Burundi

Country Operational Plan

(COP) 2022

Strategic Direction Summary

May 6, 2022

Table of Contents

i. List of Tables

ii. List of Figures

iii. Acronym List

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immunodeficiency Syndrome
ALHIV	Adolescents Living with HIV
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
CAGs	Community ART Groups
CCM	Country Coordinating Mechanism
CHW	Community Health Worker
CLHIV	Children Living with HIV
CNLS	National AIDS Council
COP	Country Operating Plan
CoT	Continuity of Treatment
CSO	Civil Society Organization
CTX	Cotrimoxazole
DBS	Dried Blood Spot
DHIS2	District Health Information System 2
DHT	District Health Team
DHS	Demographic and Health Survey
DoD	United States 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
RCA	Root Cause Analysis

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

Year on year, Burundi has consistently improved its HIV response and as a result of these efforts, Burundi has the opportunity to be the first African francophone country to achieve sustained epidemic control. 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 2022 Country Operational Plan (COP22) for Burundi will continue to build on the achievements made to date and to close known gaps in the epidemic response. The COP22 goal is to accelerate towards sustained epidemic control by consolidating gains, closing the gaps, and enhancing capacities.

To operationalize this goal, the PEPFAR Burundi program will have three main priorities:

- Priority 1: Optimizing health system strengthening investments
- Priority 2: Building on best practices to reach the last mile
- Priority 3: Promoting local ownership

Priority 1: Optimizing health system strengthening investments

In partnership with the NACP and GFATM, more support will be provided at the national level to improve coordination. Further investments will be made to streamline strategic information systems and ensure interoperability, while promoting local ownership of systems and optimizing use. PEPFAR Burundi in conjunction with NACP and GFTAM will continue to strengthen the district approach by providing technical assistance for systems using District Health Teams (DHTs) and maintaining quality standards through data-driven decision-making to ensure HIV services are person-centered. invest in

In COP22, the PEPFAR Burundi program will continue to invest in optimizing the district approach. The aim of the district approach is to create a center of excellence at the district level to provide guidance and on-the-job-training to site-level clinicians. PEPFAR Burundi will continue to work closely with the NACP and the GFATM to leverage their efforts to ensure a most effective and efficient use of PEPFAR's contributions to the national HIV response in order to build sustained capacity at the district level in COP22. By continuing to support the Government of Burundi (GoB) district health team structure, PEPFAR Burundi is investing in a sustainable model for the delivery of high quality person-centered prevention, care, and treatment services.

Priority 2: Building on best practices to reach the last mile

To capitalize on gains already made, PEPFAR Burundi will build on the important progress made in COP19, COP20 and COP21 to close the testing, treatment, and viral load coverage and suppression gaps. The COP22 vision accelerate towards reaching and sustaining epidemic control can be achieved by using evidence-based and data-driven best practices to close the gaps that persist among specific subpopulations that drive the epidemic, including children, young people, adolescent girls and young women and key populations and men so 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.

Aligning with NACP priorities, PEPFAR Burundi will expand person-centered differentiated service delivery (DSD) models, including 6-month multi-month dispensing (6MMD) of ARVs. PEPFAR Burundi will continue to implement successful targeted strategies to reach men, and will implement best practices from the OVC program within the general pediatric and adolescent HIV program to improve pediatric and adolescent HIV clinical outcomes. As adolescent girls and young women (AGYW) are disproportionately impacted by HIV, PEPFAR Burundi will continue to advocate for the expansion of PrEP for AGYW to reduce new HIV acquisitions. Further, PEPFAR Burundi in collaboration with the NACP will advance Undetectable = Untransmissible (U=U) messaging to ensure PLHIV are aware of the importance of viral load suppression.

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 Burundi will continue to invest in improved case-based surveillance systems including UID to enable tracking of all newly diagnosed individuals through the health system, and surveillance of new HIV acquisitions through recency testing and monitor the progress towards sustained epidemic control.

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 country needs to sustain access to an optimized ART regimen for all PLHIV, ensuring ART continuity.

Priority 3: Promoting local ownership

In COP22, PEPFAR Burundi will further the commitment to supporting a locally-owned HIV response through increasing local partner funding. Technical assistance will be provided to local partners to enhance capacities particularly in service delivery and durability to allow long-term impact, including managing funds and compliance, ensuring people-centered care as well as quality data collection, and timely/accurate analysis and reporting.

Additionally, the COP22 plan, in line with NACP priorities, focuses on building the involvement of the community in the HIV response, 1) by strengthening the use of Community Health Workers and the data they collect; and 2) by solidifying the community led monitoring (CLM) approach through strong GoB support of the process and involvement where appropriate.

A detailed description of PEPFAR Burundi COP22 vision and strategies is provided in Section 2.2.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden, and country profile

Program Context: The Republic of Burundi is a small, landlocked country in the African Great Lakes region bordering Lake Tanganyika. The country shares borders with Rwanda, Tanzania, and the Democratic Republic of the Congo. With an estimated population of 12.6 million in 2022,[1] Burundi is the second most densely populated country in Africa, with about 463 inhabitants per square kilometer, as of 2020.[2] Burundi's total fertility rate of 5.1 children per woman,[3] is one of the highest in the world. Burundi faces a large youth bulge, with almost half of the population below the age of 15 (45.25%)[4].

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 2022, UNHCR estimates that 264,200 refugees are remaining in neighboring countries.[5] This is a 10% decrease from the prior year. 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 $ 780 per capita[6] and remains one of the poorest countries in the world: 72.8 percent of Burundi's population lives on less than $1.90 a day (2013)[7]. Burundi is in the bottom five of the low-income categories of countries (185 of 189 countries) on the 2020 United Nations Development Programme (UNDP) Human Development Index.[8] The economy is predominantly agricultural, with a 86.21 percent employment rate (share of total employment that is employed in agriculture) in 2019.[9] Burundi remains a challenging operating environment for implementation of U.S. government (USG)-

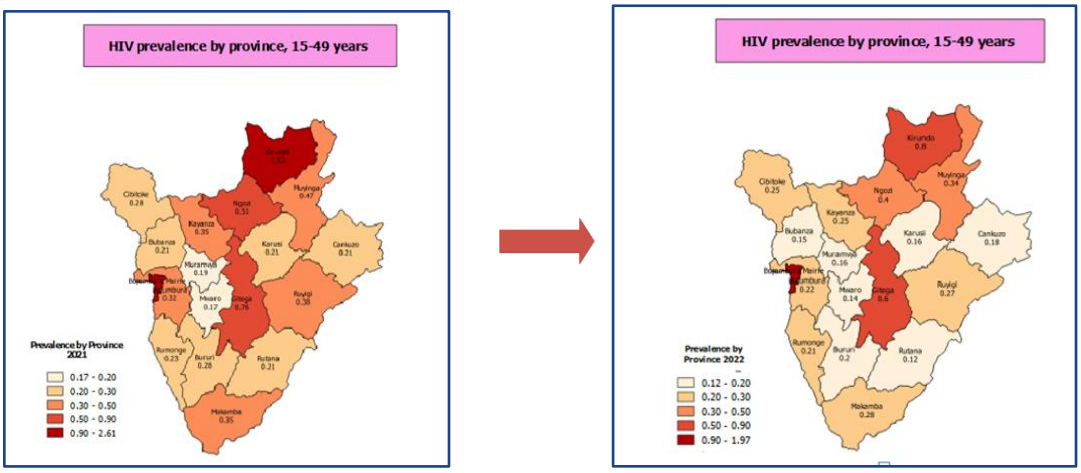
[1] https://www.unfpa.org/data/world-population/BI
[2] https://data.worldbank.org/indicator/en.pop.dnst
[3] https://www.unfpa.org/data/world-population/BI
[4] https://data.worldbank.org/indicator/SP.POP.0014.TO.ZS?locations=BI
[5] https://data2.unhcr.org/en/situations/burundi
[6] https://data.worldbank.org/indicator/NY.GNP.PCAP.PP.CD?locations=BI
[7] https://data.worldbank.org/country/BI
[8] https://hdr.undp.org/en/data
[9] https://data.worldbank.org/indicator/SL.AGR.EMPL.ZS?locations=BI

funded programs due to its fragility, its low local capacity, and security and travel restrictions for USG personnel and IPs.

HIV Prevalence: According to 2022 Spectrum modeling, Burundi's HIV prevalence is 1.0 percent among adults aged 15-49. Among adults over age 15, prevalence is 1.4 percent. Prevalence varies according to age group. The most affected age group is 50-54 years old among both males (2.1 percent) and females (3.2 percent). Comparatively, prevalence for those 30-39 years is 0.9 percent, and for those 20-29 years is 0.6 percent. Overall, there is a trend toward urbanization (2.5 percent in Bujumbura Mairie versus 0.7 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.

Substantial gains have been made in reducing the HIV prevalence rate among adults 15-49 years by province when comparing 2021 data with 2022. During the past two years, implementing partners have targeted populations with higher mobility (e.g. truck and motorbike drivers) and key populations and their social and sexual networks, resulting in a significantly decreased prevalence rate nationwide. In 2020, Kirundo and Gitega had a 1.2 percent prevalence rate and are now .8 and .6 percent respectively. Even provinces with a relatively low prevalence rate have seen improvement. Rutana, the lowest in 2020 at .4 percent is now at .12 percent. While the highest prevalence still remains in Bujumbura Mairie at 4.8 percent, this is a marked difference from 2.3 documented in 2020. COP22 will see the continuation of these very effective tactics to help achieve 95-95-95.

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



Source: Spectrum 2021

Source: Spectrum 2022

Key Populations: A recent Integrated Biological and Behavioral Surveillance Survey (IBBS) was conducted, however, results are not yet released. Hence, PEPFAR is forced to use current programmatic data and older scientific data to understand the KP epidemic. 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 programmatic data suggests a low volume of individuals with high case finding rates. A 2017 study[10] related to people who inject drug (PWID) in Bujumbura Mairie (funded by the GFATM) indicated a prevalence of 10.2 percent in a population of 127 PWID survey participants; 9.4 percent of the PWID were infected with hepatitis B virus, and 5.5 percent with hepatitis C.

Military Populations: The Burundi National Defence 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 Burundi National Defence 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 2021, there were 73,797 people living with HIV (PLHIV) on ART in Burundi, of which 67,370 were receiving ART in facilities directly supported by PEPFAR (Figure 2.1.2).

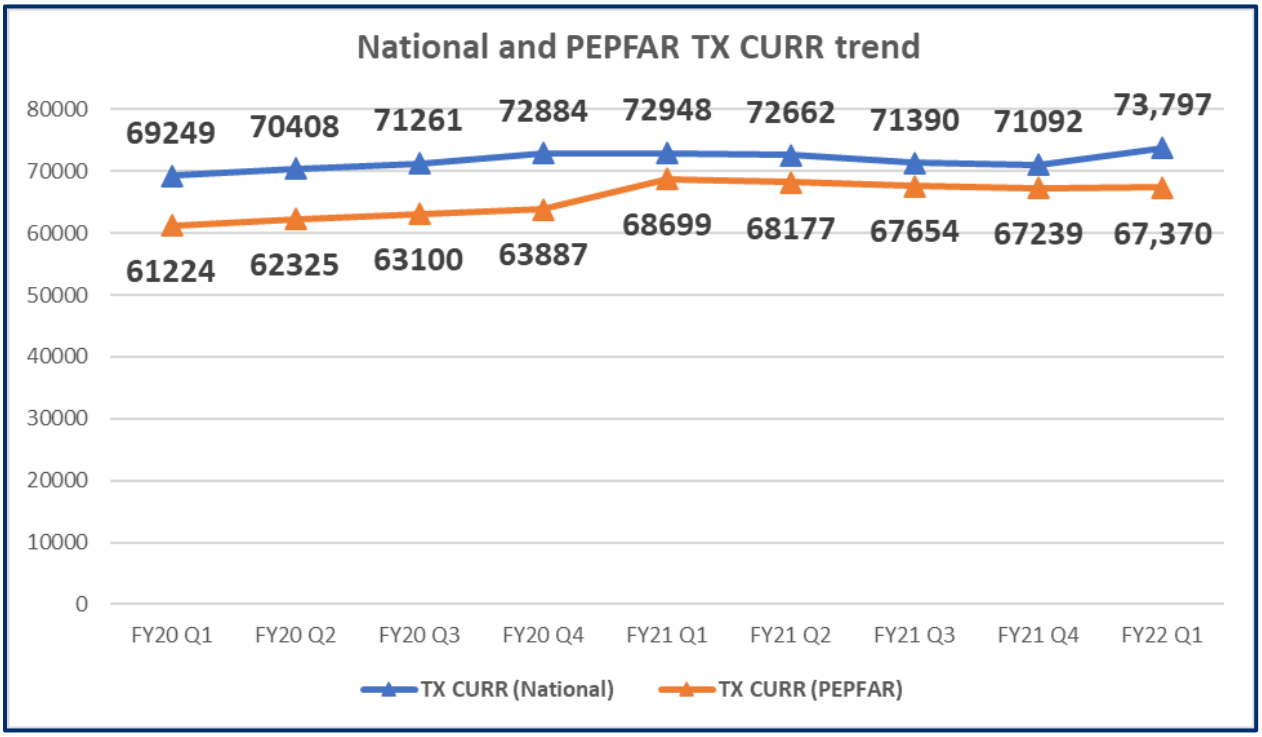
Burundi has accelerated progress toward HIV epidemic control (Figure 2.1.3). PEPFAR defines national HIV epidemic control as "the point at which the total number of new infections falls below the total number of deaths from all causes among HIV-infected individuals, with both declining."

PEPFAR Burundi investments focus on optimizing the programs and systems that support, achieve, and sustain epidemic control. PEPFAR Burundi works closely with the Government of Burundi (GOB) to support the NACP's efforts to adopt practices and policies based on the best available evidence. The GOB has adopted new international guidelines and best practices, including updates to the National Testing Strategy to optimize case-finding by scaling up targeted case-finding strategies, prioritizing index testing and self-testing, and thus also reducing the overall number of HIV tests performed nationally. Performance-based financing (PBF) indicators have also been aligned with the new testing strategies. Burundi has already made significant progress in Efavirenz phase out, full transition to Tenofovir-Lamivudine-Dolutegravir (TLD) for adults, and 3-months multi-month dispensing (MMD3). Additionally, PEPFAR is supporting the

[10] 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

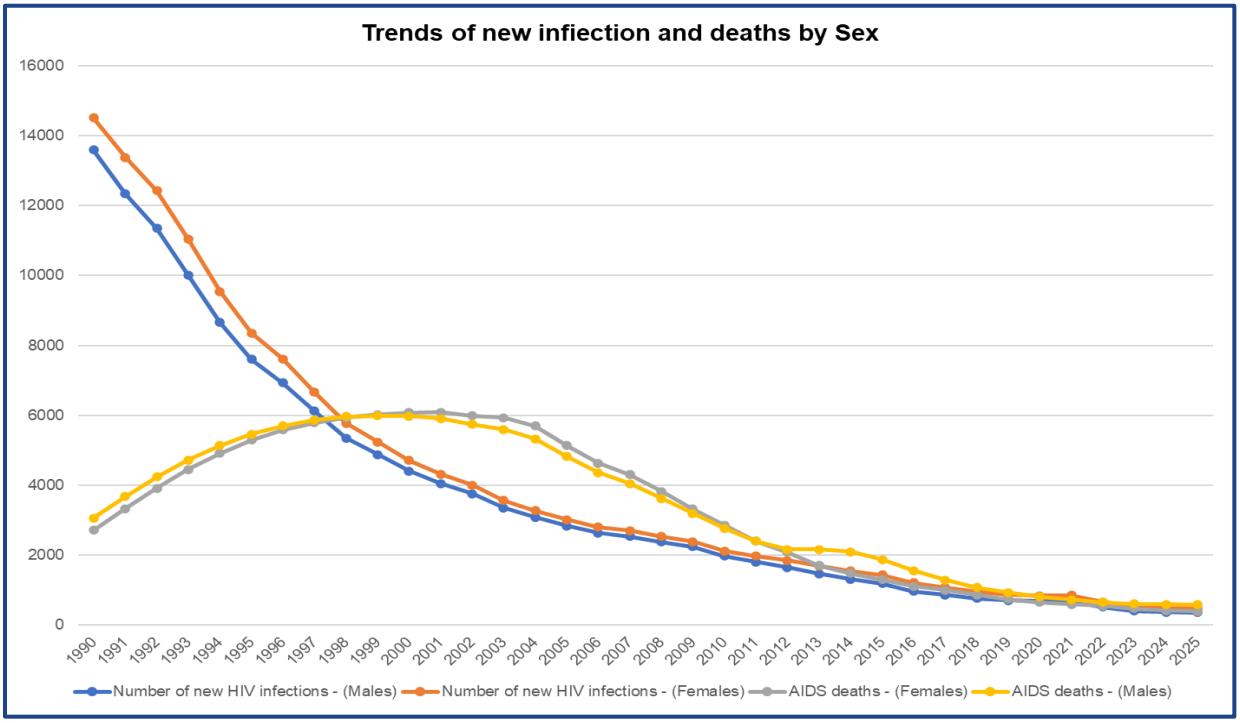
NACP to operationalize and scale up multi-month dispensing for 6-months (MMD6), and to complete the transition to pediatric dolutegravir (DTG 10mg).

Figure 2.1.2: Updated National and PEPFAR trend for individuals currently on treatment



Source: DHIS2 and PANORAMA

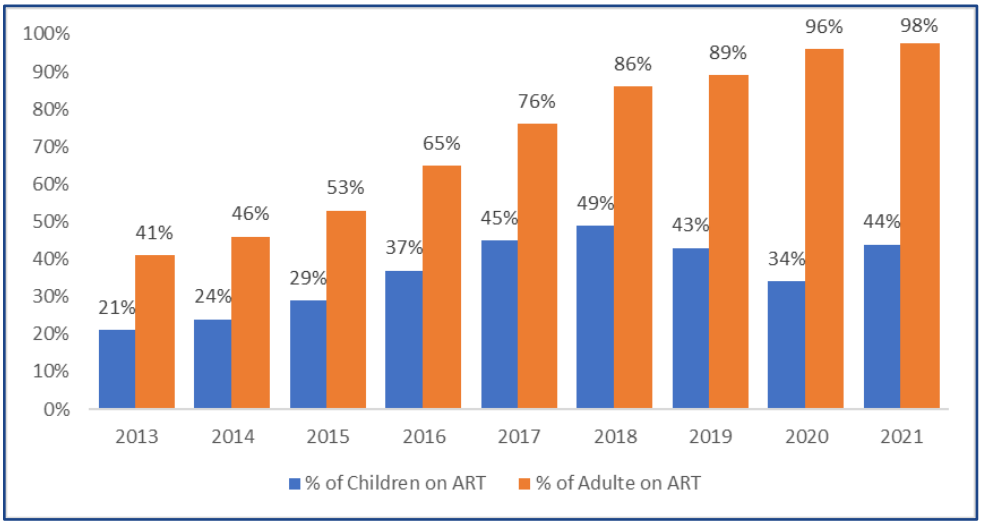
Figure 2.1.3: Trend of new infections and all-cause mortality among PLHIV



Source: 2022 Spectrum

Burundi has made substantial progress in enrolling patients on ART. At the end of 2021, according to DHIS2 data, 73,797 (93 percent) of the estimated 79,075 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)



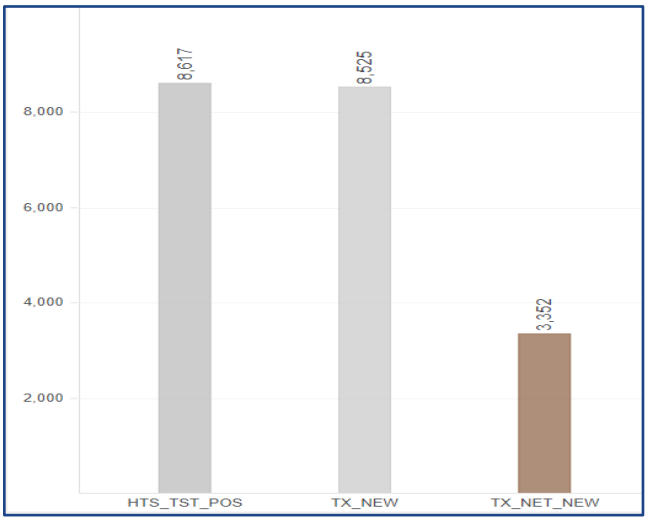
Source: DHIS2 and Spectrum

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 continues to address, and there has been visible progress over the past three quarters. However, there is still work to do to ensure continuity of treatment (Figure 2.1.5), and further improvements are expected throughout the remainder of COP21 and COP22.

