

**Burundi**

**Country Operational Plan**

**(COP) 2021**

**Strategic Direction Summary**

**May 3, 2021**



UNCLASSIFIED

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## Acronym List

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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
DHIS <sub>2</sub>	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
IIT	Interruption in treatment
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

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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 2021-2022. 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 2021 Country Operational Plan (COP21) for Burundi will focus on building on the solid achievements made to date and closing known gaps in the epidemic response. The vision for COP21 is 1) to consolidate and build upon the gains made in the past years, 2) close the testing, treatment and viral load coverage, and suppression gaps, and 3) support the development of capacities for a sustained epidemic control in Burundi.

To operationalize the COP21 vision, the PEPFAR Burundi program will have three main priorities:

- Priority 1: Geographic alignment of investment with epidemiology and performances
- Priority 2: Consolidation of achievements to close the gaps
- Priority 3: Service delivery quality improvement

### ***Priority 1: Geographic alignment of investment with epidemiology and performances***

In COP21, the PEPFAR Burundi program will invest strategically in districts and sites with the greatest needs and greatest potential for improved performance, for a maximum impact. PEPFAR Burundi will continue to work closely with the NACP and the GFATM to further refine the district approach and ensure a most effective and efficient use of PEPFAR's contributions to the national HIV response in COP21. By supporting the government district health team structure, PEPFAR Burundi is investing in a sustainable model for the delivery of quality prevention and care.

### ***Priority 2: Consolidating achievements to close the gaps***

PEPFAR Burundi will build on the important progress made in COP19 and COP20 to close the testing, treatment, and viral load coverage and suppression gaps. The COP21 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. Above-site interventions 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 biometric-based Unique Identifier (UID) 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 to maintain the provision of high-quality HIV services and to meet expanding needs in COP21. PEPFAR Burundi will continue to invest in improved surveillance systems to enable tracking of all newly diagnosed individuals and monitor the progress towards sustained epidemic control. 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.

### ***Priority 3: Service delivery quality improvement***

The COP21 plan aims to set a nationwide standard for access to quality HIV services for all those at risk of HIV infection or living with HIV. PEPFAR Burundi will expand client-centered approaches to care in order to address barriers to adherence and continuity of treatment. PEPFAR Burundi will also continue to adapt and implement solutions that are population-, age-, and gender-specific with the goal of targeting case-finding approaches, ensuring continuity of treatment nationally, and closing the viral load (VL) access and suppression gaps.

A detailed description of PEPFAR Burundi COP21 vision and strategies is provided in Section 2.2.

In summary, during COP21, PEPFAR Burundi will:

- adapt and optimize the district approach shifting significantly from reaching epidemic control to sustaining epidemic control;
- close clinical cascade gaps among men, children and adolescents living with HIV (C/ALHIV) to improve treatment outcomes and assure continuity of treatment and viral load (VL) suppression;
- expand client-centered approaches to care in order to address barriers to adherence and continuity of treatment;
- and fully support three key systems: supply chain, health information and lab systems.

## 2.0 Epidemic, Response, and Program Context

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### 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 12.3 million in 2021,<sup>1</sup> Burundi is the second most densely populated country in Africa, with about 435 inhabitants per square kilometer, as of 2018.<sup>2</sup> Burundi's total fertility rate of 5.2 children per woman,<sup>3</sup> 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 (45.1%).

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 March 2021, UNHCR estimates that 294,160 refugees are remaining in neighboring countries, the most since 2015.<sup>4</sup> 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 \$ 790 per capita<sup>5</sup> 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 (2013). Burundi is in the bottom five of the low-income categories of countries (184 of 189 countries) on the 2018 United Nations Development Programme (UNDP) Human Development Index.<sup>6</sup> The economy is predominantly agricultural, with a 86.21 percent employment rate (share of total employment that is employed in agriculture) in 2019.<sup>7</sup> 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.

**HIV Prevalence:** According to 2021 Spectrum modeling, Burundi's HIV prevalence is 1 percent among adults aged 15-49. Among adults over age 15, prevalence is 1.3 percent. Prevalence varies

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<sup>1</sup> <https://www.unfpa.org/data/world-population/BI>

<sup>2</sup> <https://data.worldbank.org/indicator/en.pop.dnst>

<sup>3</sup> Idem

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

<sup>5</sup> <https://data.worldbank.org/indicator/NY.GNP.PCAP.PP.CD?locations=BI>

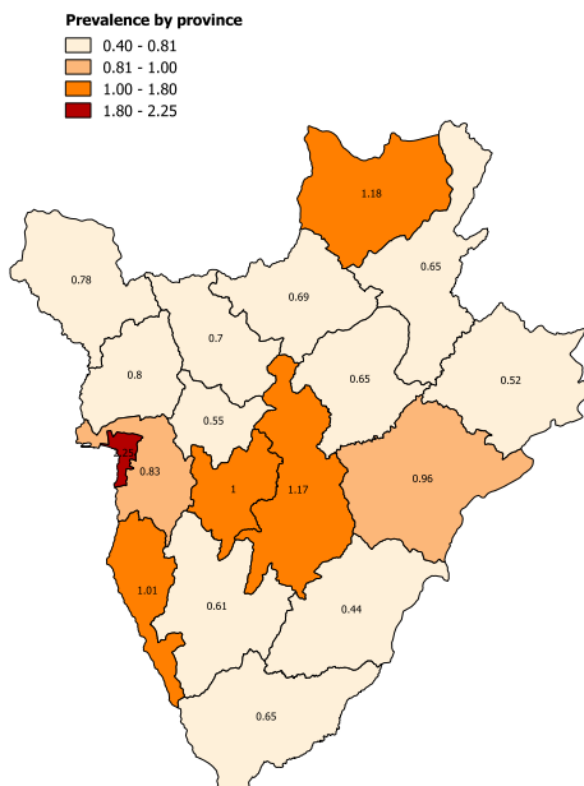
<sup>6</sup> <http://hdr.undp.org/en/composite/HDI>

<sup>7</sup> <https://data.worldbank.org/indicator/SL.AGR.EMPL.ZS?locations=BI>

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 continuity of treatment 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 continuity of treatment 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, yet programatic data suggests a low volume of individuals with high case finding rates. A 2017 study<sup>8</sup> related to injecting 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 IDUs were also living 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 2020, there were 72,713 PLHIV on ART in Burundi, of which 68,699 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 persons living with HIV, with both declining.”

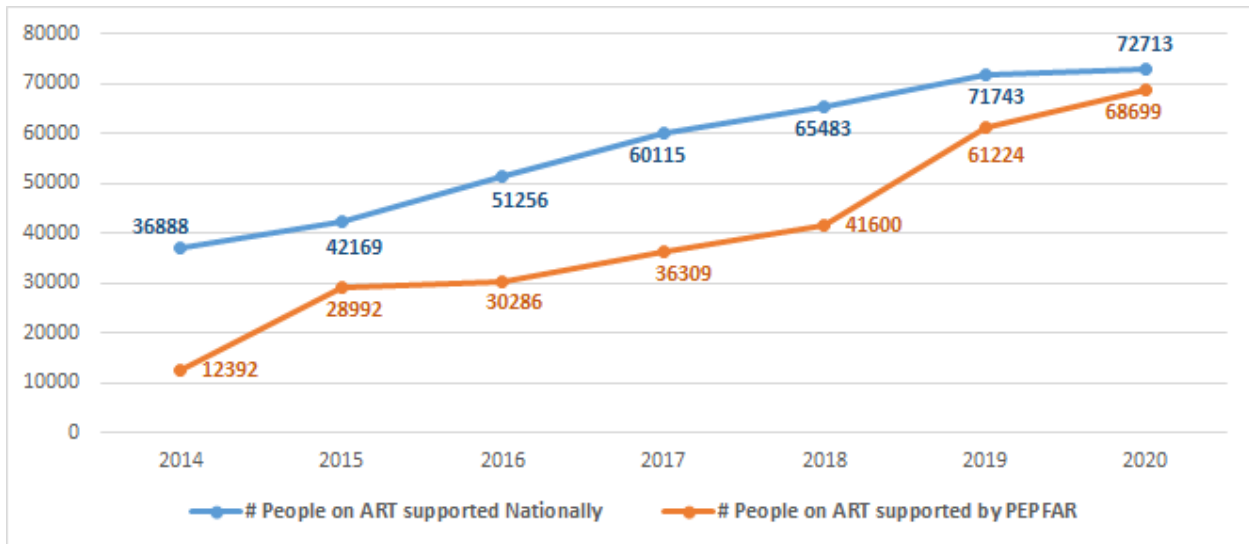
PEPFAR Burundi investments focus on optimizing the programs and systems that support, achieve, and sustain epidemic control. PEPFAR Burundi works closely with the Government of Burundi (GOB) to support the NACP’s efforts to adopt practices and policies based on the best available evidence. The GOB has 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 has already made

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<sup>8</sup> 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

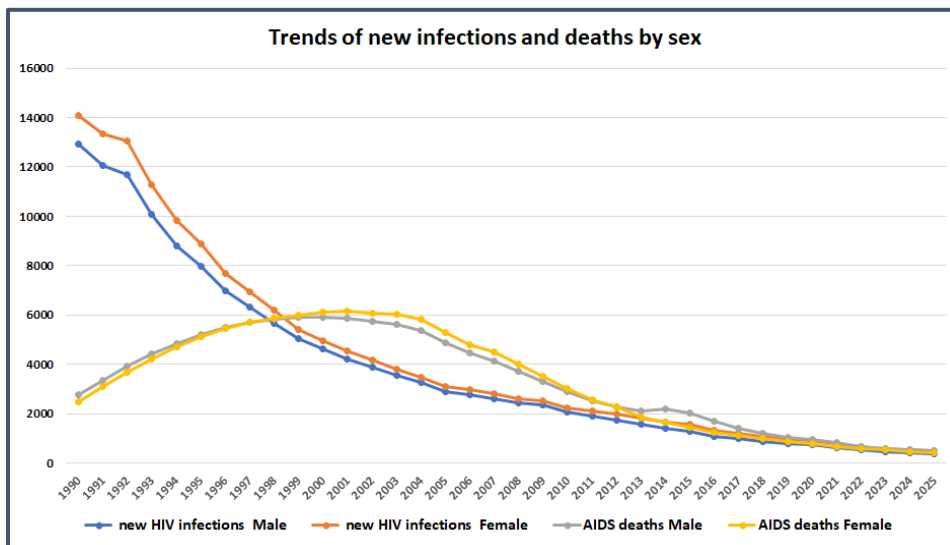
significant progress in scaling up targeted case-finding strategies, and nevirapine (NVP) recall. Additionally, PEPFAR is supporting the NACP to operationalize and fully scale MMD and to complete the full transition to tenofovir-lamivudine-dolutegravir (TLD).

**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 ( December 2020)

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

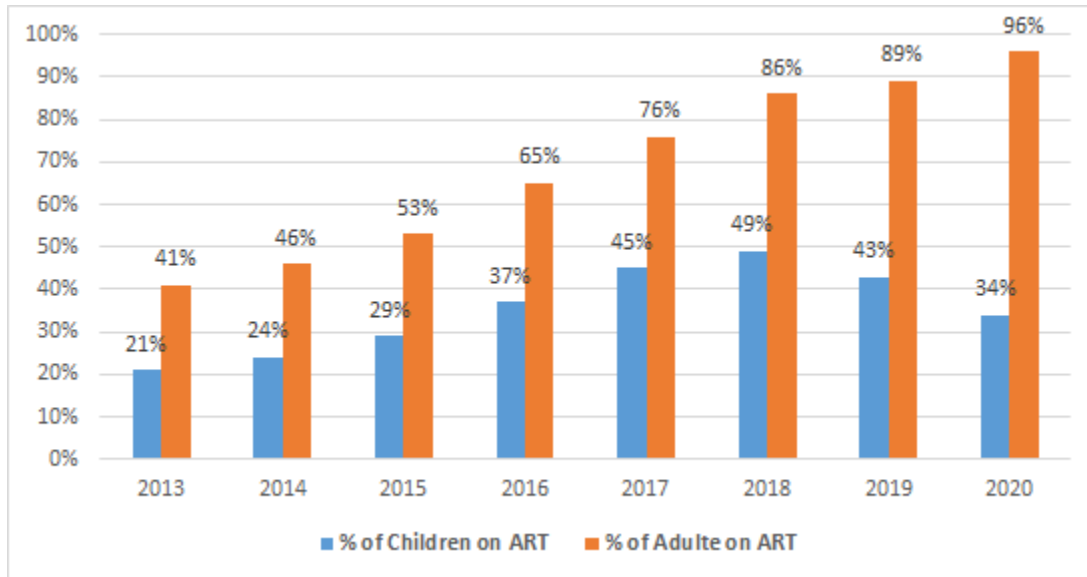


Source: 2021 spectrum estimates

Burundi has made substantial progress in enrolling patients on ART. At the end of 2020, according to DHIS2 data, 72,713 (89 percent) of the estimated 81,797 PLHIV in Burundi were on ART (Table

2.1.2). However, treatment coverage is substantially lower among children than among adults (Figure 2.1.4).

**Figure 2.1.4: Trends in ART coverage, adults (15+) and children (<15)**



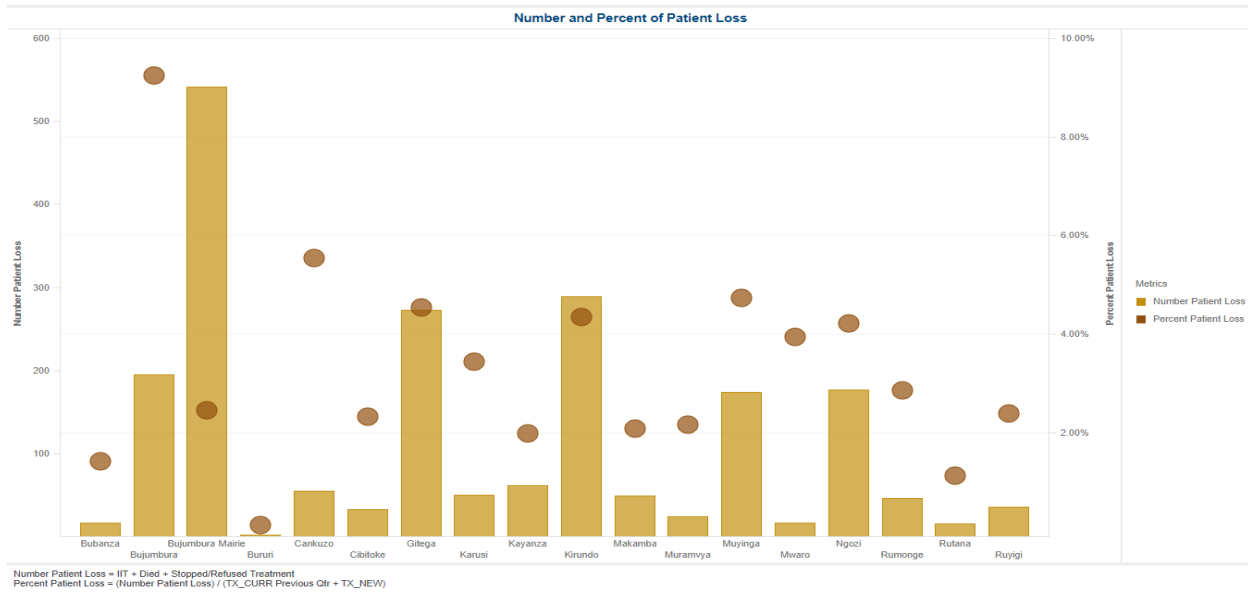
Source: DHIS2

Following the expansion of PEPFAR Burundi activities into 12 new provinces in COP19/FY20, there was an initial drop in continuity of treatment rates, which the program has worked to address. There has been visible progress over the past three quarters, but there is still work to be done in ensuring clients are not lost from treatment (Figure 2.1.5), and continued improvements are anticipated during the remainder of COP20 into COP21.

PEPFAR through its implementing partners is supporting HIV/AIDS activities in all 18 provinces. Interruption in treatment (IIT) is variable across provinces and districts, and between districts within the same province. Efforts to bring back clients to care are seen but are unequal across the country. During COP21, a focus will be made on preventing treatment interruptions and on returning clients to care in all sites. Barriers to treatment will be addressed. Treatment literacy will be increased and targeted.

**Figure 2.1.5: Number and percent of clients lost from treatment per province, Q1 FY21**





Source: Panorama

VL testing is still not widely available in Burundi, and VL coverage is particularly low in some provinces (see later Figure 2.5.1). VL access and VL suppression are 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 persons living with HIV, with a rate of 111 per 100,000 population. Among PLHIV in Burundi, 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.<sup>9</sup>

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,<sup>10</sup> 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 (MSM and IDUs) as priority populations.

<sup>9</sup> 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.

