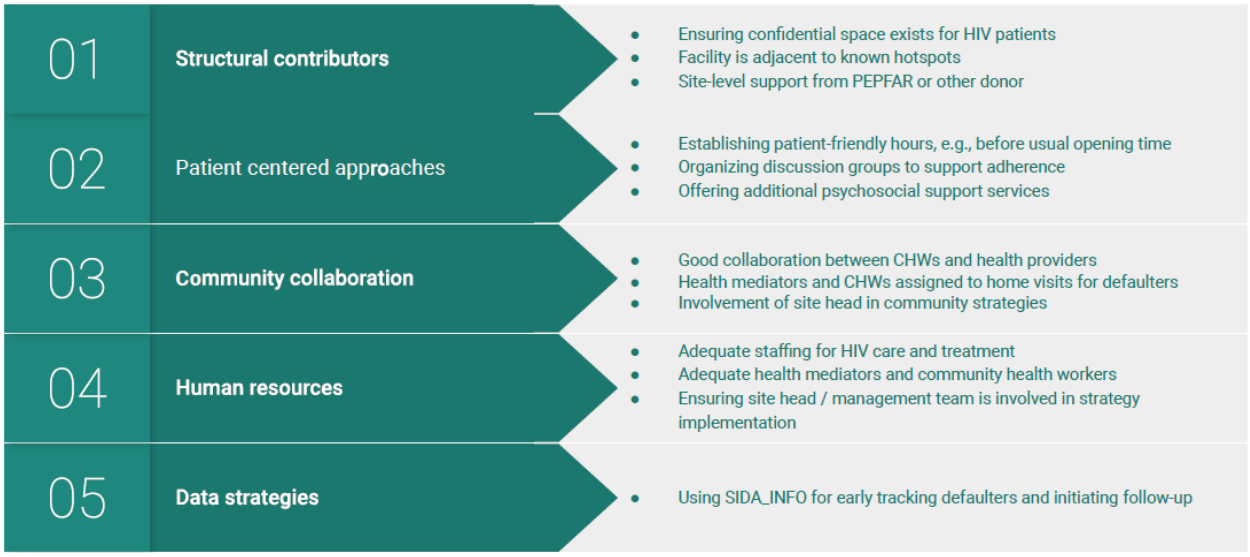
Figure 2.2.1: COP20 Vision

To operationalize this vision, the PEPFAR program will:

- invest strategically in districts and sites with the greatest needs and greatest potential for improved performance, for a maximum impact;
- prioritize children, young people and men, the populations with the lowest ART coverage;
- increase access to EID;
- focus on retaining patients in care and keeping them virally suppressed;
- make PrEP available for key populations, adolescent girls and young women, pregnant and breastfeeding women, individuals in areas with high HIV incidence or with high-risk partners, and for other identified serodiscordant couples;
- support the procurement of optimal regimens, including DTG-based regimens, 3-HP and pediatric products;
- develop and support a community-led monitoring activity, in collaboration with CSOs and networks;

PEPFAR Burundi will take advantage of lessons learned from sites succeeding in maintaining patients on ART and apply these best practices to sites that are struggling with patient retention. As described further in section 4.4, efforts to retain clients in particular in Bujumbura Mairie and Gitega provinces will be reinforced through IP program management and regular programmatic data analyses to identify which sites require remediation plans and ensure that the best practices from successful sites are being transferred. Many of these activities revolve around community collaboration and patient-centered approaches. Lessons learned from successful sites include the following:

Figure 2.2.2: Lessons learned on retention from successful PEPFAR sites



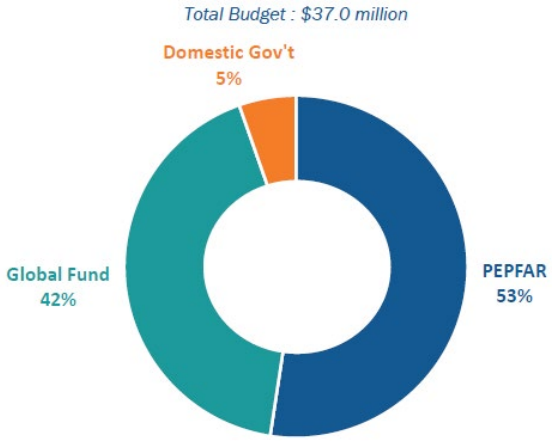
Additionally, as discussed in Section 5.4, PEPFAR will continue to support patient tracking information systems improvements, including scaling up web-based access to SIDA-Info, establishing interoperability between SIDA-Info and IBIPIMO (VL tracking app) and the DHIS2, as well as scaling up eCascade, the KP patient tracking system.

During COP20, key implementation changes will continue, addressing COP20 minimum program requirements: full implementation of optimized ARV regimens, as well as increased support for MMD implementation and closing the gaps in TPT coverage for adults and children. Together with MSPLS, PEPFAR Burundi will support development of Standard Operating Procedures (SOPs) and job aids based on these policies and guidelines and ensure dissemination in all 18 provinces. Finally, HIV commodities and supply chain systems, and the health information and surveillance system, particularly recent infection surveillance, will be strengthened as the PEPFAR Burundi program continues its shift to a sustained epidemic control model.

2.3 Investment Profile

Based on available financial data, PEPFAR remains the largest contributor to Burundi's HIV response, followed by GFATM. Together, PEPFAR and GFATM fund 95 percent of the country's HIV program costs in 2020.

Figure 2.3.1: Budget by stakeholder



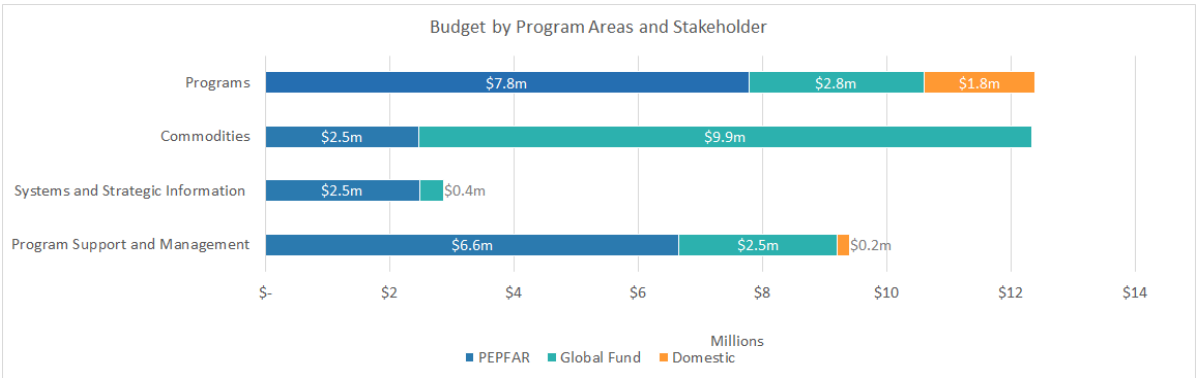
Source: HIV Resource Alignment: Burundi Country Profile, updated February 2020

Technical priorities for the current GFATM grant period include four key areas:

1. Development of a national VL strategy, including implementation of VL scale-up;
2. Improved access to and coverage of virological testing for infants born to HIV-positive mothers (early infant diagnosis);
3. Better quality of interventions for KPs; and
4. A comprehensive supply chain management plan for the country, including warehousing and distribution until the last mile.

The GFATM continues to be the largest procurer of HIV-related commodities (including ARVs and non-ARV drugs, condoms, rapid test kits, reagents, and supplies). The PEPFAR program will complement the procurement of commodities (including ARV drugs, GeneXpert cartridges, HIV self-test kits) and will continue to provide technical assistance to high-volume sites in supply chain management (Figure 2.3.2).

Figure 2.3.2: Budget by program area and stakeholder, 2020



Source: HIV Resource Alignment: Burundi Country Profile, updated February 2020

The GOB financial contribution to the NACP has increased modestly over the last few years. GOB funding covers a portion of ARV needs for the country and the NACP's operating costs, in addition to support for the broader health system (salaries, facilities, transportation network, laboratories).

Table 2.3.1: Annual investment profile by program Area, 2018 (most recent *expenditure* data)

Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country
Care and Treatment	$8,170,493	60.2	39.8	*
Prevention	$1,568,218	83.3	16.7	*
HTS	$3,457,573	93.7	6.3	*
VMMC	NA	NA	NA	NA
OVC	$1,387,074	40.1	59.9	*
Above-Site Programs	$1,749,997	71.8	28.2	*
Total	**$16,333,355****	**69.1**	**30.9**	*

Source: HIV Resource Alignment: Burundi Country Profile, updated February 2020
**Information on Government of Burundi procurements was not available by program area.*
***Does not include program management costs.*

Table 2.3.2: Annual procurement profile for key commodities, 2018 (most recent *expenditure* data)

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	$2,070,322	30.1	69.9	*	0
Rapid test kits	$284,603	0.0	100.0	*	0
Medicines	$115,731	0.0	100.0	*	0
Lab supplies	$243,481	0.0	100.0	*	0
Condoms and lubricant	$63,907	0.0	100.0	*	0
PSM costs	$570,850	0.0	100.0	*	0
Health equipment	$219,252	0	100	*	0
Total	**$3,512,585**	**18.2**	**81.8**	*	**0**

** Information on Government of Burundi procurements was not available by category.*

Table 2.3.3: Annual USG non-PEPFAR funded investments and integration					
Funding Source	Total USG Non-PEPFAR Resources (FY20)	Non-PEPFAR Resources Co-Funding PEPFAR IMs (FY20)	# Co-Funded IMs	PEPFAR COP20 Co-Funding Contribution	Objectives
USAID MCH	$2,500,000	NA	NA	NA	NA
USAID TB	NA	NA	NA	NA	NA
USAID Malaria	$8,000,000	$4,124,500	1	$6,263,128	*Supply chain systems and data/reporting enhancements (GHSC-PSM)*
Family Planning	$4,500,000	1,697,999	2	$1,800,000	*Access to Family Planning (WIYIZIRE and GIRITEKA, GHSC-PSM*)*
Total	**$15,000,000**	**$5,822,499**	3	**$6,309,224**	

**The GHSC-PSM PEPFAR contribution is included in the line above.*

2.4 National Sustainability Profile Update

The Sustainability Index and Dashboard (SID 4.0) was completed in October 2019 in collaboration with UNAIDS, the National AIDS Council, the NACP, UN agencies, the GFATM grants recipients, CSOs, the National Network of PLHIV, and public sector representatives. SID 4.0 includes new indicators in the categories of Market Openness and Data for Decision-Making Ecosystem.

2.4.1 Progress addressing sustainability strengths and vulnerabilities

Sustainability Strengths

Domain: Governance, Leadership, and Accountability

- ***Planning and coordination***: (1) The GOB has made significant strides in its capacity to develop, plan, budget, and coordinate HIV response activities. With the support of donors, the GOB has developed an updated five-year National Strategic Plan (NSP 2018-2022) that details principles, priorities, and actions to guide the national response to the HIV epidemic. This NSP is aligned with the new National Health Development Plan 2019-2023 (National Health Development Plan III), which was developed based on a collaborative Health Sector Assessment. (2) The GFATM Country Coordinating Mechanism (CCM) has been reconfigured. The new team is receiving technical assistance from the community of donors to reinforce its performance and to be restored to its central place as a national coordination body. (3) The Health and Development Partner Framework (*Cadre de Concertation des Partenaires pour la Santé et le Développement* –

CPSD) is functional under the leadership of the Minister of Health and the Fight Against AIDS and the active participation of health donors.

- ***Civil society engagement***: In Burundi, there is active civil society engagement in HIV advocacy, decision-making processes, and service delivery in the national HIV response. Improving community engagement throughout the clinical cascade is a key focus of the COP20 strategy. In particular, PEPFAR Burundi will expand support to CSOs to improve the linkage between community and facility services, and will initiate a small grants program to support community-led monitoring of HIV service quality.
- ***Public access to information***: The GOB disseminates on a regular basis reliable information on the implementation of HIV policies and programs, including goals, progress, and challenges toward achieving HIV targets. However, data quality (including timeliness and accuracy) and effective use still need improvement. In addition, full information on GOB financial investments related to the national HIV response are not readily available.

Domain: National Health System and Service Delivery

- ***Quality management***: The SID process documented improvement in quality management, including structures to support QI as an integral component of district and site-level services. QI processes are an integral part of the technical assistance approach implemented by PEPFAR-funded partners. In COP20, expansion of SIDA-Info will be an important focus, together with dedicated support as needed to optimize use of the data for program management.

Domain: Strategic Financing and Market Openness

- ***Domestic resource mobilization***: Despite small increases in GOB contributions to the national response, further efforts are needed to improve resource mobilization, efficiency, and transparency.
- ***Technical and allocative efficiencies***: The GOB has shown that it is using data on the epidemic and costs of providing HIV services to allocate resources to areas of highest burden. Over the past several years, the GOB has improved efficiency through streamlining management and integrating related medical services. This is one SID element in which there is clear incremental improvement over time.
- ***Market openness***: Burundi scored a 10.0 on this element in SID 4.0, indicating that host country and donor policies do not negatively distort the market for HIV services by reducing participation and/or competition.

Domain: Strategic Information

- ***Performance data***: The GOB routinely collects, analyzes, and makes available HIV service delivery data to track program performance. It also leads routine data review meetings at national and sub-national levels to review data quality gaps and outline improvement plans. A Health Management Information Systems (HMIS) Plan 2018-2022

has been developed. There have been improvements in the GOB stewardship of HIV data in the last year, especially with regard to District Health Information (DHIS2). Collection, validation, reporting, and utilization of data for HIV management has improved significantly at both the facility and district levels, although there remains a need to focus the attention of service providers and managers on data utilization for epidemic control.

Sustainability Vulnerabilities

Domain: Governance, Leadership, and Accountability

- ***Private Sector Engagement***: The private sector has expressed interest in opportunities to support HIV services, but the lack of systems and policies in place to support private sector engagement in HIV programming limits the contributions. Though the will of the government and private sector is growing, the enabling environment for private health service delivery remains a barrier. Formal pathways to collaboration have yet to be fostered.

Domain: National Health System and Service Delivery

- ***Commodity security and supply chain:*** Although improvement is evident through the SID process on this element, it remains a clear vulnerability in the national health system. The lack of robust domestic financing is still a sustainability concern, including for ARVs, test kits, condoms, and the supply chain plan itself. Sufficient budget has not been made available to support the national administrative body authorized to manage supply chain activities.
- ***Service delivery:*** HIV services are accessible to all Burundians through the public health sector. However, performance is weak in the areas of targeted HIV testing services, and ART patient retention, including preventing and finding those lost to follow-up (LTFU). PEPFAR will continue to support the implementation of strategies to address these weaknesses. Service delivery is the responsibility of Burundi's decentralized district health system. There are important opportunities for DHTs to play a more central role in providing technical oversight for HIV services. PEPFAR will improve DHT performance in its supervisory and support functions to health facilities and increase DHT capacity for systemic functions essential to supporting sites in delivering quality HIV services and helping "boost" the scale-up of new HIV strategies.
- ***Laboratory***: The main challenges remain weak national stewardship of the VL strategy, system maintenance, a limited number of qualified lab technicians, and a weak sample transportation system. PEPFAR Burundi, with critical support and coordination leadership from GFATM and WHO, will continue to support the implementation of the National Viral Load Scale-up plan under the umbrella leadership of the MSPLS.

Domain: Strategic Information

- ***Epidemiological and health data***: Additional capacity is still required for ongoing epidemiologic activities. Supplementary support is needed for improving capacities at the national level for analysis of data and evidence-based decision making. Data on supply chain stock information is still weak and in need of support. PEPFAR will support improvements to and expansion of SIDA-Info and use of unique identifiers to track individuals through the clinical cascade.
- ***Financial/expenditure data***: Structured expenditure data collection exists in Burundi, but is primarily initiated by outside donors. Data are also not collected annually except through the PEPFAR expenditure reporting process.
- ***Data for Decision-Making Ecosystem***: Some administrative elements are in place to support the data for decision-making ecosystem in Burundi. HIV-specific elements, however, are either not available or not integrated. For example, there is an operational civil registration and vital statistics system, but there is not yet a unique identification system for HIV or health. There is also not yet a data warehouse with interoperability capability across HIV and other related health program databases or information systems.

2.4.2 COP20 priorities for addressing SID sustainability vulnerabilities

During FY20, special attention will be given to health system strengthening at the national and district levels, with more tangible and better-tracked interventions to ensure impact. Non-service-delivery activities (Appendix C) and assistance from PEPFAR Burundi will support the GOB in the development of a framework for quality control approaches, as well as their adoption and systematization. These investments will also improve the delivery and the quality of laboratory services. PEPFAR Burundi will also continue to strengthen supply chain management, in coordination with the GFATM, to assure adequate planning, ordering systems, distribution, and reporting, including communications, between central and peripheral levels to eliminate stock-outs in health facilities.

2.4.3 Donor investments in SID areas

PEPFAR and GFATM investments in SID areas are described throughout this document. Major investments related to SID areas focus on data availability and use; laboratory systems; commodity improvement/supply chain management; quality improvement; and effective policies and plans.

2.4.4 Transitioning to local partners

During COP19, PEPFAR Burundi made awards to two local partners to implement a GBV and an OVC activity. These activities will continue through COP20.

The GBV mechanism ensures the integration of GBV services (prevention, mitigation, and post-violence care) into existing PEPFAR-supported HIV services for national-level impact. The

mechanism provides technical assistance and resources to USAID partners in the HIV clinical cascade, OVC, and KP program areas to support integration and mainstreaming of GBV services and programmatic considerations into activities. The local partner provides social and cultural competencies and may tap into global technical expertise to provide state-of-the-art advice, guidance, design, evaluation, and standards. The new mechanism will continue to support the DHTs in six provinces with the highest rates of GBV (Bujumbura Mairie, Bujumbura Rural, Gitega, Kirundo, Kayanza, Rumonge, and Makamba) to increase the coverage and quality of the GBV component of the HIV response in Burundi. The local partner will also work at a non-service-delivery level with the GOB and with GBV stakeholders such as the United Nations Population Fund (UNFPA) to advocate for GBV prevention, mitigation, and post-violence care.