PEPFAR through its implementing partners (IPs) 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. The results from efforts to bring back clients to care are seen but are variable across the country. During COP22, a stronger focus will be made on preventing treatment interruptions and on returning clients to care in all sites. Barriers to treatment continuity will be addressed. Treatment literacy will be increased and targeted.

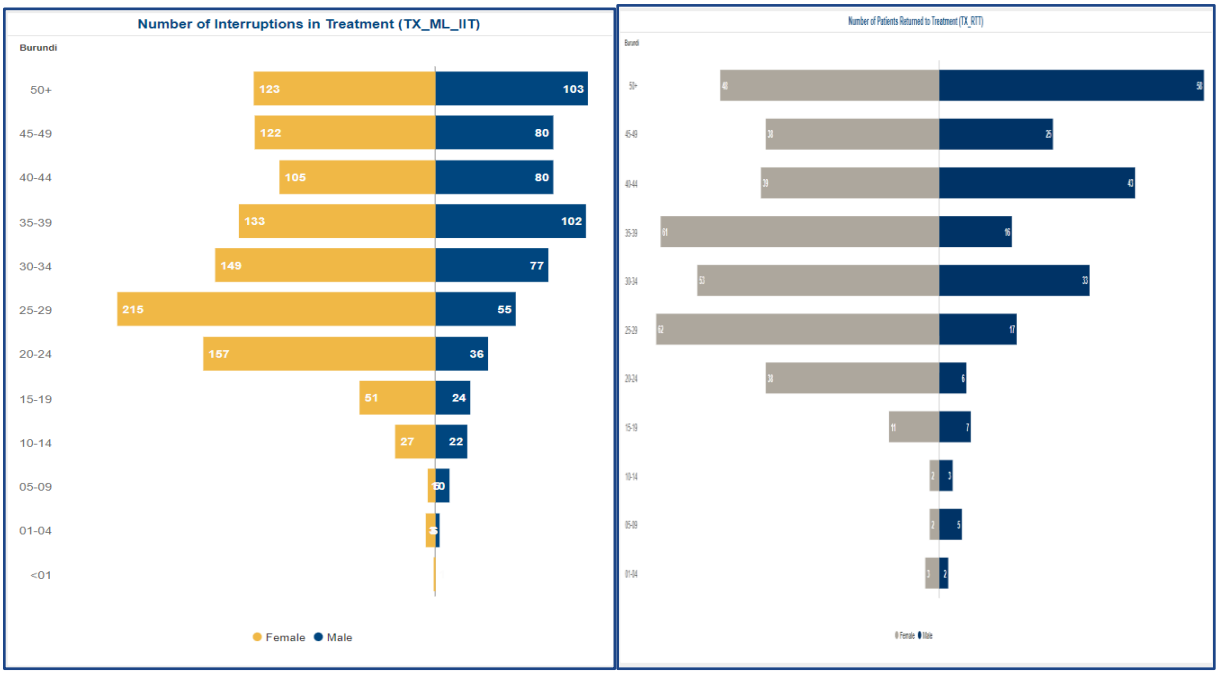
Burundi PEPFAR program received support from the USAID HQ team to conduct a continuity of treatment root cause analysis (CoT RCA) in FY22. Findings are being used to promptly address IIT issues and will continue in COP22. Note that the Unique Identifier which is in implementation nationwide in high volume sites will be leveraged to track clients who are classified as IIT when in fact they may have auto-transferred (silent transfer).

Figure 2.1.5: Assessment of ART program growth in FY21



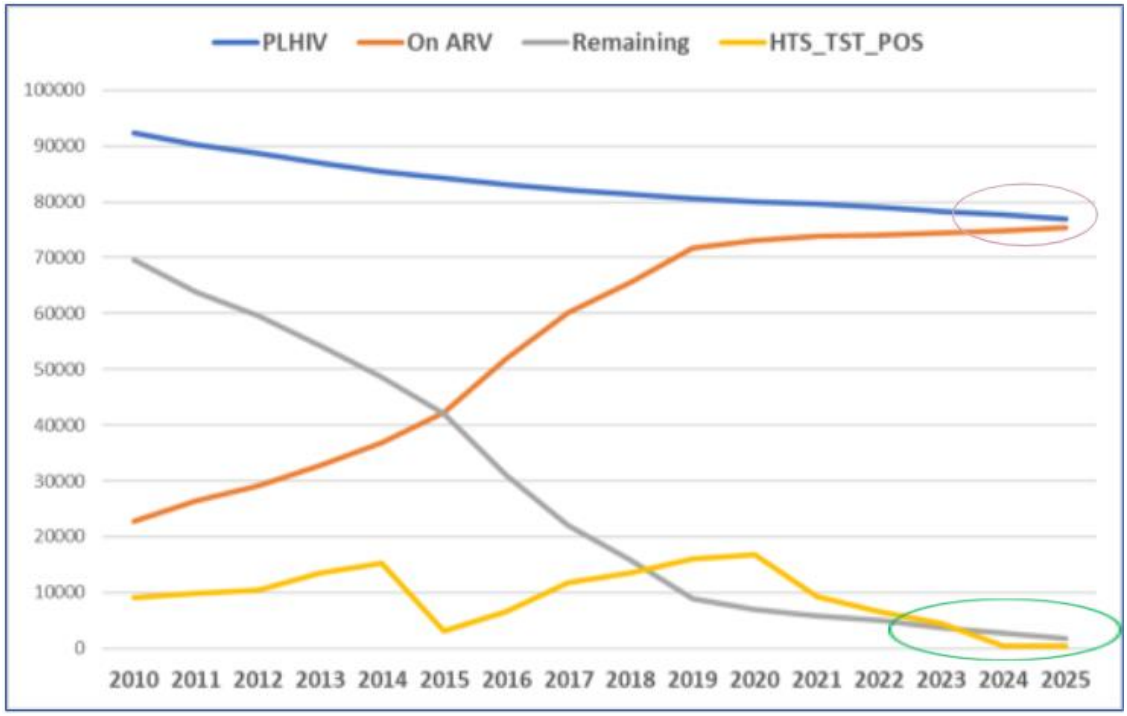
Source: Panorama

Figure 2.1.6: Clients gained/lost from ART by Age/Sex, FY21 Q4



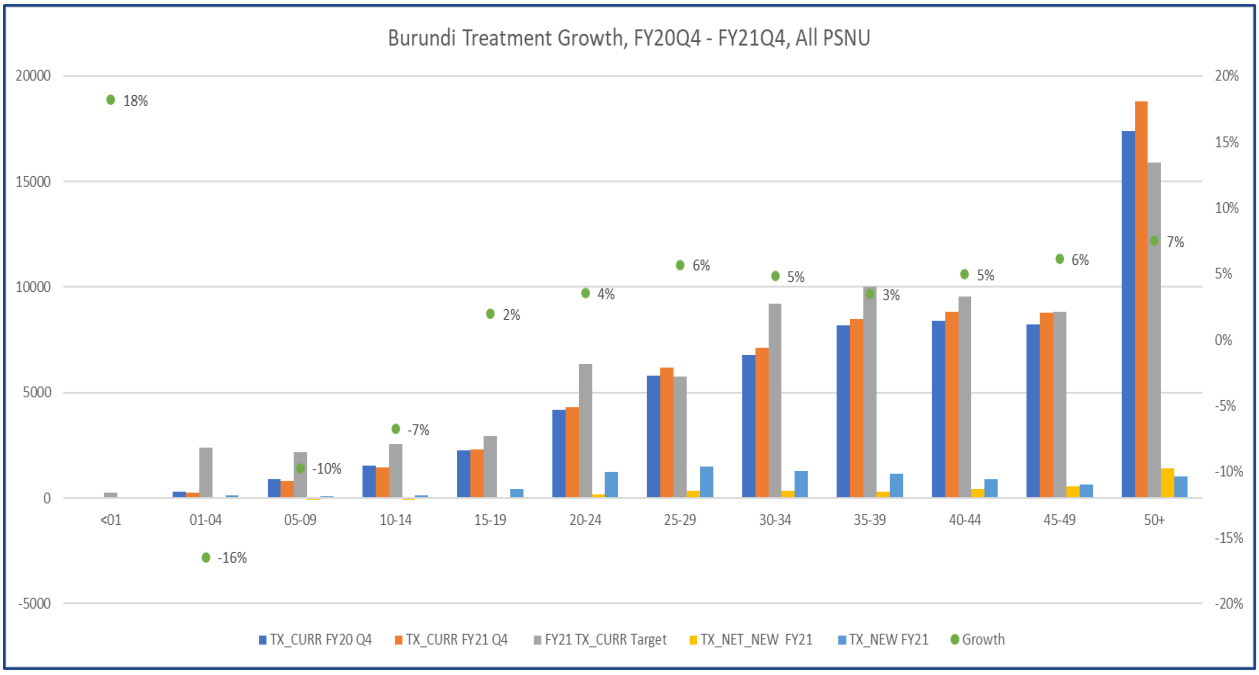
Source: Panorama

Figure 2.1.7: Epidemiologic Trends and Program Response, 2010 to 2025 (Projected)



Source: DHIS2/Spectrum

Figure 2.1.8: Net change in HIV treatment by sex and age bands, 2020 Q4 to 2021 Q4



Source: Panorama and Datapack

The viral load coverage continued to make progress 84% (FY20) to 87% (FY21). However, the VL suppression is high (97%). Note that VL access and VL suppression are lowest among children and adolescents 80% and 91% respectively. 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 (TB) affects all segments of the population. TB incidence was estimated at 12,000 (range: 8,000-18,000) in 2020, including HIV-coinfected populations, with a rate of 111 per 103,000 population. Among PLHIV in Burundi, TB incidence was estimated at 970 (range: 620 - 1,400), with a rate of 8.2 per 100,000 population. A total of 6,874 TB cases were notified in 2020, of which 100 percent had a known HIV status. Among the 6,874 notified cases, 65 percent were among men, 31 percent among women, and 4 percent among children 0-14 years.[11] 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,[12] 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 PWID) as priority populations.

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	12852515		2865925		2912214		1223778		1223591		2378525		2248480		Spectrum 2022
HIV Prevalence (%)		0.6		0.1		0.1		0.4		0.3		1.8		1.3	Spectrum 2022

[11] 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.
[12] Rapport de la revue externe du PNILT, December 2019. *Referenced in Burundi's HIV/TB Concept Note (2021-2023) submitted to GFATM, March 2020.*

AIDS Deaths (per year)	1194		216		210		83		68		351		269		Spectrum 2022
# PLHIV	79086		3170		3232		5158		4046		39274		24205		Spectrum 2022
Incidence Rate (Yr)		0.009		0.006		0.006		0.016		0.005		0.008		0.007	Spectrum 2022
New Infections (Yr)	1164														Spectrum 2022
Annual births	453987														Spectrum 2022
% of Pregnant Women with at least one ANC visit	500076	91													DHIS2 2021
Pregnant women needing ARVs	5566	89.5													Spectrum 2022
Orphans (maternal, paternal, double)	79,075														Spectrum 2022
Notified TB cases (Yr)	6,874														PNILT
% of TB cases that are HIV infected															
% of Males Circumcised															

Estimated Population Size of MSM*	6,452														
MSM HIV Prevalence	5.96%														
Estimated Population Size of FSW	24,714														
FSW HIV Prevalence	32.5%														IBBS
Estimated Population Size of PWID	7,557														
PWID HIV Prevalence	15.3%														
Estimated Size of Priority Populations (Military)	100,000														
Estimated Size of Priority Populations Prevalence (Military)	1.8%														SABERS

Table 2.1.2: 95-95-95 cascade: HIV diagnosis, treatment and viral suppression*

Epidemiologic Data					HIV Treatment and viral load suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)

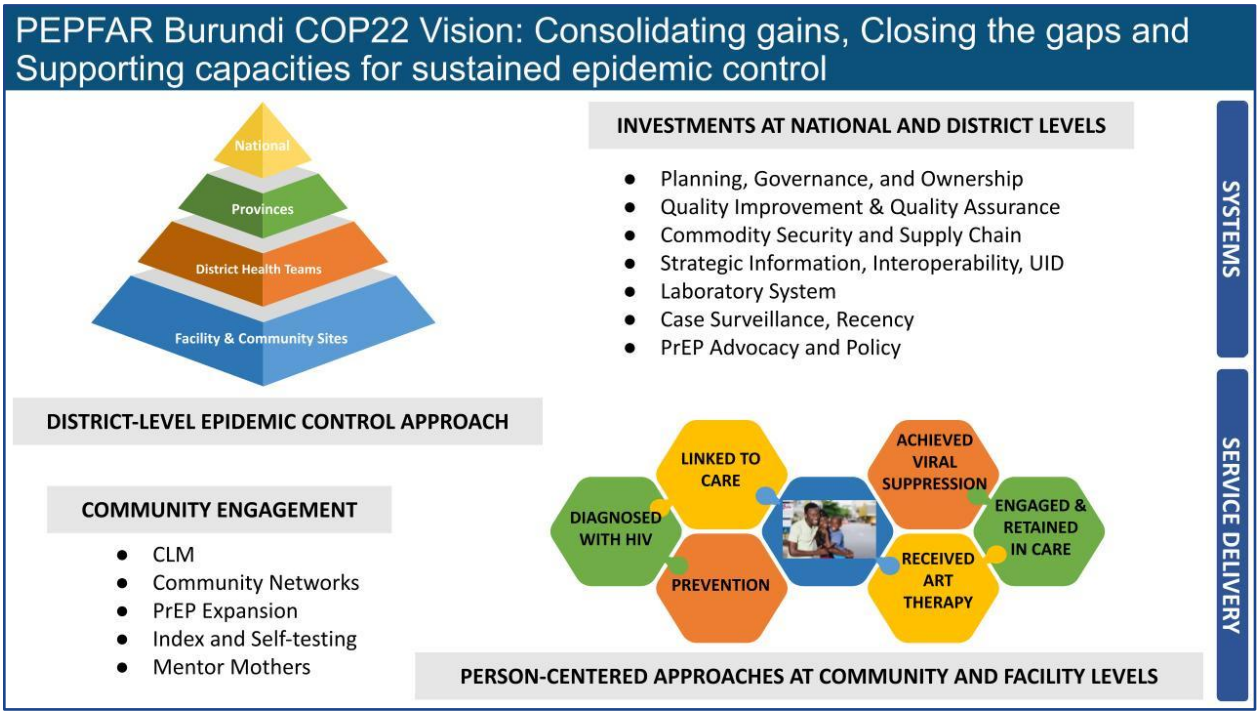
	(#)									
Total population	12852515	0.6%	79086	74752	73797	93%	53068/55563 96%	876109	9356	9344
Population <15 years	5778140	0.1%	6402	2848	2808	44%	1761/1980 89%	55152	383	379
Men 15-24 years	1223591	0.3%	4043	2150	2117	52%	1338/1465 91%	35856	276	241
Men 25+ years	2248480	1.3%	24205	22281	21958	91%	14995/15682 96%	104702	2645	2452
Women 15-24 years	1223779	0.4%	5161	5232	5136	100%	3257/3470 94%	251975	1596	1414
Women 25+ years	2378525	1.814%	39274	42241	41778	106%	31717/32966 96%	428424	4456	4195
MSM	6,452	5.96%								
FSW	24,714	32.5%								
PWID	7,557	15.3%								

*National data (DHIS2 as of December 2021); Spectrum 202
**Linkages Program data (APR 2019), PLACE Study 2013

2.2 New Activities and Areas of Focus for COP22, including Focus on ART Continuity

The COP22 vision, as presented at the COP22 Virtual Planning Meeting in March 2022 and described in Figure 2.2.1, focuses efforts on reaching and sustaining epidemic control.

Figure 2.2.1 COP22 Vision

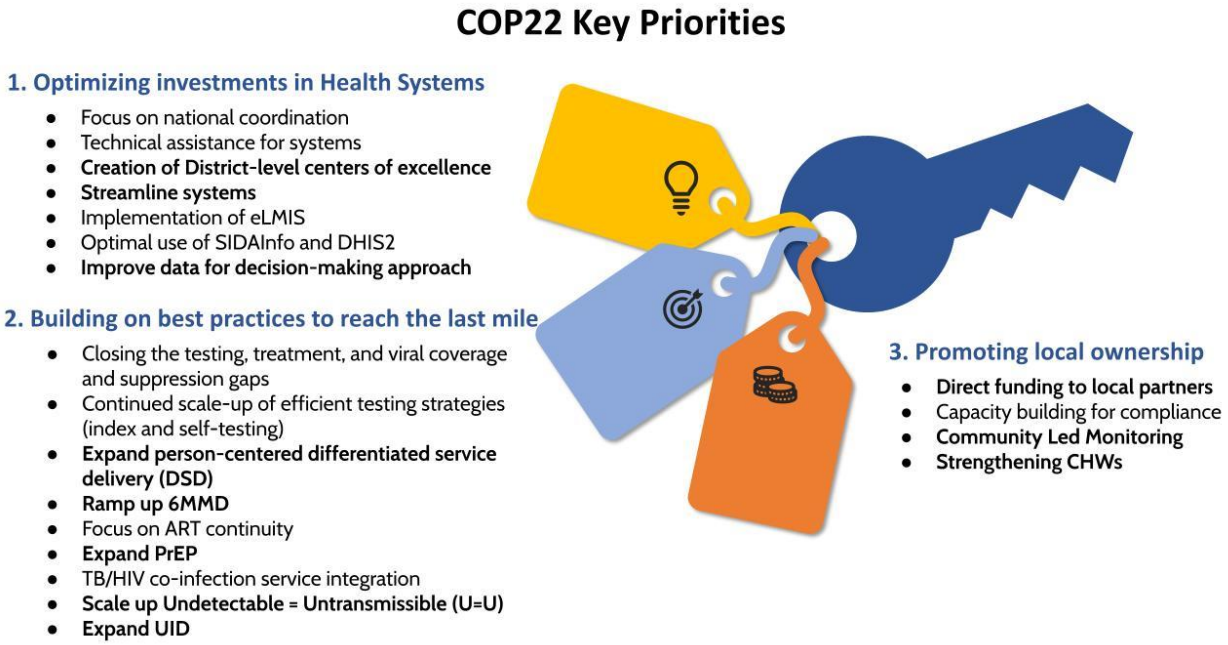


Source: PEPFAR Burundi, May 2022

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

- Priority 1: Optimizing health system strengthening investments
- Priority 2: Building on best practices to reach the last mile
- Priority 3: Promoting local ownership

Figure 2.2.2 COP22 Key Priorities



Source: PEPFAR Burundi, May 2022

2.2.1 Priority 1: Optimizing health system strengthening investments

In COP22, the PEPFAR Burundi program will continue to 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 and viral load 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 95 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. In COP22, the district approach will shift focus from providing technical support to districts that in turn support the low volume sites to a more system focus to improve coordination at the operational level, improve the last mile supply chain and the laboratory system as well as information systems that aim at improving data availability, quality and visibility for both clinical, laboratory and community services as well as the commodities logistic management information system. The aim is to create a center of excellence at the district level to

provide on-the-job training to visiting clinicians from sites which include the sites with PEPFAR indirect support.

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

PEPFAR Burundi's COP22 planning process 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 COP22 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 to improve the health system at the operational level and ensure a most effective and efficient use of PEPFAR's contributions to the national HIV response in a sustainable way. 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: Building on best practices to reach the last mile

PEPFAR Burundi will build on the important progress made from previous COPs to date to close the testing, treatment, and viral load coverage and suppression gaps. The COP22 vision will ensure that those currently left behind - principally children, young people, and men - are reached, and that the quality of HIV and tuberculosis (TB) services is increased across all provinces and all sex and age using the most optimal antiretroviral therapy (ART) regimens and drug dispensing methods.