<sup>10</sup> 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	12,401,732	100	2,788,166	22	2,831,658	23	1,167,003	9	1,165,773	9	2,289,580	18	2,159,552	17	Spectrum 2021
HIV Prevalence (%)		1		0		0		0.4		0		2		1	Spectrum 2021
AIDS Deaths (per year)	1,940		311		318		84		112		276		389		Spectrum 2021
# PLHIV	81,797		4,347		4,433		4,892		5,494		39,187		23,444		Spectrum 2021
Incidence Rate (Yr)		0.1													Spectrum 2021
New Infections (Yr)	1,422														Spectrum 2021
Annual births	473,197	4.2													Spectrum 2020
% of Pregnant Women with at least one ANC visit	408,650	100	430	0			149,626	37			258,594	63			SNIS DHIS2 2020
Pregnant women needing ARVs	5,579														Spectrum 2021
Orphans (maternal, paternal, double)	615,664														Spectrum 2021
Notified TB cases (Yr)	7,202														PNILT
% of TB cases that are HIV infected		11													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													PLACE Study, 2013
Estimated Population Size of PWID	Not available														
PWID HIV Prevalence		10													Ref. 7
Estimated Size of Priority Populations (Military)	100,000														
Priority Population Prevalence (Military)	1.80%														
*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+															

	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	12,401,732	0.8	81,797	72,783	72,713	89	100	65	725,446	13,365	10,212
Population <15 years	5,619,824	0.1	8,780	2,989	2,975	34	100	59	54,163	613	1,432
Men 15-24 years	1,165,773	0.4	5,494	2,154	2,152	39	100	59	38,001	566	212
Men 25+ years	2,159,552	1	23,444	20,733	20,706	88	100	62	103,950	3,722	3,175
Women 15-24 years	1,167,003	0.4	4,892	5,828	5,825	119	100	51	217,058	2,729	833
Women 25+ years	2,289,580	1.8	39,187	41,079	41,055	105	100	69	366,437	6,348	5,992
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	89	11,654	1,503	1,478

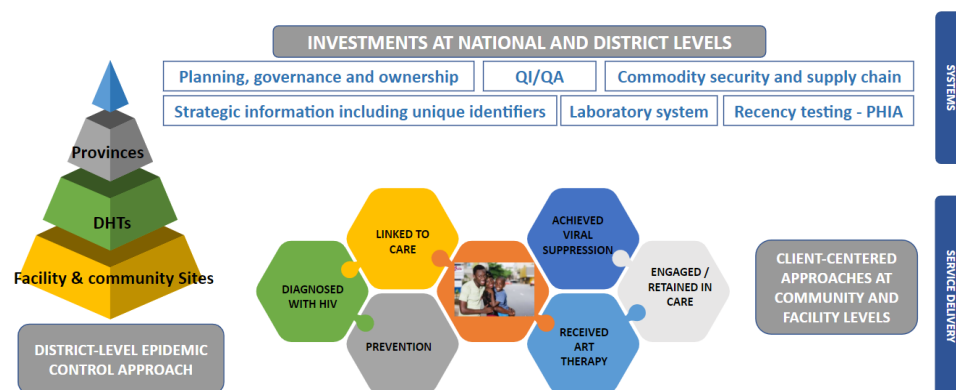
\*National data (DHIS2 as of December 2020); Spectrum 2021

\*\*Linkages Program data (APR 2019), PLACE Study 2013

## 2.2 New Activities and Areas of Focus for COP21

The COP21 Vision, as presented at the COP21 Virtual Planning Meeting in April 2021 and described in Figure 2.1.1, focuses efforts on 1) consolidating and building upon the gains made in the past years, 2) closing the testing, treatment and viral load coverage and suppression gaps, and 3) supporting the development of capacities for a sustained epidemic control in Burundi.

Figure 2.2.1 COP21 Vision



Source: PEPFAR Burundi, April 2021

During FY22, the PEPFAR Burundi program will have three main priorities:

- Priority 1: Geographic alignment of investment with epidemiology and performances
- Priority 2: Consolidation of achievements to close the gaps
- Priority 3: Service delivery quality improvement

**Figure 2.2.2 COP21 key priorities**

**1. Geographic alignment of investment with epidemiology & performances**

Focus on sites and districts with the lowest ART coverage; Formulate district-specific strategic recommendations and target definition for core indicators. Optimal use of the results of the recency testing, the PHIA, and the IBBS

**2. Consolidating achievements to close the gaps**

Closing the testing, treatment, and viral coverage and suppression gaps; addressing critical implementation barriers; HIS and UID expansion; continued scale-up of efficient testing strategies (index and \*self-testing); transition to optimized ART regimens; expansion of PreP; TB/HIV co-infection service integration.

**3. Improving quality**

Expanding client-centered approaches that are responsive to client needs and community engagement to prevent loss and support continuity in treatment



Source: PEPFAR Burundi, April 2021

**2.2.1 Priority 1: Geographic alignment of investment with epidemiology and performances**

In COP21, the PEPFAR Burundi program will invest strategically in districts and sites with the greatest needs and greatest potential for improved performance, for a maximum impact. PEPFAR Burundi's geographic approach will continue to tailor the intensity and level of support in each province to current progress toward achieving the three 95 goals for epidemic control. In each province, PEPFAR programming will prioritize technical assistance to districts with the highest-burden, the lowest ART coverage and support sites with substantial continuity of treatment gaps and/or large ART cohorts, particularly district hospitals, sites associated with sizeable key population (KP) hotspots, and TB reference facilities, with the aim of directly assisting sites that collectively serve 98 percent of all ART patients in each province. The DHTs will continue to receive targeted technical assistance to ensure that they reach the remainder of the sites.

PEPFAR Burundi will exploit the results from the Integrated Bio-behavioral Survey (IBBS) currently under implementation and from the surveillance of recent infections to refine its geographic approach.

This COP21 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. The discussions have resulted in a shared vision for this final COP21 proposal and a set

of national priorities that are aligned along the funding streams. PEPFAR Burundi will continue to work closely with the NACP and the GFATM to further refine the district approach and ensure a most effective and efficient use of PEPFAR's contributions to the national HIV response in COP21. By supporting the government district health team structure, PEPFAR Burundi is investing in a sustainable model for the delivery of quality prevention and care.

### **2.2.2 Priority 2: Consolidating achievements to close the gaps**

PEPFAR Burundi will build on the important progress made in COP19 and COP20 to close the testing, treatment, and viral load coverage and suppression gaps. The COP21 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.

#### **2.2.2.1 Closing the testing gaps**

Case finding will be essential to both closing the small treatment gaps remaining in specific age bands, and an efficient strategy to maintain epidemic control. During COP21, PEPFAR Burundi will focus on routinizing index testing as the main modality for case finding in all districts. This will imply ensuring that best practices in terms of safe and ethical index testing strategy are largely shared and implemented.

PEPFAR Burundi will also expand the HIV self-testing strategy (HIVST) that has proven to be an effective tool in reaching hard to reach populations with limited access to conventional testing services. HIVST will contribute to Burundi's efforts to increase HTS program efficiency and effectiveness by focusing limited HIV resources, space and staff time towards individuals with a reactive self-test in need of further confirmatory testing and linkage to prevention, treatment and care services. PEPFAR Burundi will also track and report numbers of those returning to the facility after a positive outcome after using the self testing strategy to effectively use the approach to reach PLHIV and ensure impact in case finding.

During COP21, PEPFAR Burundi will increasingly focus its efforts in closing the pediatric testing gaps by leveraging both facility- and community-based platforms, including the ANC, OVC and key populations platforms to find children living with HIV not yet in care. HIV case-finding efforts will also focus on young people, and adult men - all populations in which case-identification gaps are still notable in Burundi. PEPFAR Burundi will continue to use population-specific strategies and strong evidence from other countries (e.g. using FSW platforms to test men who purchase sex and other MenStar approaches for case-finding among men).

#### **2.2.2.2 Closing the treatment gaps**

PEPFAR Burundi will prioritize support for a full access to TLD and DTG 10 mg for children, the rapid scale-up of MMD three and six months and the expansion of the PODI model (as part as a sustainable community ART delivery platform) and DSD models, all strategies that will contribute

to close the treatment gaps, retain the patients in treatment by addressing issues that prevent them from attending health facilities, in particular in a COVID-19 context.

As treatment growth for children was minimal in FY20 with loss from the ART cohort, PEPFAR Burundi will identify root causes for IIT for C/ALHIV, especially for younger children <5 and 5-9 as well as those lost <3 months on treatment and continue its Peds surge efforts during FY22.

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.

#### **2.2.2.3 Closing the viral load coverage and suppression gaps**

Complementing continuity of treatment efforts, PEPFAR Burundi will build on the important progress made in COP19 and COP20 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 FY22, PEPFAR Burundi, in collaboration with the GFATM and the NACP, plans to expand the all-inclusive laboratory strategy to optimize instrument placement and use, and the provision of new machines with more capacity will alleviate the issue of machine breakdowns due to the age of the current machines. 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. PEPFAR Burundi will work closely with PLHIV and KP led groups to mobilise communities around U=U messaging to ensure a greater uptake of viral load testing services.

#### **2.2.2.4 Prevention**

Consistent with the planned introduction of HIV pre-exposure prophylaxis (PrEP) in Burundi through the 2021-2023 GFATM Concept Note, COP21 funding will continue the expansion of PrEP for KPs and serodiscordant couples, with a target of providing sustained PrEP to 2661 seronegative individuals. This will be essential for a sustained epidemic control in Burundi.

Building on the substantial successes in COP19 and COP20, 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 eligible PLHIV (including children) on ART, including introduction of optimized regimens.

Finally, during COP21/FY22, PEPFAR Burundi will contribute to cover the condom and lubricant gaps in-country.

#### **2.2.2.5 KP program**

In COP21, 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 continue to

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).

During COP21, the KP program will transition to high-performing, KP-competent local partners. To ensure the success of this transition and mitigate the fiduciary and programmatic risks, PEPFAR Burundi will continue to work with EpiC and leverage technical assistance from ACHIEVE.

The results of the stigma index and lessons learned in Burundi and elsewhere will serve as a basis to maintain and scale structural interventions for KPs, including mental health services and GBV mitigation.

#### **2.2.2.6 Orphans and Vulnerable Children (OVC) program**

In COP21, the OVC programs will continue to 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 continuity of treatment and viral suppression rates. During COP19, PEPFAR Burundi successfully transitioned its OVC investment to a local partner. In FY22, PEPFAR Burundi will increase coverage for OVC services for high burden sites for those on treatment <19 years of age, expand geographically its OVC program in one additional province, while continuing to develop the capacity of the local partner. The OVC program will continue to prioritize support for C/ALHIV in order to offer 90% of children and adolescents on treatment the opportunity to enroll in the OVC program, with particular focus on adolescents.

#### **2.2.2.7 GBV**

During COP20, PEPFAR Burundi successfully transitioned its GBV program to a local partner. During COP21, the local partner will continue to focus on reinforcing the integration of a GBV component in all relevant aspects of the HIV clinical cascade, including the prevention intervention (PrEP) and strengthening the continuum of responses between GBV prevention and clinical post-violence response service.

#### **2.2.2.8 Above-site interventions**

Above-site interventions 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 biometric-based Unique Identifier (UID) health information systems to serve the needs of a sustained epidemic control program. 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.

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 diagnostic ,

and EID testing commodities) to maintain the provision of high-quality HIV services and to meet expanding needs in COP21.

During FY22, PEPFAR Burundi will continue to 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.

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. COP21 investments will continue to 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.

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.

In COP21, PEPFAR Burundi will continue to 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 COP20, will continue in COP21 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.

### **2.2.3 Priority 3: Service delivery quality improvement**

#### **2.2.3.1 Quality of services and client-centered approaches**

The COP21 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. PEPFAR Burundi will continue to adapt and implement evidence-based solutions that are population-, age-, and gender-specific with the goal of targeting case-finding, ensuring continuity of treatment 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.



PEPFAR Burundi will ensure that for testing strategies, consent procedures and confidentiality are protected and assessment and follow-up/referral for intimate partner violence (IPV) is established.

Maintaining epidemic control will necessitate continuous adherence to ART for patients for whom HIV treatment is easily interrupted by multiple potential causes including lack of time, poor quality of service, stigma and discrimination, life circumstances. Maintaining long-term viral suppression requires planning and implementing services that are adapted to the lives of the clients, and empower clients on ART to stay the course. ART patient continuity of treatment will be the key focus in COP21, 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 and ensuring that all people living with HIV (PLHIV) are able to access optimized ART regimens. Segmented strategies to ensure continuity in treatment 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.

In COP21, PEPFAR Burundi will focus more on pediatric- and adolescent-specific continuity of treatment programming, including age appropriate differentiated models of care and leveraging bidirectional synergies with clinical and OVC implementing partners.

#### **2.2.3.2 Active community engagement and community-led monitoring of PEPFAR services**

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 continuity of treatment with quality services. COP21 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 PLHIV who have not linked to or stopped receiving ART.

To ensure that services supported by PEPFAR Burundi implementing mechanisms are of quality, the small grants program for CSOs to support community-led monitoring of ART services will continue and expand during COP21.

#### **2.2.3.3 Service integration**

To improve patient experience, PEPFAR Burundi will continue to support the 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.

PEPFAR Burundi is also working closely with the NACP and other stakeholders to plan the integration of cervical cancer screening and treatment services for women living with HIV aged 25-49 years.

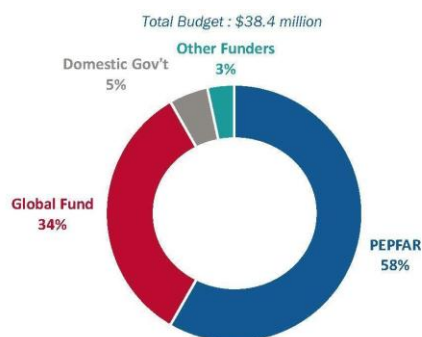
#### 2.2.3.4 Partner management

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 continuity of treatment efforts as needed in COP21.

### 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 92 percent of the country's HIV program costs in 2021.

**Figure 2.3.1: Budget by stakeholder**



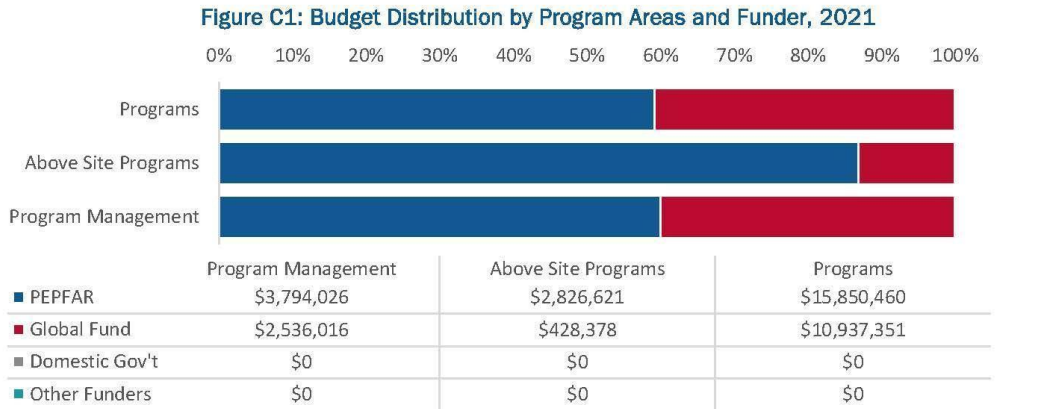
Source: HIV Resource Alignment: Burundi Country Profile, updated April 2021

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 women LHIV (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.

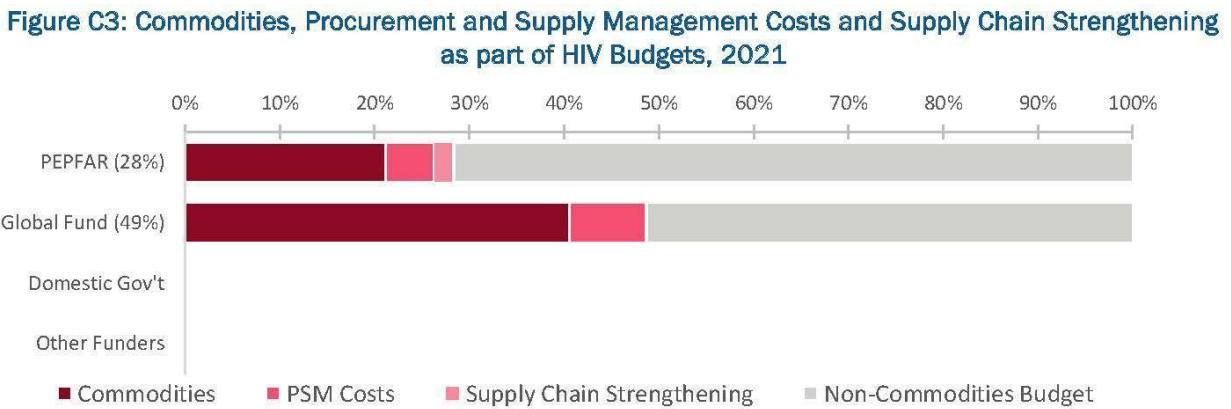
The GFATM continues to be the largest procurer of HIV-related commodities (including ARVs and non-ARV drugs, condoms, rapid test kits, reagents, and supplies). The PEPFAR program will complement the procurement of commodities (including ARV drugs, and GeneXpert cartridges,) and will continue to provide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

**Figure 2.3.2: Budget by program area and stakeholder**



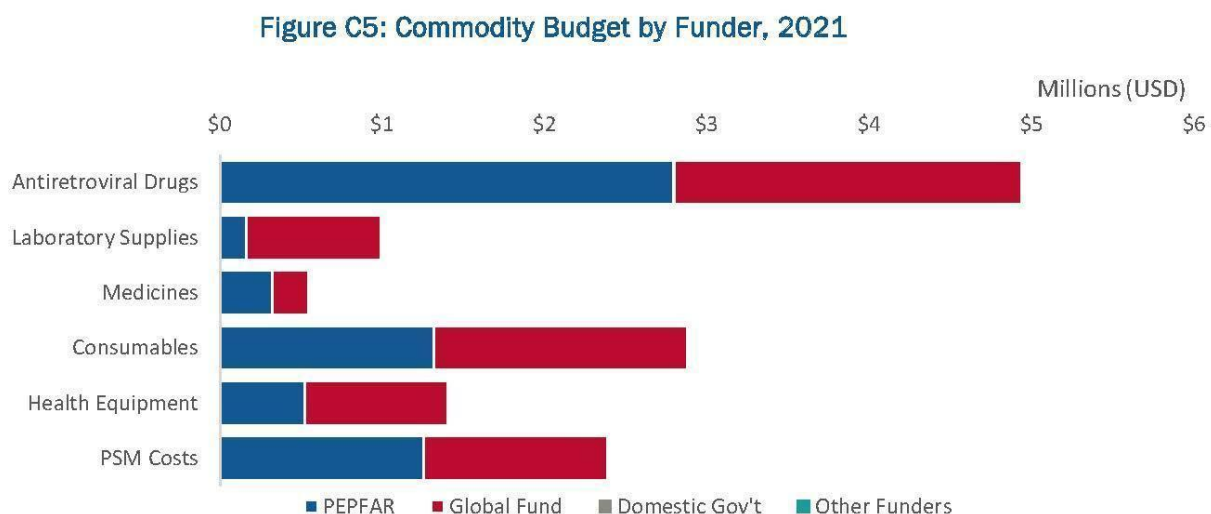
Source: HIV Resource Alignment: Burundi Country Profile, updated April 2021

**Figure 2.3.3: Commodities, procurement and supply management costs and supply chain strengthening**



Source: HIV Resource Alignment: Burundi Country Profile, updated April 2021

**Figure 2.3.4: Commodity budget by funder**



Source: HIV Resource Alignment: Burundi Country Profile, updated April 2021

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).

Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country
Care and Treatment	\$11,814,269	36	55	9
Prevention	\$1,338,072	55	37	8
HTS	\$3,443,315	86	14	*
VMMC	NA	NA	NA	NA
OVC	\$1,639,873	41	59	*
Above-Site Programs	\$1,565,603	74	26	*
<b>Total</b>	<b>\$25,809,266**</b>	<b>51</b>	<b>43</b>	<b>5</b>

Source: HIV Resource Alignment: Burundi Country Profile, updated April 2021

\* Government of Burundi data included where available by program area.

\*\* Includes program management and commodities costs.

**Table 2.3.2 Investment profile for HIV programs, 2021**

Table S1. Investment Profile (Budget Allocation) for HIV Programs, 2021						
	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	\$	%	%	%	%	2018-2021
<b>Care and Treatment</b>	<b>\$18,401,715</b>	<b>0%</b>	<b>49%</b>	<b>51%</b>	<b>0%</b>	
<i>HIV Care and Clinical Services</i>	\$10,837,981	0%	51%	49%	0%	
<i>Laboratory Services incl. Treatment Monitoring</i>	\$1,454,390	0%	8%	92%	0%	
<i>Care and Treatment (Not Disaggregated)</i>	\$6,109,344	0%	57%	43%	0%	
<b>HIV Testing Services</b>	<b>\$4,905,997</b>	<b>0%</b>	<b>9%</b>	<b>91%</b>	<b>0%</b>	
<i>Facility-Based Testing</i>	\$2,414,255	0%	13%	87%	0%	
<i>Community-Based Testing</i>	\$1,087,735	0%	6%	94%	0%	
<i>HIV Testing Services (Not Disaggregated)</i>	\$1,404,007	0%	4%	96%	0%	
<b>Prevention</b>	<b>\$2,037,623</b>	<b>0%</b>	<b>45%</b>	<b>55%</b>	<b>0%</b>	
<i>Community mobilization, behavior and norms change</i>	\$755,902	0%	16%	84%	0%	
<i>Voluntary Medical Male Circumcision</i>	\$0					
<i>Pre-Exposure Prophylaxis</i>	\$368,958	0%	5%	95%	0%	
<i>Condom and Lubricant Programming</i>	\$371,345	0%	100%	0%	0%	
<i>Opioid Substitution Therapy</i>	\$0					
<i>Primary Prevention of HIV &amp; Sexual Violence</i>	\$73,237	0%	18%	82%	0%	
<i>Prevention (Not Disaggregated)</i>	\$468,181	0%	84%	16%	0%	
<b>Socio-economic (incl. OVC)</b>	<b>\$1,442,476</b>	<b>0%</b>	<b>36%</b>	<b>64%</b>	<b>0%</b>	
<i>Case Management</i>	\$429,416	0%	16%	84%	0%	
<i>Economic Strengthening</i>	\$120,000	0%	0%	100%	0%	
<i>Education Assistance</i>	\$120,000	0%	0%	100%	0%	
<i>Psychosocial Support</i>	\$401,803	0%	67%	33%	0%	
<i>Legal, Human Rights, and Protection</i>	\$175,122	0%	100%	0%	0%	
<i>OVC (Not Disaggregated)</i>	\$196,135	0%	0%	100%	0%	
<b>Above Site Programs</b>	<b>\$3,254,999</b>	<b>0%</b>	<b>13%</b>	<b>87%</b>	<b>0%</b>	
<i>Human Resources for Health</i>	\$70,000	0%	0%	100%	0%	
<i>Institutional Prevention</i>	\$0					
<i>Procurement and Supply Chain Management</i>	\$500,000	0%	0%	100%	0%	
<i>Health Mgmt Info Systems, Surveillance, and Research</i>	\$1,388,752	0%	29%	71%	0%	
<i>Laboratory Systems Strengthening</i>	\$400,000	0%	0%	100%	0%	
<i>Public Financial Management Strengthening</i>	\$0					
<i>Policy, Planning, Coordination and Management of Disease Ctrl Programs</i>	\$209,626	0%	14%	86%	0%	
<i>Laws, Regulations and Policy Environment</i>	\$75,000	0%	0%	100%	0%	
<i>Above Site Programs (Not Disaggregated)</i>	\$611,621	0%	0%	100%	0%	
<b>Program Management</b>	<b>\$6,330,042</b>	<b>0%</b>	<b>40%</b>	<b>60%</b>	<b>0%</b>	
<i>Implementation Level</i>	\$6,330,042	0%	40%	60%	0%	
<b>Total (incl. Commodities)</b>	<b>\$38,423,269</b>	<b>5%</b>	<b>36%</b>	<b>58%</b>	<b>0%</b>	
<b>Commodities Only</b>	<b>\$13,146,864</b>	<b>0%</b>	<b>51%</b>	<b>49%</b>	<b>0%</b>	
<i>% of Total Budget</i>	34%					

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available.

Table 2.3.3: Annual procurement profile for key commodities, 2019 (most recent expenditure data)					
Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	
ARVs	\$4,399,549	12	69	19	
Rapid test kits	\$1,324,095	31	60	10	

Medicines	\$425,022	15	85	*	
Lab supplies	\$810,877	41	59	*	
Condoms and lubricant	\$322,044	0.0	100.0	*	
PSM costs	\$1,280,303	31	69	*	
Health equipment	\$176,712	8	92	*	
<b>Total</b>	<b>\$8,738,602</b>	<b>20</b>	<b>69</b>	<b>11</b>	

\* Information on Government of Burundi procurements included where available.

**Table 2.3.4 Investment profile for HIV commodities, 2021**

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	\$	%	%	%	%	2018-2021
Antiretroviral Drugs	\$4,938,578	0%	43%	57%	0%	
Laboratory Supplies and Reagents	\$992,192	0%	83%	17%	0%	
CD4	\$0					
Viral Load	\$176,352	0%	97%	3%	0%	
Other Laboratory Supplies and Reagents	\$815,840	0%	80%	20%	0%	
Laboratory (Not Disaggregated)	\$0					
Medicines	\$547,628	0%	41%	59%	0%	
Essential Medicines	\$131,930	0%	100%	0%	0%	
Tuberculosis Medicines	\$246,018	0%	39%	61%	0%	
Other Medicines	\$169,680	0%	0%	100%	0%	
Consumables	\$2,880,726	0%	54%	46%	0%	
Condoms and Lubricants	\$721,357	0%	100%	0%	0%	
Rapid Test Kits	\$2,159,369	0%	39%	61%	0%	
VMMC Kits and Supplies	\$0					
Other Consumables	\$0					
Health Equipment	\$1,403,418	0%	63%	37%	0%	
Health Equipment	\$846,550	0%	100%	0%	0%	
Service and Maintenance	\$556,868	0%	6%	94%	0%	
PSM Costs	\$2,384,321	0%	47%	53%	0%	
<b>Total Commodities Only</b>	<b>\$13,146,864</b>	<b>0%</b>	<b>51%</b>	<b>49%</b>	<b>0%</b>	

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available.

<b>Table 2.3.5: Annual USG non-PEPFAR funded investments and integration</b>					
<b>Funding Source</b>	<b>Total USG Non-PEPFAR Resources (FY20)</b>	<b>Non-PEPFAR Resources Co-Funding PEPFAR IMs (FY20)</b>	<b># Co-Funded IMs</b>	<b>PEPFAR COP21 Co-Funding Contribution</b>	<b>Objectives</b>
USAID MCH	\$5,000,000	NA	NA	NA	NA
USAID TB	NA	NA	NA	NA	NA
USAID Malaria	\$8,000,000	\$5,184,044	1	\$5,617,505	<i>Supply chain systems and data/reporting enhancements (GHSC-PSM)</i>
Family Planning	\$5,000,000	1,500,000	2	\$2,850,000	<i>Access to Family Planning and GBV services</i>
<b>Total</b>	<b>\$18,000,000</b>	<b>\$6,684,044</b>	<b>3</b>	<b>\$6,309,224</b>	

\* 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 COP21 strategy. In particular, PEPFAR Burundi will expand support to CSOs to improve the linkage between community and facility services, and will maintain the 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 COP21, 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 continuity of treatment, including preventing and finding clients experiencing an interruption in treatment. 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 is 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 COP21 priorities for addressing SID sustainability vulnerabilities**

During FY21, 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 and COP20, PEPFAR Burundi made awards to two local partners to implement a GBV and an OVC activity.

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.

In COP21, the OVC programs will continue to 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 continuity of treatment and viral suppression rates. During COP 19, PEPFAR Burundi successfully transitioned its OVC investment to a local partner. In FY22, PEPFAR Burundi will increase coverage for OVC services for high burden sites for those on treatment <19 years of age, expand geographically its OVC program in one additional province, while continuing to develop the capacity of the local partner. The OVC program will continue to prioritize support for C/ALHIV in order to offer 90% of children and adolescents on treatment the opportunity to enroll in the OVC program, with particular focus on adolescents.

The OVC mechanism is currently focused on direct service delivery in 5 provinces, covering beneficiaries in Bujumbura Mairie, Bujumbura Rural, Kayanza, Kirundo and Gitega. In COP21 the program will expand to cover 14,000 beneficiaries including 10,445 OVC <18. Activities will continue as established in COP20, and will include an expansion to Muyinga. The OVC program will prioritize enrollment of children living with HIV (CLHIV) and their households. The local partner is building on the former OVC project to implement the following package of services:

1. Health, with a focus on supporting CLHIV with adherence, ensuring viral suppression, disclosure counseling, access to other health and nutrition services and/or referrals, and 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 CLHIV enrolled within the OVC program . The OVC program will also collaborate with clinical partners to support index testing of biological children of women LHIV. The children will be provided community insurance cards, as needed, to give them access to other health services beyond HIV. Adolescent boys and girls will also receive additional sexual and reproductive education and services. Specialized services will be offered the different sub-population categories, sex and age bands to meet their specific needs.
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 monthly 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 boys, school reintegration for young adolescent mothers, and vocational training;
4. Socio-economic support to families with a focus on parents/caregivers and older and out of school OVCs through digital and traditional saving groups.

During COP21, the KP program will transition to two local, “KP competent” partners to manage the program; one working with FSWs and another with MSM and TG. Similar to the current program, these partners will hold sub-contracts with KP-led organizations, building stronger capacities within KP communities themselves. Epic will be retained in a reduced capacity to provide technical support, focusing on system information and e-cascade issues, financial reporting, and technical areas such as virtual outreach.

### ***2.5 Alignment of PEPFAR investments geographically to disease burden***

The PEPFAR program in Burundi expanded nationally to all of the country’s 18 provinces and 47 health districts during COP19. 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. More detailed information is provided in section 3.

### ***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 COP21 through participation in key sessions during a virtual strategic planning retreat in January 2021. These sessions were an opportunity to review PEPFAR and national data, discuss the main challenges at community and national levels, share 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, the PEPFAR program’s geographic expansion, and areas of synergies with the GFATM.

PEPFAR Burundi engaged with stakeholders outside of the virtual 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.

Stakeholders were also invited to take part in the COP21 virtual planning meeting held from April 15-16, 2021. Participants included the Director of the NACP, Burundi's GFATM Portfolio Manager, and representatives of WHO, UNAIDS, UNDP, and CSOs in Burundi.

After the virtual planning meeting, debriefing sessions were organized with the NACP and CSO representatives to review the level of inclusion of their priorities in the COP21 plan.

Stakeholders will continue to be engaged throughout the COP21 planning and implementation process through ongoing consultations, including sharing of quarterly results at the national and provincial levels.

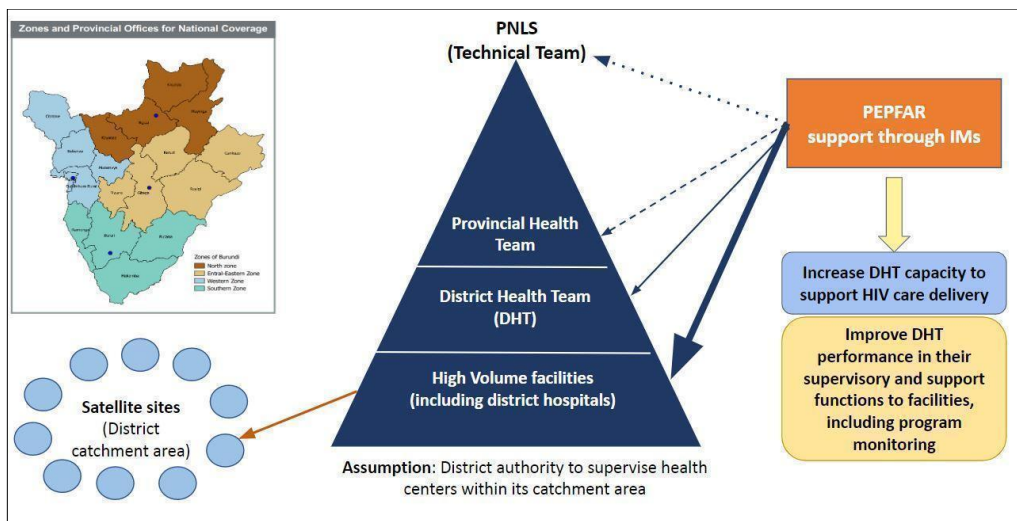
### 3.0 Geographic and Population Prioritization

#### 3.1 PEPFAR Burundi's COP21 Geographic Priorities

The GOB and its partners are dedicated to reaching the UNAIDS 95-95-95 targets with the aim of achieving and maintaining epidemic control in Burundi. In COP19 and COP20, 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.

**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**

<ul style="list-style-type: none"> <li>● District hospitals</li> <li>● High-volume sites (facility and community)</li> <li>● Case-finding for targeted populations (<i>Optimize services</i>) and large ART cohort (<i>Sustain services</i>)</li> <li>● Sites that support 80 percent of total patients in areas in which the largest numbers of PLHIV reside</li> <li>● TB reference health facilities</li> <li>● KP hotspots</li> <li>● Youth-friendly services</li> </ul>
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PEPFAR Burundi will continue to complement GFATM investments by providing technical assistance for optimized quality improvement and focused investments that prioritize

epidemiologic impact. Shifts planned in COP21 build on this framework and the progress made during COP20. These improvements include:

- **Enhanced coordination with the NACP and the GF** to situate roles and responsibilities in the implementation of the district approach. 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).
- **Improved leadership of the MOH:** The leadership role of the MOH is paramount to ensure a better appropriation of the district approach by the DHTs and for the translation of national policies and strategies into concrete actions.
- **Better accountability for results** – For districts to be accountable, the NACP, in close collaboration with the clinical IPs will set up targets and priorities for each district. IPs will support the DHTs to collect context-relevant data, to assess the progress against targets and benchmarks, and improve their decision-making and problem-solving processes.
- **Intensified capacity development of DHTs and improved technical assistance provision**, to ensure that DHTs will have the knowledge and capability to support all sites in the district catchment area. IPs should offer to districts with the greatest issues regular technical support visits to provide on-the-job coaching and training. Actions should also include peer-to-peer strategies, experience sharing and community of practices.
- **Strengthened community involvement in the district approach**, from planning to implementation.
- **Greater use of technology in the context of COVID-19** to improve communication, implementation and coordination.

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**

<ul style="list-style-type: none"><li>● <b>Northern Zone:</b> Kayanza, Muyinga, Ngozi &amp; Kirundo - Existing office in <b>Ngozi</b></li><li>● <b>Central-Eastern Zone:</b> Ruyigi, Cankuzo, Gitega, &amp; Karusi - Existing office in <b>Gitega</b></li><li>● <b>Western Zone:</b> Bujumbura Mairie, Bujumbura Rural, Cibitoke, Muramvya and Bubanza - Existing office in <b>Bujumbura Mairie</b></li><li>● <b>Southern Zone:</b> Bururi, Makamba, Rutana, Mwaro &amp; Rumonge - Existing office in <b>Bururi</b></li></ul>
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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.

Prioritization Area	Total PLHIV/% of all PLHIV for COP21	# Current on ART (FY20)	# of SNU COP18 (FY19)	# of SNU COP21 (FY22)
Scale-up Aggressive	52,668 (62%)	27,651	12	12
Sustained (including Military)	32,034 (38%)	44,092	7	7

### 3.2 Categorization of Provinces

PEPFAR Burundi has categorized Burundi's 18 provinces into *high and low burden* provinces based on the latest Spectrum estimates. The following table shows a comparison between FY20 and FY21 estimates, and the changes in terms of burden categorization. Nearly 80% (77%) of PLHIV are located in 39% of all provinces; 5 of 6 legacy provinces are in high burden zones. Makamba has shifted from low to high burden provinces and Ruyigi has shifted from high to low burden provinces.