The OVC mechanism will focus on direct service delivery in five provinces, covering 9,000 OVC 0-17 years, including the current cohort in Bujumbura Mairie, Bujumbura Rural, Kayanza and Gitega (estimated at 6,519). OVC activities will continue as established in COP19, including the expansion to Kirundo. The OVC program will expand in COP19 to reach both boys and girls 0-17, and will prioritize enrollment of children living with HIV (CLHIV) and their households. The local partner is building on the former project that focused on adolescent girls and young women (AGYW) to implement the following package of services:

1. Health, with a focus on supporting CLHIV with adherence, ensuring viral suppression, and disclosure counseling, access to other health and nutrition services and/or referrals, sexual and reproductive health, including better access to adolescent-friendly services. A particular focus will be made on referral of siblings for HIV testing, support for adherence to ART and access to VL testing among HIV-positive OVCs. The OVC program will also support clinical partners to complete index testing of biological children of HIV-positive women.
2. Case management, with a focus on family-centered, strengths-based programming, and monitoring of outcomes and benchmarks associated with health, stability, safety, and schooling through case managers during household visits;
3. Education assistance to facilitate enrollment and progression in primary and secondary education, returning back to school for out-of-school girls, and vocational training;
4. GBV prevention and response with a particular focus on 9-14 year old girls and boys; and
5. Socio-economic support to families with a focus on parents/caregivers and older girls through digital and traditional saving groups.

2.5 Alignment of PEPFAR investments geographically to disease burden

In response to the GOB's request during COP18 planning, the PEPFAR program in Burundi expanded nationally to all of the country's 18 provinces and 47 health districts. To develop an effective strategy and sharpen the focus on delivering high-quality HIV services, PEPFAR Burundi used the latest DHS data and Spectrum estimates, combined with subnational data on current

achievements and gaps, to identify specific needs of sub-categories of populations, available resources and infrastructure at the district level. Two categories of provinces were identified in COP19 to maximize resources and reach epidemic control: *Optimize* and *Sustain* provinces (Table 2.5.1 below). In Sustain provinces, the focus will remain on reaching at least 95% retention for all ages and sex bands, prevent client losses and ensure that all ART patients continue to receive high-quality treatment and care services, including access to VL testing and adherence support services to guarantee long-term VL suppression.

District-level data show varying degrees of success in case identification and retention on ART in *Optimize* provinces (Figure 2.5.1) In these provinces, *districts and high-volume sites* will receive support for targeted case finding through index testing and testing of symptomatic clients presenting at facilities, to close the gaps on ART coverage, improve the level of retention in care, and increase access to VL testing. Geographic and population prioritization are expanded upon in Section 3.0.

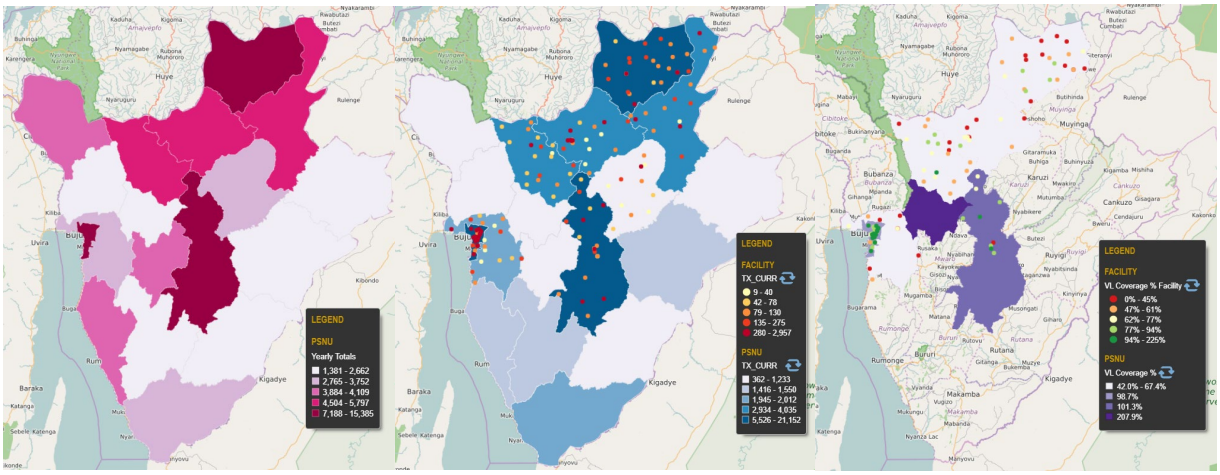
Table 2.5.1: *Sustain* or *Optimize* approach by province

Sustain provinces	*Optimize* provinces
Focus on maintaining ART coverage, retention in care, access to viral load and suppression	Case detection in specific sub-populations, ART coverage, retention in care, access to viral load and suppression
Bujumbura Mairie, Bururi, Kirundo, Makamba,, Ngozi, Rumonge	Bujumbura Rural, Karusi, Gitega, Kayanza, Mwaro,, Muramvya, Rutana, Cankuzo, Cibitoke, Bubanza,Muyinga, Ruyigi

NB. Based on updated 2020 Spectrum estimates, PEPFAR changed the designation of two of the provinces listed in Table 2.5.1. The HIV prevalence estimate for Ruyigi province increased in 2020, moving Ruyigi to the Optimize category for more intensive support. HIV prevalence estimates for Makamba and Muyinga provinces decreased in 2020 and will therefore be shifted into the Sustain category.

The differences in the package of services between *Optimize* and *Sustain* provinces are the intensity of efforts, the frequency of site visits, and the investment made to manage the transition to DHTs to ensure that key elements of the HIV programme are sustained over time.

Figure 2.5.1: PLHIV, ART and Viral Load Coverage



Source: Panorama, FY2020 Q1 data

2.6 Stakeholder Engagement

The NACP, technical and financial partners (WHO, UNAIDS, UNDP/GFATM), civil society representatives including KP organizations, PEPFAR IPs, and other stakeholders provided input for COP20 through participation in key sessions during a strategic planning retreat held at the U.S. Embassy in Bujumbura in January 2020. These sessions were an opportunity to review PEPFAR and national data, discuss the main challenges at community and national levels, share COP20 priorities, and collect opinions on the proposed strategies toward epidemic control.

Workshops and working sessions were organized with all stakeholder categories, before and after the strategic planning retreat, to deepen the discussions on important subjects: strategies to reinforce community engagement in PEPFAR programs, key systemic challenges to be considered in the development of above-service delivery strategies (Appendix C/Table 6), the PEPFAR program's geographic expansion, and areas of synergies with the GFATM.

PEPFAR Burundi engaged with stakeholders outside of the strategic planning retreat to reach consensus on national targets, discuss SIDA-Info (national electronic medical records system [EMR]) progress and plans for scale-up and interoperability with the DHIS2, complete the commodities tools, and confirm a way forward for the forthcoming community monitoring system.

Stakeholders were also invited to take part in the COP20 review meeting held in Johannesburg from March 2-6. Participants included the Director of the NACP, Burundi's GFATM Portfolio Manager, and representatives of WHO, UNAIDS, UNDP, and CSOs in Burundi.

Most importantly, the period of COP20 planning coincided with the development of the 2021-2023 GFATM Concept Note. The joint planning, activity mapping and alignment exercises that resulted from these two processes, under the leadership of the NACP, has resulted in a common vision for

this final COP20 proposal and a set of national priorities that are aligned along the funding streams.

Given the anticipated shifts (geographic and programmatic) in the PEPFAR program, the emphasis on epidemic control, and the required increased efficiencies in resource deployment, strengthening coordination with the GFATM implementing partners and coordination structures and the NACP will be a critical component of PEPFAR's partner management and coordination strategy. Stakeholders will continue to be engaged throughout the COP20 planning and implementation process through ongoing consultations, including sharing of quarterly results at the national and provincial levels.

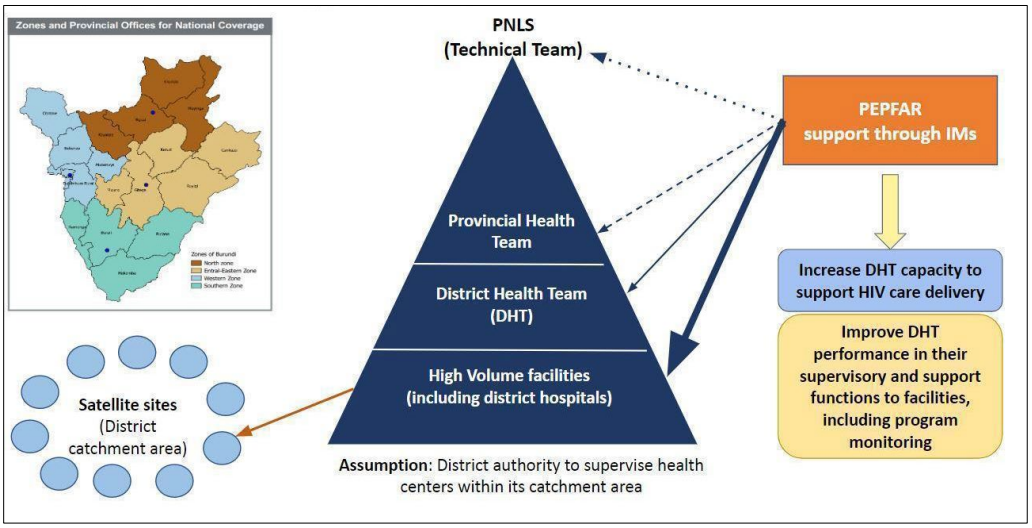
3.0 Geographic and Population Prioritization

3.1 PEPFAR Burundi's COP20 Geographic Priorities

The GOB and its partners are dedicated to reaching the UNAIDS 95-95-95 targets with the aim of achieving epidemic control in Burundi. In COP19, the PEPFAR program expanded support to cover the country's 18 provinces and 47 health districts to ensure the broad coverage of effective HIV interventions needed to have a sustained impact on HIV epidemic control in the country. The main objectives of this district-level approach (Figure 3.1.1) are twofold: i) increase the DHT capacity to support HIV service delivery; and ii) improve the performance of DHT supervisory and support functions to health facilities.

Shifts planned in COP20 build on this framework. With the introduction of a new clinical partner in COP19, the burden of program coverage will be shared across the two major clinical IPs in COP20. A particular focus will be put on supporting and reaching targets in Bujumbura Mairie and Gitega provinces, the two highest burden provinces for which data show progress in enrolling new patients on treatment paired with chronic retention challenges.

Figure 3.1.1: Geographic and technical approach



In each district, PEPFAR support is directed to high-volume facilities, including district hospitals. Characteristics of priority sites are described in the table below.

Table 3.1.1: Priority sites

• District hospitals • High-volume sites (facility and community) • Case-finding for targeted populations (*Optimize* services) and large ART cohort (*Sustain* services) • Sites that support 80% of total patients in areas in which the largest numbers of PLHIV reside • TB reference health facilities • KP hotspots • Youth-friendly services

PEPFAR Burundi will complement GFATM investments by providing technical assistance for optimized quality improvement and focused investments that prioritize epidemiologic impact. More specifically, PEPFAR Burundi will coordinate with the GFATM in the implementation of (1) strategies aimed at retaining and reengaging patients in care (upscale of MMD, community drug distribution points, TPT, and others); and (2) health system strengthening activities (lab optimization, commodity security and health information system strengthening).

Four regional IP offices will be maintained and strengthened to support ongoing national coverage.

Table 3.1.2: Zones and provincial offices for national coverage

- **Northern Zone**: Kayanza, Muyinga, Ngozi & Kirundo - Existing office in **Ngozi**
- **Central-Eastern Zone**: Ruyigi, Cankuzo, Gitega, & Karusi - Existing office in **Gitega**
- **Western Zone**: Bujumbura Mairie, Bujumbura Rural, Cibitoke, Muramvya and Bubanza - Existing office in **Bujumbura Mairie**
- **Southern Zone**: Bururi, Makamba, Rutana, Mwaro & Rumonge - Existing office in **Bururi**

PEPFAR implementing partners will continue to implement technical assistance and mentoring approaches to increase their site-level presence at high-volume sites and provide direct support to facility-based providers, particularly at low-performing sites with the capacity for significantly higher volume. They will also maintain support for the DHT to improve the quality of services provided throughout the district. Frequent and consistent site-level monitoring will ensure that program strategies are being implemented with quality and efficiency, while course corrections are made as needed.

Table 3.1.3: Current Status of ART saturation

Prioritization Area	Total PLHIV/% of all PLHIV for COP20	# Current on ART (FY19)	# of SNU COP18 (FY19)	# of SNU COP20 (FY21)
Scale-up Aggressive	52,668 (62%)	27,651	12	12
Sustained (including Military)	32,034 (38%)	44,092	7	7

3.2 Categorization of Optimize and Sustain Provinces

PEPFAR Burundi has categorized Burundi's 18 provinces into *Optimize* and *Sustain* provinces based on ART coverage gap. The differences between the two categories are described in the table below; more details are provided in the following subsections. As mentioned above, Ruyigi has been reclassified as an *Optimize* province based on 2020 Spectrum estimates, while Makamba and Muyinga are being reclassified as *Sustain* provinces.

Table 3.2.1: Summary of focus for *Optimize* and *Sustain* provinces

	***Optimize* provinces**	***Sustain* provinces**
Provinces	Bubanza, Bujumbura Rural, Cankuzo, Cibitoke, Gitega, Karusi, Kayanza, **Muyinga,** Mwaro, Muramvya, Rutana, **Ruyigi**	Bujumbura Mairie, Bururi, Kirundo, **Makamba,** Ngozi, Rumonge
Main focus	Case-finding in targeted groups, ART coverage, retention, access to VL testing and support for VL suppression	Closing the ART coverage gaps (in particular for Peds and adolescents), retention, access to VL testing and support for VL suppression
Community engagement	Key component of the PEPFAR strategy	Maintenance interventions; Targeted programming to higher-risk populations (KP, OVC, AGYW)
Support to DHT	Full package of support; Monthly to quarterly support from IP, depending on the level of priority of the districts.	Light touch on a quarterly basis. Transition readiness preparedness and focus on enhancing country ownership

3.3 Differentiation of Support across Optimize and Sustain Provinces

PEPFAR Burundi has differentiated the level of support provided to DHTs and sites in both *Optimize and Sustain* provinces based on epidemiological factors (such as PLHIV burden, TB co-infection rates, and known hotspots) and structural factors (such as level of donor support), and progress toward 95-95-95 achievements. Each district and facility will have a tailored support plan based on actual needs and targets. Across *Optimize* and *Sustain* provinces, PEPFAR Burundi will implement a robust approach to partner management and stakeholder coordination that is responsive to data. Intense partner management and regular monitoring of performance will ensure accurate data collection and recording, and improved use of data will help to readjust focus and to develop site-specific remediation plans. Regular coordination and collaboration with the GOB at the national and district levels, as well as with GFATM implementing partners and coordination structures, will be crucial to maintaining quality and to ensuring a sustainable response.

3.4 Strengthening community engagement

While CSOs are key actors in the HIV response in Burundi, several factors are hindering the full realization of the potential contribution of community health workers (CHWs) in the successful delivery of HIV and TB services, in particular for population-based HIV interventions. These factors include multiple actors implementing but with inadequate coordination and with unclear competencies, roles, and package of services; donor-driven management and funding; weak linkage with the health system; and poor supervision and quality control. During COP20, PEPFAR will continue to contribute to the remediation of these issues. Community involvement in

PEPFAR programming is anticipated to be more robust in *Optimize* provinces, which are still struggling to enroll and keep PLHIV in care. Efforts will be made to correlate the density of CHWs to areas with a high burden of PLHIV and KP through improved donor collaboration and CSO coordination.

Reinforcing the utilization of CHWs will help reduce human resource shortages at a provincial level, which remains a critical issue in Burundi affecting HIV and TB healthcare delivery.

Based on continuous monitoring of data and performance, PEPFAR will continue to refocus its efforts and target the highest risk subgroups of priority populations, including under-served or excluded vulnerable populations. Existing and new patient-centered community HIV models will be utilized to link priority population groups with available services. Bidirectional referrals between community and facility services will be fully integrated into PEPFAR programming at site and district levels.

In addition to the two local partners that will implement OVC and GBV programming, IPs will continue to strengthen community-based services alongside the HIV clinical cascade. The package of PEPFAR interventions at the community level includes:

- Supporting community-based organizations to create demand for services, in particular for dolutegravir (DTG)-based regimens and VL testing;
- Maintaining the level of effort by CHWs to perform targeted high-impact testing (e.g., finding men, children, and adolescents living with HIV), linkage, referral or transfer to public health facilities, and ensuring the provision of differentiated models of care adapted to various sub-groups of priority populations;
- Supporting functional community ART distribution points and support groups;
- Expanding community-led treatment literacy efforts, including the development and dissemination of easily understandable and culturally appropriate materials;
- Supporting U=U (undetectable = untransmissable) campaigns, seeking to reduce HIV-related stigma and discrimination and making sure that every PLHIV receives at least one annual VL test and remains virally suppressed; and
- Ensuring that community mobilization interventions that address harmful gender norms perpetuating GBV target all community influencers, including parents/caregivers, male partners of AGYW, faith and traditional leaders.

3.5 Support for DHTs and system strengthening at the district level

PEPFAR Burundi will provide technical assistance to ensure increased capacity of the DHTs to support sites in delivering quality HIV services and help "boost" the scale-up of new HIV strategies. Key activities/outputs to improve DHTs capacity for systemic functions are described in the table below. While all provinces will receive this support, the investment will be focused on

the *Optimize* provinces, with particular emphasis on those that had not received intensive PEPFAR support prior to COP19.

Table 3.5.1: System Activities for DHTs

PLANNING SYSTEMS CAPACITIES • Performance review and bottleneck analyses • Data analysis and sharing used in planning processes • Support in the development and monitoring of quarterly action plans	
PROCUREMENT AND SUPPLY CHAIN MANAGEMENT • Improvement of efficiency in logistics • Technical assistance on information systems • Improvement of stock control • Introduction of maintenance plans • Improvement of commodities distribution • Skills improvement on logistics management	**DATA & INFORMATION SYSTEMS** • Improvement of registry of patient data for pediatric and adult patients • Improvement of facility-based information systems such as systematic cleaning of patient and facility records in SIDA-Info and data quality audits • Improvement of follow-up on defaulters
QUALITY ASSURANCE/QUALITY IMPROVEMENT • QA/QI through the establishment of core standards and program reviews • QI initiatives to target a particular problem or service, such as early infant diagnosis • Training to update providers' skills or introduce new norms, protocols, and strategies; • Technical skills improvement (lab technicians, providers trained on counselling) • Re-engineering of patient flow in high-volume facilities to decrease patient waiting times, improve internal referrals and increase the efficiency of services • Strengthening the links between community and health facilities to improve demand for and access to services • Integration of community and facility HIV/TB response	**LABORATORY** • Assessment of turn-around time for laboratory tests to identify and address bottlenecks that cause delays and affect initiation and adherence to treatment • Improvement of lab info for data quality control • Preventive maintenance of lab equipment • Plan developed for lab sample collection • Improved efficiency in logistics, including better follow-up on patient status (VL); pre-treatment of lab samples/faster processing of samples; reduced waiting time for lab results; improved quality of test results

In addition, IPs will be encouraged to work with DHTs to address weaknesses within health governance systems. IPs will build DHT capacity to provide leadership and oversight functions within their area of responsibility, in particular where there is an overall poor accountability of performance toward attaining 95-95-95 goals. MER data will be used to prioritize SIMS visits and facilitate the development and implementation of focused remediation actions.