PEPFAR Burundi will use the results from the recently completed IBBS when they are released and from the surveillance of recent infections to shift the priorities to sub-population groups among which the epidemic still persists to accelerate the country's path toward reaching epidemic control.

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 COP22, PEPFAR Burundi will continue to focus on targeted testing strategies for case finding in all districts through sharing and implementing best practices. Testing strategies will be adapted to the results of the IBBS to follow the trend of the epidemic. Safe and ethical index testing strategies will continue as index testing is a modality that continues to yield more diagnoses for adults, children and key populations.

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. In COP22, PEPFAR Burundi will continue to expand self testing among key populations including injectable drug users. Focus will be made on tracking and reporting numbers of those clients returning to the facility after a positive self-test to effectively use this approach to reach PLHIV and ensure impact in case finding.

During COP22, 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. Testing for adolescent girls and young women will continue in ANC services, and additional entry points will be explored in immunization services in a family-based approach to provide testing services for breastfeeding women, their infants, and older children who were not tested during pregnancy or after delivery. Integrating screening and testing services into immunization services will leverage the high immunization rate in Burundi.

PEPFAR Burundi will continue to use population-specific strategies and adapt practices with strong evidence of success from other countries (e.g., using FSW platforms to test men who purchase sex and other MenStar approaches for case-finding among men).

The social network services (SNS) testing modality will be expanded beyond KP as another potentially successful case finding entry point in networks of PLHIV, especially among adolescents LHIV.

In COP22, the existing HIV screening tools will be adapted to tailor these tools to each type of sub-population to improve efficiency in testing services.

2.2.2.2 Closing the treatment gaps

PEPFAR Burundi will prioritize support for: 1) full access to optimized DTG-based regimens, with TLD for adolescents and adults and DTG 10 mg for children, to accelerate and maintain viral load suppression among PLHIV, and 2) the full scale-up of three- and six- MMD, and the expansion of the community adherence groups (CAGs) (as part of a sustainable community ART delivery platform), and other DSD models. Together, these strategies will contribute to closing treatment gaps and improving continuity of treatment by addressing issues that prevent clients from attending health facilities and bringing services closer to patients.

Since FY20, the Burundi program has experienced a progressive decrease of treatment growth among both children and adults. PEPFAR Burundi will leverage findings of the CoT RCA nationwide to address identified root causes for interruption in treatment (IIT). The biometric web-based unique identifier (UID) whose implementation started during COP21 will be fully scaled up in COP22 to help to define the national ART cohorts and therefore also address any double counting and silent transfer issues which have a negative impact on the continuity of treatment.

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 and PEPFAR guidance.

In COP20 and COP21, PEPFAR has supported the introduction of optimized regimens for HIV and TB, with the introduction of TLD and DTG10, as well as 1HP for optimized TB preventive treatment (TPT). In COP22, PEPFAR will help further scale up these regimens and ensure equitable access.

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, COP20 and COP21 to accelerate access to VL testing and ensure both the quality of services and high levels of 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 FY23, PEPFAR Burundi, in collaboration with the GFATM and the NACP, will implement the all-inclusive laboratory strategy and complete the diagnostic network optimization (DNO) process to optimize instrument placement and use, and the provision of new machines with more capacity to alleviate the issue of machine breakdowns due to the age of the current machines and reduce the burden on existing laboratories with the aim of removing barriers to increase viral load access. Current VL coverage and suppression gaps are particularly acute among KPs, children, young people, pregnant and breastfeeding women, and adult men. PEPFAR Burundi will implement differentiated strategies that consider 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 continue to work closely with PLHIV and KP-led groups to mobilize communities around U=U messaging to ensure a greater uptake of viral load testing services. In FY23, PEPFAR Burundi will consolidate the laboratory information system with SIDA Info to accelerate delivery of viral load results to care and treatment service providers, who in turn will provide timely results to clients and education on adherence to treatment and U=U benefits.

2.2.2.4 Prevention

In COP22, eligible clients (KPs and partners in serodiscordant couples) started to receive PrEP in PEPFAR-supported sites. Due to the slow startup of PrEP and the narrowed eligibility on PrEP enrollment, only 30% of the target (2000 patients) was reached. PEPFAR Burundi will continue to support the NACP, together with the WHO, to update national guidelines based on the best available evidence and in alignment with WHO and PEPFAR guidance. In addition, PEPFAR Burundi with other stakeholders will continue to advocate so that other populations may benefit from PrEP such as high-risk pregnant and lactating women and AGYW. More specifically, stakeholders are advocating to prioritize PrEP for these populations in the National HIV Strategic Plan currently being drafted. In COP22, it is expected that 2329 seronegative individuals will receive PrEP.

Building on the substantial successes in COP19, COP20 and COP21, 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 COP22/FY23, PEPFAR Burundi will continue to contribute to cover the condom and lubricant gaps.

2.2.2.5 KP program

In COP22, the comprehensive KP program will use evidence-based strategies to maintain programming. The KP program will implement some surge strategies to reach the harder to reach KPs including:

- Hidden/older men who have sex with men (MSM),
- Transgender individuals (TG), and
- People who inject drugs (PWID).

Testing strategies that helped the KP program successes to date will be maintained such as: enhanced peer outreach approach (EPOA), community-focused index testing, PrEP Ambassadors for demand creation, and regular viral load testing among KPs. 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 living with HIV on treatment and with suppressed viral load, through a range of community- and peer-engagement strategies, patient navigation approaches, and improved coordination among IPs.

During COP22, the KP program will also explore strategies for formalize a program for men who purchase sex (MWPS), coordinating efforts between KP partners working with sex workers and general population partners working on greater male engagement. Strategies such as prevention and testing services within sex worker hotspots, utilizing male peer educators and navigators, will be explored.

During COP22, the KP program will be fully transitioned to high-performing, KP-competent local partners: Association Nationale de Soutien aux séropositifs et malades du SIDA (ANSS) and Society of Women Against AIDS (SWAA)/Burundi. The local partners will maintain the KP program focus on person-centered services, ensuring KPs have access to a range of services meeting them where they are: at facility sites, community, and CSO sites. The program will continue and maintain a “do no harm” policy at all levels. To ensure the success of this transition and mitigate the fiduciary and programmatic risks, PEPFAR Burundi will continue to work with EpiC and will leverage technical assistance from ACHIEVE. Finally, the two partners will continue to partner formally and informally with KP-led CSOs as well as prompting KP leadership within their own organization. PEPFAR/Burundi will work with IPs to strengthen their KP competency, working to increase engagement from KP leaders and KP-led organizations. In the case of MSM, TG and PWID, ANSS will maintain its consortia approach, funding MSM, TG and PWID-led

organizations to assist in delivering services via drop-in centers, hotspot mapping and outreach and virtual means.

The results of the Stigma iIndex 2.0 and lessons learned in Burundi and elsewhere will serve to address structural barriers for KP services within private and public facilities. These will include but are not limited to: KP competency training for police and other law enforcement officials, health community workers, private sector, local administration; mitigation of stigma, discrimination and violence linked to KP status; and helping KPs understand their rights and responding when those rights are violated.

2.2.2.6 Orphans and Vulnerable Children (OVC) program

In COP22, the OVC programs will continue to focus more on the key challenges for children in the Burundi HIV 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, and the OVC program is now fully implemented by a local partner. This will continue in COP22 with the introduction of a new local award that will take over from WIYIZIRE, with continued organizational and technical capacity development support from central mechanisms. The PEPFAR Burundi team will plan sufficient overlap between mechanisms to ensure a smooth transition of beneficiaries and avoid interruption of services.

In COP22, PEPFAR Burundi will continue to increase coverage for OVC services for high burden sites for those on treatment <19 years of age, expand its OVC program geographically in one additional province, the province of Ngozi and specifically to Ngozi District which has the highest TX_CURR <20 after the six provinces (Bujumbura, Bujumbura Mairie, Kayayza, Gitega, Kirundo and Muyinga) currently covered by the program. The OVC program will continue to prioritize support for C/ALHIV in order to offer 90% of children and adolescents <19 on treatment the opportunity to enroll in the OVC program, with particular focus on adolescents (including adolescent mothers) and infants. The OVC program will continue to maintain bidirectional referrals with clinical partners, data sharing agreements, and OVC-clinical case conferencing, to support uptake of services and clinical outcomes for C/ALHIV such as viral suppression, MMD, optimized ART regimens, and TB symptoms screening with linkage to preventive (TPT) or curative TB services, accordingly. In collaboration with the clinical partners, the OVC program will continue to support the pediatric surge and PMTCT surge to improve EID services, case finding and linkage to treatment. The OVC program will increase support for HEI at greatest risk of IIT, through improved collaboration and bidirectional referrals with PMTCT sites.

2.2.2.7 Gender-Based Violence (GBV)

Since COP20, PEPFAR Burundi successfully transitioned its GBV program to a local partner. Currently, the GBV program is fully implemented by a local partner through the GIR'ITEKA mechanism. In COP22, the local partner will continue to reinforce the integration of gender-based violence (GBV) programming throughout the HIV clinical cascade with the introduction of a new

award that will take over from GIR'ITEKA. The new mechanism will continue to include HIV prevention interventions (including PrEP), HIV casefinding (e.g. index testing), and strengthening the continuum of responses between GBV prevention and clinical post-violence care within the six current geographical intervention zones (Bujumbura, Bujumbura Mairie, Gitega, Kirundo, Makamba, Rumonge).

In COP22, the GBV program will continue to engage community and religious leaders in GBV case identification, prevention, and response. The GBV program will continue to strengthen referral linkages to post-violence care, coordination with clinical partners, and the capacity of service providers in first-line support to survivors of violence. The program will also engage community actors in improving PEP initiation and completion for survivors of sexual violence, arranging experience exchange between best performing sites and the least performing ones and on best practices and strategies, engaging community leaders in dialogue sessions targetting categories of GBV perpetrators indexed by communities, as well as in implementing specific GBV prevention strategies for children and adolescents. To avoid interruption of services and promote an easy transition of beneficiaries, the PEPFAR Burundi team will plan sufficient overlap between the mechanisms.

2.2.2.8 Above-site interventions

Above-site interventions will continue to be aligned with site-level objectives to serve the needs of a sustained epidemic control program, focusing on:

- Strengthening supply chain systems from central to site levels;
- Optimizing lab networks and functionality;
- Enhancing functionality and expanding biometric-based Unique Identifier (UID); consolidating the laboratory information into SIDA Info;
- Introducing and scaling up the electronic logistic management information health information systems (eLMIS);
- In COP22, PEPFAR will continue to support the national health information system to improve the quality of data reported in DHIS2 and to align PEPFAR and national indicators and data.

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 COP22, more technical assistance will be provided to district health teams to improve the last mile supply chain, the laboratory system and the information system including the logistic management information system of health commodities through care and treatment implementing mechanisms to ensure a continuum of services.

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 COP22.

During FY23, 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 implementing 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 TB diagnosis and early infant diagnosis (EID). COP22 investments will continue to support an accurate patient-centered 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, and establishing interoperability between SIDA-Info and DHIS2. In COP22, PEPFAR will continue to improve SIDA-Info development to enhance its functionality by consolidating existing systems used to track clinical (Open Clinic), lab (Ibipimo), and community services including OVC (ComCare) and recency testing (recency dashboard). PEPFAR will explore opportunities to integrate additional modules into SIDA-Info to support PMTCT services to track pregnancies and deliveries of women living with HIV for better adherence to treatment and viral load access and EID testing. Other systems such as the eCascade, a mobile-based KP referral tracking system, will be introduced to help identify points in the cascade where KP are lost. In COP22, PEPFAR will continue to support the implementation of an end-to-end eLMIS to track commodities and stocks to improve data visibility and programming based on evidence.

In COP22, PEPFAR Burundi will continue to invest in improved surveillance systems to enable tracking of all newly diagnosed individuals, prioritizing them for index testing and partner notification. This system will feed real-time data to the dashboard for monitoring newly diagnosed cases, recent infections, ART coverage, VL suppression, and drug resistance. The 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 COP22 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.

2.2.3 Priority 3: Enhancing capacities and promoting local ownership

2.2.3.1 Quality of services and person-centered approaches

As in COP21, PEPFAR Burundi's COP22 plan aims also 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 journey experienced by a PLHIV, 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 travel and migration, treatment and health issues, no/little support, long travel, and no time. 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. Continuity of treatment will be the key focus in COP22, 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 guidelines on multi-month scripting (MMS) and MMD for ART patients and ensuring that all 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 COP22, 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. COP22 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, PEPFAR/Burundi is working to finalize its strategy for community-led monitoring (CLM) for COP22. Included in the process will be a new coordination mechanism composed of CSO advocates, PNLS, CNLS, UNAIDS, and Global Fund representatives. The coordination mechanism

will be put in place to improve PEPFAR/Burundi's ability to leverage resources and activities across a broader range of partners at community level, including CSOs conducting CLM .

Via CLM protocols as outlined by S/GAC, the health managers of the Ministry of Health along with partners will implement quarterly meetings with the CSO partners, to gain input and recommendations for service improvements. PEPFAR/Burundi will also rely on technical support from global partners, such as the International Treatment Preparedness Coalition (ITPC), to work with the coordinating mechanism and CSO CLM partners to define indicators to be measured, develop tools for data collection, analyze the data and formulate recommendations for service improvements.

2.2.3.3 Service integration

To improve the 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. Additionally, HIV testing services will be integrated into immunization platforms to leverage high uptake of immunizations. Testing services will target breastfeeding women, their infants (for EID), and older children through a family-based approach. Also the opportunity to integrate chronic diseases such as diabetes and hypertension into care and treatment services will be explored to offer HIV patients a one-stop-shop for all their needs to improve the quality of services offered to them.

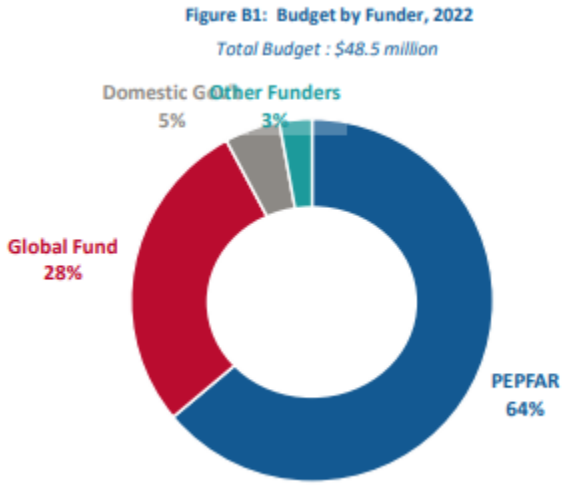
2.2.3.4 Partner management

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 support continuity of treatment efforts as needed in COP22. At the end of each quarter, quarterly meetings with all PEPFAR supported projects will be held for data analysis, experience sharing and support to the Implementing Partners. PEPFAR will continue to provide targeted technical assistance focusing on both technical and organizational capacity building to local partners directly managing awards.

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 2022. In FY22, the Ministry of Health is developing their next generation strategic plan that will aim at increasing domestic investments and will serve as an advocacy tool for more host Government contribution to the HIV response as well as other sources like the private sector.

Figure 2.3.1: Budget by stakeholder



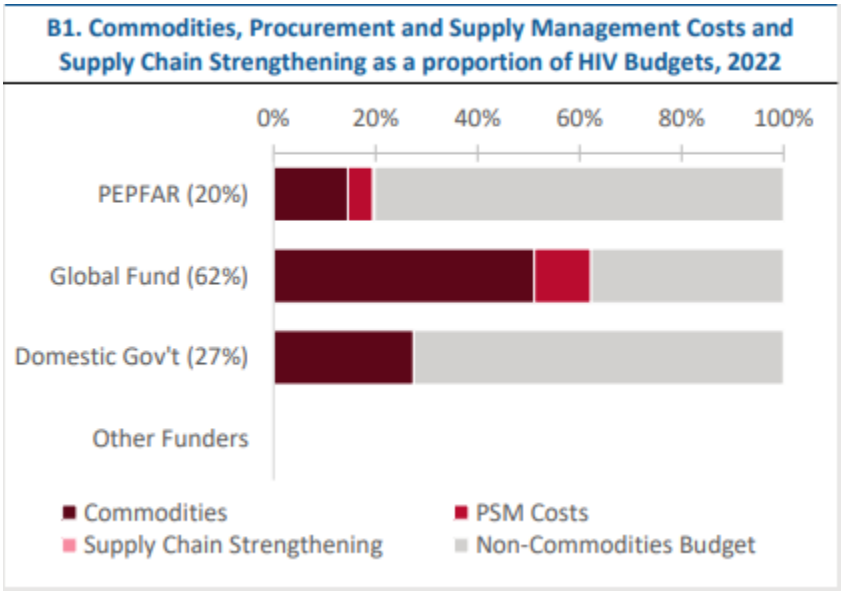
Source: HIV Resource Alignment: Burundi Country Profile, updated March 2022

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.

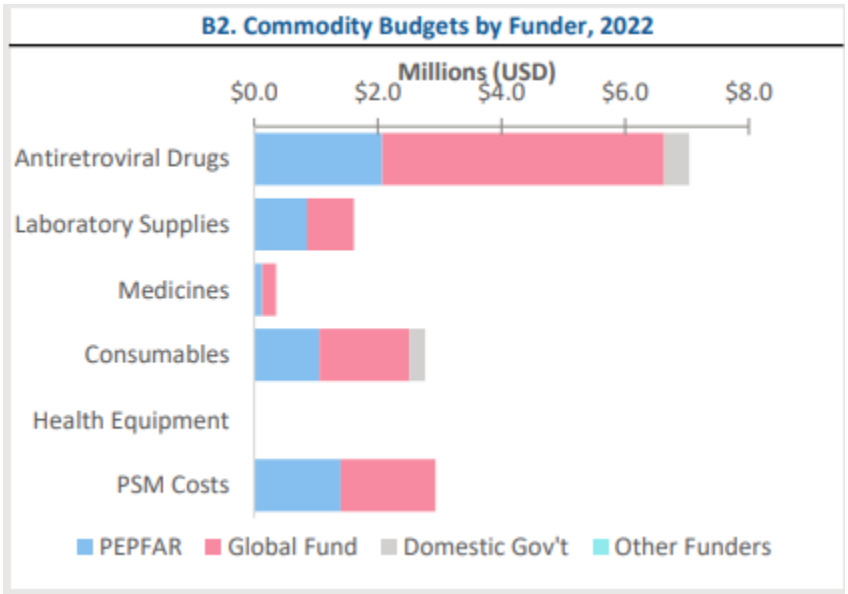
The GFATM continues to be the largest procurer of HIV-related commodities (including ARVs and non-ARV drugs, condoms, rapid test kits, reagents, and supplies). The PEPFAR program will complement the procurement of commodities (including ARV drugs, and GeneXpert cartridges,) and will continue to provide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

Figure 2.3.2: Commodities, procurement and supply management costs and supply chain strengthening



Source: HIV Resource Alignment: Burundi Country Profile, updated March 2022

Figure 2.3.3: Commodity budgets by funder



Source: HIV Resource Alignment: Burundi Country Profile, updated March 2022

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). The NACP reported more GOB committed for upcoming years to take more on ARV

and improve national programming in line with the ongoing five-year strategic planning that is being developed.