**Table 3.2.1 Change in burden with the 2021 Spectrum estimates**

HIGHEST vs LOWEST BURDEN SPECTRUM 2020			HIGHEST vs LOWEST BURDEN SPECTRUM 2021	
Burden Category	Province	2020 SPECTRUM PLHIV	Province	2021 SPECTRUM PLHIV
Highest burden	Bujumbura M	16810	Bujumbura M	26314
	Gitega	9055	Kirundo	8770
	Kirundo	7940	Gitega	7674
	Muyinga	5406	Ngozi	5866
	Kayanza	5064	Muyinga	5155
	Ngozi	4819	Kayanza	3887
	Bujumbura	4683	<b>Makamba</b>	<b>3494</b>
	<b>Ruyigi</b>	<b>4520</b>	Bujumbura	2593
Lowest burden	Rumonge	4276	Rumonge	2427
	Cibitoke	3552	<b>Ruyigi</b>	<b>2358</b>
	Mwaro	3091	Bururi	2146
	<b>Makamba</b>	<b>2895</b>	Cibitoke	2006
	Karusi	2738	Karusi	1883
	Bubanza	2638	Rutana	1864
	Bururi	2260	Bubanza	1531
	Rutana	1848	Muramvya	1355
	Muramvya	1704	Cankuzo	1292
	Cankuzo	1403	Mwaro	1182
All	84702	All	81797	

Source: Spectrum 2020 and 2021

**Table 3.2.2 Proportion of PLHIV in the highest vs the lowest burden provinces**



Indicator	Total PLHIV	Highest burden	Lowest burden
PLHIV	81797	63753	18044
Proportion PLHIV	100%	78%	22%
Proportion Province	100%	39%	61%

Source: Spectrum 2021

### **3.3 Differentiation of Support across Provinces and districts**

PEPFAR Burundi has differentiated the level of support provided to DHTs 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. 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, coaching and quality control. During COP21, PEPFAR will continue to contribute to the remediation of these issues. Community involvement in PEPFAR programming is anticipated to be more robust in *the lowest performing provinces*, which are still struggling to enroll and maintain PLHIV on continuity of treatment. 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. In addition, COP21 plans for implementing partners will aim to realize PEPFAR’s vision that clients and communities are at the center of what they do.

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, two local partners will continue to implement OVC and GBV programming, as well as two additional local IPs for the KP program, 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;
- Expanding self 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-based treatment initiation, and reinforcing client-centered community approach to strengthen continuity of treatment;
- Expanding community-led treatment literacy efforts, including the development and dissemination of easily understandable and culturally appropriate materials;
- Supporting U=U (undetectable = untransmissible) 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;
- Increasing the role of community leaders to support GBV prevention and services;
- 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;
- Using the KP platform to reach others associated with risk (e.g. men who purchase sex);
- Supporting structural interventions for KPs, such as stigma, discrimination and violence mitigation, mental health services, among others; and
- Strengthening the capacity of KP-led CSOs to deliver prevention and treatment services.

### ***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 *high burden* provinces, with particular emphasis on those that had not received intensive PEPFAR support prior to COP19.

**Table 3.5.1: System Activities for DHTs**

<p><b>PLANNING SYSTEMS CAPACITIES</b></p> <ul style="list-style-type: none"> <li>• Performance review and bottleneck analyses</li> <li>• Data analysis and sharing used in planning processes</li> <li>• Support in the development and monitoring of quarterly action plans</li> </ul>	
<p><b>PROCUREMENT AND SUPPLY CHAIN MANAGEMENT</b></p> <ul style="list-style-type: none"> <li>• Improvement of efficiency in logistics</li> <li>• Technical assistance on information systems</li> <li>• Improvement of stock control</li> <li>• Introduction of maintenance plans</li> <li>• Improvement of commodities distribution</li> <li>• Skills improvement on logistics management</li> </ul>	<p><b>DATA &amp; INFORMATION SYSTEMS</b></p> <ul style="list-style-type: none"> <li>• Improvement of registry of patient data for pediatric and adult patients</li> <li>• Improvement of facility-based information systems such as systematic cleaning of patient and facility records in SIDA-Info and data quality audits</li> <li>• Improvement of follow-up on defaulters</li> </ul>
<p><b>QUALITY ASSURANCE/QUALITY IMPROVEMENT</b></p> <ul style="list-style-type: none"> <li>• QA/QI through the establishment of core standards and program reviews</li> <li>• QI initiatives to target a particular problem or service, such as early infant diagnosis</li> <li>• Training to update providers' skills or introduce new norms, protocols, and strategies;</li> <li>• Technical skills improvement (lab technicians, providers trained on counselling)</li> <li>• Re-engineering of patient flow in high-volume facilities to decrease patient waiting times, improve internal referrals and increase the efficiency of services</li> <li>• Strengthening the links between community and health facilities to improve demand for and access to services</li> <li>• Integration of community and facility HIV/TB response</li> </ul>	<p><b>LABORATORY</b></p> <ul style="list-style-type: none"> <li>• Assessment of turn-around time for laboratory tests to identify and address bottlenecks that cause delays and affect initiation and adherence to treatment</li> <li>• Improvement of lab info for data quality control</li> <li>• Preventive maintenance of lab equipment</li> <li>• Plan developed for lab sample collection</li> <li>• 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</li> </ul>

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 COP21 targets, PEPFAR Burundi will intensify strategies to reach the populations with the greatest identified gaps in ART coverage, in all provinces.

**Table 3.6.1: Priority populations**

Priority populations
<ul style="list-style-type: none"> <li>• KPs (MSM, TG, FSW)</li> <li>• Priority populations: sexual partners of KPs and PLHIV; children of KPs; OVC; AGYW; fishermen, truck drivers, miners</li> <li>• Other subgroups of the general population: men over 25; pregnant women, breastfeeding women, and infants through PMTCT</li> <li>• TB patients</li> <li>• STI patients</li> <li>• Military populations</li> </ul>

In terms of **case identification**, Spectrum estimates by sex and age highlight continued gaps for both men and children (Table 3.6.2). In COP21, case identification will be highly targeted and focus on closing gaps in these populations. Note that during the remaining months of COP20 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 status	1st 95	PLHIV	Who know their HIV status	1st 95	PLHIV	Who know their HIV status	1st 95
28,938	22,887	79%	44,079	46,907	106%	8780	2,989	34%

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

In terms of **ART coverage**, age- and sex-disaggregated analyses show that men 15-34 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 continuity of treatment, 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 all provinces.

## 4.0 Client-Centered Program Activities to Reach Epidemic Control

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In COP21, 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 focus on ART patient continuity of treatment and viral suppression.

PEPFAR Burundi will support targeted case-finding, rapid ART initiation, continuity of treatment on ART, and access to VL monitoring at high-priority sites that comprise 95 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

The MSPLS, with the support of PEPFAR Burundi, has moved away from universal testing and has focused on strategies to increase testing efficiencies. While the focus on COP21 will be on continuity of treatment of patients on ART, testing strategies are being optimized and implemented to go the last mile to find undiagnosed PLHIV and initiate them on treatment.

PEPFAR Burundi's testing strategy will continue to emphasize shifting away from lower yield modalities and focus on targeted, safe, and ethical index testing and self-testing for hard-to-reach populations. In FY20, 63% of adult men and 81% of CLHIV were identified through index testing. In COP21, 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 and focusing on symptom-based screening.

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.<sup>11</sup>

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<sup>11</sup> 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 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 UNAIDS 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.

In COP21, the focus will be to optimizing testing strategies, to better reach those who are undiagnosed and to capitalize on comparative advantages and cost-effectiveness, while also ensuring timely linkage and enrollment in treatment by:

1. Improving and expanding safe and ethical index and self-testing with fidelity
2. Maintaining gains in case finding via social network strategies (including virtual approaches)
3. Geographic targeting: a combination of district prioritization and site-level analysis
4. Expanding differentiated testing strategies
5. Closing the gap in finding men and children by expanding the COP20 surge interventions and leveraging the OVC and KP platforms

Identifying **undiagnosed CLHIV** will be one of the key areas of PEPFAR's surge focus on the pediatric continuum of care in COP21. In COP21, PEPFAR Burundi will support completion of index testing of 100% of all biological children of women 15+ by launching index testing SOPs to support pediatric and OVC collaboration, leveraging KP programming to find children through index testing, facilitating collaboration with youth organizations to reach and offer testing to high risk adolescents, increasing the use of Youth Friendly Services by adolescents; and reducing any missed opportunities to find infants LHIV by reducing missed opportunities through the PMTCT program and assessing all potential entry points for HIV-exposed infants.

During the **pediatric surge**, PEPFAR Burundi will work collaboratively with the NACP and other stakeholders to share analysis of findings and develop plans and targets. PEPFAR Burundi will also contribute to standardize HIV policy and education material dedicated to children and adolescents. 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.

For **adolescents** not reached through the OVC program, PEPFAR Burundi will support index testing of those adolescents who have a biological parent or sibling LHIV through facility and community platforms, including KP platforms. The clinical programs will collaborate with the OVC program to support index testing for biological children of women LHIV. In addition, PEPFAR Burundi will support policy changes to lower the age of consent for HIV 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<sup>12</sup>) will be used, creating flexible/extended hours at facilities as well as adolescent-friendly centers.

In COP21, PEPFAR Burundi will continue to leverage the ANC platform for **HIV case finding of women LHIV**, including to reach and test sexual partners and biological children of women who test positive. Adult women will also be reached through index testing using men as index clients. Through all modalities, the program will support referrals to intimate partner violence (IPV)/GBV and social risk reduction services.

To improve HIV case-finding for **key populations**, the program will adapt to results from the GFATM-funded KP-specific Integrated Bio-Behavioral Surveillance Survey (IBBS) expected during COP20 implementation. The PEPFAR Burundi 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 Approach (EPOA), including use of online communication platforms and information communication technology. The program will also continue index testing following PEPFAR guidelines, with a certification program for counselors that is already in place. 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 may not fully identify as KP. The program will also utilize infrastructure designed to reach and retain FSW as a strategy to engage higher risk men, including men who purchase sex and long term partners of FSW.

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.

In COP21, **recency testing** will scale-up through a phased implementation to Bujumbura Mairie and Gitega after protocol approval by both MSPLS and IRB in COP20. 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 and identify long term infections (e.g. repeat testers, on ART, elite controllers). 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.

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<sup>12</sup> 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>

Implementing partners will also support the MSPLS at the 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 (e.g. FP/MCH/HIV).

More detailed testing strategies by sub-groups of populations are shown in Table 4.1.1.

**Table 4.1.1: Testing strategies by sub-groups of populations**

Population	Lessons learned during FY20/21	Key testing strategies
<b>Children &lt;15, including OVC</b>	Pediatric casefinding has become more efficient with expanded family-based index testing. In FY21 Q1 81% of all CLHIV were identified through index testing.	<ul style="list-style-type: none"> <li>● Active facilitation of testing for all children at risk of HIV infection</li> <li>● Increased offer of index testing and partner notification services to parents LHIV on ART (especially FSW) and siblings LHIV to identify biological children (&lt;19 years) who may not yet be diagnosed</li> <li>● Improved bidirectional referrals between OVC and clinical partners to ensure that eligible children (and caregivers) are tested for HIV and linked to ART, and children on ART are referred to the OVC program by clinical partners</li> <li>● 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.</li> </ul>
<b>Adolescents and young people (10-24)</b>	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.	<ul style="list-style-type: none"> <li>● Index testing (with a focus on community index testing)</li> <li>● HIV self-testing</li> <li>● Youth-friendly services (community outreach, facility settings)</li> <li>● Improved collaboration between OVC and clinical partners to ensure that eligible children (and caregivers) are tested for HIV and linked to ART, as appropriate</li> <li>● Referral of eligible children by clinical partners to OVC programs</li> <li>● Increased offer of index testing and partner notification services to adolescents LHIV (ALHIV) and to ALHIV who are not virally suppressed</li> </ul>
<b>Adult women (15+)</b>	Women have the highest testing rates in Burundi; in particular women between the ages of 20-29.	<ul style="list-style-type: none"> <li>● ANC platforms will ensure 100% offer of HIV testing to all women entering ANC (with linkages to PrEP and PMTCT programs as needed)</li> <li>● Increased offer of index testing and partner notification services to men LHIV</li> </ul>



		<ul style="list-style-type: none"> <li>• Increased offer of index testing and partner notification services to adult women on ART (15+) who are not virally suppressed</li> <li>• Implementation of Recency testing</li> </ul>
<b>Adult men (15+)</b>	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.	<ul style="list-style-type: none"> <li>• Index testing (focusing on ANC, STI clinics, through FSW, with referrals to IPV/GBV services as indicated)</li> <li>• Targeted community-based testing, workplace, venues for at-risk men, and home-based testing</li> <li>• Use of FSW platform to reach and test men who purchase sex and long term partners of sex workers</li> <li>• Self-testing (for hard-to-reach men)</li> <li>• Male-friendly testing services (“men-only” and evening clinic hours)</li> <li>• Increased volume of index testing for men on ART who are not virally suppressed</li> <li>• Implementation of Recency testing</li> </ul>
<b>Key populations</b>	Testing services for KPs must be highly targeted, using strategic information and network analyses to ensure high quality, data-driven outreach	<ul style="list-style-type: none"> <li>• Expand and/or relocate KP services to target unsaturated hotspots</li> <li>• Optimize self-testing, social, and sexual network testing for MSM, FSW and TG</li> <li>• Strengthen virtual strategies for case finding, linkage and continuity of treatment</li> <li>• Maintain drop-in centers, mobile testing (hotspots, informal settlements)</li> <li>• Prioritize support for KPLHIV who are not virally suppressed</li> </ul>
<b>Military</b>	Index testing has been a highly effective strategy to identify military/male cases compared to other testing modalities.	<ul style="list-style-type: none"> <li>• Elimination of high-volume/low-yield HTS modalities</li> <li>• Intensive focus to high-yield modalities and increased offer of index testing and self-testing to prioritize contacts of people newly identified PLHIV, and clients on ART who are not virally suppressed</li> <li>• Implementation of Recency testing</li> </ul>

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

**ART Coverage Gap**

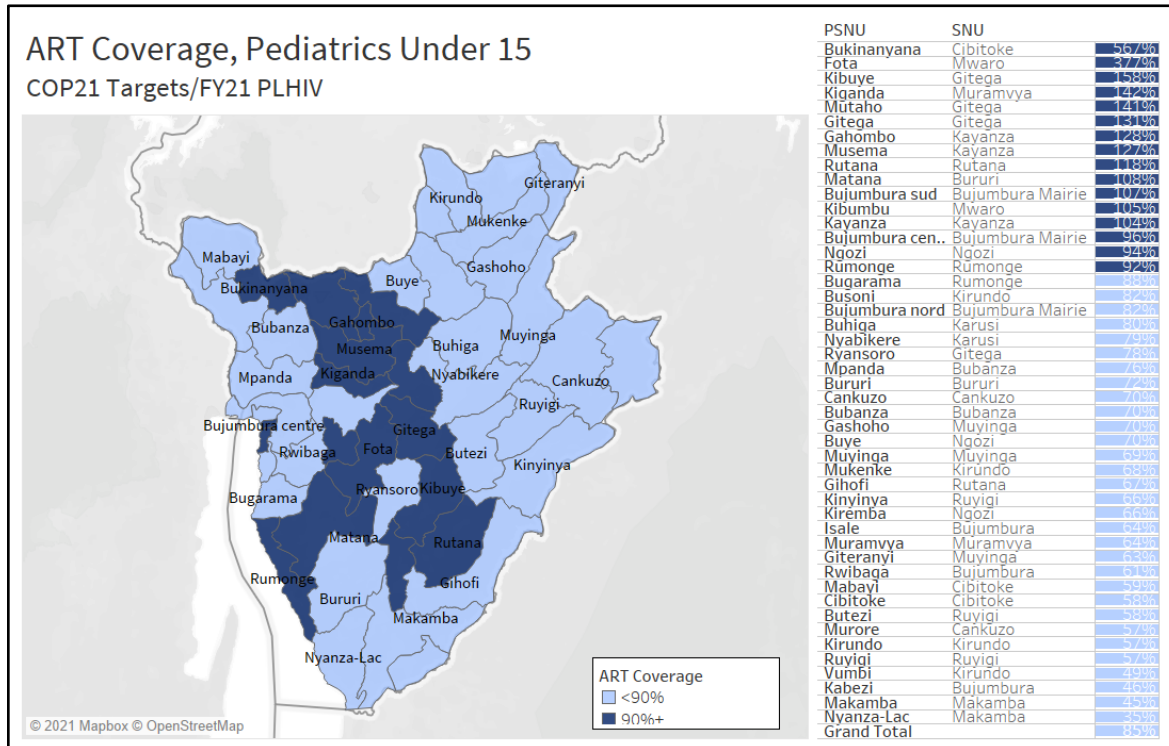
Children, adolescents, and young men will be the focus of intensified efforts to close the ART treatment gaps. The table below details national ART gaps by age and sex, identifying that the majority of the treatment gap is among children under 15 and men 30-44 years of age (Table 4.1.2). For CLHIV <15 years, only 34 percent are on ART nationally, with variations by district, indicating a critical need for effective strategies to link and retain CLHIV on treatment (Figure 4.1.1). PEPFAR’s goal for COP21 is to close the ART gap for children through increasing ART coverage to 85 percent via a community-based client-centered approach.