3.6 Priority populations

To achieve COP20 targets, PEPFAR Burundi will intensify strategies to reach the populations with the greatest identified gaps in ART coverage, in both *Optimize* and *Sustain* provinces.

Table 3.6.1: Priority populations

Priority populations
• KPs (MSM, TG, FSW) • Priority populations: sexual partners of KPs and PLHIV; children of KPs; OVC; AGYW; fishermen, truck drivers, miners • Other subgroups of the general population: men over 25; pregnant women, breastfeeding women, and infants through PMTCT • TB patients • STI patients • Military populations

In terms of **case identification**, Spectrum estimates by sex and age highlight continued gaps for both men and children (Table 3.6.2). In COP20, case identification will be highly targeted and focus on closing gaps in these populations. Note that during the remaining months of COP19 implementation PEPFAR Burundi will accelerate targeted case finding in key geographies and populations where case identification is the primary limitation to treatment coverage.

Table 3.6.2: Case identification by sex and age (First 95, Spectrum estimates, 2020)

Men			Women			Children		
PLHIV	Who know their HIV-positive status	1st 95	PLHIV	Who know their HIV-positive status	1st 95	PLHIV	Who know their HIV-positive status	1st 95
30,283	**23,350**	**77%**	**45,940**	**45,038**	**98%**	**8,477**	**3,762**	**44%**

Source: *PLHIV estimates are from Spectrum 2020; HIV-positive status is from DHIS2 as of December 2019.*

In terms of **ART coverage**, age- and sex-disaggregated analyses show that men 30-44 and children 0-14 also have the greatest coverage gaps (Table 4.1.2). Disparities in ART coverage by population are also seen by province.

To address these gaps, PEPFAR is directing its implementing partners to scale up successful strategies tailored by age and sex, concentrating efforts on ART linkage and retention, in geographic locations with the greatest needs and the highest burden. More broadly, implementing partners will also be directed to tailor HIV interventions to address specific local needs to achieve epidemic control efficiently in both *Optimize* and *Sustain* provinces.

4.0 Client-Centered Program Activities to Reach Epidemic Control

In COP20, based on available PEPFAR and national data and on discussions with the GOB, PEPFAR Burundi will continue to provide technical assistance to Burundi's 18 provinces to optimize HIV services across the clinical cascade, but with a sharp focus on ART patient retention and viral suppression.

PEPFAR Burundi will support targeted case-finding, rapid ART initiation, retention on ART, and access to VL monitoring at high-priority sites that comprise 80 percent of the total ART cohort. The program's support to DHTs and sites will be tailored depending on PLHIV, TB, STI burden, and progress toward 95-95-95 goals. The highest-priority districts will receive frequent, as-needed technical assistance by a regional office and local staff. Medium-priority districts will receive monthly technical assistance visits, and lower-priority districts will receive quarterly technical assistance visits.

4.1 Finding the Missing and Getting them on Treatment

4.1.1 Case finding

While the focus on COP20 will be on retention of patients on ART, testing strategies are being optimized and implemented in a targeted manner to find the "left-behind" HIV-positives and initiate them on treatment.

PEPFAR Burundi's testing strategy will continue to emphasize shifting away from lower yield modalities and focus on targeted index testing and self-testing for hard-to-reach populations. In COP20, PEPFAR Burundi will focus in particular on index testing to help identify men, and family tree/index testing, including in PMTCT settings. The program will also support HIV testing of clients entering services through STI, TB, and GBV post-violence care entry points, and all women at antenatal care (ANC) and post-ANC. Routine PITC approaches will be more targeted, focusing on symptom-based screening and avoiding use of overly restrictive screening tools that have the potential to turn away asymptomatic HIV-positive individuals from testing.

Across all testing modalities, PEPFAR Burundi will ensure that a rights-based approach to case-finding is undertaken; informed consent is consistently requested; clients requesting a test are not denied; and IPV/GBV referrals to non-clinical GBV services (psychosocial, legal, child protection, economic strengthening) are offered to survivors of violence in all facilities and community sites implementing index testing.[11]

[11] New HIV Testing Strategies in PEPFAR COP19: Rollout and Human Rights Concerns, amfAR, 2019 Available at: https://www.amfar.org/cop19/

PEPFAR Burundi's testing strategy will continue to promote the partnership with community health workers and CSOs to accelerate successful testing practices and ensure that patients will receive a positive and respectful clinical experience.

To achieve the 95-95-95 goals at the national level across all populations in Burundi, PEPFAR implementing partners will tailor interventions to geographies and age, sex and risk groups to replicate best testing practices and lessons learned from high-performing districts and sites.

Table 4.1.1: Testing strategies by sub-groups of populations

Population	Lessons learned during FY19/20	Key testing strategies
Children (peds and OVC)	Three HTS modalities make up 97% of new cases: in FY19, case finding by modality for <15 was: • Index (76%) • VCT (17%) • Pediatric outpatient (under-5 clinics) (5%) Refocus pediatric testing away from other PITC	• Active facilitation of testing for all children at risk of HIV infection • Use of index testing (especially among FSW) to elicit biological children (<19 years) of HIV-positive parent • Improved collaboration between OVC and clinical partners to ensure that eligible children (and caregivers) are tested and linked • Referral of eligible children by clinical partners to OVC programs • Increase access to infant virological testing/EID (more in Section 4.8) to increase the number of HIV-exposed infants tested by two months of age through (a) demand creation activities in mentor-mother groups and (b) reducing sample turnaround time.
Adolescents and young people (10-24)	Evidence shows that this age group is less likely to get tested because (a) testing services are unwelcoming or inappropriate for younger people due to HIV-related stigma, age-related stigma and discrimination from healthcare workers, and (b) laws that limit young people's ability to access services on their own.	• Index testing (with a focus on community index testing) • HIV self-testing • Youth-friendly services (community outreach, facility settings) • OVC programming (targeted testing)
Adult women	Women have the highest testing rates in Burundi, but evidence indicates that testing at ANC decreased in FY19 due to a national Rapid Test Kit (RTK) shortage.	• ANC platforms will ensure 100% testing of women entering ANC (with linkages to PrEP and PMTCT programs as needed) • HIV-positive male index testing. • Recency testing will be launched.
Adult men	Evidence indicates that men are less likely to get tested for HIV in non-clinical settings, and less likely to accept index testing in facilities.	• Index testing (focusing on ANC, STI clinics, through FSW, with referrals to IPV/GBV services as indicated) • Targeted community-based testing, workplace, venues for at-risk men, and home-based testing • Self-testing (for hard-to-reach men) • Male-friendly testing services ("men-only" and evening clinic hours) • Recency testing will be launched

Population	Lessons learned during FY19/20	Key testing strategies
Key populations	Testing services for KPs must be highly targeted, using strategic information and network analyses to ensure the ability to reach into the affected communities	• Expand and/or relocate KP services to target unsaturated hotpots • Optimize self-testing, social, and sexual network testing for MSM, FSW and TG • Drop-in centers, mobile testing (hotspots, informal settlements) • Recency testing will be launched • Increase # of sexual partners elicited
Military	Index testing has been a highly effective strategy to identify military/male cases compared to other testing modalities.	• Elimination of high-volume/low-yield HTS modalities • Intensive focus to high-yield modalities and increased volume of index testing to prioritize contacts of people newly identified HIV positive and TX_CURR patients that are not virally suppressed • Recency testing will be launched

In COP20, PEPFAR Burundi will leverage the ANC platform for case finding of HIV-positive women, including to reach and test sexual partners and biological children of positive women. Adult women will also be reached through HIV-positive male index testing. Through all modalities, the program will support referrals to intimate partner violence (IPV)/GBV and social risk reduction services.

The KP program will remain flexible, adapting to results from the GFATM-funded KP-specific Integrated Bio-Behavioral Surveillance Survey expected during COP19 implementation. To increase case-finding volumes, the team will take state-of-the-art strategies to scale, including the use of index testing and self-testing to ensure higher-yield outcomes, and will continue to capitalize on incentivized social networking strategies or Enhanced Peer Outreach Approaches (EPOA), including use of online communication platforms and information communication technology. The program will also restart index testing contingent upon guidelines from S/GAC, with a certification program for counselors that is already underway. The program will also expand its use of risk assessments, ensuring that KPs at highest risk are tested. Crucial to success will be case-finding among the hard-to-reach, i.e., those who do not identify fully as KP.

In COP20 recency testing will scale up through a phased implementation to Bujumbura Mairie and potentially to Gitega after protocol approval by both MSPLS and IRB in COP19. Results from the implementing sites will be used to monitor the rate of recent infections using both demographic and geographic data in adults over the age of 18 years old. Recent infection surveillance data will be used to identify which subpopulations have higher proportions of new HIV infections. These subpopulations and associated geographic areas will be prioritized for future HIV prevention interventions, and become a focus for targeted case-finding interventions. Results and overall data quality will be reviewed in interagency discussions on a biweekly basis, and site monitoring will take place one month post-implementation and quarterly thereafter.

Implementing partners will also support the MSPLS at district level to improve the quality of testing services, geo-target RTK distribution based on performance, introduce youth-/men-/KP-

friendly services in facilities and through targeted outreach, and gradually integrate HIV testing services within primary health care platforms (FP/MCH/HIV).

4.1.2 Scale up early initiation of optimized ART regimens and close ART coverage gaps

In COP20, PEPFAR Burundi will continue to support the scale-up of a package of best practices to link HIV patients to treatment. This package, tailored to the needs of the different categories of at-risk groups, includes:

- Same-day ART initiation;
- Follow-up phone calls and/or home visits by health mediators/community volunteers and/or health providers for clients who are not ready to initiate ART on the same day;
- Physical escort of clients to ART clinic; and
- ARV starter packs for HIV-positive clients identified outside the facility.

PEPFAR-funded IPs will be requested to ensure strong relationships between community workers and health facilities to facilitate referrals and early initiation of ART, in particular when community-based self-testing and index-testing strategies are implemented.

The focus during COP20 will also be in tracking linkages to other services. A key element of the linkage process in the context of client-centered services is to obtain consent from the client for follow-up activities that may be conducted by CHWs, health mediators, or peer navigators. Through this process, newly diagnosed HIV-positive people may be linked to trained community workers to support them in seeking referral services in the first few days or weeks after the diagnosis. In order to facilitate the uptake and follow-up of linkages, providers may also need to capture more detailed locator information, using client locator forms to track linkages and ensure successful referral.

In both *Optimize* and *Sustain* provinces, PEPFAR Burundi will support the completion of the transition to TLD by December 2020 for women of reproductive age, initially excluded by the previous national guidelines.

Children, adolescents, and young men will be the focus of intensified efforts to close the ART treatment gaps. The table below, using new 2020 Spectrum data, shows that nationally, ART gaps exist for children under 15 and men 30-44 (Table 4.1.2).

Table 4.1.2: Gaps in ART coverage by age and sex

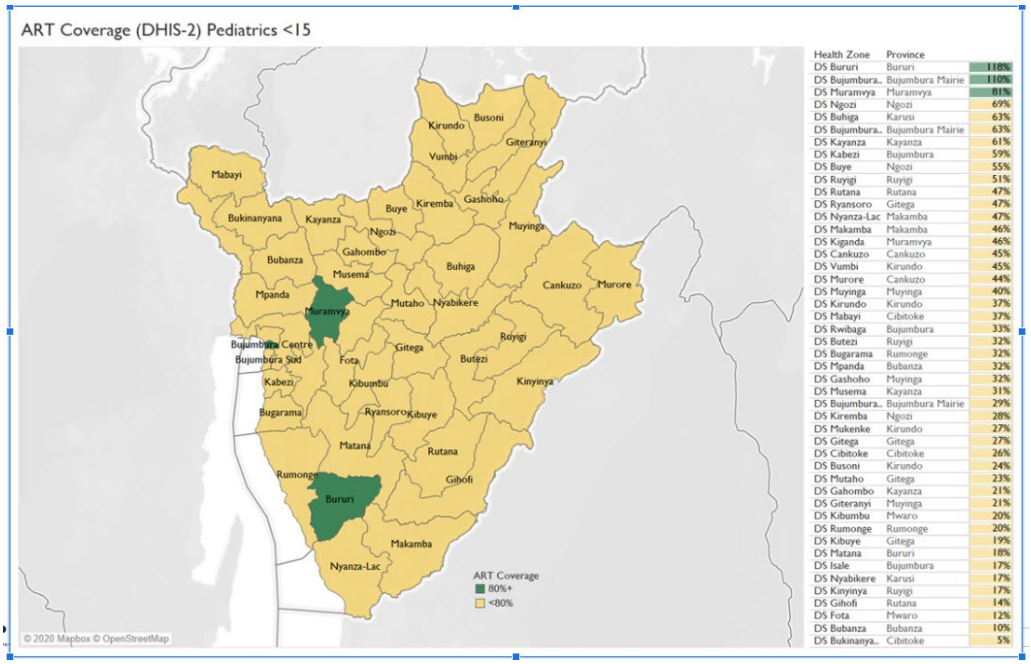
Age	PLHIV Estimates			Current on ART			ART Coverage			Remaining Needing ART		
2019	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total
<1	216	195	**411**	72	69	**141**	33%	35%	**34%**	144	126	**270**
1-4	1606	1448	**3054**	266	262	**528**	17%	18%	**17%**	1340	1186	**2526**
5-9	1203	1281	**2484**	594	578	**1172**	49%	45%	**47%**	609	703	**1312**
10-14	1193	1335	**2528**	938	843	**1781**	79%	63%	**70%**	255	492	**747**
15-19	852	597	**1449**	1729	1023	**2752**	203%	171%	**190%**	-877	-426	**-1303**
20-24	2201	1325	**3526**	4024	1305	**5329**	183%	98%	**151%**	-1823	20	**-1803**
25-29	4052	2630	**6682**	5472	1878	**7350**	135%	71%	**110%**	-1420	752	**-668**
30-34	5670	3434	**9104**	5967	2194	**8161**	105%	64%	**90%**	-297	1240	**943**
35-39	6750	4411	**11161**	6847	2853	**9700**	101%	65%	**87%**	-97	1558	**1461**
40-44	6183	4681	**10864**	6105	2985	**9090**	99%	64%	**84%**	78	1696	**1774**
45-49	4923	3557	**8480**	5469	3339	**8808**	111%	94%	**104%**	-546	218	**-328**
50+	15310	9648	24958	9281	7650	**16931**	61%	79%	**68%**	6029	1998	**8027**
Total	**50159**	**34543**	**84702**	**46764**	**24979**	**71743**	**93%**	**72%**	**85%**	**3395**	**9564**	**12959**

<70% 80-89%
70-79% >90%

Source: Spectrum 2020 Estimates

For CLHIV <15 years, only 48 percent are on ART nationally, indicating a critical need for effective strategies to link and retain CLHIV on treatment (Figure 4.1.1).

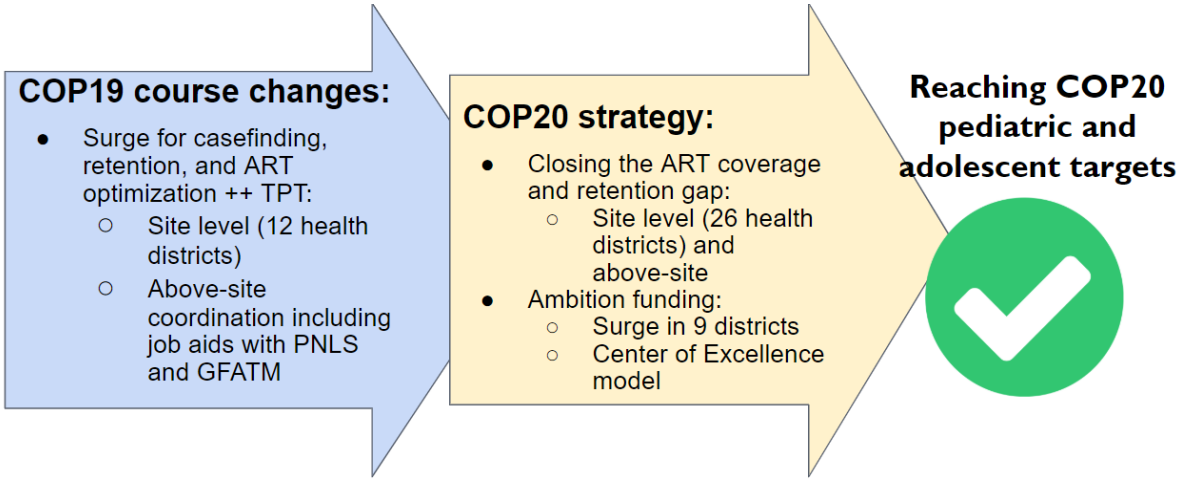
Figure 4.1.1: ART coverage by district among children under 15



Source: DHIS2, FY2019 Q4

PEPFAR's goal for COP20 is to close the ART gap for children through increasing ART coverage to 77 percent.

Figure 4.1.2: Proposed strategy to reach epidemic control among children and adolescents



The Pediatric Surge will be implemented in three waves by health district, depending on ART coverage and on the absolute numbers of CLHIV not yet on ART.

- In COP19, the Pediatric Surge is addressing case finding, retention, ART optimization, and TPT in **12 districts**, along with above-site coordination.
- In COP20, the pediatric strategy is to close ART gaps in **26 health districts.**
- If received, COP20 Ambition Funding would support provision of ART and services to further close the gaps for the children hardest to find in **nine districts** with high ART coverage along with a Center of Excellence model to support provider's capacity.

To support ART initiation for children, PEPFAR-supported sites will encourage family-based appointments on the same day and with the same provider for the whole family. In provinces where the OVC program operates, 90 percent of CLHIV <15 on ART (TX_CURR) will be offered enrollment into the OVC program, with priority given to those who are newly enrolled on treatment, LTFU, and with poor viral suppression, in order to ensure effective case management.