Table 2.3.1: Annual investment profile by program Area, 2020 (most recent *expenditure* data)

Table S3. Investment Profile (Expenditures) for HIV Programs, 2020

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	$	%	%	%	%	2018-2020
Care and Treatment	$13,663,437	0%	57%	43%	0%	
HIV Care and Clinical Services	$9,458,555	0%	65%	35%	0%	
Laboratory Services incl. Treatment Monitoring	$2,582,013	0%	29%	71%	0%	
Care and Treatment (Not Disaggregated)	$1,622,869	0%	58%	42%	0%	
HIV Testing Services	$2,853,422	0%	6%	94%	0%	
Facility-Based Testing	$1,128,423	0%	0%	100%	0%	
Community-Based Testing	$1,258,278	0%	0%	100%	0%	
HIV Testing Services (Not Disaggregated)	$466,721	0%	39%	61%	0%	
Prevention	$2,321,401	0%	66%	34%	0%	
Community mobilization, behavior and norms change	$859,914	0%	7%	93%	0%	
Voluntary Medical Male Circumcision	$0					
Pre-Exposure Prophylaxis	$0					
Condom and Lubricant Programming	$703,344	0%	100%	0%	0%	
Opioid Substitution Therapy	$0					
Primary Prevention of HIV & Sexual Violence	$0					
Prevention (Not Disaggregated)	$758,143	0%	100%	0%	0%	
Socio-economic (incl. OVC)	$790,737	0%	0%	100%	0%	
Case Management	$391,164	0%	0%	100%	0%	
Economic Strengthening	$38,196	0%	0%	100%	0%	
Education Assistance	$220,048	0%	0%	100%	0%	
Psychosocial Support	$121,589	0%	0%	100%	0%	
Legal, Human Rights, and Protection	$0					
Socio-economic (Not Disaggregated)	$19,740	0%	0%	100%	0%	
Above Site Programs	$1,985,368	0%	11%	89%	0%	
HRH Systems	$60,656	0%	0%	100%	0%	
Institutional Prevention	$0					
Procurement and Supply Chain Management	$123,329	0%	0%	100%	0%	
Health Mgmt Info Systems, Surveillance, and Research	$1,189,867	0%	19%	81%	0%	
Laboratory Systems Strengthening	$246,485	0%	0%	100%	0%	
Public Financial Management Strengthening	$0					
Policy, Planning, Coordination and Management of Disease Ctrl Programs	$245,442	0%	0%	100%	0%	
Laws, Regulations and Policy Environment	$32,440	0%	0%	100%	0%	
Above Site Programs (Not Disaggregated)	$87,149	0%	0%	100%	0%	
Program Management	$5,766,447	0%	42%	58%	0%	
Implementation Level	$5,766,447	0%	42%	58%	0%	
Total (incl. Commodities)	**$27,380,812**	**0%**	**44%**	**56%**	**0%**	
Commodities Only	**$11,347,139**	**0%**	**80%**	**20%**	**0%**	
% of Total Budget	*41%*					

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Table 2.3.2: Investment profile for HIV programs, 2022

Table S1. Investment Profile (Budget Allocation) for HIV Programs, 2022						
	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	$	%	%	%	%	2018-2022
Care and Treatment	$20,514,176	7%	47%	46%	0%	
HIV Care and Clinical Services	$15,286,025	3%	62%	35%	0%	
Laboratory Services incl. Treatment Monitoring	$2,053,977	7%	3%	90%	0%	
Care and Treatment (Not Disaggregated)	$3,174,174	25%	1%	74%	0%	
HIV Testing Services	$5,993,554	4%	10%	86%	0%	
Facility-Based Testing	$2,750,987	0%	19%	81%	0%	
Community-Based Testing	$913,364	0%	3%	97%	0%	
HIV Testing Services (Not Disaggregated)	$2,329,203	11%	1%	88%	0%	
Prevention	$2,569,499	4%	23%	73%	0%	
Community mobilization, behavior and norms change	$1,163,566	0%	10%	90%	0%	
Voluntary Medical Male Circumcision	$0					
Pre-Exposure Prophylaxis	$356,223	0%	4%	96%	0%	
Condom and Lubricant Programming	$771,787	0%	48%	52%	0%	
Opioid Substitution Therapy	$0					
Primary Prevention of HIV & Sexual Violence	$113,237	0%	12%	88%	0%	
Prevention (Not Disaggregated)	$164,686	58%	42%	0%	0%	
Socio-economic (incl. OVC)	$1,580,999	0%	25%	75%	0%	
Case Management	$627,199	0%	7%	93%	0%	
Economic Strengthening	$190,000	0%	0%	100%	0%	
Education Assistance	$190,000	0%	0%	100%	0%	
Psychosocial Support	$499,454	0%	56%	44%	0%	
Legal, Human Rights, and Protection	$74,346	0%	100%	0%	0%	
Socio-economic (Not Disaggregated)	$0					
Above Site Programs	$5,466,020	13%	1%	86%	0%	
HRH Systems	$0					
Institutional Prevention	$0					
Procurement and Supply Chain Management	$70,835	0%	0%	100%	0%	
Health Mgmt Info Systems, Surveillance, and Research	$1,797,547	0%	1%	99%	0%	
Laboratory Systems Strengthening	$494,000	0%	0%	100%	0%	
Public Financial Management Strengthening	$101,119	100%	0%	0%	0%	
Policy, Planning, Coordination and Management of Disease Ctrl Programs	$469,626	0%	6%	94%	0%	
Laws, Regulations and Policy Environment	$0					
Above Site Programs (Not Disaggregated)	$2,532,893	24%	0%	76%	0%	
Program Management	$8,188,614	0%	30%	70%	0%	
Implementation Level	$8,188,614	0%	30%	70%	0%	
Total (incl. Commodities)	**$44,312,862**	**5%**	**31%**	**64%**	**0%**	
Commodities Only	**$14,700,968**	**4%**	**58%**	**37%**	**0%**	
% of Total Budget	*33%*					

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Table 2.3.3: Annual procurement profile for key commodities, 2020 (most recent expenditure data)

Table S4. Investment Profile (Expenditures) for HIV Commodities, 2020

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	$	%	%	%	%	2018-2020
Antiretroviral Drugs	$4,347,853	0%	85%	15%	0%	
Laboratory Supplies and Reagents	$1,562,569	0%	42%	58%	0%	
CD4	$0					
Viral Load	$815,960	0%	0%	100%	0%	
Other Laboratory Supplies and Reagents	$746,609	0%	88%	12%	0%	
Laboratory (Not Disaggregated)	$0					
Medicines	$783,106	0%	76%	24%	0%	
Essential Medicines	$263,059	0%	30%	70%	0%	
Tuberculosis Medicines	$520,047	0%	100%	0%	0%	
Other Medicines	$0					
Consumables	$2,166,022	0%	97%	3%	0%	
Condoms and Lubricants	$1,448,764	0%	100%	0%	0%	
Rapid Test Kits	$715,958	0%	90%	10%	0%	
VMMC Kits and Supplies	$0					
Other Consumables	$1,300	0%	100%	0%	0%	
Health Equipment	$289,406	0%	100%	0%	0%	
Health Equipment	$261,740	0%	100%	0%	0%	
Service and Maintenance	$27,666	0%	100%	0%	0%	
PSM Costs	$2,198,183	0%	78%	22%	0%	
Total Commodities Only	**$11,347,139**	**0%**	**80%**	**20%**	**0%**	

Source: HIV Resource Alignment; Note: Domestic Gov't and Other Funders data included where available. Aggregated Domestic Gov't data has been included where disaggregation is not available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Table 2.3.4: Investment profile for HIV commodities, 2022

Table S2. Investment Profile (Budget Allocation) for HIV Commodities, 2022

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	$	%	%	%	%	2018-2022
Antiretroviral Drugs	$7,036,069	6%	65%	29%	0%	
Laboratory Supplies and Reagents	$1,613,185	0%	47%	53%	0%	
CD4	$0					
Viral Load	$742,460	0%	9%	91%	0%	
Other Laboratory Supplies and Reagents	$870,725	0%	80%	20%	0%	
Laboratory (Not Disaggregated)	$0					
Medicines	$355,307	0%	63%	37%	0%	
Essential Medicines	$345,475	0%	65%	35%	0%	
Tuberculosis Medicines	$9,833	0%	0%	100%	0%	
Other Medicines	$0					
Consumables	$2,766,368	9%	53%	38%	0%	
Condoms and Lubricants	$803,632	0%	65%	35%	0%	
Rapid Test Kits	$1,962,737	13%	48%	39%	0%	
VMMC Kits and Supplies	$0					
Other Consumables	$0					
Health Equipment	$0					
Health Equipment	$0					
Service and Maintenance	$0					
PSM Costs	$2,930,038	0%	52%	48%	0%	
Total Commodities Only	**$14,700,968**	**4%**	**58%**	**37%**	**0%**	

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Table 2.3.5: Annual USG non-PEPFAR funded investments and integration

Funding Source	Total USG Non-	Non-PEPFAR Resources Co-	# Co-	PEPFAR COP22 Co-	Objectives

	PEPFAR Resources (FY21)	Funding PEPFAR IMs (FY21)	Funded IMs	Funding Contribution	
USAID MCH	$5,000,000	$1,000,000	1	$1,000,000	*Nutritional support to OVCs*
USAID TB	NA	NA	NA	NA	NA
USAID Malaria	$7,500,000	$7,733,160	1	$5,487,911	*Supply chain systems and data/reporting enhancements (GHSC-PSM)*
Family Planning	$5000,000	1,500,000	3	$3,564,474,000	*Access to Family Planning and GBV services**
Total	**$17,500,000**	**$10,233,160**	3	**$10,052,385**	

** 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 September 2021 in collaboration with UNAIDS, the National AIDS Council (CNLS), the National AIDs Control Program (NACP/PNLS), UN agencies, the GFATM grants recipients, CSOs, the National Network of PLHIV, and private sector representatives. The SID 2021 revisions were made in critical areas or to keep them current and relevant for decision-making.

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.
- ***Public access to information***: The GOB widely disseminates reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress, and

challenges toward achieving HIV/AIDS 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: 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 issues and outline improvement plans. Planning , monitoring and implementation bodies are available.However, both the national monitoring, and evaluation plan and procedures manual still need to be updated.

Sustainability Vulnerabilities

Domain: Governance, Leadership, and Accountability

- ***Policies and governance:*** The country has policies in place that support the collection and appropriate use of patient-level data for health, including HIV/AIDS. It has no law nor policy that specify protections for key populations

- ***Civil society engagement***: In Burundi, there is active civil society engagement in HIV/AIDS advocacy, decision-making processes, and service delivery in the national HIV/AIDS response. However, there is a need to continue supporting the CSOs for capacity building in project development (setting targets and measurable indicators), fundraising, and management. There are no laws, policies, or regulations in place which permit CSOs to be funded from a government budget for HIV services through open competition.

- ***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

- ***Service delivery:*** 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. Service delivery is the responsibility of Burundi's decentralized district health system. PEPFAR will continue to support District Health Teams (DHTs) which need to play a more central role in providing technical oversight for HIV services through the improvement of their supervisory and support functions to health facilities.

- ***Human resources for health:*** The GOB does not have sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. It does not have a strategy or plan for transitioning staff funded by donors.

- ***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.

- ***Quality management***: The GOB has a current QM/QI plan for HIV care and treatment. QI processes are an integral part of the technical assistance approach implemented by PEPFAR-funded partners. However, there is need for improvement of data collection and use.

- ***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 COP22 priorities for addressing SID sustainability vulnerabilities

During FY23, 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.

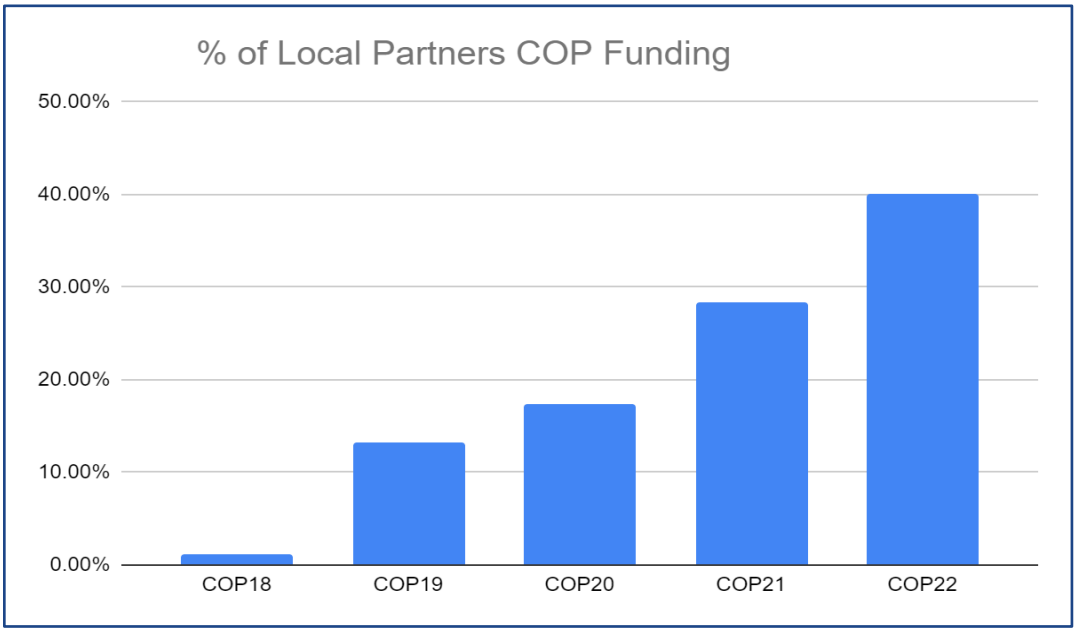
2.4.3 Donor investments in SID areas

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

In addition to SIMS awarded to a local partner every year since COP16, the proportion of COP funds for local partner-led implementation has increased in COP19, COP20 and COP21 (Figure 2.4.1). In addition to SIMS, PEPFAR Burundi funds awards to two local partners to implement the GBV and OVC program.

Figure 2.4.1: Mission's transition to local partners



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 GBV 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 FY23, PEPFAR will continue to fund the current award and its follow-on to be awarded to a local partner as well to ensure a smooth transition and a continuity of services and technical assistance.

In COP22, the OVC programs will continue to focus on 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 FY23, PEPFAR Burundi will increase coverage for OVC services for high burden sites for those on treatment <19 years of age, expand its OVC program geographically 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 expanded into Muyinga to cover a total 14,000 beneficiaries including 10,445 OVC <18. In

COP2022 the OVC program will expand into Ngozi to cover the district of Ngozi that has the highest burden among CLHIV in the province. 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.

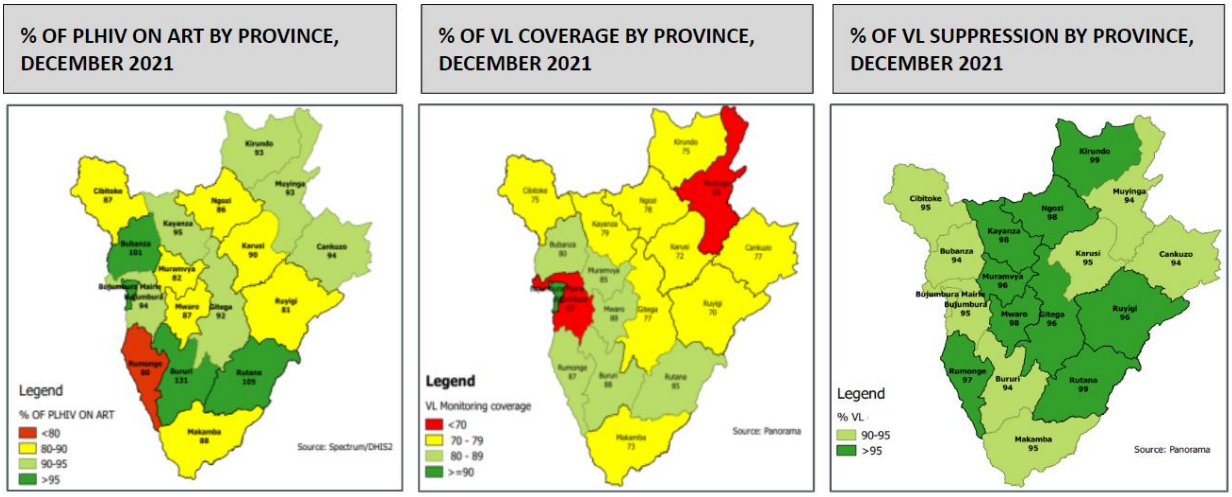
In COP22 the transition to local partners will continue through EpiC, which is a transition award handing over the management of key population activities to two local NGOs: the Association Nationale de Soutien aux Seropositifs et Malades du Sida (ANSS) to implement the men who have sex with men (MSM), transgender persons (TG), and people who inject drugs (PWID) sub populations; and the Society for Women against AIDS in Africa (SWAA/ Burundi) to implement the female sex workers (FSWs) component of the KP program.

2.5 Alignment of PEPFAR investments geographically to disease burden

The PEPFAR program in Burundi covers all 18 provinces of the country to accelerate epidemic control by providing direct support to all high volume sites in the 47 districts and offering targeted technical assistance to district health teams and well performing district hospitals (Centers of Excellence) that perform well to support low volume sites. All provinces have reached at least 80% of ART coverage and 55% of them reached more than 90% of ART coverage. Targeted interventions will be implemented in provinces with lower ART coverage to improve and maintain care and treatment of PLHIV in those provinces. The updated 2022 Spectrum estimate (Figure 2.5.1) has shown significant variations between provinces in terms of the number of

PLHIV and the IBBS results will help to show the trends and variations among sub-population groups. The analysis of the different variations and trends will identify gaps, develop an effective strategy and sharpen the focus on delivering high-quality HIV services, to meet the specific needs of sub-categories of populations, as well as to better align available resources and infrastructure at the district level.

Figure 2.5.1: Treatment coverage, VL coverage and suppression by SNU



Source: Spectrum+DATIM+DHIS2 Dec 2021

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 COP22 through participation in key sessions during a hybrid (in person and virtual) strategic planning retreat in January 2022 and during virtual planning meeting (VPM) that took place in March 2022. These sessions were an opportunity to review PEPFAR and national data, discuss the main challenges at community and national levels, share priorities, and collect inputs on the proposed strategies toward epidemic control. In COP22, planning implementing partners and other stakeholders attended the full VPM sessions.

Workshops and working sessions were organized with all stakeholder categories, before and after the strategic planning retreat, to deepen the discussions on important subjects, including: recency testing, strategies to reinforce community engagement in PEPFAR programs through community led monitoring, inclusion of PWID in PEPFAR programming, as well as key systemic challenges to be considered in the development of above-service delivery strategies, refining the PEPFAR district approach, and areas of synergies with the GFATM including filling commodities gaps, nutritional support to CLHIV, and PrEP.

PEPFAR Burundi engaged with stakeholders outside of the strategic planning retreat and the VPM to reach consensus on national targets, discuss consolidation existing systems such as Ibimipo (lab information system) with SIDA Info (national electronic medical records system [EMR]) and introducing additional modules such as recency dashboard as well as ensuring interoperability of SIDA-Info with existing and planned information systems such as eLMIS.

Stakeholders that engaged in both the strategic planning meeting and the VPM and other relevant meetings include the Minister of Health, the Director of the NACP, the Director of the TB program, the Director of HMIS, the Director of the Planning Department, Burundi's GFATM Portfolio Manager, and representatives of WHO, UNAIDS, UNDP, and CSO representatives in Burundi. After the VPM, debriefing sessions were organized with the NACP and CSO representatives to review the level of inclusion of their priorities in COP22. A meeting with the Minister of Health and the Burundi PEPFAR Chair to discuss specific issues, such as PrEP for adolescent girls and young women, and GBV was held at the Ministry of Health with the participation of the National HIV Council Director. Stakeholders will continue to be engaged throughout the COP22 planning and implementation process through ongoing consultations, including sharing of quarterly results at the national and provincial levels.

In the COP22 planning process, strong engagement with GFATM and UNDP led to in-depth discussions on the country's gaps and needs in terms of HIV commodities, nutritional support needs and PrEP implementation. This has led to a commitment of GFATM to fill HIV commodities gaps in 2022, 2023 and to plan for a six months buffer in 2024 during the transition to a new grant to prevent interruption of services and stock outs.