Table 4.1.2: Gaps in ART coverage by age and sex

Age	PLHIV estimates			Current on ART			ART coverage			Remaining needing ART		
	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total
<01	180	165	345	24	25	49	13%	15%	14%	156	140	296
01-04	920	834	1754	190	176	366	21%	21%	21%	730	658	1388
05-09	1395	1454	2849	464	473	937	33%	33%	33%	931	981	1912
10-14	1852	1980	3832	844	779	1623	46%	39%	42%	1008	1201	2209
15-19	1991	2446	4437	1605	956	2561	81%	39%	58%	386	1490	1876
20-24	2901	3048	5949	4220	1196	5416	145%	39%	91%	-1319	1852	533
25-29	4272	3298	7570	5809	1648	7457	136%	50%	99%	-1537	1650	113
30-34	5961	3561	9522	6142	2056	8198	103%	58%	86%	-181	1505	1324
35-39	7248	3720	10968	6745	2785	9530	93%	75%	87%	503	935	1438
40-44	7019	3714	10733	6368	2924	9292	91%	79%	87%	651	790	1441
45-49	4100	2411	6511	5789	3265	9054	141%	135%	139%	-1689	-854	-2543
50+	10587	6740	17327	10202	8028	18230	96%	119%	105%	385	-1288	-903
Total	48426	33371	81797	48402	24311	72713	100%	73%	89%	24	9060	9084
							<70%		80-89%			
							70--79%		>90%			

Source: Spectrum 2021 Estimates

Figure 4.1.1: ART coverage by district among children under 15



Source: COP21 Data Pack

Linkage to ART

For Q1 FY21, linkage to ART for clients identified in PEPFAR Burundi's programs is 98% while it was 75% in COP 19. In COP21, PEPFAR Burundi will continue to support the scale-up of a package of best practices to link HIV patients to optimized ART regimens. The linkage 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 clients LHIV identified outside the facility.

PEPFAR-funded IPs will be requested to develop Memorandums of Understanding (MOUs) 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 COP21 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 PLHIV may be linked to trained community workers to support them in seeking referral services in the first few days or weeks after their diagnosis, either in person or through virtual approaches (e.g. SMS or phone). 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.

Thanks to the COVID-19-responsive policies developed by the MSPLS, PEPFAR Burundi supported the scale up of 3-month MMD for PLHIV on ART from 0% in FY20 Q1 to 80% in FY21 Q1. Among CLHIV, 54% are on 3-month MMD as of FY21 Q1. PEPFAR Burundi will continue to support the NACP to scale up 6-month MMD to eligible clients in COP21. PEPFAR Burundi has also supported the NACP on the transition to optimized regimens across Burundi, as detailed in section 4.5 and the pediatric and adolescent section, below.

### **Pediatric and Adolescent Treatment and Collaboration with OVC**

PEPFAR Burundi has supported the national transition towards optimized ART regimens started during COP18 to enhance virologic suppression and to improve health outcomes for C/ALHIV. This has led to an increase in children and adolescents on DTG-based regimens, a progressive phase out of EFV-based regimens (to be completed in June FY21) and a completed phase out of NVP-based regimens in children. In COP20, pediatric DTG (DTG10) is expected to become available in Burundi, and PEPFAR Burundi will support expedited transition of eligible C/ALHIV onto this more effective regimen. However, few children are yet on MMD, which can enhance continuity of treatment. 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.

To further support ART initiation for C/ALHIV in COP21, PEPFAR-supported sites will continue to 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 children and adolescents 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.

Health districts with the largest gaps in CLHIV on ART will be prioritized for pediatric surge activities which will consolidate successes in linkage to ART, as well as gains from COP19 and COP20 in ART optimization and TPT along with above-site coordination.

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 and adolescents 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 continuity of treatment in treatment services. Adolescent and youth peer services will also be reinforced to provide needed support in adherence and continuity of treatment as well as transition to self care.

At least 90 percent of CLHIV on ART under 19 years of age (TX\_CURR <19) who live in OVC-supported provinces will be offered enrollment into the OVC program, with priority given to those who are newly enrolled in treatment, interrupted treatment, or with poor viral suppression. The OVC program will also prioritize enrollment of survivors of sexual violence, children with caregivers LHIV (particularly those newly initiated on treatment, interrupted treatment, and with poor viral suppression), HIV-exposed Infants (HEIs), and children of KP. CLHIV who are also OVC will receive psychosocial support to enhance adherence to treatment and improve their ART continuity of treatment, VL suppression, and school continuity of treatment. Additionally, their parents/caregivers will receive socio-economic support through savings groups or income-generating activities to strengthen the household's ability to pay for school fees and medical costs for children under 18 years of age.

### **Treatment for Key Populations**

For KP in COP21, ARV enrollment and continuity of treatment 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 continuity of treatment. Working directly with KP-led and KP-competent CSOs, as well as community health workers and peer navigators who are trusted by the KP clients is vital to building and maintaining 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 continuity of treatment, adherence and VL outcomes, the program will scale eCascade, an app designed specifically for KPs.

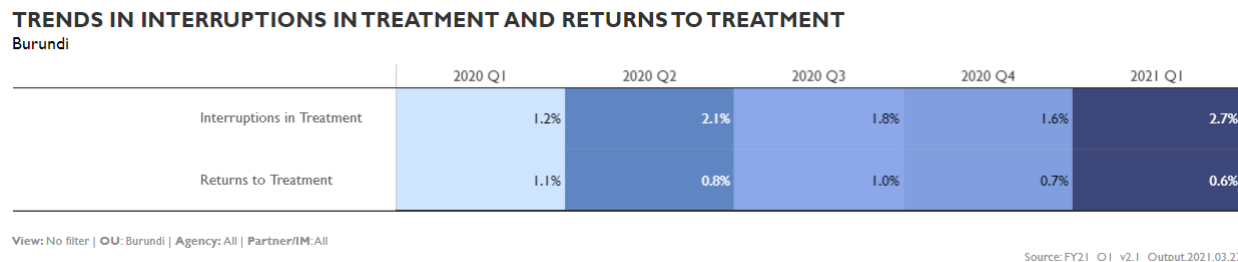
#### 4.2 Retaining clients on treatment and ensuring viral suppression

##### 4.2.1 Retaining clients on treatment

Starting in COP19, PEPFAR Burundi launched a continuity of treatment surge to specifically and thoroughly address the challenge of interrupted antiretroviral treatment and client loss, especially among children and adolescents.

An analysis of patients who experience interruptions in treatment (IIT) from Q1 FY20 to Q1 FY21 shows that a higher proportion of clients were lost in Q1 FY21 compared with previous quarters (Figure 4.2.1). In FY21 Q1, 2.7% of clients on ART supported by PEPFAR Burundi experienced IIT.

**Figure 4.2.1: Percentage of IIT from Q1 FY20 to Q1 FY21**



Source: MER

The continuity of the treatment surge process will prioritize high-volume sites in all provinces. Based on data from Q1 FY21, more clients who interrupted treatment were on ART for 3 months or more (Figure 4.2.2). More female clients interrupt treatment compared to male; interruption in treatment is also relatively even across age groups.

**Figure 4.2.2: Timeframe for patients leaving treatment, by age/sex (FY21 Q1)**



Source: Panorama

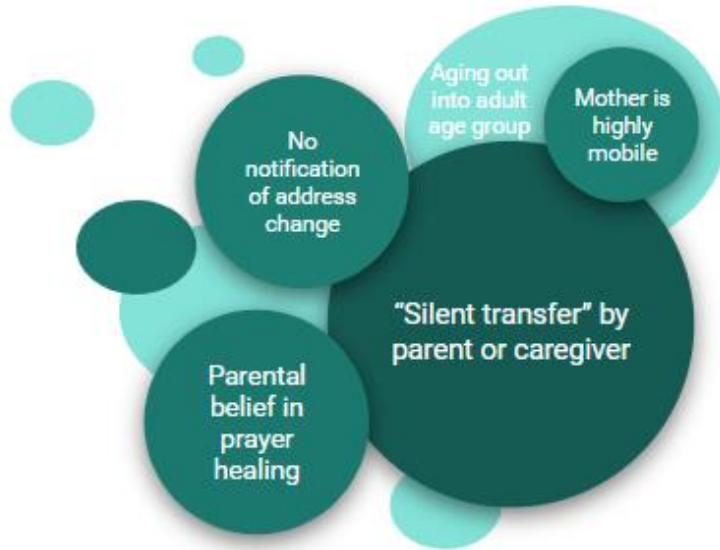
The reasons for interruption in treatment vary by population, as shown in Figures 4.2.3 and 4.2.4 below from results of assessments performed in COP19.

**Figure 4.2.3: Reasons for loss to follow-up: Issues impacting continuity of treatment 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

In COP21, the objective of the surge strategy is: 1) to identify the specific factors contributing to poor continuity of treatment at a site level, and: 2) 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, self-sustaining, differentiated peer support groups (such as mothers-to-mothers, youth groups, KP-specific groups, men-to-men) as well as family-support groups for children, will be reinforced to support continuity of treatment 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 continuity of treatment (by age, sex and subgroup) with a focus on getting patients back to care. Where continuity of treatment challenges are observed at high-volume sites, IPs will strengthen the collaboration between community (e.g. patient navigators) and facility actors to reinforce the tracing and re-engagement of clients experiencing an interruption in treatment.
- **At the district and national levels**, PEPFAR will continue to support the transition to DTG-based regimens and the enrollment of eligible PLHIV on ART, including CLHIV, 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 and the expansion of 6MMD to clients as well as to children <10 years of

age. 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 PLHIV on ART.

In COP21, continuity of treatment interventions will be adapted to the different categories of priority populations, with a greater focus on children, OVC, KPs, and adolescents.

### **Children and Adolescents**

PEPFAR Burundi will carry out several analyses to understand the profile of children who interrupt treatment and to develop interventions tailored by age and site, including: ageing out analysis; interruption in treatment over time and after 3, 6, 12, 18 months on ART analysis; and a root cause analysis of reasons for interruption among children. The results from these analyses will be shared with stakeholders and used to develop evidence-based client-centered interventions to support children and adolescents on treatment.

### **OVC and AGYW**

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 continue 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 strengthened between the PEPFAR clinical program and the OVC program to ensure coverage of services and to increase the number of CLHIV enrolled in the OVC program.

For the AGYW, PEPFAR Burundi will work hand in hand with the community partners to address challenges to service uptake and retention and to meet them where they are with services that meet their needs. Continuous adherence and continuity of treatment support will be offered through peer adherence support groups. Prevention of stigma and intimate partner violence reduction at the community-level will be part of the prevention and treatment package.

### **Key Populations**

For COP21, the KP program will continue to expand its use of information communication technology / social media to enhance continuity of treatment. 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 continue to roll out U=U messaging and measure stigma reduction related to the implementation of the KP strategies.

### **Adult Women**

At the end of 2020, according to DHIS2 data, 41,055 (over 100 percent) of the estimated 39,187 adult women (25+ years) living with HIV in Burundi were on ART (Table 2.1.2). PEPFAR Burundi



will support continuity of treatment services for adult women living with HIV who are identified both within and outside of the ANC/PMTCT platform.

***To enhance continuity of treatment of women outside PMTCT programs, PEPFAR Burundi will:***

- 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 continuity of treatment of women and infants in PMTCT programs, PEPFAR Burundi will continue to:***

- Link pregnant and breastfeeding women LHIV (and their infants) to community-based follow-up and peer groups to support continuity of treatment. 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 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 continuity of treatment 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 continuity of treatment and outcomes (including final outcome) separately to allow measurement of continuity of treatment 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 2020, according to DHIS2 data, 20,706 ( 88 percent) of the estimated 23,444 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 COP21. 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 clients who are experiencing treatment interruptions into care**

PEPFAR Burundi will reinforce any initiative to track patients who interrupted treatment. An emphasis will be put on the high-volume sites in districts with large numbers of clients experiencing IIT, as well as districts with the highest interruption rates to intensify granular district 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 interruption in treatment, 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.

To maintain PLHIV in care, PEPFAR Burundi will strengthen health education sessions in waiting rooms and adherence counselling during ARV procurement.

#### **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 95 percent of clients on ART receiving a VL test by the end of FY22. 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 -- promoting U=U
  - 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 interruption in treatment 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

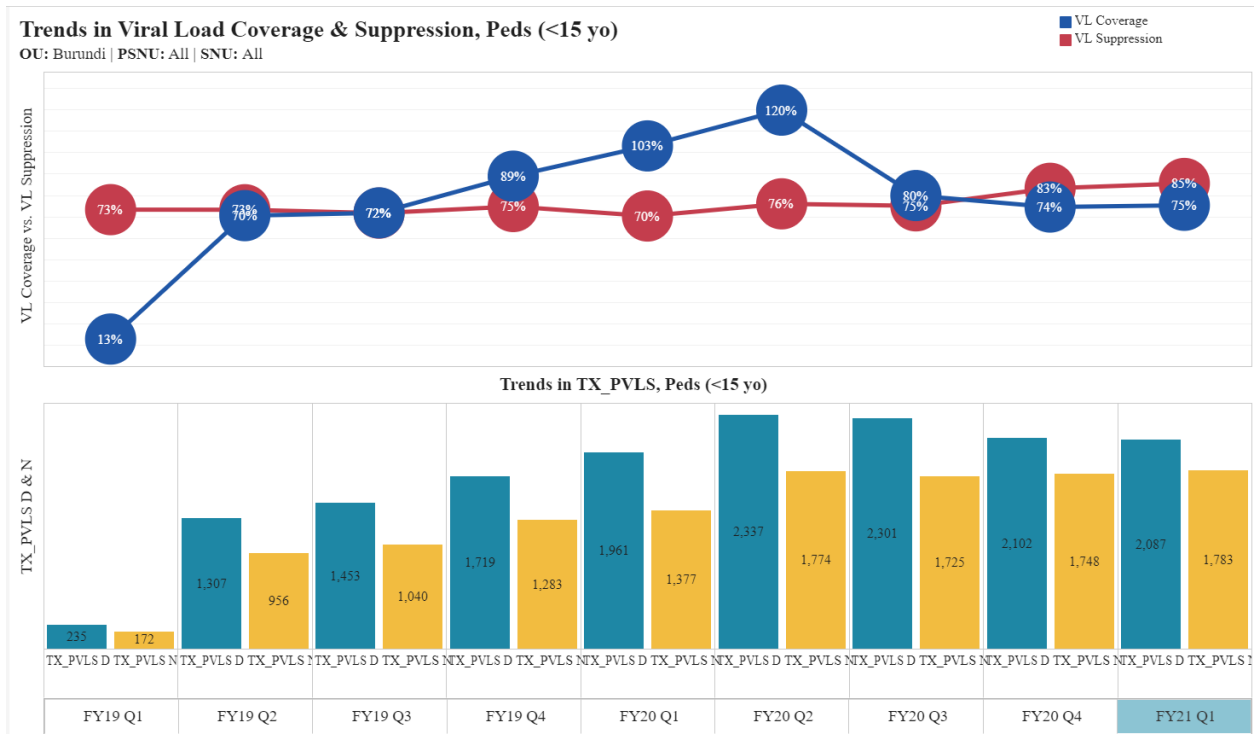
4. Scale-up client-centered approaches to prevent loss and improve continuity of treatment such as MMD, PODI, DDD App
5. Accelerate ARV treatment optimization to ensure full access for all eligible clients
6. Scale-up the new version of SIDA-Info (WB + UID) + Interoperability with IBIPIMO
7. Improvement of community engagement

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

Among children under 15 years of age, VL suppression has steadily increased to 85% as of Q1 FY21, but is still lower than adults (93%). VL access is also lower for children, plateauing at 75%, compared to adults (83%) (Figure 4.2.6). In COP21, PEPFAR Burundi is aiming for 90-95% viral load suppression among CLHIV across all health districts (Figure 4.2.7).

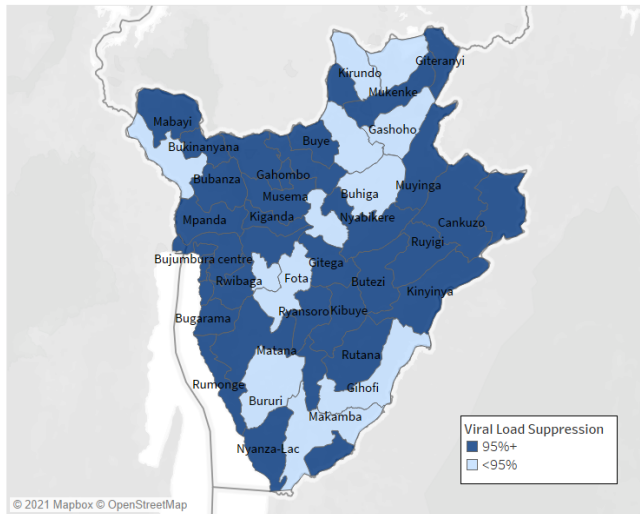
**Figure 4.2.5: Viral load coverage and suppression trends among children**



Source: MER

**Figure 4.2.6: Pediatric viral load suppression targets by district, COP21**

Pediatrics Viral Load Suppression (Under 15)  
COP21 Targets



PSNU	SNU	Suppression Rate
Rwibaga	Bujumbura	100%
Muroro	Cankuzo	100%
Mabayi	Cibitoke	100%
Butezi	Ruyigi	100%
Bugarama	Rumonge	100%
Vumbi	Kirundo	97%
Bubanza	Bubanza	97%
Kabazi	Bujumbura	97%
Bukinanyana	Cibitoke	97%
Muramvya	Muramvya	97%
Nyabikere	Karusi	96%
Cankuzo	Cankuzo	96%
Isale	Bujumbura	96%
Muyinga	Muyinga	96%
Rumonge	Rumonge	96%
Kiganda	Muramvya	96%
Kibuye	Gitega	95%
Mukenke	Kirundo	95%
Gahombo	Kayanza	95%
Giteranyi	Muyinga	95%
Kinyinya	Ruyigi	95%
Bujumbura sud	Bujumbura Mairie	95%
Mpanda	Bubanza	95%
Kayanza	Kayanza	95%
Rutana	Rutana	95%
Ngozi	Ngozi	95%
Buye	Ngozi	95%
Bujumbura nord	Bujumbura Mairie	95%
Ryansoro	Gitega	95%
Musema	Kayanza	95%
Matana	Bururi	95%
Gitega	Gitega	95%
Bujumbura cen.	Bujumbura Mairie	95%
Nyanza-Lac	Makamba	95%
Kirundo	Kirundo	95%
Busoni	Kirundo	95%
Makamba	Makamba	95%
Buhiga	Karusi	95%
Bururi	Bururi	94%
Mutaho	Gitega	94%
Fota	Mwaro	94%
Gihofi	Rutana	94%
Gashoho	Muyinga	94%
Kiremba	Ngozi	94%
Cibitoke	Cibitoke	93%
Kibumbu	Mwaro	93%

Source: COP21 Data Pack

As part of the COP20 and COP21 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. PEPFAR Burundi will work with implementing partners to closely review ARV regimen and VL data and address gaps.