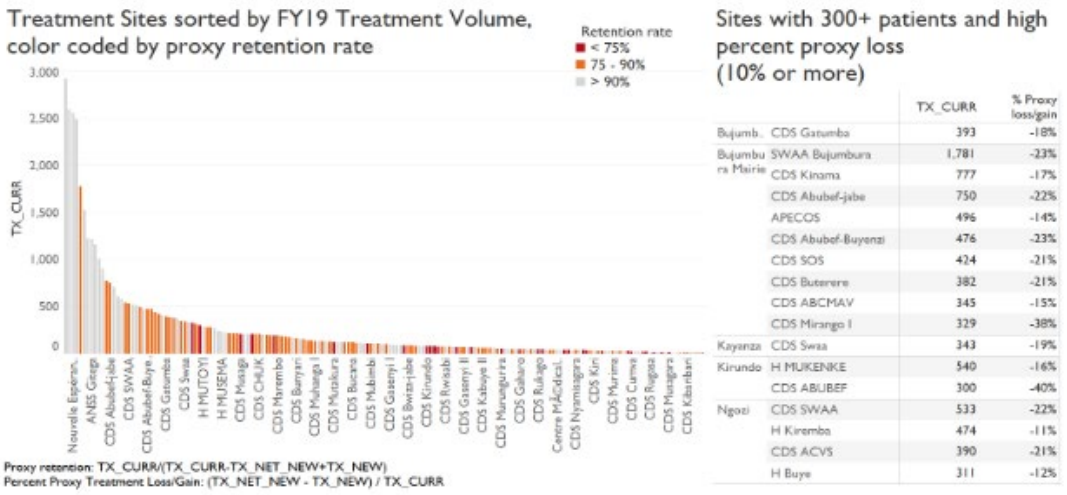
4.2 Retaining clients on treatment and ensuring viral suppression

4.2.1 Retaining clients on treatment

Starting from COP19, PEPFAR Burundi will develop a retention surge process to specifically and thoroughly address the challenge of interrupted antiretroviral treatment and client loss, especially among children and adolescents.

An analysis of APR19 program data shows that most patients are lost to follow up from high-volume sites (Figure 4.2.1).

Figure 4.2.1: Sites ranked by proxy loss/gain from treatment (APR 19)



Sites with 300+ patients and high percent proxy loss (10% or more)

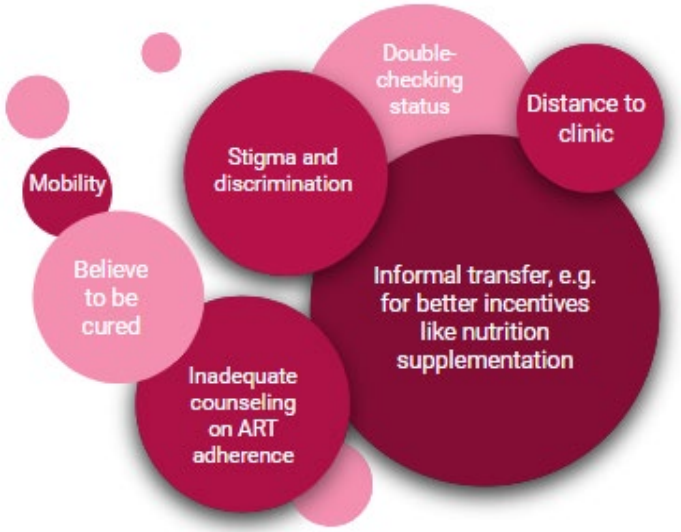
		TX_CURR	% Proxy loss/gain
Bujumb..	CDS Gatumba	393	-18%
Bujumbura Mairie	SWAA Bujumbura	1,781	-23%
	CDS Kinama	777	-17%
	CDS Abubef-Jabe	750	-22%
	APECOS	496	-14%
	CDS Abubef-Buyenzi	476	-23%
	CDS SOS	424	-21%
	CDS Buterere	382	-21%
	CDS ABCMAV	345	-15%
	CDS Mirango I	329	-38%
Kayanza	CDS Swaa	343	-19%
Kirundo	H MUKENKE	540	-16%
	CDS ABUBEF	300	-40%
Ngozi	CDS SWAA	533	-22%
	H Kiremba	474	-11%
	CDS ACVS	390	-21%
	H Buye	311	-12%

The retention surge process will prioritize high-volume sites in all provinces. Based on data from COP18, more clients were leaving treatment in the first three months after initiation than after three months (Figure 4.2.2). There does not appear to be a difference by sex in the rate at which those on ART leave treatment; LTFU is also relatively even across age groups. However, while up to a quarter of children and adolescents LTFU leave treatment in the 3-6 month timeframe, many are LTFU after 18+ months on ART. With the support of CHWs, more focus will be made to ensure that patients are retained in care especially during the vulnerable period of the first three months after initiation.

Figure 4.2.2: Timeframe for patients leaving treatment, by age/sex (APR 19)

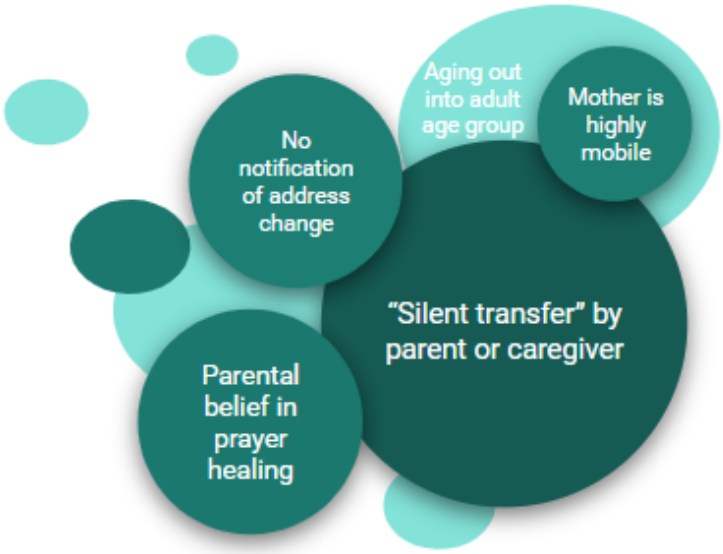
The reasons for loss to follow up vary by population, as shown in the Figures 4.2.3 and 4.2.4 below from preliminary results of ongoing assessments.

Figure 4.2.3: Reasons for loss to follow-up: Issues impacting retention among KP



Source: LINKAGES analysis of LTFU; *bubble size not linked to # of respondents

Figure 4.2.4: Reasons for loss to follow-up: Issues impacting children and adolescents



Source: RAFG rapid assessment in 5 sites in Bujumbura Mairie and Rumonge; *bubble size not linked to # of respondents

The objective of the surge strategy is to identify the specific factors contributing to poor retention at a site level, and to address them through demand creation and effective, client-centered interventions at the community, facility, district, and national levels:

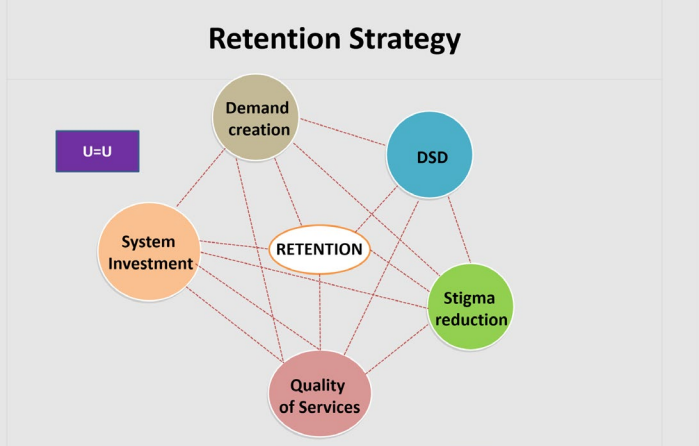
- At the community level, PEPFAR will continue to support community and civil society engagement and will both create demand and strengthen differentiated service delivery (DSD) models, including finalizing the expansion of community ART distribution points and CAGs. In addition, differentiated peer support groups (such as mothers-to-mothers,

youth groups, men-to-men) as well as family-support groups for children, will be established/reinforced to support retention in care and/or track clients lost to follow-up.

- At the facility level, patient management approaches will include the optimized use of the SIDA-Info EMR and CommCare systems for tracking and communicating with clients, along with the national expansion of MMS/MMD. IPs will produce an in-depth root cause analysis to document factors contributing to poor retention (by age, sex and subgroup) with a focus on getting patients back to care. Where retention challenges are observed at high-volume sites, IPs will strengthen the collaboration between community and facility actors to reinforce the tracing and re-engagement of LTFU clients.
- At the district and national levels, PEPFAR will continue to support the transition to DTG-based regimens and the enrollment of TB-negative patients on TPT. PEPFAR Burundi will also support the transition from paper-based systems to SIDA-Info, while increasing the interoperability of SIDA-Info across the facility, district, and national levels through dataset improvements and linking patient data to unique identifiers. PEPFAR Burundi will work closely with the NACP to support the implementation of the MMS/MMD policy with the development of a national implementation plan and SOPs. The issue of silent transfer will be resolved through a more effective referral and counter-referral system and the gradual use of biometrics for all HIV-positive patients.

This retention surge process will ensure growth of PEPFAR Burundi's treatment program in COP20. Once available, PEPFAR Burundi will adapt the strategy using the results of two surveillance activities to be completed in COP19 -- Stigma Index Survey and Integrated Bio-Behavioral Surveillance Survey.

Figure 4.2.5: Retention Strategy



In COP20, retention interventions will be adapted to the different categories of priority populations, with a greater focus on children, OVC, and adolescents.

Children - ***The Pediatric Surge***

At the end of 2019, according to DHIS2 data, 3,622 (43 percent) of the estimated 8,477 CLHIV in Burundi were on ART (Table 2.1.2), indicating a critical need for effective strategies on linkage and retention on treatment across the pediatric clinical cascade. PEPFAR's goals for FY21 are to close the ART gap for children through increasing ART coverage to 77 percent. To reach this ambitious goal, dependent on receipt of Ambition Funds, PEPFAR Burundi will launch a Pediatric Surge in FY20 to include:

- ***Retention:*** PEPFAR Burundi will carry out several analyses to understand the profile of children LTFU and to develop interventions tailored by age and site, including: ageing out analysis; LTFU over time and after 3, 6, 12, 18 months on ART analysis; and a root cause analysis of reasons for LTFU among children.
- ***Pediatric ARV optimization and MMD:*** PEPFAR will build on ART optimization activities in COP18, which led to an increase in children on DTG-based regimens and a decrease in children on NVP-based regimens (with no children on NVP as of January 2020). However, few children are yet on MMD, which can enhance retention. PEPFAR will carry out a baseline review to identify children on suboptimal regimens, and work with stakeholders to develop implementation plans to roll out MMD to children <15 years, including transition plans and provider training.
- ***Stakeholder collaboration:*** PEPFAR Burundi will work collaboratively with the NACP and other stakeholders throughout the Pediatric Surge to share analysis of findings and develop plans and targets.
- ***Regular data review:*** PEPFAR Burundi will implement a monthly review and monitoring of the surge progress and treatment outcome indicators for children, including data source triangulation, and real-time course corrections.

Throughout the surge in COP19 and into COP20, all children, particularly those who are virally unsuppressed, should be transitioned urgently to the optimal regimens.

PEPFAR will continue to train, mentor, and provide supportive supervision to providers on CLHIV care and treatment, including age-appropriate status disclosure and transition to adult care that reflects the national guidelines. In provinces where the PEPFAR-supported OVC program operates, PEPFAR will ensure that links with clinical and OVC partners are formalized to ensure at least 90 percent of children on ART are offered the opportunity to enroll in the comprehensive OVC program (see below). In non-OVC-supported provinces, children will benefit from family support groups in the community, led by PLHIV CSOs as one of the multiple interventions being supported to improve adherence and retention in treatment services. Adolescent and youth peer services will also be stood up to provide needed support in adherence and retention as well as transition to self-care. Interventions based on Operation Triple Zero and Zvandiri will be implemented.

OVC, AGYW, and Adolescents

In the OVC program, collaboration and coordination with clinical IPs and clinical facilities will be continued and enhanced. MOUs between the clinical and OVC programs will be reviewed to ensure prioritization of HIV testing for OVC beneficiaries, to establish OVC linkage coordinators/focal persons at facilities, and to ensure integration with ANC, EID, clinical and community programs. A bidirectional referral network will be established between the PEPFAR clinical program and the OVC program to ensure coverage of services and to increase the number of HIV-positive children enrolled in the OVC program. At least 90 percent of TX_CURR <15 who live in OVC-supported provinces will be offered enrollment into the OVC program, with priority given to those who are newly enrolled on treatment, LTFU, or with poor viral suppression. The OVC program will also prioritize enrollment of survivors of sexual violence, children with HIV-positive caregivers (particularly those newly initiated on treatment, LTFU, and with poor viral suppression), HIV-exposed Infants (HEIs), and children of KP.

For adolescents not reached through the OVC program, PEPFAR Burundi will support index testing of adolescents with an HIV-positive parent or caregiver and children of KPs. The OVC program will support clinical programs to ensure that biological children of HIV-positive mothers are tested. In addition, the program will support policy changes to lower the age of testing to 12 years of age. To ensure that services are responsive to adolescents, peer support for those newly diagnosed will be supported, and evidence-based approaches (e.g. modeled on the Zvandiri program[12]) will be used, creating flexible/extended hours at facilities as well as adolescent-friendly centers. HIV-positive OVC will receive psychosocial support to enhance adherence to treatment and improve their ART retention, VL suppression, and school retention. Furthermore, their parents/caregivers will receive socio-economic support through saving groups or income-generating activities to strengthen the household's ability to pay for school fees and medical costs for children under 17 years of age.

Key populations

In all instances, the PEPFAR program will ensure competency in KP service delivery, including ensuring confidential services to mitigate harm, as well as offering differentiated service delivery models via KP-specific drop-in centers. Offering comprehensive health services, drop-in centers support HIV testing and treatment with complementary services, such as family planning, mental health, and/or violence mitigation services, that increase the program's ability to find, test, and retain KPs living with HIV.

ARV enrollment and retention strategies will build upon past successes, highlighting patient navigation strategies. KP community engagement via formal partnerships with KP-led and competent CSOs will be crucial in new sites for stronger linkage and retention. Having community health workers and peer navigators who are trusted by the KP individuals is vital, and

[12] PEPFAR Solution on Zvandiri program for Adolescents: https://www.pepfarsolutions.org/adolescents/2018/1/13/zvandiri-peer-counseling-to-improve-adolescent-hiv-care-and-support?rq=zvandiri

working directly with KP-led and competent CSOs assists in building and maintaining this trust. Additionally, IPs will strengthen the connection between drop-in centers and facilities, offering differentiated service delivery models. To improve tracking cohorts of clients on treatment and analyse treatment retention, adherence and VL outcomes, the program will scale eCascade, an app designed specifically for KPs.

For COP20, the program will also continue to expand its use of information communication technology / social media to enhance retention. With the overall geographic expansion, often being optimized based on KP hotspots along trucking routes, the program will continue its efforts to train public and private sector healthcare providers in KP-competent prevention and treatment services in general population facilities. Finally, the program will roll out U=U messaging and measure stigma reduction related to the implementation of the KP strategies.

Adult Women

At the end of 2019, according to DHIS2 data, 39,141 (91 percent) of the estimated 42,888 adult women (25+ years) living with HIV in Burundi were on ART (Table 2.1.2). However, analysis of data from the COP19 *Sustain* provinces indicate that retention among women is quite poor (data not shown). PEPFAR Burundi will support retention services for adult women living with HIV who are identified both within and outside of the ANC/PMTCT platform.

To enhance retention of women outside PMTCT programs, PEPFAR Burundi will:

- Accelerate transition of women of reproductive age to DTG-based regimens; support women's choice for better-tolerated ARVs; and support training for quality DTG counseling.
- Ensure provision of family-focused DSD models, including alignment of routine clinic visits with ARV pickups.
- Support implementation of community based follow-up and peer groups (CSO-led) for women and their families.

To enhance retention of women and infants in PMTCT programs, PEPFAR Burundi will continue to:

- Link HIV-positive pregnant and breastfeeding women (and their infants) to community-based follow-up and peer groups to support retention (e.g. modeled on Mothers-to-Mothers).
- Support women's choice for better tolerated ARVs (e.g. DTG-based regimens) during pregnancy and breastfeeding; support transition of pregnant and breastfeeding women to TLD+folate or TLE400 if seroconversion while pregnant, in alignment with WHO guidance.
- Integrate ANC care into DSD models to allow women who become pregnant while receiving HIV care through DSD models to remain in these models.
- Integrate PMTCT and EID services into all antenatal, neonatal, postpartum, and child

health services (e.g. EID into immunization) to provide one-stop shops for mothers and infants to enhance retention in care.

- Work with the GOB to support expansion of MMD for pregnant and breastfeeding women who are stable on ART and align routine clinic visits with ARV pickups.
- Adapt existing tools and registers or implement new cohort registers that measure maternal and infant retention and outcomes (including final outcome) separately to allow measurement of retention over time.
- Leverage routine home visits through OVC programs for follow-up of mothers and infants at high risk for LTFU, e.g., pregnant and postpartum adolescents.

Adult Men

At the end of 2019, according to DHIS2 data, 20,899 (74 percent) of the estimated 28,362 adult men (25+ years) living with HIV in Burundi were on ART (Table 2.1.2); linking men to ART and keeping them on ART is a priority for COP20. Male-friendly ART services will be provided through "men-only" and evening clinic hours and will draw on evidence-based PEPFAR Solutions from other contexts. Men enrolling or currently on ART will be encouraged to join male-only peer adherence groups and will receive targeted treatment literacy information to sensitize men to the importance of ART adherence.

4.2.2 Re-engaging LTFU back in care

PEPFAR Burundi will reinforce any initiative to track patients recently lost to follow-up starting with those lost over the last six months of care. An emphasis will be put on the high-volume sites with the highest LTFU rates to intensify granular site management. IPs will implement weekly data monitoring, closer supervision of sub-partners and sites, and greater involvement of CSOs, KP and PLHIV associations and networks.

To prevent patient loss, a system will be put in place to encourage sites to use reminder calls or sms the day before the appointment. Early interventions for patients who miss appointments will include follow-up phone or sms within 24 hours of the missed appointment, followed by mobilization of CHWs to actively track and bring clients who missed appointments back to care within seven days. For patients for whom clinic location is a barrier, updated SOPs will provide guidance on (a) counseling to help patients decide on the most convenient ART site, and (b) assisting and documenting patient transfer.