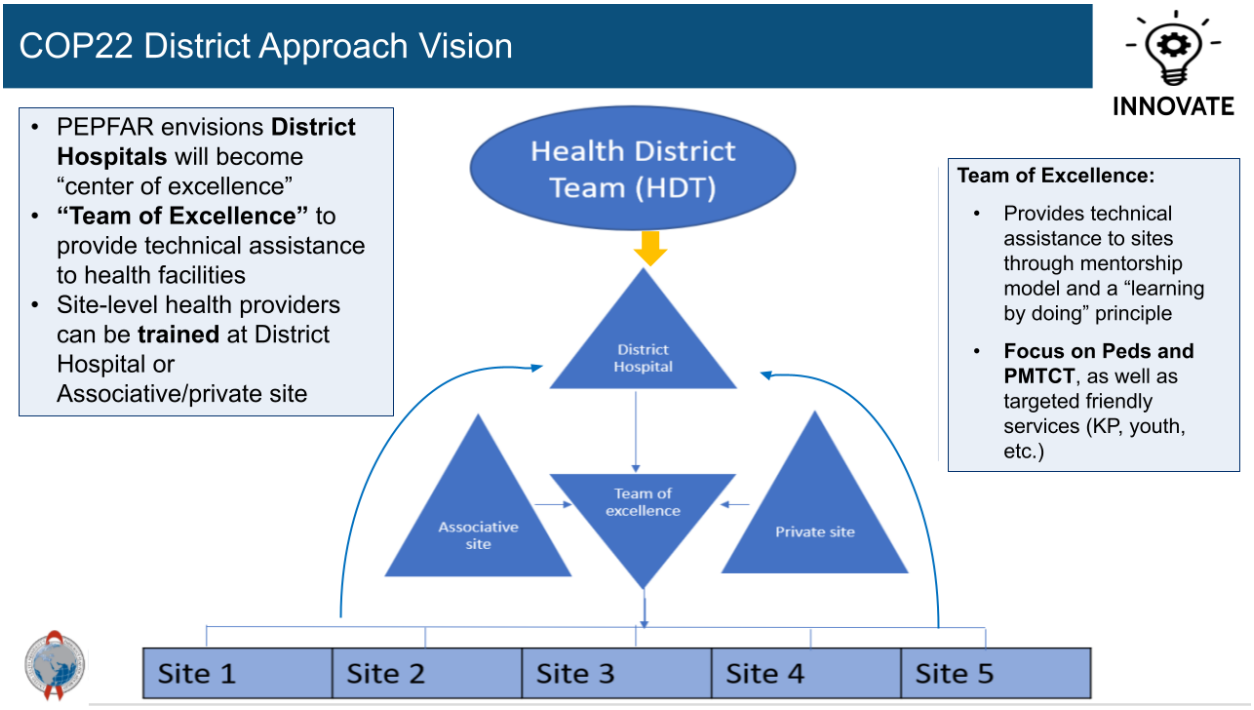
3.0 Geographic and Population Prioritization

3.1 PEPFAR Burundi's COP22 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 48 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 and Figure 2.2.1) are to 1) increase the DHT capacity to support HIV service delivery; and 2) Create a "center of excellence" at the district hospital with NGO, Private sites (for non profit including faith based) and providers that can be skilled at the center of excellence with learning by doing and 3) improve the performance of DHT supervisory and support functions to health facilities.

Figure 3.1.1: District 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. In COP22, PEPFAR will target specific interventions that target the needs of each province and each district to meet their specific needs in case finding, linkage to treatment, and viral load coverage to accelerate their epidemic control. Support for OVC and GBV will focus on provinces with the highest TX_CURR and highest prevalence respectively (figure 2.5.1).

Table 3.1.1: Characteristics of Priority Sites

• District hospitals • High-volume sites (facility and community) • Case-finding for targeted populations (*Optimize* services) and large ART cohort (*Sustain* services) • Sites that support 81 percent of total patients in areas in which the largest numbers of PLHIV reside • TB reference health facilities • KP hotspots • Youth-friendly services

PEPFAR Burundi will continue to complement GFATM investments by providing technical assistance for optimized quality improvement and focused investments that prioritize epidemiologic impact. Shifts planned in COP22 build on this framework and the progress made during COP21. 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, optimized TPT completion, 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. Further, the NACP will be empowered to oversee the districts to build their capacity to strengthen the system at the district level.
- **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. In COP22, PEPFAR will help establish performing district hospitals as centers of excellence so they can provide the right technical assistance to other sites in the district and beyond as needed.
- **Strengthened community involvement in the district approach**, from planning to implementation. In COP22, the initiation of community led monitoring will contribute to shaping the district approach implementation to improve the quality of services.
- **Greater use of technology** such as electronic medical records, electronic logistic management information systems and other information systems will contribute to improve communication, data quality and use for decision making, reduce stock out and improve coordination.

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.

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 FY21 and FY22 estimates, and the changes in terms of burden categorization. **There is a minor decrease in burden (-3.3%) between the 2021 and 2022 Spectrum estimates; 80% of PLHIV are in 50% provinces (9 provinces out of 18, see green bar).**

Table 3.2.1: Comparison of FY21 and FY22 Spectrum PLHIV Estimate Differences and Percent Change

Province	FY21 Spectrum PLHIV	FY22 Spectrum PHIV	Difference (FY22 - FY21)	% Change
Bujumbura Mairie	26314	24710	-1604	-6.10%
Kirundo	8770	8004	-766	-8.73%
Gitega	7674	7915	241	3.14%
Ngozi	5866	6010	144	2.45%
Muyinga	5155	4810	-345	-6.69%
Kayanza	3887	3599	-288	-7.41%
Makamba	3494	3547	53	1.52%
Bujumbura	2593	2525	-68	-2.62%
Rumonge*	2427	2920	**493**	**20.31%**
Ruyigi	2358	2318	-40	-1.70%
Bururi	2146	1435	**-711**	**-33.13%**
Cibitoke	2006	2274	268	13.36%
Karusi	1883	1945	62	3.29%
Rutana**	1864	1475	**-389**	**-20.87%**
Bubanza	1531	1474	-57	-3.72%
Muramvya	1355	1482	127	9.37%
Cakunzo	1292	1388	96	7.43%
Mwaro	1182	1244	62	5.25%
Total	**81797**	**79075**	**-2722**	**-3.33%**

Source: Spectrum 2021 and 2022

- *Highest PHIV increase
- **High decrease of PLHIV

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

Indicator	Total PLHIV	Highest Burden	Lowest Burden
PLHIV	79,075	64,040	15,035
Proportion of PLHIV	100%	81%	19%
Proportion by province	100%	50%	50%

Source: Spectrum 2022

3.3 Differentiation of Support across Provinces and districts

PEPFAR Burundi will continue to offer in COP22 a data-driven, differentiated level of support to DHTs and district hospitals as centers of excellence, based on the IBBS and the 2022 Spectrum estimates, as well their progress toward 95-95-95 achievements. Each district and facility will continue to 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. Intensive 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 other 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 HIV services, 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, mentoring and quality control. During COP22, 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, COP22 plans for implementing partners will aim to realize PEPFAR's vision that PLHIV, KPs and communities are at the center and lead the monitoring of services provided to them.

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, and hidden vulnerable populations. Existing and new person-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. In COP22, with the OVC and GBV mechanisms ending, new awards will be introduced to continue OVC and GBV programming. To strengthen community-based services alongside the HIV clinical cascade, the KP program will also be transitioned to two local partners: one being the current direct implementer of the GBV program, SWAA Burundi; and the other, being the third local partner: Association Nationale de Soutien aux Séropositifs et Malades du Sida (ANSS).

The package of PEPFAR interventions at the community level includes:

- Supporting community-based organizations to create demand for services, in particular for 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 = untransmissable) campaigns, seeking to reduce HIV-related stigma and discrimination and making sure that every PLHIV receives at least one annual VL test and remains virally suppressed;
- Increasing the role of community leaders to support GBV prevention and response 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);
- Engaging community leaders in dialogue sessions targeting categories of GBV perpetrators

indexed by communities

- Supporting structural interventions for KPs, such as KP competency training for police and other law enforcement officials, health community workers, private sector, local administration; mitigation of stigma, discrimination and violence linked to KP status; 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 and centers of excellence to support sites in delivering quality person-centered HIV services and help scale-up new HIV strategies in low volume sites that are not directly supported by the PEPFAR program. Support to the DHTs will focus on improving the continuum of care system by improving the last mile supply chain, data collection, processing, analysis and quality as well as strengthening laboratory capacity for viral load and EID testing. Key activities/outputs to improve DHTs capacity for systemic functions are described in the table below. While all provinces will receive this support, each district may receive tailored assistance to meet its needs and goals.

Table 3.5.1: System Activities for DHTs

<table>
<tr><td colspan="2">PLANNING SYSTEMS CAPACITIES
● Performance review and bottleneck analyses
● Data analysis and sharing used in planning processes
● Support in the development and monitoring of quarterly action plans</td></tr>
<tr><td>PROCUREMENT AND SUPPLY CHAIN MANAGEMENT
● Improvement of efficiency in logistics
● Technical assistance on information systems
● Improvement of stock control
● Introduction of maintenance plans
● Improvement of commodities distribution
● Skills improvement on logistics management</td><td>DATA & INFORMATION SYSTEMS
● Improvement of registry of patient data for pediatric and adult patients
● Improvement of facility-based information systems such as systematic cleaning of patient and facility records in SIDA-Info/UID and data quality audits
● Improve case based surveillance
● Improvement of follow-up on defaulters
● Improve interoperability between systems</td></tr>
<tr><td>QUALITY ASSURANCE/QUALITY IMPROVEMENT
● QA/QI through the establishment of core standards and program reviews
● QI initiatives to target a particular problem or service, such as IIT
● Training to update providers' skills or introduce new norms, protocols, and strategies;
● Technical skills improvement (lab technicians, providers trained on counseling)
● Re-engineering of patient flow in high-volume facilities to decrease patient waiting times, improve</td><td>LABORATORY
● Assessment of turn-around time for laboratory tests to identify and address bottlenecks that cause delays and affect initiation and adherence to treatment
● Improvement of lab info for data quality control
● Preventive maintenance of lab equipment
● Plan developed for lab sample collection
● Improved efficiency in logistics, including better follow-up on patient status (VL);</td></tr>
</table>

internal referrals and increase the efficiency of services ● Strengthening the links between community and health facilities to improve demand for and access to services ● Integration of community and facility HIV/TB response ● Create the center for excellence at District Hospital	pre-treatment of lab samples/faster processing of samples; reduced waiting time for lab results; improved quality of test results; assistance in sample transportation

In addition, IPs will be encouraged to work with DHTs to address weaknesses within health governance systems (see figure 3.1.1). IPs will build DHT capacity to provide leadership and oversight functions within their area of responsibility, in particular where there is a lower 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 COP22 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
● KPs (MSM, TG, FSW, PWID) ● Priority populations: sexual partners of KPs and PLHIV; children of KPs; OVC; AGYW; fishermen, truck drivers, miners ● Other subgroups of the general population: men over 25; pregnant women, breastfeeding women, and infants through PMTCT ● TB patients ● STI patients ● Military populations

In terms of **case identification**, Spectrum estimates by sex and age highlight continued gaps for both men and children (Table 3.6.2). In COP22, case identification will be highly targeted and focus on closing gaps in these populations. Note that during the remaining months of COP21 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, 2022)

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
28,247	24,432	86%	44,432	47,473	107%	6396	2848	45%

Source: PLHIV estimates are from Spectrum 2022; HIV status is from DHIS2 as of December 2021.

In terms of **ART coverage**, age- and sex-disaggregated analyses show that men 15-39 and children 0-14 also have the greatest coverage gaps. Disparities in ART coverage by population are also seen by province.

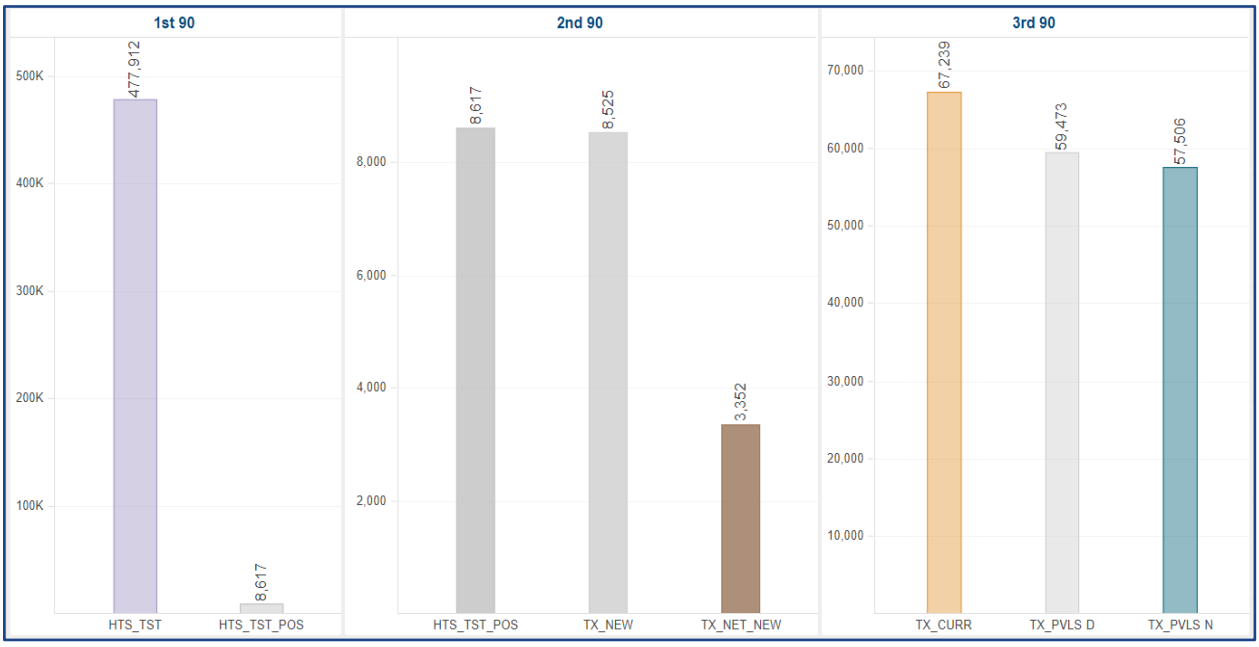
To address these gaps, PEPFAR is directing its implementing partners to scale up successful strategies tailored by age and sex, concentrating efforts on ART linkage and continuity of treatment, in geographic locations with the greatest needs and the highest burden. More broadly, implementing partners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

4.0 Person-Centered Program Activities to Reach Epidemic Control

In COP22, 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.

Figure 4.0.1 Overview of 95/95/95 Cascade, FY21

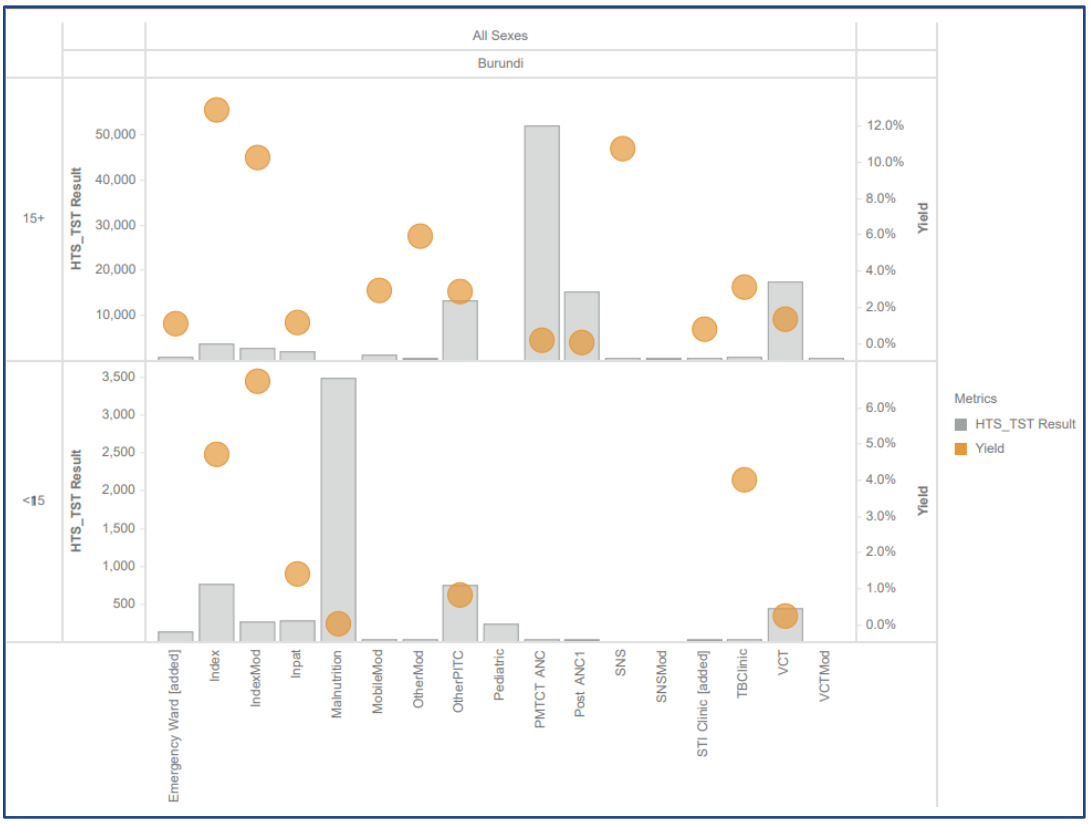


Source: Panorama

4.1 Finding the Missing and Getting them on Treatment

4.1.1 Case finding

Figure 4.1.1: Testing Volume and Yield by Modality and Age/Sex, FY22 Q1



Source: Panorama

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 COP22 will be on continuity of treatment of patients, testing strategies are being optimized and implemented to go to 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 FY21, 52% of adults and 82% of CLHIV were identified through index testing. In COP22, PEPFAR Burundi will focus 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.

In addition, PEPFAR will provide support IPs to focus on the use of social network services (SNS) modality outside the KP program, which demonstrated an increase in case finding particularly in adolescents and young people (yield at 10.7% in FY22Q1). To avoid any missed opportunity to test exposed infants and at high-risk mothers, PEPFAR will leverage the high national coverage in immunization to provide EID to exposed infants and offer HIV testing to mothers at immunization services.

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.[13]

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 COP22, the focus will be to optimize 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 COP20/21 surge interventions and leveraging the OVC and KP platforms

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.

Identifying **undiagnosed CLHIV** will continue to be one of the COP22 PEPFAR priorities. Best practices from the Pediatrics surge and Peds CoT RCA findings will be expanded to improve the pediatric continuum of care in COP22. PEPFAR Burundi will strengthen support to complete index testing of 100% of all biological children <19 years of women 15+ by ensuring index testing SOPs are used 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, and increasing the use of Youth Friendly Services by adolescents. Within the PMTCT program, PEPFAR will reduce missed opportunities to find infants LHIV through assessing all potential entry points for HIV-exposed infants, including immunization, OVC, and through the KP program.

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

In FY23, to build on experiences in the Peds Surge, PEPFAR Burundi will continue to work collaboratively with the NACP and other stakeholders to incorporate WHO guidance into national policies and to develop tools, job aids, SOPs, and education material dedicated to children and adolescents.

For **adolescents** not reached through the OVC program, PEPFAR Burundi will continue to support index testing of those adolescents who have a biological parent or sibling LHIV <19 years through facility and community platforms, including KP platforms; and also the use of their social network for HIV testing (SNS HIV testing modality) as well as the HIV self test when applicable. The clinical programs will collaborate with the OVC program to support index testing for biological children <19 years of women LHIV. In addition, PEPFAR Burundi will work with IPs to support health care providers to provide HIV tests for 12+ years as integrated in national policy. To ensure that services are responsive to adolescents, peer support for those newly diagnosed will be implemented, and evidence-based approaches (e.g., modeled on the Zvandiri program[14]) will be used, creating flexible/extended hours at facilities as well as adolescent-friendly centers.

In COP22, 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 <19 years of women who test positive. Adult women will also be reached through index testing with men as index clients. Through all modalities, the program will support referrals to intimate partner violence (IPV)/GBV and social risk reduction services. In addition, to avoid any missed opportunity to test women, PEPFAR Burundi will work with the NACP, MCH and immunization programs to integrate systematic targeted HIV testing services for women attending postnatal care and immunization services.

To improve HIV case-finding for **key populations**, the program will adapt results from the GFATM-funded KP-specific IBBS, when these results are released. 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 to offer 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 offered testing services. 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 FSWs as a strategy to engage higher risk men, including men who purchase sex and long-term partners of FSWs.

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

[14] 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

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 COP22, HIV recent infection surveillance will be implemented in Bujumbura Mairie and Gitega as approved in COP21 by the MSPLS and the RBI. 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 15 years old. Recent infection surveillance data will be used to identify which subpopulations have higher proportions of new HIV infections and identify clients with long term infections. These clients and associated geographic areas will be prioritized for future HIV prevention interventions and become a focus for targeted case-finding interventions. Results and overall data quality will be reviewed in interagency discussions on a biweekly basis, and site monitoring will take place one-month post-implementation and quarterly thereafter.