To address lower viral load coverage, PEPFAR Burundi will conduct a deep dive into factors affecting VL coverage for children and adolescents. At the above-site level, PEPFAR will support point of care (POC) VL testing for infants and children, and will support the transition to the all-inclusive model of laboratory reagent procurement and platform support to ensure consistency in platform availability. In addition, the implementation of family-centered DSD models can facilitate viral load specimen collection for children.

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. PEPFAR will also support phlebotomy training and procurement of pediatric-friendly commodities for blood collection.

Within the OVC program, enrolled CLHIV and families will be supported as part of case management approaches to build demand for timely VL services by monitoring when beneficiaries are eligible for new VL tests, and supporting CLHIV to access VL testing and receive results.

## **Key Populations**

Viral suppression strategies for KPs will build upon past successes in patient navigation strategies to enhance adherence and continuity of treatment. 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 FY21 Q1 was particularly low (15 percent). To ensure pregnant and breastfeeding women receive timely VL monitoring (and action to prevent mother-to-child HIV transmission), COP21 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 work with the NACP to provide guidelines for VL tests for breastfeeding women. 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, along with infants and children as part of a family-based approach.

### **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. FY21 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 COP21, 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 expansion of PrEP. Specific populations and approaches for prevention activities include:

### **4.3.1 PrEP for key and priority populations**

In COP21, PEPFAR Burundi will support the NACP to expand PrEP for HIV-negative at-risk individuals. Target populations include KPs and serodiscordant couples in alignment with national guidelines. PEPFAR clinical partners will continue to support health facilities to expand PrEP and implement PrEP screening tools for specific populations, as well as strategies to retain individuals on PrEP. PEPFAR will continue to engage communities to assist in (a) developing and disseminating demand creation messages (including the use of PrEP Ambassadors), (b) addressing

misconceptions, (c) retaining those enrolled on PrEP, and (d) building the capacity of health care workers to normalize and deliver 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, this 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 to reach viral suppression through better adherence to optimized treatment regimens. Adolescent boys and girls (aged 9-14 year) who are identified as survivors of violence will be provided with first line support , and referred for medical and non-medical services, including post-exposure prophylaxis and medical/legal support. Older AGYW will also be evaluated for PrEP eligibility and supported to remain on PrEP.

#### **4.3.4 Key Populations**

COP21 will see the advent of two local partners assuming the role as primary IP, recognizing a shift to more local focused strategies for implementation. The new partners will build on the successes of the KP program, continuing 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 COP21, 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 continue the 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 interruption in treatment among KP enrolled on ART, the eCascade program, designed to optimize clinical tracking of KP, will be scaled to improve treatment continuity of treatment, adherence, and VL outcomes. Improved data analysis, including clarification of reasons for ART defaulting, will inform the design of targeted interventions to address IIT. 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 and FSW hotspots near 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 continuity of treatment in care for PLHIV, accelerate VL access and suppression, and ensure condom promotion, distribution, and skills building. PEPFAR Burundi will support the military sites to roll out PrEP among sero-discordant couples and implement recency testing. 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 COP21, PEPFAR will focus on providing PrEP to HIV-negative pregnant and breastfeeding women in serodiscordant couples until their 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-

ANC<sub>1</sub> 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 COP<sub>21</sub> Planning Level Letter***

Starting in COP<sub>18</sub>, PEPFAR Burundi has ensured implementation of context-, age-, gender-, and systems- specific approaches to significantly improve case-finding, linkage, continuity of treatment, and VL suppression, and to reduce all barriers and gaps along the 95-95-95 cascade at site and district levels. In COP<sub>21</sub> PEPFAR will continue to support rollout and scale-up of key policies and practices that will improve client tracking and continuity of treatment on ART with a particular focus on high burden provinces.

##### **4.4.1 Geographic focus**

During COP<sub>21</sub>, the district approach will focus on districts with the greatest gaps or high burden provinces. 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. Based on an analysis of FY<sub>21</sub>Q<sub>1</sub> data, district-level assessments by implementing partners on obstacles to success and how to address them, and best practices from successful districts, in COP<sub>21</sub> PEPFAR Burundi will focus resources on technical assistance for provinces with challenges for the following priorities: to increase (1), (2) return to treatment for patients who defaulted from ART, (3) understanding of interruption in treatment in facilities and communities, (4) implementation of best practices in facility/community collaboration to trace patients who interrupted, and (5) access to VL testing and improved suppression through adherence support.

PEPFAR Burundi will work together with IPs to analyze district-level data and perform programmatic inquiries into successful models to improve continuity of treatment at an operational level. Districts that are performing well will share lessons for strengthening continuity of treatment. 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 interruption in treatment 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 COP<sub>21</sub>, PEPFAR will also continue to 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 COP20 and maintain this trend in COP21.

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 continuity of treatment.

#### **4.4.3 Support for patient medical records**

By the end of COP19, all sites in Burundi received direct or indirect PEPFAR support through DHTs. In close collaboration with the NACP and UNDP (the current GFATM Principal Recipient), this support included 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, COP21 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 COP20, the MSPLS initiated new testing algorithms with new RTKs and introduced the optimized ART regimens with the transition to TLD and phasing out Nevirapine and Efavirenz. 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 July 2021.

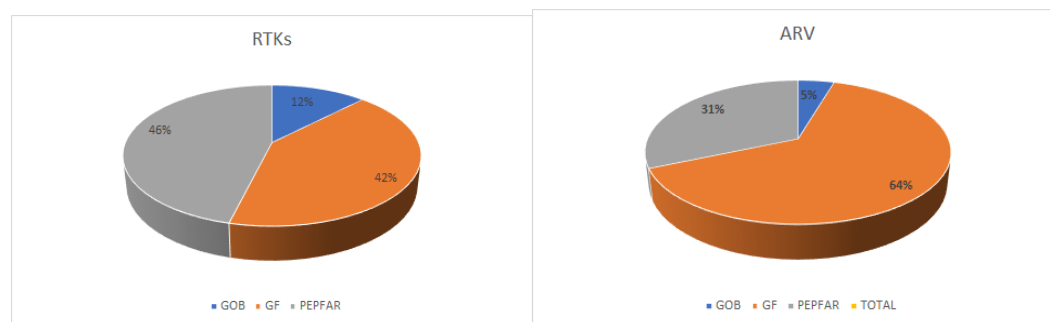
Pediatric regimens are being updated and include DTG 10mg for pediatric patients under 20 kgs of weight and regimens that include DTG 50mg for patients between 20-30 kgs of weight. Patients over 30 kgs of weight will be transitioned to TLD.

In COP20, Burundi began to procure 90-tablet bottles of TLD (three-month ARV supply) which led to a rapid scale up of MMD<sub>3</sub> in all provinces. PEPFAR will complement the GFATM to procure TLD in quantities that will enable 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 September 2021, replacing them with Alere HIV Combo Set and SD Bioline HIV-1/2 v3.0, respectively. The new policy recommends replacing HIV<sub>1+2</sub>/Syphilis Combo Card Test with SD BIOLINE HIV/Syphilis Duo. 13 provinces with HIV prevalence < 0.5% are already using the new RTKs, while the other 5 provinces will use the old testes until complete depletion of the stock.

In COP21, PEPFAR will procure SD BIOLINE HIV/Syphilis Duo for PMTCT, SD Bioline HIV-1/2 v3.0 and HIV One Step Anti-HIV 1&2 for testing of targeted populations including OVC and KP. The GFATM will continue to be key player in the procurement of HIV commodities, accounting for an estimated 64 percent of ARVs, 42 percent of HIV tests, and 46 percent of lab tests in 2022 with PEPFAR accounting for 31 percent of ARVs, 46 percent of HIV tests, and 64 percent of viral load testing using the all-inclusive services rental.

**Figure 4.5.1: COP21 donor contribution to ARVs and RTKs**



Source: Burundi's Global Fund concept note, 2021-2023

As Burundi is fully transitioning to TLD by June 2021, in COP21 PEPFAR will procure 117,342 doses of TLD-90 for \$2,397,896 to cover 29,336 adults, 8,921 doses of ABC/3TC and 4,476 doses of ABC/3TC/LPV/r (once approved by FDA) 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 COP21, PEPFAR will cover the lease contract cost of two platforms to complete at least 52,296 VL tests.

In COP21, PEPFAR will procure 36,345 doses of TDF/3TC 300/300mg, 30 tablets for PrEP.

For EID reagents and consumables, PEPFAR will procure all of the EID cartridges needed to conduct POC or near-POC EID in Burundi for testing 8,118 HIV-exposed infants.

In COP21, PEPFAR will procure pediatric TPT doses for 1,042 children.

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

In COP21, 3,171 boxes of 3,000 pieces of condoms, for the amount of \$400,000 to complement the Global Fund, PSI and the GOB procurements.

## ***4.6 Collaboration, Integration and Monitoring***

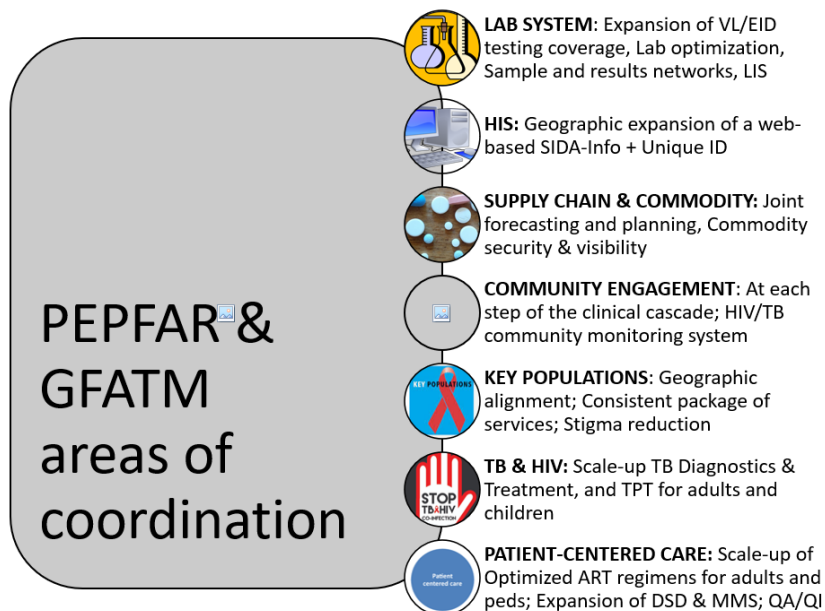
### **4.6.1 Coordination with the GFATM and other health donors**

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 and COP21 implementation, key areas of synergy are outlined in Figure 4.5.2 at the programmatic level (case-finding, linkage and continuity of treatment, KP programs) and the systemic level (supply chain and commodity, lab optimization, and health information systems).

Figure 4.5: Technical coordination with the GFATM



Source: PEPFAR Burundi

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 MOUs 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 the highest IIT for more efficient return to care strategies (establishment of continuity of treatment 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, continuity of treatment, reenrollment of IIT 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.

PEPFAR Burundi will ensure that sufficient resources will be provided to communities to ensure that community-led monitoring will be rolled out and maintained, and that issues identified will be addressed and resolved in a timely and satisfactory manner.

#### **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 continuity of treatment interventions, particularly among men, children and adolescents, and KPs.

#### 4.7 COP21 Performance targets

PEPFAR Burundi COP21 targets are fully aligned to the national targets, which were established to reach epidemic control. PEPFAR will implement direct support to facilities that provide ART services to 76953 PLHIV (98% of the national target). A total of 5306 patients are expected to start ART. 95% of PLHIV are expected to have a viral load test and 95% of them are expected to have a suppressed viral load.

<b>Table 4.7.1 ART targets by prioritization for epidemic control</b>			
<b>Entry Streams for ART Enrollment</b>	<b>Tested for HIV (APR FY22) <i>HTS_TST</i></b>	<b>Newly Identified Positive (APR FY22) <i>HTS_TST_POS</i></b>	<b>Newly Initiated on ART (APR FY22) <i>TX_NEW</i></b>
Total Men	39692	2547	2463
Total Women	259743	2470	2388
Total Children (<15)	10229	457	455
Total from Index Testing	25939	4084	4002
<b><u>Adults</u></b>			
TB Patients	5470	81	81
Pregnant Women	197837	458	451
KPs	23050	1117	1013
Other Testing	83307	3818	3761
<b><u>Children (&lt;15)</u></b>			
HIV Exposed Infants	1322	5	5
Other pediatric testing	8907	452	450

**Table 4.7.2: Target populations for prevention interventions to facilitate epidemic control**

Target Populations	Population Size Estimate	Coverage Goal (FY22)	FY22 Target (KP_PREV)
<b>Key Populations (13 provinces)</b>			
Bubanza FSW	695	80%	556
Bubanza MSM	270	80%	216
Bubanza TG	20	80%	16
Bujumbura FSW	1344	80%	1075
Bujumbura MSM	615	80%	492
Bujumbura TG	79	80%	63
Bujumbura Mairie FSW	7568	80%	6054
Bujumbura Mairie MSM	1904	80%	1523
Bujumbura Mairie TG	306	80%	245
Cibitoke FSW	873	80%	698
Cibitoke MSM	405	80%	324
Cibitoke TG	3	80%	2
Gitega FSW	4395	80%	3516
Gitega MSM	792	80%	634
Gitega TG	16	80%	13
Karusi FSW	1255	80%	1004
Karusi MSM	239	80%	191
Kayanza FSW	3968	80%	3174
Kayanza MSM	663	80%	531
Kirundo FSW	3813	80%	3050
Kirundo MSM	651	80%	521
Kirundo TG	32	80%	25
Makamba FSW	2381	80%	1905

Makamba MSM	410	80%	328
Makamba TG	15	80%	12
Muyinga FSW	1778	80%	1422
Muyinga MSM	370	80%	296
Muyinga TG	151	80%	121
Ngozi FSW	4394	80%	3515
Ngozi MSM	863	80%	690
Rumonge FSW	1130	80%	904
Rumonge MSM	226	80%	181
Rumonge TG	108	80%	86
Rutana FSW	705	80%	564
Rutana MSM	253	80%	202
Rutana TG	85	80%	68
<b>TOTAL</b>	<b>42775</b>	<b>80%</b>	<b>34219</b>

<b>Table 4.7.3 Targets for OVC and linkages to HIV services</b>			
<b>SNU</b>	<b>Estimated # of Orphans and Vulnerable Children</b>	<b>Target # of active OVC (FY21 Target) OVC_SERV</b>	<b>Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY21 Target)</b>
Bujumbura Mairie, Bujumbura Rural, Gitega, Kayanza, Kirundo, Muyinga	14,284	14,000	10,445
<b>TOTAL</b>	<b>14,284</b>	<b>14,000</b>	<b>10,445</b>

#### **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.



In 2020, 18 GeneXpert machines were calibrated for EID testing and an IBIPIMO application has been set up in all the 7 labs and all labs using GeneXpert to perform EID. However, these GeneXpert machines are still underutilized.

While overall VL coverage is 82 percent, coverage continues to vary substantially by geography, with coverage rates particularly low in Mwaro(30%), Rutana(53%) and Ruyigi(56%) . Specific populations, including pregnant women, children and adolescents, also continue to have low VL coverage.

For EID, 72 percent of HEIs received a test by two months of age and 39 percent by 12 months of age. The time required to receive an EID test result is long - recent SIMS visits documented turnaround times for test results of more than one month at 4 of 10 sites visited.

PEPFAR Burundi has ambitious targets in COP21 to increase VL access to 95 percent. EID targets are proposed at 90 percent of HEIs receiving an EID test 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 COP20 and COP21 , 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 two additional VL/EID platforms 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. 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 continue to 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 COP21, 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 infants living with HIV 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 COP21, 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

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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 COP21 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 COP21 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 MMD, 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 COP21 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 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 them into a costed implementation plan. To increase visibility into the VL/EID cascade, COP21 will build on COP20 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 a 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 DHIS2 and DATIM are key priorities. To address this, COP21 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. In addition, there will be efforts to improve the SIDA-Info user interface, robustness, and web-based performance, and begin the formal transition to NACP ownership of technical support. The aim will be to record all patients in SIDA-Info at high-volume sites in all provinces. System indicators will be aligned with revised service delivery indicators, aiming for SIDA-Info to exchange 80 percent of data with DHIS2. Data quality analysis of DHIS2 data will be conducted monthly to flag any issues, including completeness and validation checks. This analysis will be circulated with NACP and PEPFAR IPs to reconcile issues identified. PEPFAR will continue to support the DQA in collaboration with key stakeholders. PEPFAR will also continue to support the spectrum estimates that provide the data used for the COP planning process. In COP20, the SIDA-Info web-based platform, which integrates UID, was developed, and COP21 will contribute to its deployment, coordinated by the MoH through the SIDA-Info TWG.