4.2.3 Ensuring viral load access and suppression

PEPFAR Burundi will support a differentiated approach to VL monitoring in *Optimize* provinces with the goal of 83 percent of clients on ART receiving a VL test by the end of FY20. PEPFAR will transfer successes and lessons learned from VL monitoring scale-up in *Sustain* provinces by taking a holistic approach through:

1. Optimization of the laboratory network (further described in Section 4.8)

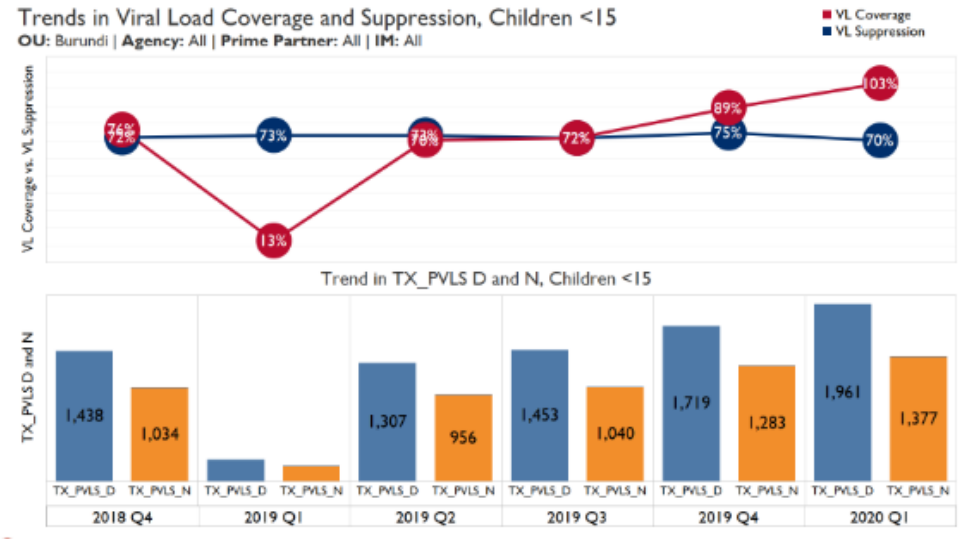
2. Increasing provider and client demand creation and management/use of VL results
    a. Improve client and provider VL literacy
    b. Strengthen community-to-facility linkage for clients requiring VL test
    c. Intensify monitoring and management of unsuppressed PLHIV
    d. Enhance adherence support
3. Increasing VL testing capacity at the site and laboratory level
    a. Improve lab-clinical interface and expand sample and results referral system transmission
    b. Enhance clinical use of VL clinical data
    c. Use tools for patient tracking to reduce LTFU and to flag clients requiring VL test at each visit
    d. Ensure laboratories prioritize samples from those failing ART, children and pregnant and breastfeeding women

PEPFAR Burundi will ensure prioritization of VL coverage and suppression for high-risk and priority populations. The strategies for each population profile are described below.

Children, Adolescents, and OVC

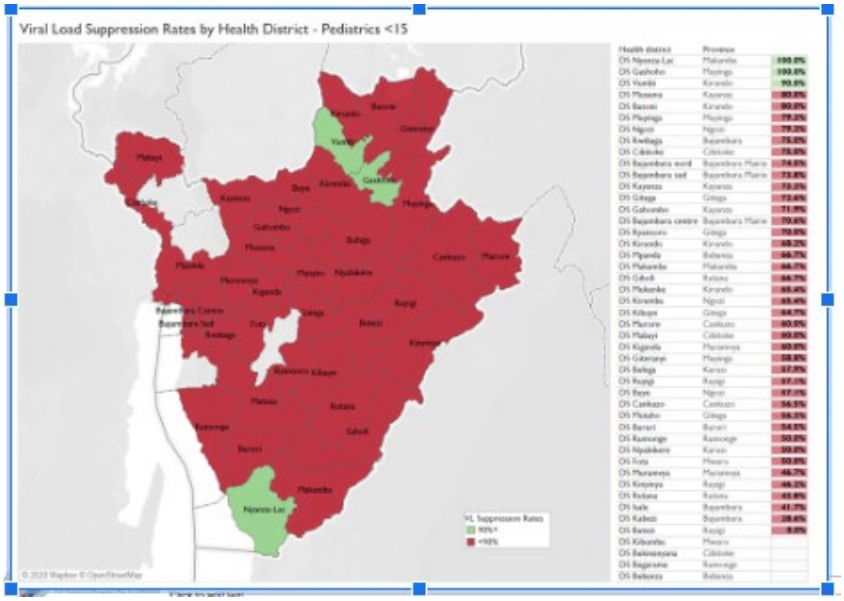
Viral suppression is low in children and adolescents (Figure 4.2.6) compared to adults, and this is consistent across most health districts (Figure 4.2.7).

Figure 4.2.6: Viral load coverage and suppression trends among children



As part of the COP19/20 Pediatric Surge, PEPFAR will accelerate ART optimization for children and adolescents to improve VL suppression. For virally unsuppressed children, services will include appointments for a viremia clinic, family or peer support services through community CSOs and enhanced adherence counseling.

Figure 4.2.7: Pediatric viral load suppression rates by district



PEPFAR Burundi will work with implementing partners to closely review regimen and VL data and address gaps. Implementing partners will continue to support VL sample collection and transportation for pediatrics and adolescents, monitor of VL registers and/or data in SIDA-Info, and provide targeted clinical mentoring to support clinical decision-making and regimen switch for non-suppressed children and adolescents.

Within the OVC program, enrolled CLHIV and families will be supported as part of case management approaches to build demand for timely VL services.

Key Populations

Viral suppression strategies for KPs will build upon past successes in patient navigation strategies to enhance adherence and retention. The program will roll out U=U messaging to build VL demand creation, provide information on VL test locations, and measure stigma reduction related to the implementation of U=U.

Adult Women

VL coverage among pregnant adult women in FY20 Q1 was particularly low (<10 percent). To ensure pregnant and breastfeeding women receive timely VL monitoring (and action to prevent mother-to-child HIV transmission), COP20 community interventions will focus on demand creation on the importance of VL monitoring during pregnancy and breastfeeding, and site-level interventions will ensure VL testing is offered to women living with HIV attending postpartum and immunization clinics with their infants. In addition, health facilities and laboratories will be mentored to ensure VL samples from pregnant and breastfeeding women are prioritized, and high VL (>1000 copies/mL) are immediately communicated to health facilities for action.

PEPFAR Burundi will also plan to expand point-of-care (POC) or near-POC VL testing for pregnant and breastfeeding women to increase access to testing.

Adult Men

Viral load access and suppression for men were consistently lower than that of women across all 15 and older age bands in FY19. FY20 Q1 data confirm these trends. Male-friendly (VL) services will be provided through "men-only" and evening clinic hours. Men enrolling or currently on ART will receive targeted treatment literacy information, including on the U=U campaign to increase demand for VL monitoring.

4.3 Prevention - Priority programming

In COP20, PEPFAR Burundi will continue to support the NACP by incorporating evidence-based combination HIV prevention activities into all clinical and community-based programs. In addition, PEPFAR Burundi will support the launch of PrEP. Specific populations and approaches for prevention activities include:

4.3.1 PrEP for key and priority populations

In COP20, PEPFAR Burundi will support the NACP to launch and initiate 2,000 HIV-negative at-risk individuals on PrEP. Target populations include KP, adolescents, and pregnant and breastfeeding women, in alignment with national guidelines. PEPFAR clinical partners will support health facilities to roll out PrEP and develop PrEP screening tools for specific populations, as well as strategies to retain individuals on PrEP. PEPFAR will engage communities to assist in (a) developing and disseminating demand creation messages, (b) addressing misconceptions, (c) retaining those enrolled on PrEP, and (d) building the capacity of health care workers to normalize PrEP.

4.3.2 Gender-based and intimate partner-based violence (crosscutting)

In COP19, USAID Burundi launched a new three-year activity with the objective of improving the integration of GBV prevention and response into HIV services. This activity has a local Burundian organization as its prime partner and is focused on ensuring that GBV prevention and response is integrated into all PEPFAR-funded HIV prevention and care interventions. The main areas of focus include improving GBV and HIV prevention for adolescent girls, young women, and key and vulnerable populations; improving GBV case identification and response in HIV index testing and partner notification; and improving clinical post-GBV care in HIV service delivery. Using a technical assistance model, the new activity directly supports current PEPFAR IPs to integrate effective GBV prevention and response activities into their work. The activity prioritizes strengthening data systems, data analytics, and site-level monitoring; utilizing a process of continuous QI at the site and partner level; and ensuring that gender equality and elimination of stigma and discrimination are addressed meaningfully in partner work plans.

4.3.3 AGYW and Children

The OVC program will focus on supporting girls and boys 0-17 and their caregivers with HIV prevention services, with special emphasis on supporting CLHIV on ART. Adolescent boys and girls (aged 9-14 year) who are enrolled in the OVC comprehensive program will be screened for sexual abuse, encouraged to report, and referred for medical and non-medical services, including post-exposure prophylaxis and medical/legal support. The OVC program will also strengthen the capacity of caregivers and community leaders to prevent, respond to and support victims of sexual abuse. Older AGYW will also be evaluated for PrEP eligibility and supported to remain on PrEP.

4.3.4 Key Populations

The focus in COP20 for prevention among KPs is through: continuing service provision of the core prevention package to include PrEP; launching U=U; and engaging KPs through individualized risk assessments and microplanning.

The KP program will continue to engage KPs in prevention services via state-of-the-art strategies such as microplanning (e.g., using mapping and size estimation data to assign peer outreach workers to hotspot-based ratios of peer outreach workers to peers, and peer contacts within hotspots). The program will provide services at hotspots and KP-specific drop-in centers that include both prevention and treatment services. In COP20, the program will continue to use individualized risk assessments to shift the focus of peer outreach away from high-volume/low-quality approaches toward more individual and personalized engagement aimed at prevention messaging, commodity provision, and service uptake. This approach also supports prioritizing KP members who may be at higher risk for HIV. Stigma, discrimination, and violence mitigation strategies will be enhanced, working with KP community members to reduce internalized stigma, as well as KP-competency training for health and social service providers and law enforcement personnel to increase access to services. The program will maintain support of KP-led and competent CSOs, seeking to maintain trust within these highly marginalized populations. As KP and their sexual partners are at ongoing risk for HIV acquisition, the program will launch implementation of screening for and enrollment in PrEP as per the national guidelines.

PEPFAR Burundi will also continue to implement strategies to increase substantially the number of KPs tested and linked to treatment. Strategies include optimization of EPOA's demonstrated ability to increase reach to KP networks, uptake of HIV testing, and HIV case detection; scaling up self-testing for hard-to-reach and hidden KP sub-populations; use of virtual approaches to improve reach and case finding; and micro-planning and use of data for planning and quality improvement. To reduce LTFU among KP enrolled on ART, the eCascade program, designed to optimize clinical tracking of KP, will be scaled to improve treatment retention, adherence, and VL outcomes. Improved data analysis, including clarification of reasons for ART defaulting, will inform the design of targeted interventions to address LTFU. Results from the Integrated Biological and Behavioral Surveillance Survey will improve target-setting for case-finding and ensure that planning at strategic and operational levels is based on reliable and current data.

Finally, the program will accelerate the use of lessons learned and best practices, as well as cross-organizational and cross-district learning.

4.3.5 Military populations

Military personnel have an estimated HIV 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 priority population prevention package will include advocacy and demand creation to increase awareness, uptake, and acceptability of relevant prevention and clinical services. It will also include education and skills to reduce HIV risk and accurately identify HIV prevention methods, sustain behavior change, promote gender-equitable principles, address HIV stigma and discrimination, provide or refer to HIV testing, facilitate linkage to and retention in care for HIV-positive individuals, accelerate VL access and suppression, and ensure condom promotion, distribution, and skills building. PEPFAR will intensify the level of support in each military site, which will be tailored toward achievement of the three 95s for epidemic control.

4.3.6 Prevention for pregnant and breastfeeding women

In COP20, PEPFAR will focus on providing PrEP to HIV-negative pregnant and breastfeeding women in serodiscordant couples until their HIV-positive partner achieves VL suppression and will also ensure appropriate provider training and support. PEPFAR will ensure linkage of pregnant and breastfeeding AGYW to appropriate support programs (e.g., OVC, clinical programs). PEPFAR-funded activities will also support implementation of maternal re-testing approaches in targeted entry points following the first ANC visit (ANC1), e.g., labor and delivery, postpartum FP services, MCH/immunization clinics, to identify incident infections during pregnancy and the breastfeeding period. Maternal testing after ANC1 will be reported in HTS_TST using the disaggregate for post-ANC1 testing. Systematic testing and follow-up for all HEIs identified through maternal re-testing approaches will be improved. PEPFAR will also support testing male partners at ANC and linking them to ART or HIV prevention services. PEPFAR will ensure implementation of tools to track mother-baby pairs receiving PMTCT services up to their final HIV outcome (18 months and/or six weeks after cessation of breastfeeding), and transition to ART clinic. IPs will ensure active linkages from ANC to labor and delivery to postnatal care and MCH services.

4.4 Additional country-specific priorities listed in the planning level letter

Starting in COP18, PEPFAR Burundi has ensured implementation of context-, age-, gender-, and systems- specific approaches to significantly improve case-finding, linkage, retention, and VL suppression, and to reduce all barriers and gaps along the 95-95-95 cascade at site and district levels. In COP20 PEPFAR will support rollout and scale-up of key policies and practices that will improve client tracking and retention on ART with a particular focus on Gitega and Bujumbura Mairie provinces.

4.4.1 Geographic focus on Gitega and Bujumbura Mairie

Gitega and Bujumbura Mairie are the provinces bearing the highest burden of HIV in the country; they also face challenges in retaining patients on ART. Although sites in both provinces are continually enrolling new patients through generally successful testing and linkage strategies (with some district-specific challenges to be addressed, such as subpar linkage rates in Bujumbura Sud), the net number of new patients on treatment is suboptimal. Gitega in particular also is challenged with low VL testing coverage, although where VL testing is available and used, viral suppression rates are high. Based on an analysis of FY20Q1 data, site-level assessments by implementing partners on obstacles to success and how to address them, and best practices from successful sites, in COP20 PEPFAR Burundi will focus resources on technical assistance for Gitega and Bujumbura Mairie for the following priorities: to increase (1) patient linkage to care where needed, (2) return to treatment for patients who defaulted from ART, (3) understanding of LTFU in facilities and communities, (4) implementation of best practices in facility/community collaboration to trace patients LTFU, and (5) access to VL testing and improved suppression through adherence support.

PEPFAR Burundi will work together with IPs to analyze site-level data and perform programmatic inquiries into successful models to improve retention at an operational level. Sites that are performing well will share lessons for strengthening retention. IPs and DHTs will support data-sharing meetings for providers to understand when and why they may be losing patients so they can develop and implement remediation plans. PEPFAR will continue to support socialization of the unique identifier concept and solicit PLHIV feedback on the format, as efforts are made to roll out unique identifiers to reduce LTFU and better track clients across sites. PEPFAR will work with communities to increase treatment literacy and create demand for quality services, including VL testing, fostering understanding of the principle of U=U. In COP20 PEPFAR will also support MMD rollout and scale-up of community ART groups and points of distribution, as well as *groupes de paroles,* or support groups using adherence champions.

4.4.2 Effective implementation of DSD models

Six-month MMS and three-month MMD have been adopted as national policy, but with limited implementation due primarily to concerns about ARV stock adequacy. PEPFAR will support development of a national implementation plan and SOPs for the current policy, and ensure rapid roll-out of three-month MMD. PEPFAR Burundi will task its IPs to ensure a rapid scale-up of MMS/MMD for all eligible patients in the remainder of COP19 and maintain this trend in COP20.

In addition, PEPFAR Burundi will work with the MSPLS to advocate for national adoption of the current PEPFAR guideline to extend six-month MMD to stable patients and to PLHIV who require it because of travel or other hardship, based on the evidence that it is an effective intervention to retain patients on ART. PEPFAR will support the MSPLS to draft the necessary documents to ensure the policy, once adopted, is implemented across sites. Specific questions will be integrated in SIDA-Info in order to anticipate patient needs for longer MMD. PEPFAR Burundi's supply chain activity is procuring 90-day-supply ARV bottles to facilitate MMD.

PEPFAR Burundi, in coordination with the MSPLS and partners, will put in place an intervention package to ensure continuity of communication with patients on MMD, and appropriate referral for clinical visits when necessary.

In addition to MMS/MMD, other differentiated services delivery models, such as community drug distribution points and extended clinic hours, will be offered to PLHIV on treatment in an effort to develop a patient-centered approach, with patient-centered solutions to reduce barriers to retention.

4.4.3 Support for patient medical records

By the end of COP19, all sites in Burundi will be receiving direct or indirect PEPFAR support through DHTs. In close collaboration with the NACP and UNDP (the current GFATM Principal Recipient), this support will include ensuring that, at a minimum, sites are using appropriate health registries and paper data collection tools required for PEPFAR programming. The larger effort is continuing the roll-out of SIDA-Info, including training, maintenance, updates, and operationalizing the transition to a web-based version in sites with a permanent reliable internet connection. (See section 5.2 for more detail on information systems.) Remediation strategies include weekly reporting and analysis of program data, supportive supervision to ensure compliance with the new testing guidelines, the systematic use of the screening tool and clinical mentoring, and learning from successful sites, such as sharing partner notification best practices.

To improve management and data visibility of commodities, COP20 funds will leverage malaria and family planning funds to implement an end-to-end electronic logistic management information system (eLMIS) to track commodities and stocks along the pipeline. This will improve efficiency, track commodities use and match it with clinical data. The eLMIS will be interoperable with existing sub-systems on the health management information system including DHIS2 and SIDA-Info.

4.5 Commodities

In COP19 the MSPLS updated the national policy for testing strategies using new algorithms with new RTKs, introducing the optimized ART regimens with the transition to TLD and phasing out Nevirapine. The MSPLS decided to transition to TLD all adolescent boys, adult men, and women, including women who conceive while on TLD. The TLD transition of all eligible patients is expected to be completed by December 2020.

Pediatric regimens will also be optimized to include LPV/r pellets (already used in Burundi) for pediatric patients under 20 kgs of weight and regimens that include DTG 50mg for patients between 20-30 kgs of weight. Patients over 30 kgs of weight will be transitioned to TLD.

MMD will also scale up in all provinces. For this purpose, Burundi has begun procuring 90-tablet bottles of TLD (three-month ARV supply) and will procure TLD 180 tablets in COP20 for stable ART patients to offer them options of three-month and six-month resupply. Using one-time

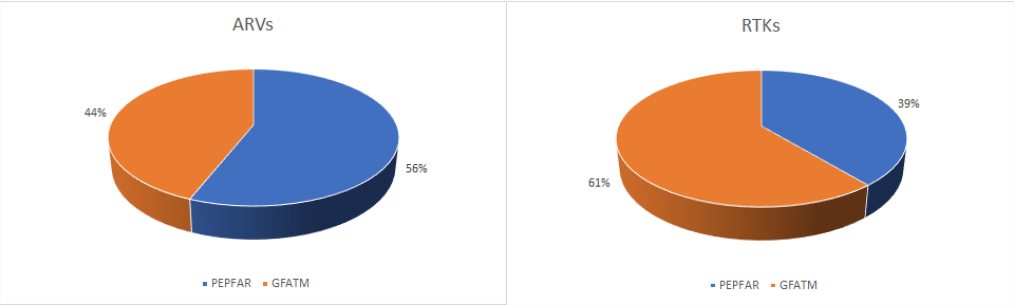
funding to increase available stock substantially, PEPFAR will procure TLD in quantities that will enable immediate implementation of MMD 3-6 months with no risk of stock-outs.