Implementing partners will also support the MSPLS at the district level to improve the quality of testing services, geo-target RTK distribution based on performance, expand youth-/men-/KP-competent services in facilities and through targeted outreach, and gradually integrate HIV testing services within primary health care platforms (e.g., FP/MCH/HIV).

Implementing partners will also work with each Health District to create a center of excellence on case finding at District Hospital to accompany health facilities, using the learning by doing principle, to improve quality of testing, care and treatment services. The team for excellence on case finding will be formed on the basis of technical area performance.

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 - 22	Key testing strategies
Children <15, including OVC	Pediatric case finding has become more efficient with expanded family-based index testing. In FY21 Q1 81% of all CLHIV were identified through index testing.	• Active facilitation of testing for all children at risk of HIV infection • Increased offer of index testing and partner notification services to parents LHIV on ART (especially FSW) and siblings LHIV to identify biological children (<19 years) who may not yet be diagnosed • 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 • Increase access to infant virological testing/EID (more in Section 4.8) to increase the number of HIV-exposed infants tested by two months of age through (a) demand creation activities in mentor-mother groups and (b) reducing sample turnaround time.

Adolescents and young people (10-24)	Evidence shows that this age group is less likely to get tested because (a) testing services are unwelcoming or inappropriate for younger people due to HIV-related stigma, age-related stigma and discrimination from healthcare workers, and (b) laws that limit young people's ability to access services on their own.	• Index testing (with a focus on community index testing) • HIV self-testing • Social network services • Youth-friendly services (community outreach, facility settings) • Improved collaboration between OVC and clinical partners to ensure that eligible children (and caregivers) are tested for HIV and linked to ART, as appropriate • Referral of eligible children by clinical partners to OVC programs • Increased offer of index testing and partner notification services to adolescents LHIV (ALHIV) and to ALHIV who are not virally suppressed
Adult women (15+)	Women have the highest testing rates in Burundi; in particular women between the ages of 20-29.	• ANC platforms will ensure 100% offer of HIV testing to all women entering ANC (with linkages to PrEP and PMTCT programs as needed) • Integrate systematic targeted HIV testing in postnatal, MCH and immunization services • Increased offer of index testing and partner notification services to men LHIV • Increased offer of index testing and partner notification services to adult women on ART (15+) who are not virally suppressed • Implementation of HIV recent infection surveillance
Adult men (15+)	Evidence indicates that men are less likely to get tested for HIV in non-clinical settings, and less likely to accept index testing in facilities.	• Index testing (focusing on ANC, STI clinics, through FSW, with referrals to IPV/GBV services as indicated) • Targeted community-based testing, workplace, venues for at-risk men, and home-based testing • Use of FSW platform to reach and test men who purchase sex and long-term partners of sex workers • Self-testing (for hard-to-reach men) • Social network services • Male-friendly testing services ("men-only" and evening clinic hours) • Increased volume of index testing for men on ART who are not virally suppressed • Implementation of HIV recent infection surveillance
Key populations	Testing services for KPs must be highly targeted, using strategic information and network analyses to ensure high quality, data-driven outreach	• Expand and/or relocate KP services to target unsaturated hotpots • Optimize self-testing, social, and sexual network testing for MSM, FSW, PWID and TG • Strengthen virtual strategies for case finding linkage and continuity of treatment • Maintain drop-in centers, mobile testing (hotspots, informal settlements) • Prioritize support for KPLHIV who are not virally suppressed

		● Use of online communication platforms and information communication technology
Military	Index testing has been a highly effective strategy to identify military/male cases compared to other testing modalities.	● Elimination of high-volume/low-yield HTS modalities ● Intensive focus to high-yield modalities and increased offer of index testing and self-testing to prioritize contacts of people newly identified PLHIV, and clients on ART who are not virally suppressed ● Self-testing ● Social network services ● Implementation of HIV recent infection surveillance

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

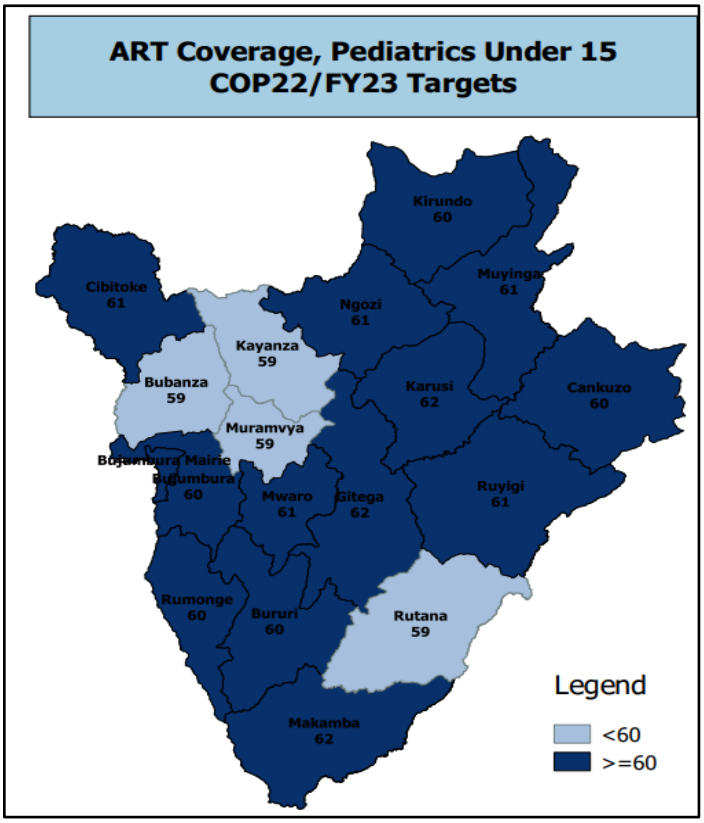
ART Coverage Gap

Children, adolescents, and young men will be the focus of intensified efforts to close the ART treatment gaps in COP22. 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 15-39 years of age (Table 4.1.2). For CLHIV <15 years, only 35 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).

Table 4.1.2: Gap Analysis for 95-95-95 Achievement Across Programs

	PLHIV estimates			1st_95			2nd_95			3rd_95		
Age	Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total
<01	86	91	177	742%	33%	377%	4%	100%	8%		50%	50%
01-04	733	754	1487	24%	22%	23%	98%	91%	92%	75%	77%	76%
05-09	976	993	1969	45%	45%	45%	98%	95%	96%	87%	86%	86%
10-14	1372	1391	2763	58%	55%	57%	99%	95%	96%	93%	91%	92%
15-19	1992	1744	3736	77%	58%	68%	99%	97%	96%	92%	92%	92%
20-24	3169	2299	5468	117%	50%	89%	98%	96%	95%	95%	91%	94%
25-29	4727	2981	7708	117%	58%	94%	98%	95%	94%	95%	93%	94%
30-34	5944	3554	9498	102%	59%	86%	99%	95%	95%	95%	93%	95%
35-39	5686	3248	8934	120%	89%	108%	99%	93%	94%	96%	93%	96%
40-44	5983	3400	9383	110%	98%	105%	99%	92%	94%	96%	95%	96%
45-49	5260	2856	8116	118%	117%	118%	99%	93%	94%	97%	97%	97%
50+	11671	8165	19836	95%	109%	101%	99%	94%	95%	97%	97%	97%
Total	**47599**	**31476**	**79075**	104%	82%	95%	98%	94%	94%	96%	95%	96%
				Under 50%			50-90%			Over 90%		

Figure 4.1.2: ART coverage by district among children under 15 (%)



Source: COP22 Data Pack

Linkage to ART

For Q1 FY22, linkage to ART for clients identified in PEPFAR Burundi's programs is 98%, an increase from 75% in COP19. In COP22, 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 update Memorandums of Understanding (MOUs) as needed 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 COP22 will also be in tracking linkages to other services. A key element of the linkage process in the context of person-centered services is to obtain consent from the client for follow-up activities that may be conducted by CHWs, health mediators, or peer navigators as well as mother-mentors and male "champions" in the PMTCT context. 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.

Due to the COVID-19-responsive policies developed by the MSPLS, PEPFAR Burundi successfully supported the scale up of 3-month MMD for PLHIV on ART from 0% in FY20 Q1 to 91% in FY22 Q1. Among CLHIV, 71% are on 3-month MMD as of FY22 Q1. PEPFAR Burundi will continue to support the NACP to scale up 6-month MMD to eligible persons in COP22. PEPFAR Burundi has also supported the NACP on the transition to optimized regimens across Burundi, as detailed in Section 4.5 and in 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 initiated 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, and the completion of a phase out of EFV-based regimens and NVP-based regimens in children. Since COP21, pediatric DTG (DTG10) has been available in Burundi, and PEPFAR Burundi will ensure the finalization of the transition of eligible C/ALHIV onto DTG10. However, few children are yet on MMD, which is a patient-centered approach that can enhance continuity of treatment for children and their families. PEPFAR will regularly review pediatric ART cohorts to identify

children on suboptimal regimens, and work with stakeholders to develop implementation plans to roll out MMD3 and MMD6 to eligible children <15 years, including transition plans and provider training. To further support ART initiation for C/ALHIV in COP22, PEPFAR-supported sites will continue to encourage family-based appointments on the same day and with the same provider for the whole family.

At least 90 percent of C/ALHIV 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, experiencing interruptions in 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. In non-OVC-supported provinces, C/ALHIV 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 adult treatment.

Health districts with the largest gaps in CLHIV on ART will be prioritized for the implementing use of best practices from Pediatric Surge activities to consolidate successes in linkage to ART, as well as gains made from COP19 to COP21 in ART optimization and TPT along with above-site coordination. PEPFAR will continue to train, mentor, and provide supportive supervision to providers at site and district levels on CLHIV care and treatment, including age-appropriate status disclosure and transition to adult care that reflects the national guidelines.

Treatment for Key Populations

For KP in COP22, 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 sites for stronger linkage and continuity of treatment. Working directly with KP-led and KP-competent CSOs, as well as community health workers, peer educators and peer navigators who are trusted by the KP clients/patients 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 analyze continuity of treatment, adherence and VL outcomes, the program will support providers and KP clients on the U=U strategy and will scale eCascade, an app designed specifically for KPs.

4.2 ART continuity and ensuring viral suppression

4.2.1 Retaining PLHIV on treatment

Multi-month dispensing

In COP 22, to maintain PLHIV in care, PEPFAR Burundi will focus on scaling up the offer of MMD6. As of Q1 FY22, 91% of patients were on MMD3 and only 1% on MMD6 (Fig.4.2.1). During COP21, PEPFAR will support the NACP to operationalize and scale up MMD6.

Figure 4.2.1: Number and Percent Contribution of Clients Receiving MMD by Age/Sex, FY21

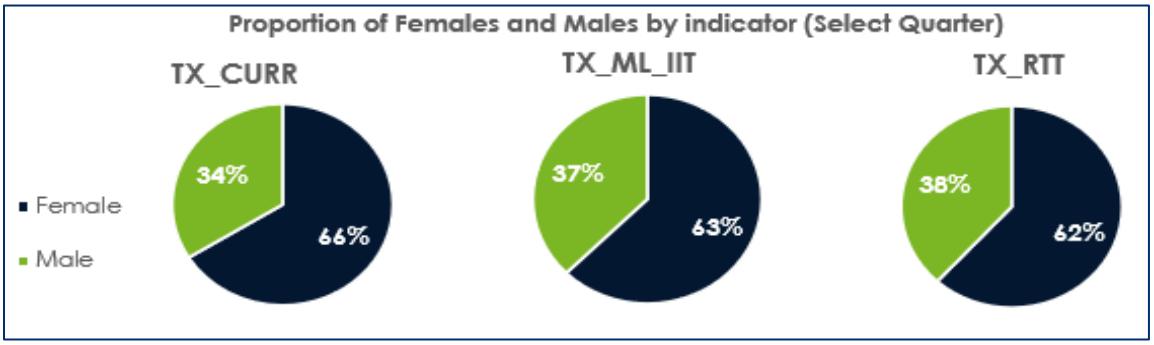
Source: Panorama

Continuity of Treatment Root Cause Analysis

During FY21, PEPFAR Burundi noticed a decrease in the TX_CURR ART cohort and a concomitant increase in clients experiencing interruption in treatment. In Q3, PEPFAR Burundi launched a Root Cause Analysis (RCA) in 20 sites with high numbers of clients experiencing IIT. This RCA helped to identify the main cause of IIT and therefore identify ways to ensure CoT for clients on ART.

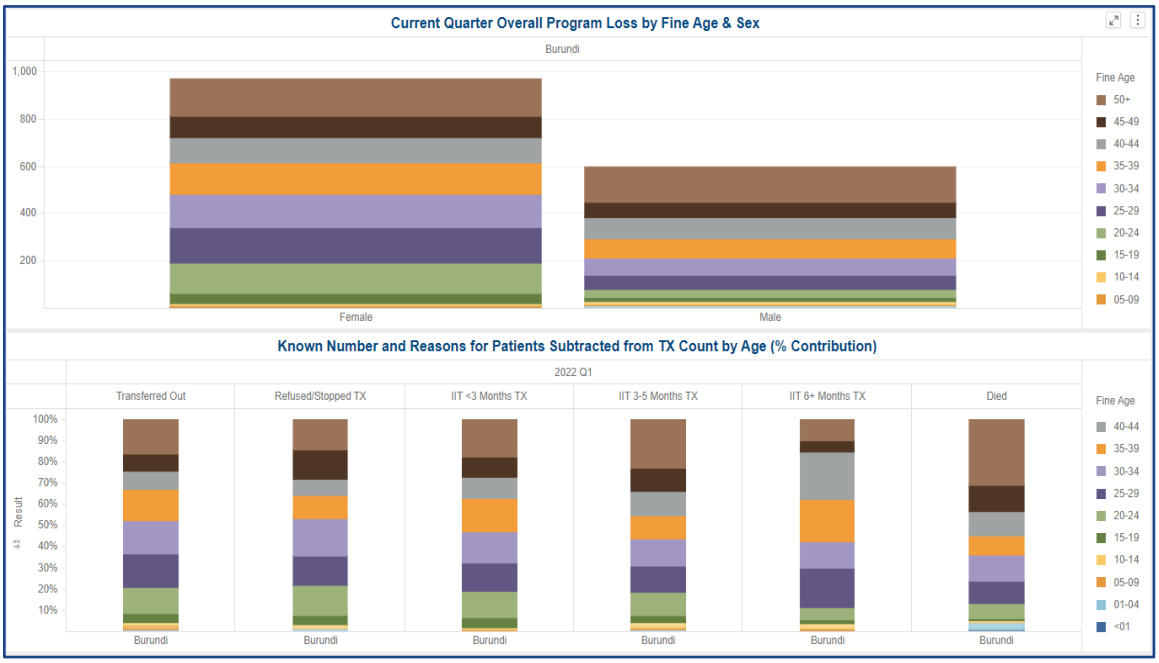
In Q1 FY22, more female PLHIV interrupted treatment compared to male as seen in Figure 4.2.2, likely due to women representing 66% of the cohort, as seen in Figure 4.2.1.

Figure 4.2.2: Proportion of females and males by indicator



Source: CoT Dashboard

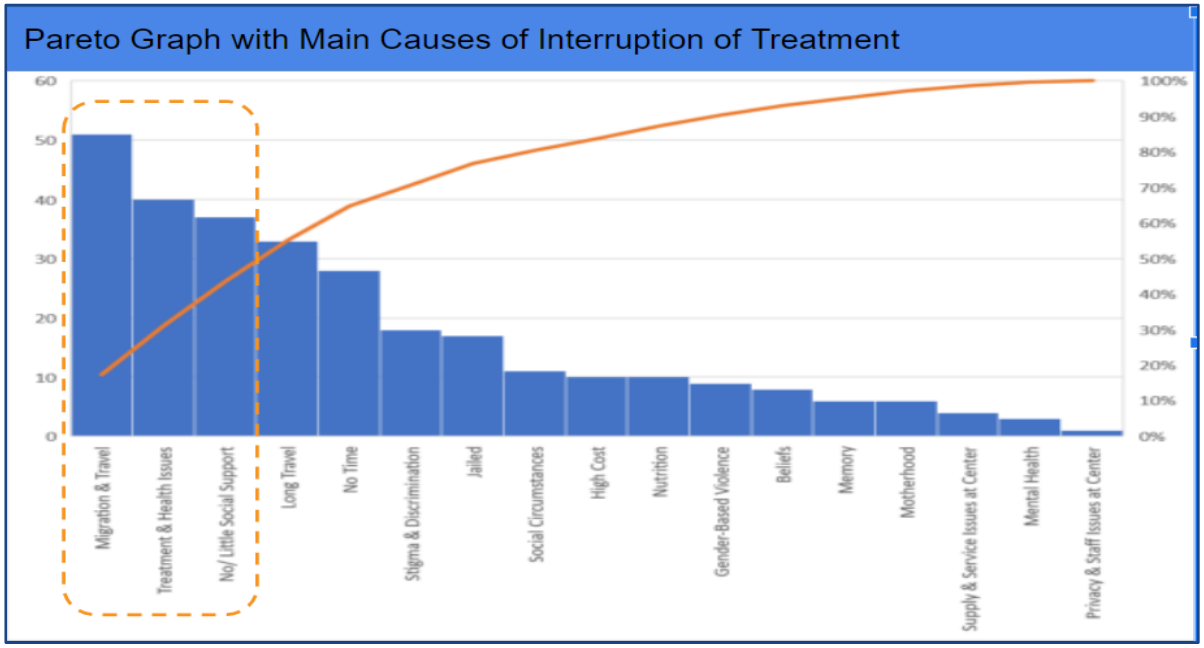
Figure 4.2.3: Timeframe for patients leaving treatment, by age/sex (FY22 Q1)



Source: Panorama

The reasons for interruption in treatment vary by population, as shown in Figures 4.2.2 above and 4.2.3 below from RCA results from COP21.

Figure 4.2.4: Reasons for interruption in treatment: RCA Results in 20 sites



Source: RCA Results

In COP22, PEPFAR Burundi results show positive growth from COP21 of the ART cohort. The following interventions contributed to this improvement: early active tracing & tracking of patients, person-centered approaches with harmonization of ARVs pick-ups, treatment adherence and continuity support and community/peer involvement. The web-based version of Sida-Info and the unique identifier (UID) which are being expanded during FY22 will also contribute to improve retention in care and therefore to treatment growth. PEPFAR Burundi is also leveraging the RCA findings to develop CoT strategies which aim to address specific factors contributing to poor continuity of treatment at a site level, through demand creation and effective, person-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 and clubs adherence groups for children and adolescents, will be reinforced to support continuity of treatment in care and/or track clients in interruption in treatment.
- **At the facility level,** patient management approaches will include the optimized use of the SIDAInfo EMR, the biometric unique identifier web-based and CommCare systems for tracking and communicating with clients, along with the national expansion of MMS/MMD. IPs will produce continue to implement routine data collection using the

RCA protocol 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 continue to support the transition from paper-based systems to SIDAInfo, while increasing the interoperability of SIDAInfo 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, which has shown positive results: as of March 2022, 28645 patients in PEPFAR supported-sites were enrolled in the UID system.

In COP22, 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 continue to carry out several analyses to understand the profile of children who interrupt treatment and to develop interventions tailored by age and site, including an aging 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, maintain OVC linkage coordinators/focal persons at facilities, maintain data sharing agreements and case conferencing meetings, and ensure integration with ANC, EID, clinical and community programs. The existing bidirectional referral network will continue to be strengthened between the PEPFAR clinical program and the OVC program to ensure coverage of services, including TB symptoms screening, and to continue 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. In Burundi, AGYW have the highest rates of new infections. As one of the most effective ways to prevent new infections, PEPFAR Burundi will continue to advocate for AGYW to be eligible to receive PrEP.

Key Populations

For COP22, 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 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 2021, according to DHIS2 data, 46,914 (over 100 percent) of the estimated 44,432 adult women (15+ years) living with HIV in Burundi were on ART . 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 TLD 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 NACP 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 2021, according to DHIS2 data, 24,075 (85 percent) of the estimated 28,247 adult men (15+ years) living with HIV in Burundi were on ART ; linking men to ART and keeping them on ART is a priority for COP22. 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 initiatives 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 counseling during ARV procurement.