COP21 will contribute to institutionalizing the data quality review using the composite score tool within the MOH (NACP). NACP will organize annual data quality assessments and support the districts in data collection, reporting, validation and analysis. Burundi will adopt standardized methodologies for Data Review Processes for data use for improved decision making and program planning:

- Root cause analysis, asking the right questions to improve data interpretation, monitoring actions, feedback across levels, and capturing lessons learned.
- Rapid Course Correction: Support the NACP and the districts to organize periodic data review to allow for the close monitoring of HIV data in real-time and compare performance across sites, districts and regions.
- Programming: Support programming at the district level based on new Spectrum estimates and regular assessment of performance progress

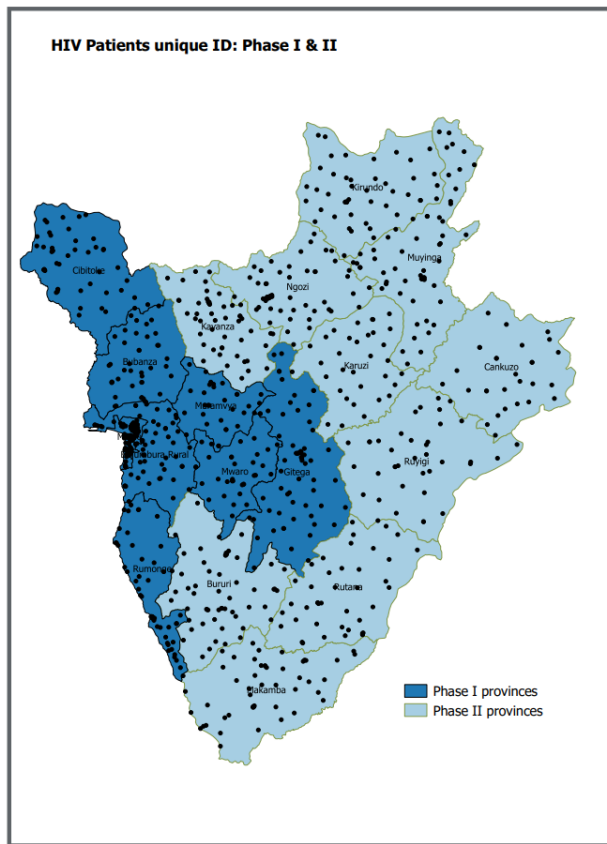
COP21 will also prioritize HMIS data governance and coordination and will:

- Support the three TWGs (SIDA-Info/UID, DHIS2, Spectrum);
- Strengthen HIS leadership and informatics expertise in-country;
- Continue a coordinated UID roll out including data protection training through the 3 TWGs;

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 COP21, 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 September 2020.

**Figure 5.2.1: Unique Identifier phased expansion**



Source: PEPFAR Burundi

### **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 continuity of treatment significantly.

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 Population-based HIV Impact Assessment (PHIA)***

In COP21, Burundi will conduct a subnational PHIA survey, with 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, continuity of treatment on treatment and viral suppression (95-95-95 clinical cascade); and (4) uptake of key HIV prevention, care, and treatment services.

## 6.o USG Operations and Staffing Plan to Achieve Stated Goals

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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.

In COP20, the USAID PEPFAR Team added (1) an M&E/Quality Improvement Technical Advisor to focus on program quality and partner coordination (created by repurposing an existing vacant position, with expected hire date in March 2020); and (2) a Program Management Assistant to support the team's administrative and partner management requirements. With funding through CDC for the Surveillance and Public Health Response, USAID is recruiting a locally employed staff member to support the launch of recency testing in Burundi. [Note that this position was initially pursued as an international hire.]

In addition to these three positions, USAID has also filled two staff vacancies that resulted when two staff members were promoted within USAID: the Supply Chain/Laboratory Advisor, and the HIV Care/Treatment Advisor.

DOD hired a HIV/AIDS Clinical Services Specialist to report to the DOD Program Manager. This position will enable increased monitoring of service quality and implementation fidelity.

Due to the small staffing footprint and security-related restrictions on up-country travel, the PEPFAR Burundi program uses a third-party contractor to conduct the majority of SIMS visits.

## **7.0 American Rescue Plan Act (ARPA) COVID-19 Appropriation for PEPFAR**

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A total of \$1,499,328 from the ARPA COVID-19 Appropriation will be used to mitigate the impact of COVID-19 on PEPFAR Burundi programs and the laboratory system, specifically supporting laboratory capacity, improving telehealth/virtual communication methods, reducing interruptions in treatment (IIT), and supporting program recovery. The proposed activities detailed below are highly feasible in Burundi as they build on current activities and past experience and reflect current evidence-based gaps. The total amount planned is \$928,628 in COP20 and is \$570,700 in COP21.

### ***Mitigation of impacts of COVID-19 on the laboratory system (Total requested funding: \$452,459)***

Burundi's laboratory systems have been severely impacted by COVID-19, affecting the PEPFAR program's ability to process HIV samples, and increasing turnaround time for results, and subsequent clinical management. INSP's Abbott and two GeneXpert machines are simultaneously being used for COVID-19 testing, resulting in increased turnaround time and workload, a decrease in the number of point-of-care tests performed for early infant diagnosis, and in viral load coverage for pregnant women.

The four proposed activities to be funded through ARPA will be implemented in COP20 and COP21 to strengthen the capacity of the laboratory system. These activities support the Government of Burundi's National COVID-19 Response Plan in which nine key pillars are identified, including "building laboratory capacity". More information is detailed below:

1. Develop standard operating procedures for multiplexing equipment sharing and diagnostic network optimization, as recommended by the PEPFAR COVID-19 and COP21 Guidance, through collaboration with MOH and other stakeholders.
2. Conduct in-service training for laboratory technicians for all of Burundi's labs on new equipment, as well as GeneXpert, to increase access and to reduce user error and turnaround time, especially for point of care for early infant diagnosis and viral load monitoring for pregnant women.
3. Provide laboratory consumables (disposable gloves and masks) as PPE for both laboratories and health facilities.
4. Provide additional EID and VL cartridges for GeneXpert machines to reduce long delays due to the use of Abbott machines originally procured for VL/EID and repurposed for COVID-19 testing. These cartridges will be specifically used to improve VL access to pregnant women and early infant HIV diagnosis, two aspects of the PEPFAR Burundi program that need to be accelerated. These cartridges will be directed to the sites with the largest gaps for VL coverage for pregnant women (PW) and EID testing.

### ***Mitigation of COVID-19 impacts on PEPFAR Burundi program (Total requested funding: \$1,046,869)***



PEPFAR Burundi has experienced program impacts due to COVID-19, especially in the treatment program. Clients in PEPFAR’s treatment program have experienced increased interruptions in treatment (IIT) during the COVID-19 pandemic, with double the rate of IIT seen in FY21 Q1 (2.7%) compared with FY20 Q1 (1.2%). Clients newly initiated on ART (<3 months on ART) were lost at even higher rates in FY21 Q1 compared with FY20 Q1. While information by priority and key population is unavailable, age and sex data indicates that clients experiencing IIT are males older than 50 years and females in the 20-29 year age bands.

The proposed activities detailed below to address IIT are planned for COP20 and COP21, and are in alignment with the PEPFAR Guidance under purpose II-C (“Mitigate COVID-19 Impact on PEPFAR programs and beneficiaries and support program recovery from the impacts of coronavirus; “Repair of Program Injury” i.e., support for programmatic acceleration and recovery from adverse impacts on program performance due to COVID-19”).

1. Leverage FY20 successes in decentralized drug distribution of multi-month dispensation (MMD) of ART by expanding the community-based model (PODI) and the establishment of community adherence clubs (CACs) to reach additional clients on ART, including key populations and military personnel. Expansion of the PODI model will reduce the need for clients to attend the health facility for drug refills during COVID-19 pandemic with the goal of enhancing retention and adherence to ART. The establishment of community adherence clubs will be a conduit for group-based treatment adherence counselling and support.
2. Expand existing virtual communication/telehealth support for HWs and CHWs to ensure continuity of treatment, through improving timely links to ART and helping newly diagnosed or reengaged ART clients establish and maintain long-term treatment compliance. May include virtual case management for community-based adherence support.

### ***Complementarity and Coordination***

PEPFAR Burundi is closely coordinating with the national program and all donors in Burundi in the COVID-19 response. For the proposed ARPA-funded activities, there is no overlap with activities included in the National pandemic response plan for COVID-19, April - September 2021. The National program and USAID will ensure that other donor contributions in Burundi are complementary through activities funded under ARPA.

### ***Monitoring and Evaluation***

PEPFAR Burundi will work closely with all partners implementing ARPA funding to monitor the impact of funds on the program through MER indicators, monthly IP meetings, reports, and program narratives.

## **APPENDIX A – Geographic Prioritization**

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

SNU	COP	PRIORITISATION	RESULT REPORTED	Attained 90-90-90 (88%) by each Age/Sez Band to reach 95-95-95 overall																					Average	# TX		
				Treatment coverage by at APR by Age and Sex																								
				0-4		1-4		5-9		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 19	Sustained	APR 20	0%	0%	11%	15%	46%	45%	19%	20%	9%	15%	11%	12%	7%	24%	5%	14%	15%	7%	18%	16%	6%	7%	9%		
	COP 20	Optimization	APR 21	33%	33%	16%	20%	5%	4%	5%	2%	6%	2%	5%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%		
Bujumbura	COP 19	Sustained	APR 20	0%	0%	30%	42%	14%	3%	30%	34%	4%	22%	1%	3%	15%	8%	13%	8%	14%	13%	11%	3%	17%	10%	9%		
	COP 20	Optimization	APR 21	20%	20%	14%	15%	2%	2%	2%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%		
Bujumbura M	COP 19	Optimization	APR 20	1600%	118%	55%	64%	24%	60%	196%	40%	26%	90%	100%	1%	182%	3%	27%	1%	5%	2%	10%	1%	24%	3%	0%	8%	
	COP 20	Sustained	APR 21	5%	5%	34%	110%	8%	6%	6%	3%	8%	7%	13%	20%	34%	8%	12%	8%	13%	12%	10%	24%	3%	24%	9%	5%	
Bururi	COP 19	Sustained	APR 20	64%	63%	10%	10%	3%	2%	10%	7%	10%	8%	8%	13%	21%	34%	8%	12%	9%	6%	13%	13%	6%	9%	10%	10%	
	COP 20	Optimization	APR 21	100%	100%	52%	76%	4%	6%	6%	5%	7%	21%	11%	16%	13%	13%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	
Cankuzo	COP 19	Sustained	APR 20	120%	100%	16%	16%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	
	COP 20	Optimization	APR 21	100%	100%	14%	54%	44%	70%	63%	56%	40%	25%	64%	15%	3%	19%	5%	10%	5%	10%	5%	10%	5%	10%	5%	10%	
Cibitoke	COP 19	Sustained	APR 20	0%	0%	3%	20%	100%	40%	5%	200%	190%	140%	3%	12%	6%	104%	2%	12%	2%	120%	4%	11%	8%	10%	6%	6%	
	COP 20	Optimization	APR 21	25%	125%	15%	150%	8%	70%	7%	4%	6%	40%	120%	4%	1%	10%	7%	8%	3%	14%	6%	15%	3%	18%	6%	10%	
Gitga	COP 19	Sustained	APR 20	382%	2033%	186%	638%	16%	400%	21%	10%	12%	66%	32%	3%	10%	4%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	
	COP 20	Optimization	APR 21	12%	12%	224%	242%	150%	144%	78%	66%	36%	6%	18%	11%	17%	18%	20%	132%	207%	16%	19%	132%	204%	83%	15%	142%	
Karuzi	COP 19	Sustained	APR 20	13%	13%	230%	24%	15%	150%	63%	1%	3%	7%	7%	18%	12%	214%	18%	20%	132%	213%	10%	19%	132%	204%	83%	15%	144%
	COP 20	Optimization	APR 21	25%	167%	7%	44%	6%	4%	4%	3%	22%	18%	20%	3%	8%	34%	17%	62%	17%	2%	16%	10%	13%	12%	12%	12%	
Kayanza	COP 19	Sustained	APR 20	100%	67%	124%	13%	62%	62%	74%	64%	5%	4%	9%	4%	11%	1%	10%	1%	1%	1%	1%	1%	1%	1%	1%	1%	
	COP 20	Optimization	APR 21	100%	100%	12%	13%	13%	6%	7%	80%	70%	60%	6%	9%	5%	44%	11%	8%	10%	9%	7%	8%	10%	8%	10%	8%	
Kirundo	COP 19	Sustained	APR 20	42%	25%	5%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	
	COP 20	Optimization	APR 21	88%	125%	17%	20%	32%	11%	3%	34%	12%	1%	14%	7%	14%	74%	15%	3%	15%	154%	16%	15%	200%	206%	11%	15%	
Makamba	COP 19	Sustained	APR 20	127%	343%	32%	114%	22%	6%	26%	6%	110%	6%	6%	232%	42%	30%	6%	4%	3%	4%	3%	4%	3%	4%	3%	4%	
	COP 20	Optimization	APR 21	43%	43%	8%	6%	3%	30%	2%	2%	50%	24%	2%	7%	3%	3%	6%	4%	5%	5%	3%	3%	3%	3%	3%	3%	
Muramvya	COP 19	Sustained	APR 20	33%	33%	27%	1%	5%	8%	44%	7%	34%	11%	54%	102%	63%	5%	14%	16%	44%	21%	40%	21%	44%	23%	3%	18%	3%
	COP 20	Optimization	APR 21	100%	100%	120%	162%	78%	88%	72%	7%	6%	64%	11%	6%	70%	4%	80%	34%	11%	12%	120%	12%	7%	16%	214%	86%	132%
Muyinga	COP 19	Sustained	APR 20	100%	100%	12%	162%	8%	32%	78%	8%	6%	8%	11%	64%	70%	5%	30%	100%	112%	12%	12%	6%	16%	214%	86%	132%	
	COP 20	Optimization	APR 21	40%	50%	11%	3%	6%	5%	11%	102%	162%	105%	2%	54%	24%	15%	14%	110%	13%	110%	13%	223%	1%	21%	223%		
Mwaro	COP 19	Sustained	APR 20	40%	50%	11%	3%	6%	5%	11%	102%	162%	105%	2%	54%	24%	15%	14%	110%	13%	110%	13%	223%	1%	21%	223%		
	COP 20	Optimization	APR 21	40%	50%	12%	10%	6%	5%	60%	5%	3%	3%	11%	8%	4%	3%	4%	3%	3%	3%	3%	3%	3%	3%	3%	3%	
Ngazi	COP 19	Sustained	APR 20	0%	167%	3%	10%	6%	6%	3%	7%	6%	10%	3%	11%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	
	COP 20	Optimization	APR 21	16%	16%	21%	32%	11%	15%	12%	144%	8%	7%	10%	5%	80%	12%	20%	12%	21%	21%	12%	21%	200%	216%	13%	33%	
Rumonge	COP 19	Sustained	APR 20	121%	2100%	8%	2%	6%	12%	62%	3%	26%	12%	10%	164%	3%	2%	11%	2%	3%	2%	3%	2%	3%	2%	3%	2%	
	COP 20	Optimization	APR 21	153%	140%	23%	21%	7%	4%	5%	4%	7%	50%	13%	6%	150%	80%	7%	11%	124%	73%	104%	12%	14%	13%	14%		
Rutana	COP 19	Sustained	APR 20	13%	140%	24%	21%	80%	52%	60%	54%	7%	6%	6%	6%	150%	81%	7%	124%	73%	104%	12%	14%	13%	14%	13%		
	COP 20	Optimization	APR 21	25%	0%	140%	6%	13%	25%	38%	10%	8%	6%	9%	8%	13%	4%	42%	14%	44%	204%	73%	23%	6%	30%	3%		
Ruyigi	COP 19	Sustained	APR 20	100%	15%	11%	11%	11%	80%	30%	35%	10%	2%	44%	2%	6%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	
	COP 20	Optimization	APR 21	80%	40%	10%	1%	2%	5%	34%	13%	4%	13%	4%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%		