Burundi has changed the testing algorithm and planned the phaseout of Abbott Determine™ HIV-1/2 kits and HIV-1/2 STAT-PAK® DIPSTICK by January 2021, replacing them with Alere HIV Combo Set and SD Bioline HIV-1/2 v3.0, respectively. The new policy recommends replacing HIV1+2/Syphilis Combo Card Test with SD BIOLINE HIV/Syphilis Duo. In COP20, PEPFAR will procure SD BIOLINE HIV/Syphilis Duo for PMTCT and SD Bioline HIV-1/2 v3.0 for testing of targeted populations including OVC and KP and will continue to procure OraQuick® HIV Self-Test for self-testing for hard-to-reach KPs.

The GFATM will continue to be the most important donor for HIV commodities, accounting for an estimated 80 percent of procurement in 2020, with PEPFAR accounting for 20 percent, according to February 2020 resource alignment documents (Figure 2.3.2). GOB commodity procurement was not available for 2020.

In COP20, if Ambition Funding is received, the PEPFAR contribution to the procurement of ARVs and RTK will increase significantly to improve access to DTG-containing regimens for children, adolescents and adults, PrEP for KPs and serodiscordant couples, EID POC and near-POC and testing capacity for pregnant and breastfeeding women, OVC, and KPs, as well as introducing 3HP for TPT.

Figure 4.5.1: COP20 donor contribution to ARVs and RTKs



As Burundi is fully transitioning to TLD by December 2020, in COP20 PEPFAR will procure 148,623 doses of TLD-90 for $3,083,207 to cover 37,155 adults and 19,113 doses of Dolutegravir 50mg for children.

PEPFAR Burundi will introduce “All-Inclusive Agreements” (to include: platform lease, reagents, consumables, service, maintenance, etc.) to increase VL and EID testing access. In COP20, PEPFAR will cover the lease contract cost of one platform to complete at least 40,416 VL tests.

In COP20, PrEP will be introduced for the first time in Burundi to target 2,000 high-risk individuals for HIV prevention.

For EID reagents and consumables, PEPFAR will procure all of the EID cartridges needed to conduct POC or near-POC EID in Burundi for a target of 8,118 HEIs.

In COP20, PEPFAR will introduce the use of 3HP for TPT by supporting policy changes and procurement of commodities for 9,905 patients in 2021 to achieve 100 percent TPT coverage in Burundi.

To support the initiation of HIV-positive clients on TPT, PEPFAR Burundi will also procure 1,650 GeneXpert MTB/RIF cartridges to complement the quantity already supported by the GFATM.

4.6 Collaboration, Integration and Monitoring

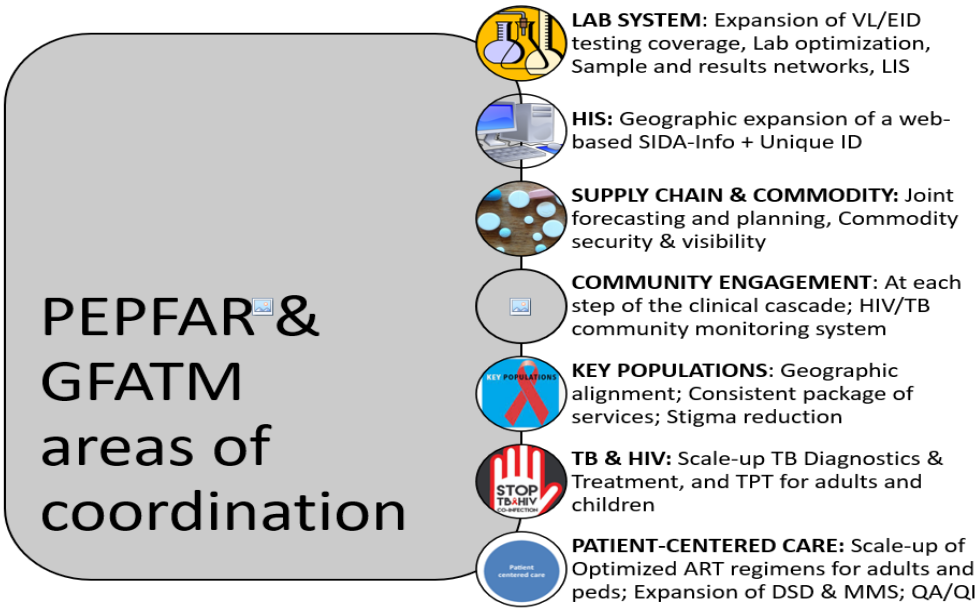
4.6.1 Coordination with the GFATM and other health donors

The GFATM is the only other major donor to HIV programs in Burundi. PEPFAR Burundi invests substantial staff time in ensuring strong coordination mechanisms with GFATM, including with the current GFATM Principal Recipient (UNDP), with the Geneva-based Fund Portfolio Manager, as the Ambassador's representative to the CCM, and beginning in COP19 as a member of the CCM Oversight Committee. These coordination mechanisms occur both formally and through informal discussions to ensure bi-directional information-sharing and a common understanding of the implementation context.

In addition to USG staff investments, PEPFAR Burundi IPs participate actively as commodity/supply chain and laboratory focal points, meeting regularly with UNDP and NACP representatives to coordinate quantification, supply planning, distribution, and systems strengthening.

As noted previously, the NACP-led joint planning, activity mapping and alignment exercises that resulted from the concurrent development of COP20 and the 2021-2023 GFATM Concept Note have resulted in a common vision and shared national priorities that are aligned along the funding streams. During COP20 implementation, key areas of synergy are outlined in Figure 4.5.2 at the programmatic level (case-finding, linkage and retention, KP programs) and the systemic level (supply chain and commodity, lab optimization, and health information systems).

Figure 4. 5.2: Technical coordination with the GFATM



In addition to GFATM and its Principal Recipient, PEPFAR Burundi will continue to coordinate closely in-country with the Health Donors Group (currently chaired by the French Embassy) and bilateral and multilateral organizations that have targeted funding. For all policy matters, PEPFAR Burundi coordinates closely with WHO at country level to support evidence-based policy and guidelines development processes.

Because PEPFAR and the GFATM remain the primary funders of HIV programs, the continued strong leadership of NACP is crucial to ensure alignment of technical priorities between PEPFAR and the GFATM through ongoing collaborative planning and debriefing.

4.6.2 Improving oversight and accountability of partners and sub-partners

PEPFAR Burundi will continue monthly one-on-one review meetings with IPs, concentrating on site-level performances, barriers to progress, data quality, and capacity challenges. IPs will be directed to work more closely with high-volume site leadership and district health officers to facilitate rapid improvement, verify actual practice, carry out data spot checks, and assist in monitoring roll-out of best practices (including index client testing, same-day initiation of optimized ART regimens, and DSD).

PEPFAR Burundi will implement strict measures to improve oversight of partners and sub-partners and their accountability toward delivery of quality services. All clinical IPs will document specific minimum expectations for the sites they supervise. Among other expectations, clinical IPs will be required to ensure:

- the development of MOU with health providers to guarantee that services are provided with no stigma or discrimination in all HIV service delivery sites they support.

- the completion of the TLD transition of all eligible patients at all sites and provided optimal ART regimens for all patients at all sites they supervise, including complete phase out of non-optimized regimens by December 2020.
- the provision of several options of DSD models, including MMS/MMD for up to six months and community ART distribution, offered to all eligible patients.
- a particular emphasis on sites with highest LTFU for more efficient return to care strategies (establishment of retention targets).

IPs will work closely with low-performing sites to develop site improvement plans tailored to address specific challenges, and facilitate the submission of weekly reports on key indicators, focused around index testing, linkage, retention, reenrollment of LTFU patients, TLD transition, MMD, and VL access and suppression.

In terms of financial oversight, the PEPFAR team monitors IP expenditures, ensuring partners' resources are focused on achieving targets within COP outlay limits and on gaining efficiencies. Clear and regular communication with IPs and with IP headquarters' offices is conducted to facilitate active course correction and the development of quality work plans that reflect program shifts and strategic implementation of the program.

Finally, above-service-delivery interventions will be monitored with measurable key benchmarks to ensure regular monitoring and assessment of progress, thereby informing further program developments and strategies toward achieving epidemic control.

4.6.3 Enhancing broader partner coordination

PEPFAR Burundi will continue and enhance its strong partner coordination mechanisms, while also expanding coordination to a broader group of collaborators, particularly those engaged at the community level.

PEPFAR Burundi will continue its effective joint quarterly data review meetings with IPs, their sub-partners and NACP. In addition, in COP19 and COP20, new coordination mechanisms will be implemented among IPs whose work has clear opportunities to leverage resources and expertise. For example, PEPFAR Burundi will request an MOU between the Supply Chain Management IP, and the clinical partners to reinforce the coordination for improved commodity security at all levels. Similar MOUs will be requested between clinical and OVC partners.

Because community systems and CSO engagement will be a critical focus of implementation in COP19 and COP20, new coordination mechanisms will be put in place to improve our ability to leverage resources and activities across a broader range of partners at community level, including CSOs conducting community-led monitoring. The team will implement quarterly meetings with key GFATM sub-recipients, IP sub-partners, and the NACP representatives to improve coordination of community-based HIV services and their linkage to health facilities, to measure progress made and reorient the strategies if necessary. At the provincial and district levels, IPs will be asked to document their coordination mechanisms to improve coordination among the key

CSO stakeholders at the site level (volunteers, peer educators, case managers, patient navigators and/or health mediators) and with health service providers. These efforts are expected to improve effective implementation of HIV testing, treatment, and retention interventions, particularly among men, children and adolescents, and KPs.

4.7 COP20 Performance targets

National targets for Burundi were developed and agreed during the joint process of finalizing Burundi's GFATM 2021-2023 Concept Note and PEPFAR's COP20 proposal. The key target of number of PLHIV on ART for Burundi is set at 80,654, which will result in an ART coverage of 95% nationally (Table A.2). PEPFAR Burundi COP20 targets are fully aligned to the national targets, which were established to reach epidemic control. PEPFAR implements direct support to facilities that provide ART services to 75,905 PLHIV (94% of this national target); PEPFAR therefore reports on performance against an annual target of 75,905 on ART.

Table 4.7.1 ART targets by prioritization for epidemic control			
Entry Streams for ART Enrollment	**Tested for HIV (APR FY21)** ***HTS_TST***	**Newly Identified Positive (APR FY21)** ***HTS_TST_POS***	**Newly Initiated on ART (APR FY 21)** ***TX_NEW***
Total Men	26,110	2,454	2,433
Total Women	260,345	2,113	1,845
Total Children (<15)	40,514	1,616	1,559
Total from Index Testing	19,032	3,675	3,567
Adults			
TB Patients	5,218	30	30
Pregnant Women	246,983	556	545
KPs	14,315	1,095	853
Other Testing	19,939	2,886	2,850
Pediatrics (<15)			
HIV Exposed Infants	1,917	73	73
Other pediatric testing	38,597	1,543	1,486

Table 4.7.2: Target populations for prevention interventions to facilitate epidemic control			
Target Populations	**Population Size Estimate**	**Coverage Goal (in FY21)**	**FY21 Target** (KP_PREV)
Key Populations (13 provinces)			
Bubanza FSW	553	90%	498
Bubanza MSM	324	50%	162
Bubanza TG	20	50%	10
Bujumbura FSW	1344	90%	1210
Bujumbura MSM	615	50%	308
Bujumbura TG	0	50%	0
Bujumbura Mairie FSW	3941	90%	3547
Bujumbura Mairie MSM	885	50%	443
Bujumbura Mairie TG	250	50%	125
Cibitoke FSW	618	90%	556

Cibitoke MSM	306	50%	153
Cibitoke TG	3	50%	2
Gitega FSW	1381	90%	1243
Gitega MSM	285	50%	143
Gitega TG	6	50%	3
Karusi FSW	1255	90%	1130
Karusi MSM	239	50%	120
Kayanza FSW	3964	90%	3568
Kayanza MSM	526	50%	263
Kirundo FSW	3575	90%	3218
Kirundo MSM	136	50%	68
Makamba FSW	2381	90%	2143
Makamba MSM	402	50%	201
Makamba TG	15	50%	8
Muyinga FSW	1594	90%	1435
Muyinga MSM	338	50%	169
Muyinga TG	151	50%	76
Ngozi FSW	4394	90%	3955
Ngozi MSM	257	50%	129
Rumonge FSW	997	90%	897
Rumonge MSM	139	50%	70
Rumonge TG	108	50%	54
Rutana FSW	379	90%	341
Rutana MSM	253	50%	127
Rutana TG	85	50%	43
TOTAL	31,719	83%	26,410

PEPFAR Burundi KP interventions are implemented in 13 provinces.

Table 4.7.3 Targets for OVC and linkages to HIV services			
SNU	**Estimated # of Orphans and Vulnerable Children**	**Target # of active OVC (FY20 Target) OVC_SERV**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY20 Target)**
Bujumbura Mairie, Bujumbura Rural, Gitega, Kayanza, Kirundo	14,284	9,000	8,550
TOTAL	**14,284**	**9,000**	**8,550**

4.8 Viral Load and Early Infant Diagnosis Optimization

In 2019, PEPFAR, the GFATM, and WHO/AFRO consultants completed several lab optimization activities. These activities found that Burundi had sufficient platforms to cover national needs in VL and EID and that the 24 GeneXpert machines procured by the GFATM were underutilized and could be used for EID without compromising TB diagnosis capacity.

While overall VL coverage is 63 percent, coverage continues to vary substantially by geography, with coverage rates less than 40 percent in 13 of 18 provinces. Specific populations, including pregnant women, children, and adolescents, also continue to have low VL coverage.

For EID, 59 percent of HEIs received a test by two months of age, increasing to 85 percent by 12 months of age. The time required to receive an EID test result is long - recent SIMS visits documented turn-around times for test results of more than one month at 14 of 22 sites visited.

PEPFAR Burundi has ambitious targets in COP20 to increase VL access to 80 percent in *Sustain* provinces through transferring best practices, and to reach 90 percent in *Optimize* provinces. EID targets are proposed at 80 percent of HEIs receiving an EID by two months of age across Burundi. To reach these ambitious goals, PEPFAR Burundi plans to implement both site-level and above-service-delivery-level improvements to the national laboratory network, taking into account previous optimization efforts and complementarities with GOB and the GFATM planned investments.

In COP19/20, four key focus areas were identified to accelerate VL and EID scale up:

1. **Lab optimization, including all-inclusive reagent agreements:**
    a. PEPFAR Burundi will support a laboratory optimization exercise to identify the optimal sample referral network for VL, EID (conventional and POC/near-POC) and TB samples, and to optimize the placement of potential new platforms. This approach will address the misalignment of instrument capacity with testing demand.

b. PEPFAR will consider bringing in one additional VL/EID platform through an all-inclusive reagent rental model to improve instrument and service performance, in collaboration with national stakeholders pending the decision to phase out the non-WHO-prequalified OPP-ERA platforms, as discussed at the COP20 RPM meetings. This approach will address frequent breakdowns of VL/EID platforms in Burundi.

2. **Improving visibility on the VL/EID cascade, including results return**
   a. PEPFAR will support the expansion of a promising VL results return application (IBIPIMO) to all labs in Burundi, and to utilize it for EID results return. This expansion will allow acceleration of results return and therefore clinical management of individuals with actionable test results (high VL or positive EID).

   b. PEPFAR will support development of: 1) a web-based version of SIDA-Info with linkages to IBIPIMO to support analytical approaches for rapid triangulation exercises; 2) a national EID/VL dashboard; and 3) additional core laboratory operational metrics into IBIPIMO. These investments will also enable timely clinical decision-making and improved patient-centered care.

3. **Collaborative planning on EID POC/near-POC**
   a. PEPFAR will collaborate with partners and GOB to use IBIPIMO/SIDA-Info analyses to identify sites that could benefit from increased EID access through POC or near-POC, using existing GeneXpert platforms, and to develop a costed implementation plan.

   b. PEPFAR will procure GeneXpert HIV-1 Qual reagents and consumables needed for EID POC to complement those procured by the GFATM, and will train operators in the HIV-1 Qual protocol. The results from the 2019 laboratory optimization activity will be key in informing the shift in sample referral networks from conventional-only to a combination of near-POC/POC. This will support the GOB's request to move toward EID POC and will support EID access across Burundi.

4. **VL/EID demand creation and enhanced clinical capacity** (discussed in section 4.2).

Demand creation is an essential component of the national scale-up of routine VL/EID testing. PEPFAR Burundi will work closely with NACP, DHTs and with CSO organizations to increase demand for and use of VL/EID testing. Demand-creation activities will be implemented nationally, but will focus particularly on geographies and populations with the lowest coverage of VL and EID testing.

VL demand-creation strategies will target patients, peer educators, health mediators, and other CHWs, as well as healthcare providers. During COP20, PEPFAR investments will focus on increasing VL demand among populations with low VL coverage -- pregnant and breastfeeding women, KP, men, adolescents and CLHIV (the latter through parents/caregivers).

PEPFAR Burundi will invest substantial efforts to increase use of EID testing. EID is a life-saving test, as diagnosing and treating HIV-infected babies as soon as possible after birth greatly improves their long-term survival. Demand-creation strategies target healthcare providers at both

the community and facility level, and mothers, male partners and other caregivers. Demand-creation messaging will include the importance of early HIV testing in infants, as well as the need for repeat testing during the period of continued exposure (breastfeeding). Education about EID and infant HIV testing will start early in ANC and be reinforced throughout pregnancy, delivery and breastfeeding. In addition to messaging, PEPFAR Burundi will ensure active enrolment of women and HEIs into a tracking system to ensure follow-up and EID testing. A particular focus will be on adolescent pregnant and breastfeeding girls, and also districts with the lowest EID performance.

At the above-service delivery level in COP20, PEPFAR will work to boost the capacity of the NACP and DHTs for EID and VL testing implementation through knowledge exchange of best practices from PEPFAR sites, including through color-coding patient files for clients eligible for VL and EID, and identification of sample pre-treatment hubs for VL. The program will also collaborate with the GOB to develop a functional QM/QI system to scale up quality laboratory services.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

The ultimate goal of health systems investments at the country level is to ensure that the conditions exist to enable the success of health investments at all levels of the system, leveraging GOB systems investments and investments of other donors through complementarity and additionality. Above-site investments (described in Appendix C) in conjunction with site-level investments address epidemic control priorities by improving the supply chain and commodity supply and ensuring prevention of stock-outs of key commodities. Information system investments improve the availability, reliability, and accuracy of data needed to monitor the epidemic and track coverage rates for testing, treatment, and Viral Load.