4.2.3 Ensuring viral load access and suppression

Figure 4.2.5: Viral Load Outcomes, FY21

Source: Panorama

In COP21, PEPFAR in partnership with the NACP and other laboratory stakeholders initiated a diagnostic network optimization process (DNO). In COP22, PEPFAR will complete the DNO activities for VL/EID/TB 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
    e. Use of POC and near-POC for VL for pregnant women
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 person-centered approaches to prevent loss and improve continuity of treatment such as MMD, PODI, DDD App

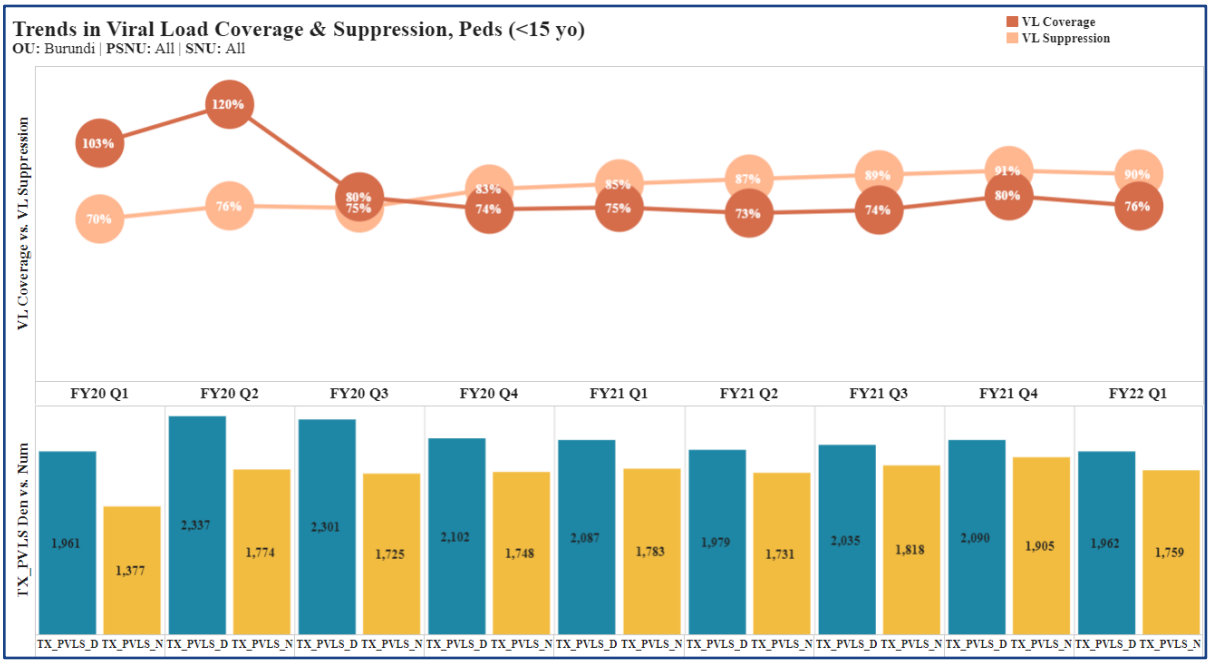
5. Accelerate ARV treatment optimization to ensure full access for all eligible clients
6. Scale-up the new version of SIDA-Info (web-based + UID) + Interoperability with IBIPIMO
7. Improvement of community engagement

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

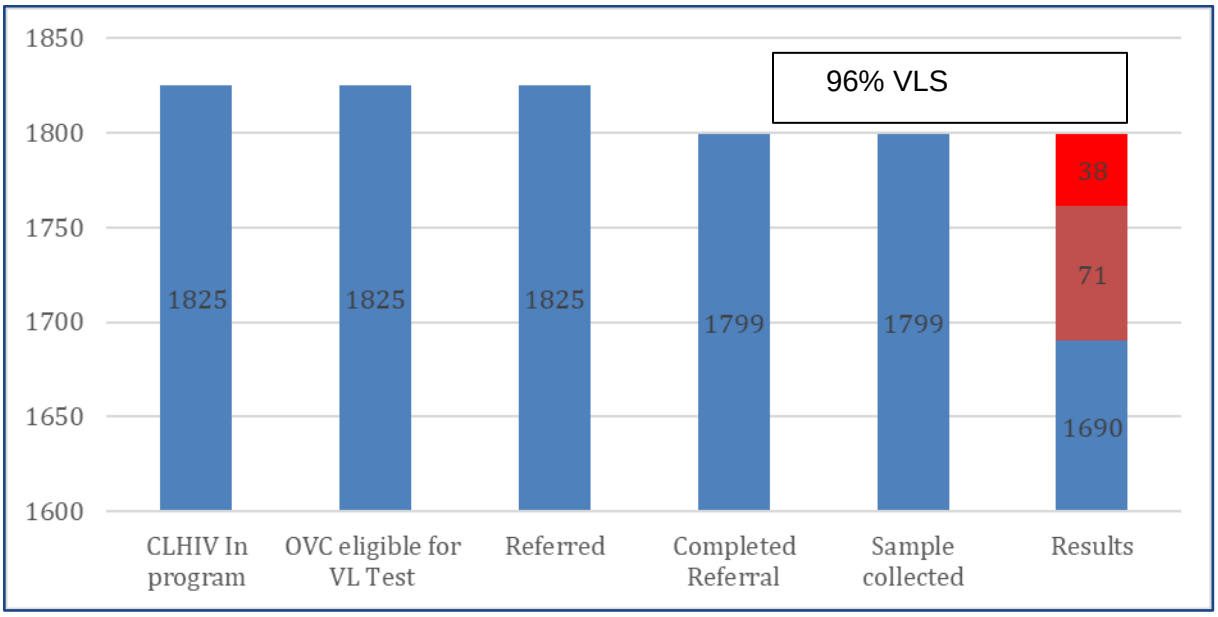
Among children under 15 years of age, viral load suppression was 90% and viral load coverage was 76% in FY22 Q1 across PEPFAR-supported sites (Figure 4.2.6). Notably, VL suppression among CLHIV enrolled in the OVC program reached 96% (Q1 FY22, Figure 4.2.7). These experiences from the OVC program and best practices will be shared through the Peds Surge, with the COP22 goal for 90-95% viral load suppression among CLHIV across all health districts (Figure 4.2.8).

Figure 4.2.6: Viral load coverage and suppression trends among children FY20 to FY22 Q1



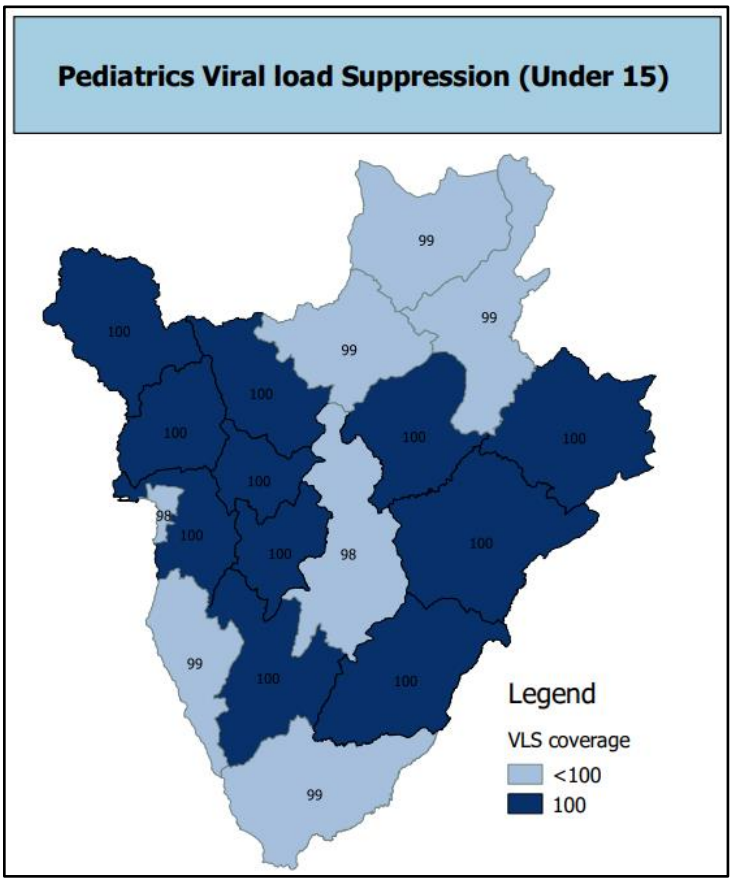
Source: Tableau

Figure 4.2.7: Viral load coverage and suppression trends among OVCs as of FY22Q2



Source: Wiyzire Fy22Q2 report

Figure 4.2.8: Pediatric viral load suppression targets by district, COP22



Source: COP22 Data Pack

In COP22, as part of the gains from the COP20 and COP21 Pediatric Surge, PEPFAR will continue to ensure the provision of 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 test availability. In addition, the implementation of family centered DSD models will facilitate viral load specimen collection for children. In COP22, PEPFAR will procure pediatric blood draw commodities (including smaller gauge winged/butterfly needles) to improve viral load coverage rates for children under 5 years of age, which have been historically <50%.

Implementing partners will continue to support VL sample collection and transportation for pediatrics and adolescents, monitoring VL registers and/or data in SIDAInfo, and providing

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 C/ALHIV 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 C/ALHIV 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. To address viral load coverage gaps, the program will work with KP and CSOs communities, as well as PLHIV networks to instill a social norm around VL testing.

Adult Women

VL coverage among pregnant adult women in FY22 Q1 remains low (66%) even though it has improved since prior quarters. To ensure pregnant and breastfeeding women receive timely VL monitoring and appropriate clinical management to reduce the risk of vertical transmission, COP22 community interventions will focus to create and promote demand to test in ANC1 and EID 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 SOPs are in place at labs and health facilities to rapidly identify women with an unsuppressed viral load (as defined by national guidelines) for clinical intervention.

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 is lower than that of women across all 15 and older age bands in FY22 Q1. Male-friendly 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.

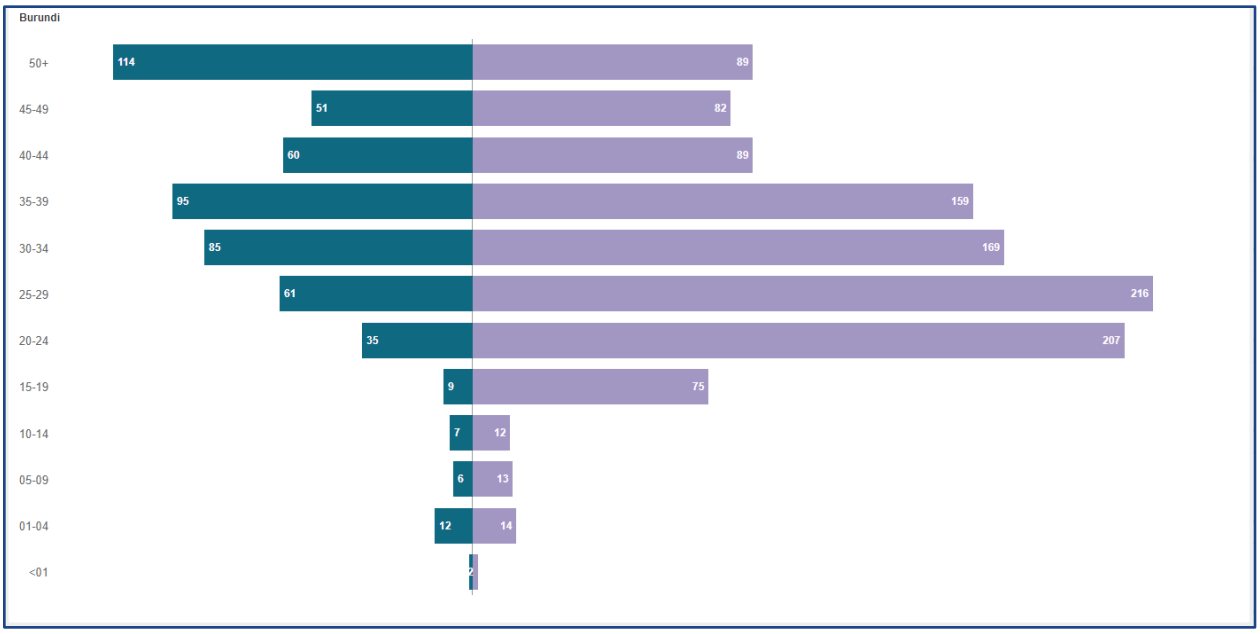
4.3 Prevention - Priority programming

In COP22, 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

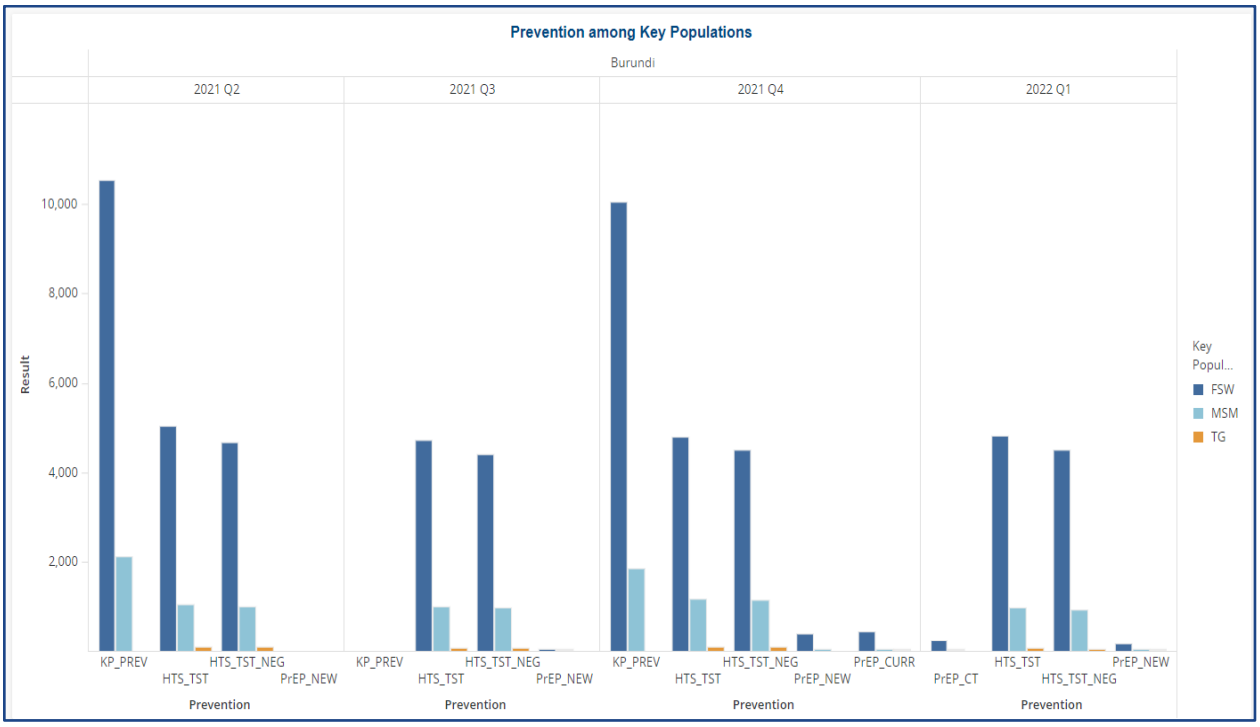
In COP22, PEPFAR Burundi will support the NACP to expand PrEP for HIV-negative at-risk individuals. Target populations include KPs and serodiscordant couples in alignment with national guidelines. As women aged 15-29 are the population with the greatest number of new HIV infections in 2021, PEPFAR Burundi will continue to advocate with the MOH to include AGYW as a priority population to receive PrEP. 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.

Figure 4.3.1 Age distribution of HTS_TST_POS by sex, FY22 Q1



Source: Panorama

Figure 4.3.2 Prevention Continuum by Key Population Group



Source: Panorama

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

In COP19, PEPFAR Burundi launched GIR'ITEKA, a three-year activity with the objective of improving the integration of GBV prevention and response into HIV services. This activity has SWAA Burundi, a local Burundian organization as its prime partner and is focused on ensuring that GBV identification, prevention and response is integrated into all PEPFAR-funded HIV prevention and care interventions. In COP22, with the GIR'ITEKA mechanism ending, a new award will be introduced to continue SWAA Burundi's GBV programming. The main areas of focus include improving GBV and HIV prevention for adolescent girls, young women, and key 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, including PrEP and PEP uptake. 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. It also works to engage religious and community leaders to promote GBV prevention, refer survivors of violence to post-violence care, and create strategies to prevent sexual violence in adolescents and children.

4.3.3 AGYW and Children

The OVC program will focus on supporting girls and boys 0-17 years and their caregivers with HIV prevention services, with special emphasis on supporting C/ALHIV on ART to reach viral suppression through better adherence to optimized treatment regimens, peer support groups, and OVC-clinical case conferencing meetings. Adolescent boys and girls 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. As women aged 15-29 are the population with the greatest number of new HIV infections in 2021, PEPFAR Burundi will continue to advocate with the MOH to include AGYW as a priority population to receive PrEP. The OVC program will support eligible adolescent girls who have dropped out of school due to pregnancy, to petition and re enroll in school.

4.3.4 Key Populations

COP22 will see the advent of two local partners assuming the role of primary IP, recognizing a shift to more locally-focused strategies for implementation. The new local 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, CSOs' clinics, and KP-specific drop-in centers that include both prevention and treatment services. The KP program will also expand services at KP friendly public facilities and private clinics.

In COP22, the KP 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, including U=U messaging to instill demand creation, 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 substantially increase the number of KPs tested and linked to treatment. Strategies include optimization of Enhanced Peer Outreach Approach (EPOA) 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, decision-making 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 IBBS 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 serodiscordant couples, AGYW and FSW who interact with militaries; 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 COP22, PEPFAR will continue to 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, mentor-mothers, champion men, clinical programs) and will work with the NACP to enable their enrollment on PrEP. PEPFAR will also support implementation of maternal re-testing approaches for high-risk HIV-negative women in targeted entry points following the first ANC visit (ANC1) to identify incident infections during pregnancy and breastfeeding, e.g., labor and delivery, postpartum FP services, MCH/immunization clinics. Using this approach, HIV-exposed infants identified through maternal re-testing approaches will be followed up and provided with comprehensive services. PEPFAR will also support testing of 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 COP22 Planning Level Letter

Starting in COP18, PEPFAR Burundi has ensured implementation of context-, age-, gender-, and systems- specific approaches to significantly improve case-finding, linkage, 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 COP22 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 COP22, the district approach will continue to focus on districts with low ART Coverage under 90%: Rumonge, Ruyigi, Muramvya, Ngozi, Cibitoke, Mwaro and Makamba . Sites are continually enrolling new patients through generally successful testing and linkage strategies. In Q1FY22, the program has reverted, enrolled and maintained more clients on ART, thus reversing the negative trend of TX_NET_NEW from the last 3 quarters. Based on data analysis, on district-level assessments by implementing partners on obstacles to success, and on best practices from successful districts, in COP22 PEPFAR Burundi will continue to focus resources on technical assistance for provinces with challenges for the following priorities: to (1) increase case finding, (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) increase access to VL testing and improved suppression through adherence support, especially among PBFW and children.

PEPFAR Burundi will work together with IPs to analyze district-level data and perform programmatic deep-dives into successful approaches to improve continuity of treatment, pediatric and PMTCT services. Districts that are performing well will share lessons to strengthen continuity of treatment and to improve pediatric and PMTCT services. IPs and DHTs will support data-sharing meetings for providers to understand when and why they may be losing clients so they can develop and implement remediation plans. PEPFAR will continue to support socialization of the unique identifier (UID) concept and solicit PLHIV feedback on the format, as efforts are made to roll out UID 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, and U=U. In COP22 PEPFAR will also continue to support MMD rollout and scale-up of DSD models, as well as *groupes de paroles,* or support groups using adherence champions.