Table A.2 ART Targets by prioritization for epidemic control

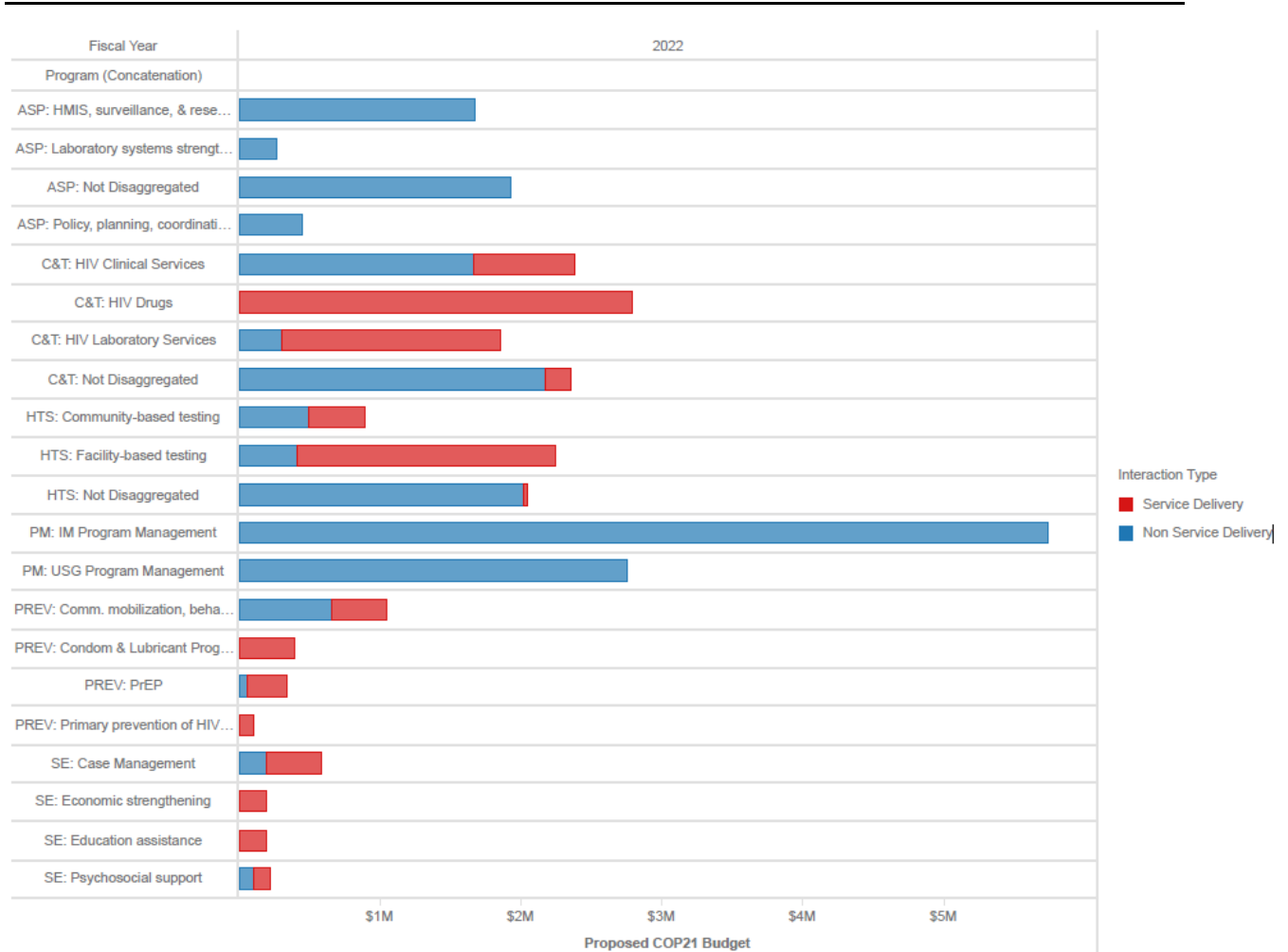
Level of Prioritization on	Total PLHIV	Expected current on ART (APR FY21)	Additional PLHIV required for 95% ART Coverage	PEPFAR Targets for PLHIV currently on AT (APR FY22) TX_CURR	National Targets for PLHIV Currently on ART	PEPFAR Targets for PLHIV new on ART initiated (APR FY22) TX_NEW	ART Coverage (APR FY22)
Optimize	32,582	22,914	8,039	22,014	23,758	1,413	73%
Sustain	49,215	53,741	N/A	54,939	54,834	3,893	111%
<b>Total</b>	<b>81,797</b>	<b>76,655</b>	<b>N/A</b>	<b>76,953</b>	<b>78,592</b>	<b>5,306</b>	<b>96%</b>

- PEPFAR implements direct support to facilities that provide services to 98% of the national targets for PLHIV currently on ART and reports on performance against an annual target of 76,953 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 PLHIV from other provinces seeking services in the capital city, or from clients entering treatment who have been identified at sites not supported by PEPFAR.

## APPENDIX B – Budget Profile and Resource Projections

### B.1 Budget Profile

**Table B.1.1 COP21 Budget by Program Area**



**Table B.1.2 COP21 Total Planning Level**

Applied Pipeline	New Funding	Total Spend
\$209,175	\$30,190,825	\$30,400,000

**Table B.1.3 COP21 Budget by Program Area**

Program	Fiscal Year		2022					
	Metrics		Proposed COP21 Budget			Percent of COP 21 Proposed Budget		
	Subprogram		Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
<b>Total</b>			\$20,876,342	\$9,523,658	\$30,400,000	68.67%	31.33%	100.00%
C&T	<b>Total</b>		\$4,149,000	\$5,217,556	\$9,366,556	44.30%	55.70%	100.00%
	HIV Clinical Services		\$1,667,000	\$716,663	\$2,383,663	69.93%	30.07%	100.00%
	HIV Drugs			\$2,783,424	\$2,783,424		100.00%	100.00%
	HIV Laboratory Services		\$310,000	\$1,540,469	\$1,850,469	16.75%	83.25%	100.00%
	Not Disaggregated		\$2,172,000	\$177,000	\$2,349,000	92.46%	7.54%	100.00%
HTS	<b>Total</b>		\$2,926,513	\$2,244,781	\$5,171,294	56.59%	43.41%	100.00%
	Community-based testing		\$492,600	\$393,883	\$886,483	55.57%	44.43%	100.00%
	Facility-based testing		\$412,000	\$1,024,756	\$2,236,756	18.42%	81.58%	100.00%
	Not Disaggregated		\$2,021,913	\$26,142	\$2,048,055	98.72%	1.28%	100.00%
PREV	<b>Total</b>		\$718,000	\$1,166,721	\$1,884,721	38.10%	61.90%	100.00%
	Comm. mobilization, behavior & norms change		\$662,000	\$380,221	\$1,042,221	63.52%	36.48%	100.00%
	Condom & Lubricant Programming			\$400,000	\$400,000		100.00%	100.00%
	PrEP		\$56,000	\$286,500	\$342,500	16.35%	83.65%	100.00%
	Primary prevention of HIV and sexual violence			\$100,000	\$100,000		100.00%	100.00%
SE	<b>Total</b>		\$290,800	\$894,600	\$1,185,400	24.53%	75.47%	100.00%
	Case Management		\$190,000	\$394,600	\$584,600	32.50%	67.50%	100.00%
	Economic strengthening			\$190,000	\$190,000		100.00%	100.00%
	Education assistance			\$190,000	\$190,000		100.00%	100.00%
	Psychosocial support		\$100,800	\$120,000	\$220,800	45.65%	54.35%	100.00%
	Not Disaggregated							
ASP	<b>Total</b>		\$4,305,180		\$4,305,180	100.00%		100.00%
	HMIS, surveillance, & research		\$1,675,000		\$1,675,000	100.00%		100.00%
	Laboratory systems strengthening		\$264,000		\$264,000	100.00%		100.00%
	Not Disaggregated		\$1,926,180		\$1,926,180	100.00%		100.00%
	Policy, planning, coordination & management of disease control programs		\$440,000		\$440,000	100.00%		100.00%
PM	<b>Total</b>		\$8,486,849		\$8,486,849	100.00%		100.00%
	IM Program Management		\$5,736,579		\$5,736,579	100.00%		100.00%
	USG Program Management		\$2,750,270		\$2,750,270	100.00%		100.00%

**Table B.1.4 COP21 Resource Allocation by Program and Beneficiary**

Fiscal Year	2022															
	Program	C&T		HTS		PREV		SE		ASP		PM		Not Specified		Total
Beneficiary	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total
<b>Total</b>	\$2,204,429,466	100%	\$298,414,992	100%	\$580,734,821	100%	\$277,505,693	100%	\$350,028,115	100%	\$909,081,416	100%	\$381,000	100%	\$4,620,575,503	100%
Females	\$72,982,681	3%	\$3,137,772	1%	\$165,483,711	28%	\$92,655,175	33%	\$5,521,565	2%	\$9,485,250	1%			\$349,266,154	8%
Key Pops	\$72,482,006	3%	\$59,119,545	20%	\$87,666,936	15%	\$2,783,047	1%	\$17,810,412	5%	\$2,442,120	0%			\$242,304,066	5%
Males	\$24,554,863	1%	\$9,040,679	3%	\$151,576,175	26%	\$1,500,000	1%	\$470,391	0%	\$162,120	0%			\$187,304,228	4%
Non-Targeted Pop	\$1,937,247,089	88%	\$200,189,021	67%	\$109,919,717	19%	\$10,589,092	4%	\$299,536,676	86%	\$872,505,049	96%			\$3,429,986,644	74%
Not Specified									\$41,500	0%			\$381,000	100%	\$422,500	0%
OVC	\$5,762,333	0%	\$5,307,793	2%	\$15,335,466	3%	\$168,080,398	61%	\$19,393,602	6%	\$11,904,410	1%			\$225,784,002	5%
Pregnant & Breastfeeding Women	\$60,492,840	3%	\$9,358,061	3%	\$11,912,319	2%			\$757,500	0%					\$82,520,720	2%
Priority Pops	\$30,907,654	1%	\$12,262,121	4%	\$38,840,497	7%	\$1,897,981	1%	\$6,496,469	2%	\$12,582,467	1%			\$102,987,189	2%

**B.2 Resource Projections**

For COP21, the PEPFAR Burundi budget is projected to be \$30,400,000. The COP20 Care & Treatment budget is \$15,348,000, which represents about 50 percent of the OU’s total new money budget. For COP21, Burundi has exceeded its OVC earmark, with \$2,222,335 allocated for OVC programming. New in COP21, Burundi received \$400,000 under USAID central funding for procurement of condoms. Of the total OU budget, 90 percent of the funding is allocated to USAID, seven percent to DOD, and the remaining three percent to HHS/CDC.

Each mechanism was costed in the FAST by reviewing mechanism-level PEPFAR interventions, deliverables, and budgets. Given the resource envelope for COP21, budgets were carried forward by using COP20 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 COP21.

## APPENDIX C – Tables and Systems Investments for Section 5.o (“Table 6”)

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N/A

## APPENDIX D – Minimum Program Requirements

	Minimum Program Requirements	Progress
	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. <sup>13</sup>	The Test and Start policy was updated in December 2019, and reinforced in October 2020 to include adolescents and women of childbearing potential based on latest WHO guidelines. It was rolled out nationally in 47 districts and 289 sites that are directly supported by PEPFAR. As of FY21 Q1 the overall linkage rate is 98%, with demonstrated improvement in the key populations linkage rate at 99%. In addition, implementation plans of new guidelines and relevant SOPs for data collection to avoid double counting, as well as a sustainability plan is underway. In COP21, Burundi will continue to 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 who are >4 weeks of age and weigh >3 kg, and removal of all NVP- and EFV-based ART regimens. 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. <sup>14</sup>	In COP19 Burundi completed the phase out of all nevirapine-based regimens, and by August 2020 58% of the PLHIV cohort transitioned to TLD, including women of childbearing age. A full transition to TLD is expected by July 2021 as there is a remaining stock of TLE until April 2021. During COP20, Burundi advocated for the phase out of EFV, introduction of DTG 10mg and update of the pediatric ARV treatment protocol. Quantification and procurement of DTG 10mg was completed, and the development of SOPs for pediatric ART is underway. In COP21, Burundi will introduce and rapidly scale-up DTG 10mg for Pediatric ARV treatment.
	Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups. <sup>15</sup>	During COP18, Burundi adopted 6-month multi-month scripting (MMS) and 3-month multi-month dispensing (MMD), consistent with WHO and PEPFAR guidance. PEPFAR supported the 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. During COP19 Significant progress was made, from 0% to 75% in the implementation of 3-5 month MMD, however there was limited implementation of 6-month MMD in all districts. Advocacy efforts were made to increase procurement of ARVs to meet the demand for 6-month MMD. During COP20, Burundi focused on the scale-up of PODIs as the DSD model for ARV distribution, as well as the development of national DSD policy, scale-up plan, and SOPs for DSD implementation. In COP21, Burundi will continue to promote the rapid roll-out of 6-month MMD for long-term stable patients/travelers, and continue the expansion of the PODI model.
	All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of COP21, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient. <sup>16</sup>	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. During COP20; 99.2% of PLHIV were screened for TB with a 0.8% positivity rate, and INH was provided to adults and children in all provinces and districts. A TB diagnosis operational plan and sample transport scale-up plan is under development. In addition to improving TB-testing for TB screened positive since TB confirmation is low (<5%), and DSD considerations for TPT for patients already on ART. In COP21, Burundi plans to promote full-scale TPT coverage for adults and children, emphasizing high completion rates with improved monitoring and use of optimal regimens 3HP.
	Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality	During COP19, PEPFAR Burundi, in collaboration with NACP, GFATM, and stakeholders, completed VL/EID optimization exercises and developed a QM/QI system. COP20 focused on improving and expanding the use of IBIPIMO (integration of a dashboard) and linking it to SIDA-Info in all sites. VL test turnaround time was

<sup>13</sup> Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, Sept 2015

<sup>14</sup> Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019

<sup>15</sup> Consolidated guidelines on the use of ARV drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016

<sup>16</sup> Latent Tuberculosis infection: Updated and consolidated guidelines for programmatic management. Geneva: World Health Organization, 2018

	across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	reduced to 14 days. Development of a sustainability plan, client continuity of treatment plan, VL operational plan, and a sample transport scale-up plan for VL, EID, and TB diagnosis is underway. In COP21, PEPFAR Burundi will continue to improve VL access, testing, and reporting as well as EID coverage including turnaround time of 7 days.
	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 a biological parent or sibling LHIV should be offered testing for HIV. <sup>17</sup>	A national HTS policy and strategy (including index testing and HIVST) was approved in November 2018, testing guidelines were updated in December 2019 and reinforced in 2020. In COP20, Burundi focused on ongoing rapid scale-up of index testing across all districts, focusing on Gitega and Mwaro provinces, and the ongoing roll-out of self-testing with a particular focus on the 13 provinces supported by the KP program. This included gender-sensitive, stigma-free language training, a review of the national tools to improve the integration of IPV screening and monitoring in index testing services, including consent and reporting of adverse events, and strengthening the monitoring and reporting systems at the community level. In COP21, Burundi will continue to focus on index testing of all children under age 19 with a biological parent LHIV, and sexual partners. In addition, Burundi will improve self-testing targeting of prioritized sub-populations (hard to reach KP, partners of index clients, and partners of PMTCT women).
	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) <sup>18</sup>	PrEP is part of Burundi's 2016 and 2019 national guidelines, and the GOB adopted the policy in 2020. PrEP is also part of the GFATM Concept Note submitted by Burundi for 2021-2023 and will be part of the national prevention program. In COP20, PEPFAR Burundi is supporting the development of a national PrEP strategy, sensitization, and training of stakeholders, and the start-up of the PrEP prevention program in pilot provinces. In COP21, PrEP will continue to be expanded for KP and serodiscordant couples in other provinces based on the outcomes and lessons learned from the pilot phase.
	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 girls 0-17 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 expanded the comprehensive prevention and treatment service package for OVC to include girls and boys ages 0-17 years, and their caregivers. In COP21, Burundi will focus on enrolling toward 90% of CLHIV, supporting the pediatric surge and targeting adolescents for differentiated services. There will be a geographic expansion in a new province (Muyinga).
	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. <sup>19</sup>	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. <sup>20</sup>	Program data provide evidence that CQI is implemented actively among partners with clear improvements in many areas; evidence includes innovative registers for tracking clients experiencing an interruption in treatment and MMD. SIMS visits now activated through a third-party contractor also provide evidence of measurement against site standards. In COP21, Burundi will continue district-level and clinical mentoring in all provinces, focusing on priority indicators.

<sup>17</sup> Guidelines on HIV self-testing and partner notification. Supplement to consolidated guidelines on HIV testing services. Geneva: World Health Organization, 2016 <https://www.who.int/hiv/pub/self-testing/hiv-self-testing-guidelines/en/>

<sup>18</sup> Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015 (<http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en>).

<sup>19</sup> The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care. Geneva: World Health Organization, December 2005

<sup>20</sup> Technical Brief: Maintaining and improving Quality of Care within HIV Clinical Services. Geneva: WHO, July 2019



<p>• ▼ f c</p>	<p>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.</p>	<p>Health facilities display and utilize educational visuals and messaging related to U=U. During COP20, PEPFAR-supported CSO treatment providers take the lead 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. In COP21, U=U messaging and Viral Load Literacy activities and tools roll out will continue in KP-supported provinces and provinces with a greater focus on case-finding among men and continuity of treatment.</p>
<p>• ▼ f</p>	<p>Clear evidence of agency progress toward local, indigenous partner direct funding.</p>	<p>In COP19, PEPFAR Burundi awarded two new local partners, one for GBV and one for OVC. COP20 included full-speed implementation of the two new mechanisms with increased responsibilities and resources transferred over time. In COP21, the KP program will transition to two local partners receiving direct awards.</p>
<p>• ▼ f</p>	<p>Evidence of host governments assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.</p>	<p>In COP19, the focus was on ART procurement commitments and improved NACP coordination, leadership, and ownership. As a result, the GOB has increased its commitment year to year from 2018 to 2020. In COP21, PEPFAR Burundi will continue to advocate for increased government resource commitment.</p>
<p>• ▼ f c</p>	<p>Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.</p>	<p>In COP19, PEPFAR Burundi initiated the groundwork for establishing case-based surveillance through SIDA-Info. However, the weak HMIS infrastructure and sensitivities around the use of biomarker identification were a challenge for developing a stand-alone surveillance system. PEPFAR also tracked mortality and interruption in treatment data through the MER indicator TX_ML and triangulated it with MSPLS mortality data. In COP21, Burundi will continue to work with the NACP to improve TX_ML and continuity of treatment reporting systems and roll out relevant SOPs.</p>
<p>• ▼ f c</p>	<p>Scale-up of case-based surveillance and unique identifiers for patients across all sites.</p>	<p>In COP18 and 19, PEPFAR held consultations with NACP to pilot a unique identifier and explore the feasibility of a fingerprint ID system on a pilot basis, initiating the groundwork for establishing case-based surveillance through SIDA-Info. COP20 plans focused on the active development of a web-based version of SIDA-Info, with fingerprint integrated, to establish a national unique identifier system. In COP21, Burundi will continue to roll out SIDA-Info.</p>