Above-site investments in COP20 will continue to leverage systems investments by the GOB and the GFATM to strengthen site-level impact and address the main challenges identified in the SID and in program implementation, leading to epidemic control. The main areas of focus in COP20 will be the following:

5.1 Lab Support and Supply Chain Management

Laboratory capacity has improved since 2015, when it was identified as one of the only "red" categories in the SID, citing at that time the lack of adequate and consistent capacity to perform timely EID and VL testing at a large scale. Commodity security and supply chain are still considered system vulnerabilities. Above-site investments in the laboratory and supply chain management systems are critical to ensuring VL and commodity distribution at the site level. Activities to address this issue include forecasting and quantification, including for MMS, quality assurance systems, warehousing, inventory management, and commodity distribution. PEPFAR Burundi will also invest in providing support and supervision to DHTs on use of the logistics information management system to inform accurate reporting of commodity consumption.

Working collaboratively to leverage the resources of the GFATM and MSPLS, lab services will be supported to increase VL and EID coverage. One of the major shifts in COP20 will be supporting lab optimization through transition to an all-inclusive laboratory approach that will guarantee one type of machine is installed across sites, with reagents and maintenance included. Support for the NACP will continue for a functional QM/QI system to scale up lab services, including VL and EID scale-up. Technical assistance will continue for VL/EID transport and establishing an integrated sample transport system for the rapid return of results, with standardized reporting and performance monitoring, starting in two provinces. Access to VL, EID, and TB testing will expand based on a national lab strategy mapping completed in COP18. Development and implementation of external quality assurance and QI programs will take place at the lab hubs. PEPFAR will also support a collaborative process to leverage GeneXpert for POC/near-POC EID access, identifying locations with high EID volume and GeneXpert machines and incorporating into a costed implementation plan. To increase visibility into the VL/EID cascade, COP20 will build on COP19 plans to expand implementation of IBIPIMO, a VL tracking software, by establishing a web-based version of SIDA-Info and expanding the functionality and

interoperability of the IBIPIMO app to increase access to data, reduce turnaround time for test results, and facilitate timely clinical decision-making.

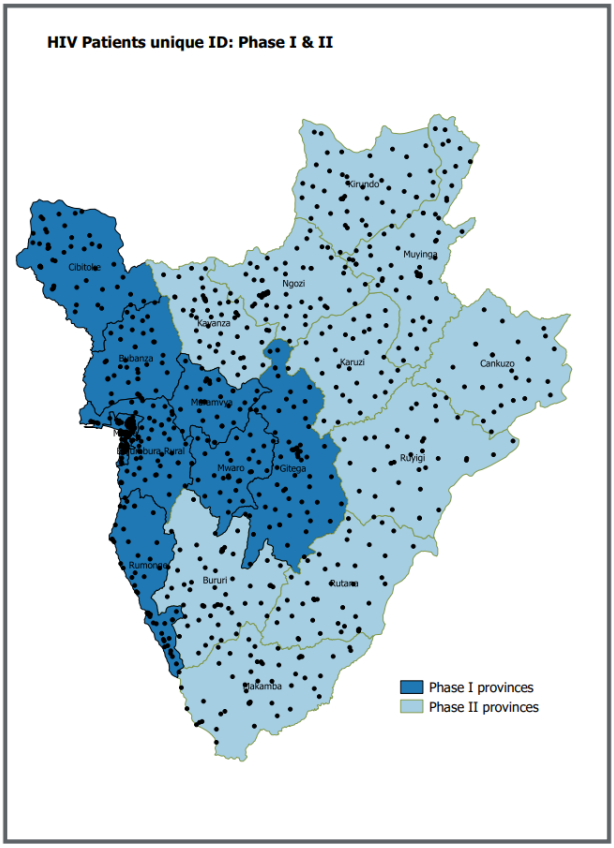
5.2 Information Systems

Information systems were highlighted as "yellow" in SID due to lack of adequate QM/QI systems with dedicated leadership or a current QM/QI plan for HIV care and treatment. The development and maintenance of interoperable platforms for SIDA-Info and DHIS2 and for DHIS2 and DATIM are key priorities. To address this, COP20 will prioritize capacity-building in the utilization of data systems that are able to communicate with each other and exchange data in a common format. There will be efforts to improve the SIDA-Info user interface, robustness, and improved web-based performance. The aim will be to record all patients in SIDA-Info at high-volume sites in all provinces. We will align system indicators with revised service delivery indicators, aiming for SIDA-Info to exchange 80 percent of data with DHIS2.

Expansion of IBIPIMO, a VL tracking app that has laboratory and health care provider dashboard access as well as patient-notification capacity via SMS, will have interoperability with SIDA-Info and will be scaled up.

In COP20, PEPFAR Burundi will move into Phase II of unique identifier implementation (Figure 5.2.1). Phase I is expected to be complete by the end of COP19.

Figure 5.2.1: Unique Identifier phased expansion



5.3 Policy, Governance, Technical Guidance and Support

From a policy perspective, the PEPFAR Burundi program will continue to support the NACP, together with the World Health Organization (WHO), to adapt and implement national guidelines based on the best available evidence and in compliance with WHO guidance and PEPFAR standards. In particular, PEPFAR Burundi will prioritize support for the rapid scale-up of MMD (discussed in Section 4.4.2) according to its implementation plan and for full access to TLD, which together are expected to improve patient retention significantly. Through Ambition Funding, COP20 also proposes to support the introduction of optimized TPT.

PEPFAR will continue to support policy development and strategic planning in supply chain forecasting and planning to improve stock management, in particular related to MMD implementation and TLD transition.

PEPFAR will also work to initiate and build capacity in technical working groups such as the national lab and pediatrics TWG.

PEPFAR will continue to provide technical support to the Directorate of Pharmacy, Drugs and Laboratories to establish a functional lab committee managing roll-out of QA/QI for VL, optimized use of GeneXpert machines, and monitoring of HIV testing strategies, including QA.

5.4 Human Resources for Health: Workforce Development and Pre-Service Training

A strong, well-qualified workforce is the cornerstone of providing high-quality HIV services to patients. Military officers from the School of Nursing (Ecole Paramedicale Militaire) will receive pre-service training to enhance the capacity to provide quality HIV services.

5.5 Population-based HIV Impact Assessment (PHIA)

In COP20, Burundi will conduct a subnational PHIA survey, with the support from the Centers for Disease Control and Prevention (CDC). Given the low prevalence of HIV in Burundi, the survey will focus on five urban areas where HIV prevalence is more than two percent: Bujumbura Mairie, Bujumbura Rural, Gitega, Kirundo and Rumonge. To gauge progress toward the UNAIDS 95-95-95 goal, the primary objectives of the survey will be to estimate prevalence of VL suppression (defined as <1,000 HIV RNA copies/mL), in each of the five sampled areas. Secondary objectives are to estimate: (1) HIV incidence; (2) HIV prevalence; (3) HIV testing, treatment, retention on treatment and viral suppression (95-95-95 clinical cascade); and (4) uptake of key HIV prevention, care, and treatment services.

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

The PEPFAR team includes the USAID HIV team, acquisition and assistance staff, financial staff, and the Department of Defense (DOD) program manager. The USAID Health Team Leader and the USAID PEPFAR Team Lead serve as points of contact to S/GAC in the absence of a PEPFAR Coordination Office. The interagency space is small, highly collaborative, and efficient. The USAID and DOD teams coordinate interagency processes seamlessly through monthly and quarterly joint data reviews with partners, POARTs, and COP development.

[REDACTED]

APPENDIX A – Geographic Prioritization

Table A.1 Continuous Nature of SNU Prioritization to Reach Epidemic Control

SNU	COP	RIORITISATIO	Result reported	Attained 90-90-90 (81%) by each Age Sex Band to Reach 95-95-95 overoll																								Overo ll TX
				Treatment coverage at APR by Age and Sex																								
				<01		01-04		05-09		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
				F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Bubanza	COP 18	Optimization	APR19	68%	0%	12%	10%	34%	29%	24%	22%	143%	158%	129%	73%	83%	47%	69%	49%	58%	37%	43%	36%	50%	35%	30%	38%	53%
	COP 19	Optimization	APR20	72%	0%	13%	11%	36%	31%	26%	23%	153%	169%	139%	78%	89%	50%	74%	52%	62%	40%	46%	39%	54%	38%	32%	41%	57%
	COP 20	Optimization	APR21	23%	25%	12%	18%	28%	28%	46%	17%	134%	56%	130%	37%	91%	41%	70%	51%	46%	50%	41%	26%	54%	41%	21%	38%	47%
Bujumbura	COP 18	Optimization	APR19	0%	28%	25%	24%	35%	49%	47%	44%	107%	131%	104%	71%	93%	53%	99%	64%	82%	63%	52%	47%	128%	74%	47%	60%	64%
	COP 19	Optimization	APR20	0%	30%	27%	26%	37%	52%	51%	47%	115%	140%	111%	76%	99%	56%	105%	69%	88%	67%	55%	51%	137%	80%	51%	64%	68%
	COP 20	Optimization	APR21	21%	24%	13%	15%	16%	22%	34%	45%	56%	118%	53%	14%	61%	35%	63%	41%	68%	41%	20%	7%	30%	14%	23%	47%	37%
Bujumbura Mairie	COP 18	Sustained	APR19	41%	30%	13%	24%	82%	61%	180%	125%	403%	320%	289%	108%	207%	63%	155%	49%	162%	60%	198%	76%	245%	134%	180%	167%	141%
	COP 19	Sustained	APR20	44%	32%	14%	25%	87%	65%	192%	133%	431%	343%	309%	116%	222%	68%	166%	53%	174%	64%	212%	81%	262%	143%	192%	179%	150%
	COP 20	Sustained	APR21	31%	35%	73%	89%	136%	122%	146%	196%	281%	367%	293%	518%	51%	113%	226%	106%	118%	131%	113%	92%	167%	180%	101%	122%	159%
Bururi	COP 18	Sustained	APR19	104%	128%	41%	26%	121%	92%	106%	113%	215%	325%	236%	102%	138%	89%	120%	76%	133%	73%	116%	57%	195%	122%	119%	124%	124%
	COP 19	Sustained	APR20	111%	137%	44%	28%	130%	98%	114%	120%	230%	348%	253%	109%	148%	96%	129%	81%	142%	78%	124%	61%	209%	130%	127%	132%	132%
	COP 20	Sustained	APR21	117%	52%	67%	61%	114%	134%	134%	115%	372%	441%	198%	199%	115%	83%	110%	60%	108%	63%	137%	92%	226%	180%	85%	109%	140%
Cankuzo	COP 18	Sustained	APR19	59%	52%	28%	37%	59%	64%	59%	100%	128%	257%	189%	150%	158%	67%	101%	81%	100%	89%	88%	76%	94%	82%	47%	64%	93%
	COP 19	Sustained	APR20	63%	56%	30%	39%	63%	68%	63%	107%	137%	275%	202%	161%	169%	72%	108%	87%	107%	95%	94%	81%	101%	88%	51%	69%	99%
	COP 20	Optimization	APR21	70%	91%	13%	19%	78%	58%	49%	67%	116%	303%	110%	147%	102%	59%	60%	54%	86%	61%	116%	84%	66%	77%	32%	45%	82%
Cibitoke	COP 18	Optimization	APR19	20%	38%	26%	19%	54%	33%	26%	26%	76%	72%	95%	43%	79%	46%	60%	41%	56%	57%	40%	34%	40%	48%	35%	36%	46%
	COP 19	Optimization	APR20	22%	41%	27%	21%	58%	35%	28%	27%	81%	77%	102%	46%	85%	49%	64%	44%	60%	61%	43%	36%	43%	51%	37%	39%	49%
	COP 20	Optimization	APR21	20%	61%	29%	18%	48%	33%	24%	23%	85%	72%	86%	44%	53%	53%	41%	39%	35%	60%	37%	47%	37%	53%	25%	26%	44%
Gitega	COP 18	Optimization	APR19	19%	28%	8%	15%	41%	57%	76%	69%	142%	147%	118%	76%	86%	53%	89%	53%	83%	57%	90%	63%	97%	86%	55%	66%	70%
	COP 19	Optimization	APR20	20%	30%	9%	17%	44%	61%	81%	74%	152%	157%	126%	82%	92%	56%	95%	56%	89%	61%	96%	68%	104%	93%	59%	71%	75%
	COP 20	Sustained	APR21	88%	93%	90%	99%	127%	123%	71%	78%	158%	177%	166%	124%	145%	152%	107%	125%	86%	111%	72%	88%	76%	97%	40%	58%	106%
Karusi	COP 18	Optimization	APR19	28%	65%	28%	19%	58%	46%	79%	79%	95%	122%	117%	58%	93%	58%	86%	55%	79%	57%	73%	52%	68%	83%	28%	54%	66%
	COP 19	Optimization	APR20	30%	69%	30%	20%	62%	49%	85%	85%	102%	130%	125%	62%	99%	62%	92%	59%	85%	61%	78%	56%	73%	89%	29%	57%	70%
	COP 20	Optimization	APR21	51%	34%	18%	11%	52%	42%	80%	69%	97%	133%	90%	69%	83%	57%	70%	60%	58%	58%	63%	43%	49%	73%	22%	49%	60%
Kayanza	COP 18	Optimization	APR19	15%	32%	15%	17%	49%	42%	77%	86%	183%	180%	132%	73%	109%	64%	87%	62%	85%	74%	67%	57%	85%	91%	37%	68%	74%
	COP 19	Optimization	APR20	16%	34%	16%	18%	53%	45%	82%	92%	196%	192%	141%	78%	116%	68%	93%	66%	91%	79%	71%	60%	91%	98%	39%	73%	80%
	COP 20	Sustained	APR21	50%	63%	46%	51%	101%	112%	140%	131%	242%	284%	133%	138%	100%	67%	95%	66%	110%	79%	125%	87%	112%	104%	56%	98%	108%
Kirundo	COP 18	Sustained	APR19	40%	12%	17%	19%	42%	49%	75%	48%	264%	169%	288%	195%	191%	169%	131%	143%	112%	125%	81%	88%	87%	120%	36%	71%	107%
	COP 19	Sustained	APR20	43%	13%	18%	20%	45%	52%	80%	51%	282%	180%	308%	208%	204%	181%	140%	153%	120%	134%	87%	94%	93%	129%	39%	76%	115%
	COP 20	Optimization	APR21	49%	60%	36%	38%	75%	59%	84%	84%	153%	202%	95%	121%	70%	76%	69%	77%	72%	79%	77%	85%	74%	81%	36%	53%	79%
Makamba	COP 18	Sustained	APR19	118%	69%	30%	31%	57%	38%	92%	83%	231%	145%	209%	98%	166%	84%	145%	105%	111%	74%	108%	78%	132%	144%	70%	87%	104%
	COP 19	Sustained	APR20	127%	74%	32%	33%	61%	41%	98%	89%	248%	155%	223%	105%	178%	90%	155%	112%	119%	79%	116%	84%	141%	154%	75%	93%	112%
	COP 20	Optimization	APR21	52%	35%	23%	21%	34%	50%	56%	48%	152%	120%	126%	59%	89%	59%	79%	61%	71%	51%	78%	59%	91%	80%	45%	67%	67%
Muramvya	COP 18	Optimization	APR19	0%	78%	5%	13%	54%	70%	97%	64%	114%	182%	93%	111%	61%	24%	58%	38%	85%	52%	83%	58%	104%	76%	51%	74%	69%
	COP 19	Optimization	APR20	0%	83%	5%	14%	58%	75%	104%	69%	122%	195%	99%	119%	65%	25%	63%	40%	91%	55%	89%	62%	112%	81%	55%	80%	73%
	COP 20	Sustained	APR21	70%	58%	50%	81%	81%	99%	108%	124%	167%	218%	122%	109%	60%	47%	73%	91%	98%	95%	120%	49%	123%	142%	53%	89%	97%
Muyinga	COP 18	Optimization	APR19	17%	58%	18%	16%	32%	31%	55%	55%	133%	128%	202%	86%	149%	93%	112%	65%	108%	71%	88%	65%	83%	76%	35%	54%	76%
	COP 19	Optimization	APR20	18%	62%	19%	18%	34%	34%	59%	59%	142%	137%	217%	92%	159%	100%	119%	70%	115%	76%	94%	69%	89%	81%	37%	58%	82%
	COP 20	Optimization	APR21	28%	44%	26%	35%	69%	43%	83%	75%	206%	234%	152%	124%	53%	41%	46%	53%	65%	38%	86%	46%	96%	70%	57%	78%	77%
Mwaro	COP 18	Optimization	APR19	22%	35%	4%	2%	23%	14%	52%	44%	107%	111%	50%	33%	37%	25%	31%	24%	43%	22%	51%	28%	65%	43%	34%	39%	39%
	COP 19	Optimization	APR20	24%	38%	5%	3%	25%	15%	56%	47%	114%	119%	54%	36%	39%	26%	33%	26%	46%	23%	55%	30%	69%	46%	36%	42%	42%
	COP 20	Optimization	APR21	43%	30%	11%	15%	34%	36%	59%	42%	72%	101%	38%	16%	24%	21%	29%	46%	37%	52%	40%	21%	47%	39%	26%	33%	38%
Ngozi	COP 18	Sustained	APR19	33%	29%	17%	25%	68%	65%	78%	58%	234%	187%	261%	168%	180%	139%	136%	113%	133%	106%	107%	100%	110%	110%	47%	71%	107%
	COP 19	Sustained	APR20	35%	31%	19%	27%	72%	70%	84%	62%	251%	200%	279%	179%	192%	148%	146%	121%	142%	114%	115%	107%	118%	117%	51%	76%	115%
	COP 20	Sustained	APR21	33%	37%	27%	35%	107%	103%	161%	148%	225%	286%	91%	112%	45%	37%	64%	32%	104%	53%	113%	82%	114%	102%	57%	96%	94%
Rumonge	COP 18	Optimization	APR19	26%	40%	13%	18%	34%	16%	36%	43%	98%	77%	108%	70%	67%	30%	55%	51%	54%	36%	45%	37%	40%	43%	29%	40%	46%
	COP 19	Optimization	APR20	28%	43%	13%	19%	37%	17%	38%	46%	105%	83%	116%	75%	72%	32%	59%	54%	57%	39%	48%	40%	43%	46%	31%	43%	49%
	COP 20	Optimization	APR21	21%	23%	12%	12%	41%	32%	37%	32%	95%	102%	85%	61%	78%	46%	54%	52%	56%	48%	59%	45%	67%	51%	49%	50%	50%
Rutana	COP 18	Sustained	APR19	125%	55%	24%	28%	45%	38%	106%	81%	195%	155%	184%	129%	104%	92%	108%	78%	88%	69%	103%	84%	129%	124%	54%	78%	95%
	COP 19	Sustained	APR20	134%	59%	26%	30%	48%	41%	113%	86%	209%	166%	197%	138%	112%	99%	115%	84%	95%	74%	110%	90%	138%	132%	58%	83%	102%
	COP 20	Sustained	APR21	100%	83%	42%	38%	167%	108%	158%	156%	278%	355%	113%	167%	66%	66%	66%	44%	72%	52%	117%	71%	101%	109%	37%	71%	110%
Ruyigi	COP 18	Optimization	APR19	11%	89%	11%	6%	74%	52%	84%	42%	169%	149%	121%	125%	115%	58%	86%	74%	101%	67%	97%	73%	79%	69%	43%	71%	78%
	COP 19	Optimization	APR20	12%	95%	11%	6%	79%	56%	90%	45%	181%	159%	129%	134%	123%	62%	92%	79%	108%	72%	104%	78%	85%	74%	45%	76%	83%
	COP 20	Optimization	APR21	26%	49%	24%	16%	40%	32%	87%	45%	166%	177%	75%	98%	29%	51%	24%	37%	42%	22%	70%	38%	55%	46%	25%	46%	55%

Table A.2 ART targets by prioritization for epidemic control							
Prioritization Area	Total PLHIV	Expected current on ART (APR FY20)	Additional patients required for 95% ART coverage	PEPFAR Target* for PLHIV currently on ART (APR FY21) TX_CURR	National Target for PLHIV currently on ART	PEPFAR Target for PLHIV new on ART initiated (APR FY21) TX_NEW	ART Coverage (APR 21)**
Optimize	52,668	29,057	6,055	30,575	35,112	2,106	67%
*Sustain**	32,034	42,505	N/A	45,330	45,542	3,731	142%
Total	**84,702**	**71,562**	**6,055**	**75,905**	**80,654**	**5,837**	**95%**

**PEPFAR implements direct support to facilities that provide services to 94% of the national target for PLHIV currently on ART, and reports on performance against an annual target of 75,905 on ART.*

***ART coverage is calculated using the national target of PLHIV on ART as a proportion of total PLHIV. ART coverage of >100% in Sustain provinces is largely related to results from Bujumbura Mairie, which draws PLHIV from other provinces who seek services in the capital city. Bujumbura Mairie's results therefore are expected to include services provided to individuals who are not in the denominator of estimated PLHIV in the province. Conversely, low ART coverage in Optimize provinces may be influenced by those who seek care in Bujumbura Mairie.*

APPENDIX B – Budget Profile and Resource Projections

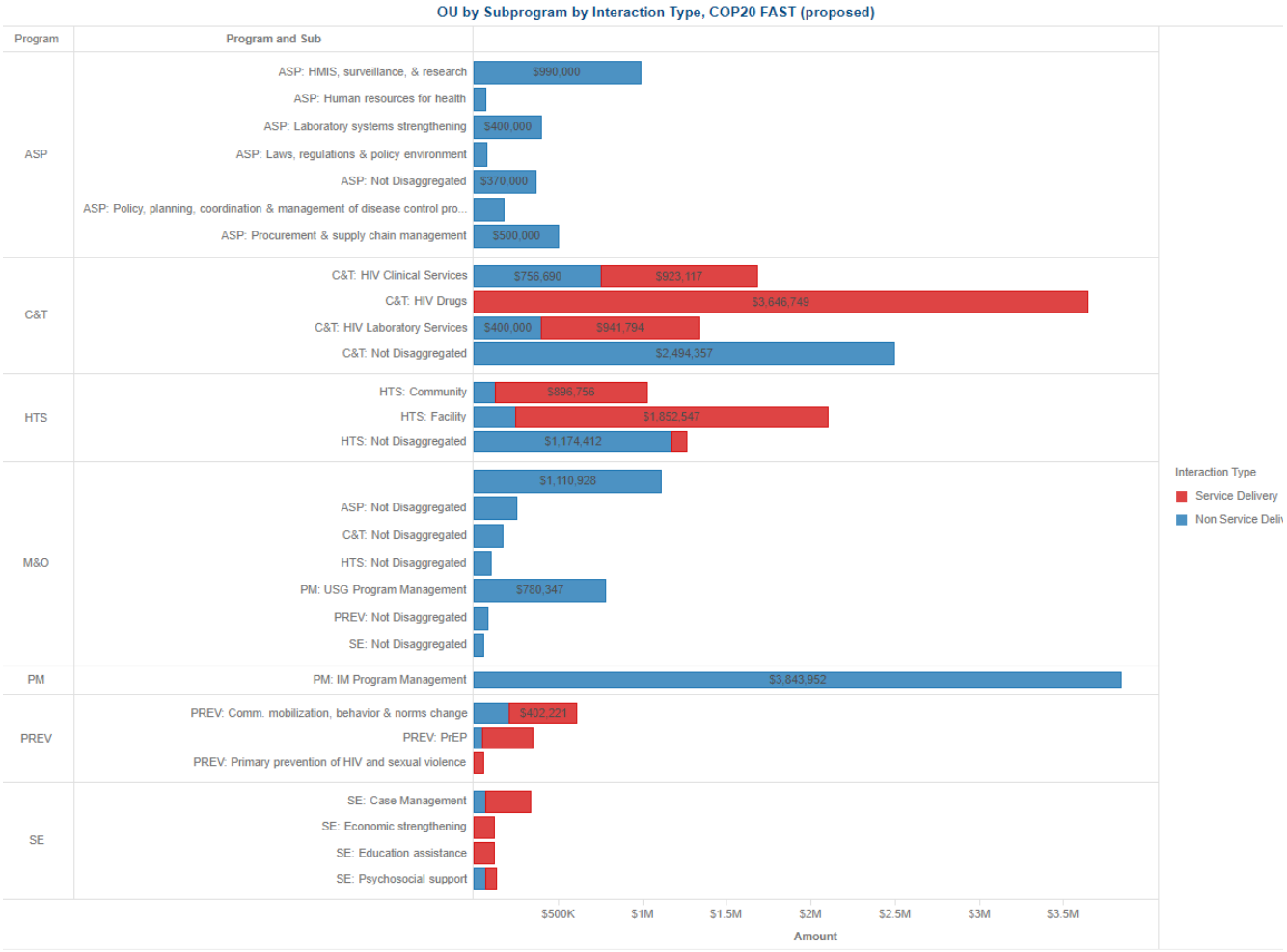


Table B.1.2 COP20 Total Planning Level

Applied Pipeline	New Funding	Total Spend
$747,097	$23,515,211	$24,262,304

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	$1,528,538
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	$85,714
HVOP	Other Sexual Prevention	$1,203,712
IDUP	Injecting and Non-Injecting Drug Use	$0
HMBL	Blood Safety	$0
HMIN	Injection Safety	$0
CIRC	Male Circumcision	$0
HVCT	Counseling and Testing	$3,058,453
HBHC	Adult Care and Support	$199,146
PDCS	Pediatric Care and Support	$541,744
HKID	Orphans and Vulnerable Children	$1,011,429
HTXS	Adult Treatment	$5,729,656
HTXD	ARV Drugs	$3,476,354
PDTX	Pediatric Treatment	$1,020,116
HVTB	TB/HIV Care	$460,545
HLAB	Lab	$517,277
HVSI	Strategic Information	$1,387,778
OHSS	Health Systems Strengthening	$1,347,974
HVMS	Management and Operations	$1,946,775
TOTAL		**$23,515,211**

B.2 Resource Projections

Including Ambition Funding requested as part of COP20, the PEPFAR Burundi budget is projected to be $24,262,304. The COP20 Care & Treatment budget is $14,544,041, which represents nearly 60 percent of the OU's total new money budget. For COP20, Burundi was directed to budget to a higher OVC earmark than in past COPs, with $1,500,000 allocated to the HKID budget code. Of the total OU budget, 89 percent of the funding is allocated to USAID, eight percent to DOD, and the remaining three percent to HHS/CDC.

Each mechanism was costed in FAST by reviewing mechanism-level PEPFAR interventions, deliverables, and budgets. Given the resource envelope for COP20, budgets were carried forward by using COP19 as a baseline after which interventions were adjusted by PEPFAR Activity Managers based on agreed-upon shifts in policy and priorities. The PEPFAR team reviewed the FAST summary visualizations to ensure budgets were aligned in accordance with targets set in DataPack and according to the overall programmatic strategies for COP20.

APPENDIX C – Tables and Systems Investments for Section 5.0 ("Table 6")

Table 6-E (Entry of Above Site Programs Activities)							
Funding Agency	COP20 Program Area	COP20 Beneficiary	COP20 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP 20 Benchmark
USAID	ASP: Laws, regulations & policy environment-NSD	Key Pops: Not disaggregated	Assessing impact of policies and regulations on HIV	Stigma and reduction resulting in limited access to health services and poor patient experience	COP19	COP20	KP TWG meets quarterly and at least two major advocacy events have been implemented
USAID	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	Commodity security and end-to-end LMIS	COP18	COP20	1. Less than 5% stock outs and expiries; 2. Commodity forecasting matches consumption, and new strategies scale-up needs; 3. Phased implemtation of MMD - at least 70 % of stable patients on MMD 6 mois; 4. Functional lab committee managing the roll-out of the new equipments and strategy, QA/QI, VL/EID accesss, optimized use of X pert machines, and monitoring of HIV testing strategies
USAID	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Upscale of laboratory diagnostic access, capacity and data visibility	COP18	COP20	1. Maintain 85% VL access and TX_PVLS 95%; 2. PNLS QM/QI document for ART implemented in all new provinces by EOY
USAID	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	Implementation and effective roll out of the new treatment strategies with fidelity and quality	COP18	COP20	TB_PREV Targets: 33857, achieved. PreP targets: 940, achieved.
USAID	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Weak HMIS - Limited access to the updated version of SIDA Info (HIV EMR), with an integrated Unique ID system, at site level	COP19	COP20	SIDA Info web based version + Unique ID finalized and available in all PEPFAR supported sites.
DOD	ASP: Human resources for health-NSD	Priority Pops: Military & other uniformed services	Pre-service training	DOD: Insufficient qualified human resources to provide HIV services in military settings	COP18	COP20	Trained 30 military personnel - Preservice training for 3 personnel for every military health center to provide HIV services completed.
USAID	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Weak HMIS - Limited access to the updated version of SIDA Info (HIV EMR), with an integrated Unique ID system, at site level	COP18	COP20	SIDA Info exchanging 90% of data with DHIS2 & IBIPIMO, limiting LTFU using TX_ML to 10%;

USAID	& research-NSD	disaggregated	data quality management	the updated version of SIDA Info (HIV EMR), with an integrated Unique ID system, at site level			through DQA. At least two data analysis meetings are organized. HTS_POS; TX_CURR;
USAID	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Vital registration systems	Weak HMIS - Limited access to the updated version of SIDA Info (HIV EMR), with an integrated Unique ID system, at site level	COP20	COP20	At least 80% of high volumes in each district have developed and implemented a site quality monitoring plan.
USAID	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Training in HMIS systems or processes	Weak HMIS - Limited access to the updated version of SIDA Info (HIV EMR), with an integrated Unique ID system, at site level	COP20	COP20	100 % of the 47 DHTs have received at least one traing in data quality management and use
USAID	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Upscale of laboratory diagnostic access, capacity and data visibility	COP20	COP20	1. Maintain 85% VL access and TX_PVLS 95%; 2. PNLS QM/QI document for ART implemented in all new provinces by EOY
USAID	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	Weak HMIS - Limited access to the updated version of SIDA Info (HIV EMR), with an integrated Unique ID system, at site level	COP20	COP20	SIDA Info web based version + Unique ID finalized and available in all PEPFAR supported sites.
USAID	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	Implementation and effective roll out of the new treatment strategies with fidelity and quality	COP20	COP20	1. Expanded national ART and TB strategy implemented with fidelity in all provinces; 2. Expanded national ART and TB PREV strategy implemented in at least 12 provinces. 3. TB PREV target of xxx achieved
USAID	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Upscale of laboratory diagnostic access, capacity and data visibility	COP18	COP20	
DOD	ASP: HMIS, surveillance, & research-NSD	Priority Pops: Military & other uniformed services	HMIS systems	Weak HMIS - Limited access to the updated version of SIDA Info (HIV EMR), with an integrated Unique ID system, at site level	COP19	COP20	SIDA Info exchanging 90% of data with DHIS2.
USAID	ASP: Not Disaggregated-NSD	Non-Targeted Pop: Not disaggregated		Lack of local partners impedes local ownership, sustainability, and efficiency of HIV program	COP19	COP20	work completed and local partners are priming independently
DOD	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	Insufficient information to inform HIV estimates, to monitor the trajectory of the epidemic and to guide prevention interventions.	COP19	COP21	Recency testing with viral load implemented in 10 target facilities in Bujumbura Mairie.

[REDACTED]: Prime partner names

APPENDIX D – Minimum Program Requirements

	Minimum Program Requirements	Progress
Care and Treatment	Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[13]	The Test and Start policy was updated in December 2019 based on WHO guidelines. It was rolled out nationally in 47 districts and 289 sites that are directly supported by PEPFAR. In COP20, Burundi will focus on direct and immediate (>95%) linkage from testing to treatment across all age, sex, and risk groups with particular emphasis on children, adolescents, and key populations.
	Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.[14]	By the end of COP19 Burundi will complete the transition from TLE to TLD, including among women of reproductive age. During COP20, Burundi will focus on optimization of TLD ART to persons weighing at least 30 kilograms and of DTG-based regimens for children weighing at least 20 kilograms. In COP19, Burundi has removed all nevirapine-based regimens.
	Adoption and implementation of differentiated service delivery models, including six-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[15]	Burundi adopted 6-month multi-month scripting (MMS) and 3-month multi-month dispensing (MMD), consistent with WHO and PEPFAR guidance. In COP18 PEPFAR supported rapid roll-out of 6-month MMS and 3-month MMD for long-term, stable patients and travelers; however, due to limited ARV commodity supplies, implementation was limited to PEPFAR-supported districts in the COP18 provinces. Advocacy efforts to increase procurement of ARVs to meet the demand for 3-month MMD are the focus of PEPFAR Burundi in COP19. Through COP20, Burundi will focus on scale-up plans and national SOPs for DSD implementation and continue to implement the MMS and MMD efforts at the site level.
	All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of COP20, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[16]	Burundi adopted TPT policies for adults and children and revised the national TB and HIV guidelines. TPT completion rates improved during COP18 to ~74% with lower rates among newly enrolled on ART; INH was provided in all provinces (42/47 districts) but TPT for children has not yet been implemented at site level. In COP20, Burundi plans to promote full-scale TPT coverage for adults and children with emphasis on ensuring high completion rates.
	Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	In COP19, PEPFAR Burundi, in collaboration with NACP, GFATM, and stakeholders, will be working at the above-service-delivery level and at the site level to complete VL/EID optimization exercises by the end of COP19 and to develop a QM/QI system. Further information is detailed in Section 4 and in Appendix C (Table 6). COP20 will focus on improving and expanding use of IBIPIMO (integration of a Dashboard) and linking it to SIDA-Info. PEPFAR Burundi will improve VL access, testing, and reporting in new provinces and sites, and improve EID coverage including turnaround time within 4 weeks.

Case Finding	Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV-positive biological parent must be tested for HIV.[17]	A national index testing policy was approved in November 2018 and testing guidelines were updated in 2019. In 2019, Burundi focused on rapid scale-up efforts of index testing across all populations to get to 75% of HIV-positives identified, and ongoing roll-out of index testing in all 12 new PEPFAR-supported provinces. Burundi achieved this through gender-sensitive, stigma-free language training and ongoing roll-out of self-testing in the 13 provinces supported by KP programs. In 2020, Burundi plans to focus on children of HIV-positive biological parents; review the national tools to improve integration of IPV screening and monitoring in index texting services, including consent, and reporting of adverse events; improve targeting of prioritized sub-populations (hard-to-reach KP populations, partners of index clients, and partners of PMTCT clients); and strengthen the monitoring and reporting systems at community level.
Prevention and OVC	Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)[18]	PrEP is included in Burundi's 2016 and 2019 national guidelines. PrEP is not yet part of the national prevention program, but will be integrated in COP20 and is part of the GFATM Concept Note submitted by Burundi for the period 2021-2023. In COP19/20, PEPFAR Burundi will support the development of a PrEP national strategy.
	Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	In COP18 and COP19, PEPFAR Burundi successfully transitioned the comprehensive OVC service package to focus on supporting comprehensive treatment service support to adolescent girls in five provinces. The program focuses efforts on a bi-directional referral network to support referral to and from pediatric clinical care and treatment. In COP20 PEPFAR Burundi will expand the comprehensive prevention and treatment service package for OVC to include children and adolescents ages 0-17 years, of both sexes, and their household members.

Policy & Public Health Systems Support	Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[19]	No fees charged in Burundi
	OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[20]	Program data provide evidence that CQI is implemented actively among partners and is documenting clear improvements in many areas; evidence includes innovative registers for tracking loss to follow-up and MMD. SIMS visits now activated through a third-party contractor also provide evidence of measurement against site standards.
	Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	Health facilities display and utilize educational visuals and messaging related to U=U, but this is an area that requires additional investment (planned for COP19/20). PEPFAR-supported CSO treatment providers are leading on health care worker/client interaction to reduce stigma, with additional work required. Urban facilities have been identified for training specifically to interface effectively with KPs.

	Clear evidence of agency progress toward local, indigenous partner direct funding.	In COP19, PEPFAR Burundi has awarded two new local partners, one for GBV and one for OVC. COP20 plans include full-speed implementation of the two new mechanisms. Increased responsibilities and resources being transferred over time.
	Evidence of host governments assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	In COP19, the focus was on ART procurement commitments, and improved NACP coordination, leadership and ownership. The GOB has increased its commitment year to year from 2018 to 2020.
	Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	In COP19, PEPFAR Burundi initiated the groundwork for establishing case-based surveillance through SIDA-Info. The development of a stand-alone surveillance system was challenged by weak HMIS infrastructure and sensitivities around the use of biomarker identification. PEPFAR also tracked mortality and LTFU data through the MER indicator TX_ML, and can triangulate with MSPLS mortality data. In COP20, Burundi will work with the NACP to improve TX_ML and retention reporting systems.
	Scale-up of case-based surveillance and unique identifiers for patients across all sites.	In COP18/19 PEPFAR held consultations with NACP about piloting a unique identifier, exploring the feasibility of a fingerprint ID system on a pilot basis. PEPFAR Burundi initiated the groundwork for establishing case-based surveillance through SIDA-Info. These initial investigations were successful, and COP20 plans revolve around active development of a web-based version of SIDA-Info, with fingerprint integrated, to establish a national unique identifier system.