4.4.2 Effective implementation of client-centered services

DSD models, such as Community Adherence Groups (CAGs), community drug distribution points (PODI), MMS/MMD; and extension of clinic hours, will be offered to PLHIV on treatment in an effort to develop a person-centered approach, with person-centered solutions to reduce barriers to continuity of treatment.

DSD (Differentiated Service Delivery) models have been adopted as national policy, but are limited to the CAG model with slow implementation due to lack of implementation guidelines. In COP21, PEPFAR is supporting the development of DDD national guidelines, implementation plan and SOPs for the current policy to ensure that it contains diversified DSD models and can be rapidly implemented. PEPFAR Burundi will continue to require IPs to ensure rapid scale-up of different DSD models for all eligible patients in COP22.

Based on the evidence that DSD models are effective interventions to retain patients on ART, PEPFAR will provide support to the MSPLS to ensure the policy is implemented across sites.

To monitor the implementation of the DSD model and capture individuals who are receiving HIV services in these models, particularly for ARVs refill, there are tools and materials that are being used by the community group leaders to report to the Health Facility Centers. In addition, to improve this monitoring in real time, a DDD application web-based, named HAFI App, is under development in COP21 and will be deployed in COP22. Hafi (or "Close") was chosen to imply that clients can obtain ARTs and other commodities for prevention (TPT, cotrimoxazole, etc.) at a closer location to where they live, i.e. the community level. Hafi App is designed to be a module of SIDAInfo and to be used for data collection tools and management of DSD model information nationwide. In COP 22, PEPFAR Burundi will work closely with the MOH to support the use of the Hafi App to contribute to CoT.

Six-month MMS and three-month MMD have been adopted as national policy and eligibility criteria expanded to women of reproductive age, and children 2+ years old. While MMD3 is already implemented, there is a slow start up of MMD6. In COP 21, PEPFAR is supporting development of a national implementation plan and SOPs for the current policy and ensuring rapid roll-out of MMD6. In COP 22, PEPFAR Burundi will task its IPs to ensure a rapid scale-up of MMS/MMD6 for all eligible patients.

In addition, PEPFAR Burundi will work with the MSPLS to advocate for national adoption of the current PEPFAR guideline to extend MMD6 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 MMD6 is implemented at the site level. Specific questions will be integrated in SIDAInfo in order to anticipate patient needs for longer MMD. PEPFAR Burundi, in coordination with the MSPLS and partners, will ensure continuity of communication with patients on MMD, and appropriate referral for clinical visits when necessary.

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 SIDAInfo web based with UID, including training, maintenance, updates, and

operationalizing the transition to a web-based version with dashboards which will include recency data 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.

In COP21, PEPFAR in collaboration with other GoB partners initiated the implementation of an end-to-end electronic logistic management information system (eLMIS) to track commodities and stocks along the pipeline. In COP22, PEPFAR will enhance the functionality of the eLMIS and scale it up. The eLMIS will improve efficiency as it will be able to 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 SIDAInfo.

4.5 Additional Program Priorities

During COP20 and COP21, PEPFAR supported the country to amend policies and guidelines to introduce new optimized ART treatment with the introduction of Dolutegravir (DTG) based medicines for both adults and children. Under the leadership of the national HIV council, Burundi is updating the national strategic plan for the next five years. PEPFAR is advocating for the integration of new evidence based strategies such as MMD6 scale up, the use of PrEP services for adolescent girls and young women, expanding HIV services to injectable drug users as part of the key population package, community led monitoring, and improved ethical index testing. The policy changes and harmonization between the HIV program and the TB program for the use of 1HP for TB preventive treatment (TPT) is ongoing. PEPFAR will help accelerate those policy changes. PEPFAR will support policies that aim to reduce HIV stigma at all levels including service providers and health clinic levels.

During COP22, the scale up of index testing will be continued in alignment with PEPFAR Guidance on Implementing Safe and Ethical Index testing in all PEPFAR-supported sites. Continuous supportive supervision will be done by the IPs at site level over the quarters. In order to ensure compliance with the PEPFAR Guidance, SIMS tool will be used and re-evaluation for sites that do not comply fully will be done in the next months to ensure that all required CEEs are met at the site.

Program data analysis, the new spectrum estimate, and the expected IBBS results will drive the programming in COP22 to follow the trend of the epidemic and provide targeted interventions to specific sub-populations, provinces and districts. Data analysis has shown a high number of CLHIV but low ART coverage in the district of Ngozi suggesting the extension of the OVC program in Ngozi. An analysis of the district approach has shown that there are opportunities to reshape the strategy and improve it to improve HIV programming at the district level through

effective last mile supply chain, improve data quality and analysis, and optimized lab services for viral load and EID testing. Further, the district approach will build the capacity of centers of excellence among district hospitals to mentor and support low volume sites that are not directly supported by the PEPFAR program. COP22 will expand support to injectable drug users (PWID) based on additional data made available during the COP22 planning process.

PEPFAR/Burundi is working to finalize its strategy for community-led monitoring (CLM) for COP22. COP22 investments include a new funding mechanism to provide small grants to CSOs to monitor and help improve the quality of services for PLHIV and KPs by strengthening community/facility linkages and communication pathways. A new coordination mechanism composed of CSO advocates: Croix Rouge, PNLS, CNLS, UNAIDS, and Global Fund representatives, will be included in the process. The coordination mechanism will be put in place to improve PEPFAR/Burundi's ability to leverage resources and activities across a broader range of partners at community level, including CSOs conducting CLM.

4.6 Commodities

In COP21, the MSPLS transitioned to new testing algorithms with new RTKs and scale up the optimized ART regimens with the transition to TLD and introduction of pediatric dolutegravir (DTG10). By the end of COP21, all eligible adolescent boys and girls, adult men and women, including pregnant and breastfeeding women will be receiving DTG-based regimen.

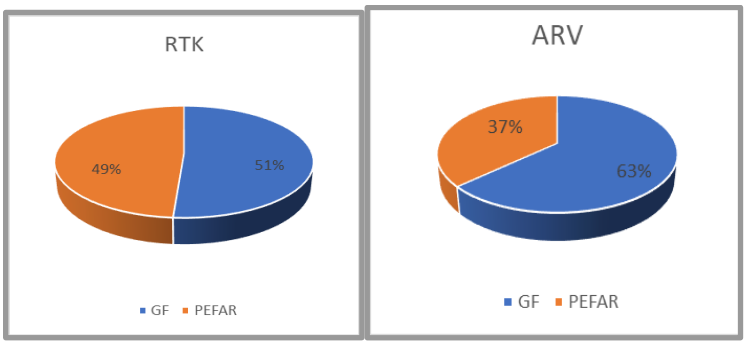
Pediatric regimens were updated and include DTG 10mg for pediatric patients under 20 kgs of weight and regimens that include DTG 50mg for patients who weigh between 20-30 kgs. Pediatric dolutegravir was introduced in October 2021 and all eligible children are expected to transition to DTG-based regimen by the end of COP21.

In COP21, PEPFAR complemented the GFATM to procure 90- tablet bottles of TLD- in quantities that enabled the country the scale-up of MMD 3-6 months with no stock-outs.

In COP22, PEPFAR will complement GFATM and the GoB to procure SD BIOLINE HIV/Syphilis Duo for PMTCT, Determine Early Detect, SD Bioline HIV-1/2 v3.0, HIV One Step Anti-HIV 1&2 and Oraquick Self tests for testing of targeted populations including OVC and KP.

The GFATM and PEPFAR will continue to be key players in the procurement of HIV commodities. GFATM will support the procurement of an estimated 63 percent of ARVs, 51 percent of HIV tests and 35 percent of VL tests in FY23 , and PEPFAR is supporting 37 percent of ARVs, 49 percent of HIV tests and 65 percent of viral load testing through the all-inclusive services approach.

Figure 4.6.1: COP22 donor contribution to ARVs and RTKs



Source: Burundi Supply Plan Tool, 2022

Burundi is fully transitioning to optimized regimens by September 2022. In COP22 PEPFAR will procure 60,000 doses of TLD-90 for $1,020,000 to cover 15,000 adults, 9,244 doses of pediatric ABC/3TC, 3,737 doses of pDTG.

PEPFAR Burundi will continue to support the "All-Inclusive Agreements" (that include platform lease, reagents, consumables, service, maintenance, etc.) to increase VL and EID testing access. In COP22, PEPFAR will cover the lease contract cost of two platforms to complete at least 52,296 VL tests and procure 4,410 kits for emergency VL testing (especially for pregnant women).

In COP22, PEPFAR will procure 15,008 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 4,464 HIV-exposed infants.

In COP22, PEPFAR will procure pediatric and adult TPT doses for 3,838 adults.

To support the initiation of PLHIV on TPT, PEPFAR Burundi will also procure 2,100 GeneXpert MTB/RIF cartridges to complement the quantity already supported by the GFATM.

In COP22, PEPFAR will procure 2,875 boxes of 3,000 condoms for the amount of $400,000 to complement the Global Fund, PSI and the GOB procurements.

For rapid test kits, PEPFAR will procure 150,000 Early Detect tests, 45,700 SD Bioline tests, 8,750 One Step tests, 210,125 HIV/Syphilis Duo tests, and 75,750 self tests.

4.7 Collaboration, Integration and Monitoring

4.7.1 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 since 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

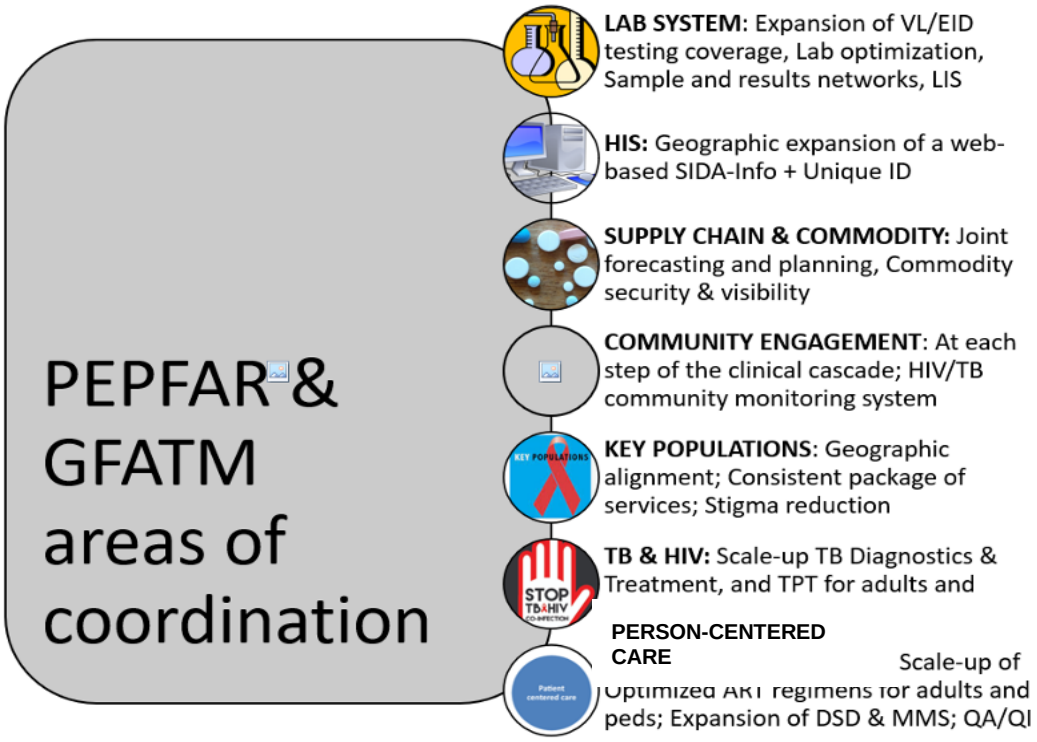
implementation context. In COP21, monthly coordination meetings between UNDP and USAID commenced to further improve collaboration and these meetings will continue in COP22. .

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.

During the development of COP22, the collaboration between GFATM and PEPFAR was further strengthened through weekly discussions with the Burundi SGAC chair and program manager. With the 18% budget cut for PEPFAR Burundi, these weekly meetings with GFATM were key in identifying approaches for funding complementarity. PEPFAR Burundi is grateful for the partnership with GFATM, as GFATM will be covering more of the commodities gap in COP22 to ensure that Burundi stays on track to reach and sustain epidemic control.

PEPFAR Burundi and GFATM continue to have a common vision and shared national priorities that are aligned along the funding streams and in support of the NACP's vision and national priorities. The key areas of synergy between PEPFAR Burundi and GFATM 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 4.7.1: 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 European Union) 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.

4.7.2 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 encourage IPs to work with Health Districts to create a center of excellence on achieving the three "95s" at district hospitals.

PEPFAR Burundi will work also with implementing partners to 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.
- to maintain the completion of the TLD transition of all eligible patients at all sites and provision of optimal ART regimens for all patients at all sites they supervise, including complete phase out of non-optimized regimens.
- 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)
- the optimization of the lab investments to benefit individuals (EID, VL).

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 on 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.

4.7.3 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.

PEPFAR/Burundi will also continue coordination 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. Of note for COP22, PEPFAR and GFATM will work to align CLM strategies, based on models already working in West Africa. 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.

4.8 Targets by Population

PEPFAR Burundi COP22 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 71573 PLHIV (95% of the national target). A total of 3987 patients are expected to start ART. In COP22, 94% of PLHIV are expected to have a viral load test and 98% of them are expected to have a suppressed viral load.

Fig.4.1 Key indicators: Children and adults

Burundi		SNU Prioritizations			
		No Prioritization	Scale-up: Aggressive	Sustained	Total
TX_NEW	<15	20	76	79	175
	15+	262	1,226	2,324	3,812
	Total	**282**	**1,302**	**2,403**	**3,987**
TX_CURR	<15	98	1,843	1,997	3,938
	15+	3,790	25,427	38,379	67,596
	Total	**3,888**	**27,270**	**40,376**	**71,534**
TX_PVLS	<15	72	1,767	1,887	3,726
	15+	3,378	24,336	34,256	61,970
	Total	**3,450**	**26,103**	**36,143**	**65,696**
HTS_SELF	<15	-	-	-	-
	15+	265	20,795	41,940	63,000
	Total	**265**	**20,795**	**41,940**	**63,000**
HTS_TST	<15	319	1,576	2,612	4,507
	15+	9,114	164,816	176,476	350,406
	Total	**9,433**	**166,392**	**179,088**	**354,913**
HTS_TST_POS	<15	20	63	64	147
	15+	278	1,477	2,522	4,277
	Total	**298**	**1,540**	**2,586**	**4,424**
HTS_RECENT	**Total**	**241**	**-**	**981**	**1,222**

Table 4.8.1: ART Targets by Prioritization for Epidemic Control

Prioritization Area	Total PLHIV	Additional patients required for 80% ART coverage	Target current on ART (APR FY23) *TX_CURR*	Newly initiated (APR FY23) *TX_NEW*	ART Coverage (APR 23)*
Scale-Up Aggressive	33408	0	27270	1302	**85%**
Sustained(including Military)	45667	0	44264	2685	**100%**
TOTAL	**79,075**	**0**	**71573**	**3987**	**94%**

*The ART Coverage is calculated based on TX_CURR expected at national level at the end of FY23 (74,500)

Table 4.8.2: Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate* (SNUs)	Disease Burden (PNLS Document)*	FY23 Target (KP_PREV)
FSW	**24,714**	**30.9%**	**23,478**
MSM	**6,452**	**5.96%**	**5,414**
PWID	**7,557**	**15.3%**	**758**
TOTAL	**38,723**		**29,650**

Table 4.8.3: Targets for OVC and Linkages to HIV Services

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY23 Target) OVC_SERV Comprehensive	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY23 Target) OVC*
Bujumbura Mairie, Bujumbura Rural, Gitega, Kayanza, Kirundo, Muyinga, Ngozi	37,680	15,788	11,786
TOTAL	**37,680**	**15,788**	**11,786**

4.9 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 the SIDAInfo IBIPIMO application module was set up in all the 7 labs and all labs using GeneXpert to perform EID. Although there is an increase in the use of these GeneXpert machines (69% of EID tests were done on GeneXpert machines as of Dec 2021) - they are still underutilized. In order to increase utilization and increase access to EID, COP22 will focus on demand creation for EID testing.

In 2021, an all-inclusive pricing scheme agreement was signed with Abbott, which includes leasing and full equipment service and maintenance components to replace aged instruments. In addition, a diagnostic network optimization exercise is in progress to improve viral load, EID and TB testing. Twenty-one additional GeneXpert machines are funded by the World Bank as part of COVID-19 testing. These additional POC instruments will also serve to improve the VL, EID and TB testing coverage.

While overall VL coverage is 82 percent, coverage continues to vary substantially by geography, with coverage rates particularly low in Muyinga (65%), Bujumbura Rural (67%) and Ruyigi (70%). Specific populations, including pregnant women, children and adolescents, also continue to have low VL coverage.

For EID, Burundi has had challenges with meeting PEPFAR targets to ensure timely diagnosis of 90-95% of HIV-exposed infants (HEI) by two months of age. In FY22Q1, 65 percent of HEIs received a test by two months of age and 105 percent by 12 months of age. The time required to receive an EID test result is long; recent SIMS visits documented turn-around times for test results of more than one month at 13 of 16 sites visited, which may not only result in missed infants and increased morbidity and mortality, but may also deter mothers from bringing infants in for testing.

In COP22, PEPFAR Burundi has ambitious targets to increase VL access to 100 percent, and to reach 95-100% of HEIs with a diagnostic test by two months of age. 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 COP21 and COP22, four key focus areas were identified to accelerate VL and EID scale up:

1. **Lab optimization, including all-inclusive reagent agreements:**
    a. PEPFAR Burundi is supporting 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 brought 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 open source 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 continue to support the scale up of 1) the web-based version of SIDA-Info with linkages to IBIPIMO to support analytical approaches for rapid triangulation exercises; 2) the national EID/VL dashboard; 3) additional core laboratory operational metrics into IBIPIMO; and 4) the mView database of the All-inclusive platforms. These investments will also enable timely clinical decision-making and improved patient-centered care.

3. **Collaborative planning on VL/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 reagents and consumables needed for EID and VL POC 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, mentor-mothers, and other CHWs, as well as healthcare providers. During COP22, PEPFAR investments will focus on increasing VL demand among populations with low VL coverage -- pregnant and breastfeeding women, KP, men, adolescents and CLHIV (the latter through parents/caregivers).

PEPFAR Burundi will invest substantial efforts to increase use of EID testing. EID is a life-saving test, as diagnosing and treating HIV-infected babies as soon as possible after birth greatly improves their long-term survival. Demand-creation strategies target healthcare providers at both the community and facility level, and mothers, male partners and other caregivers. Demand creation messaging will include the importance of early HIV testing in infants, as well as the need for repeat testing during the period of continued exposure (breastfeeding). Education about EID and infant HIV testing will start early in ANC and be reinforced throughout pregnancy, delivery and breastfeeding. In addition to messaging, PEPFAR Burundi will ensure active enrolment of women and HEIs into a tracking system to ensure follow-up and EID testing in alignment with

the national algorithm, including determination of final HIV status after cessation of breastfeeding. 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 COP22, 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/excellence centers, including through color-coding patient files for clients eligible for VL and EID, and identification of sample pre-treatment hubs for VL. The program will also collaborate with the GOB to develop a functional QM/QI system to scale up quality laboratory services.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

The ultimate goal of health systems investments at the country level is to ensure that the conditions exist to enable the success of health investments at all levels of the system, leveraging GOB systems investments and investments of other donors through complementarity and additionality. Above-site investments 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 COP22 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 COP22 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 COP21/22 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 the diagnostic network optimization results .

Development and implementation of external quality assurance and QI programs will continue 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 cost implementation plan. To increase visibility into the VL/EID cascade, COP22 will build on COP20-21 plans to expand implementation of IBIPIMO, a VL tracking software, by consolidating it with the web-based version of SIDInfo to expand the functionalities of SI and Lab information systems 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 SIDInfo-OpenClinic-eLMIS- DHIS2 and DHIS2 and DATIM are key priorities. Ibipimo Application for the lab will be integrated into SIDAINFO as the SIDAINFO Lab module and will be linked to SIDAINFO at site level. SIDAINFO and DHIS2 interoperability was successfully tested by DATA.FI during FY22 Q2, the implementation will be conducted in Q3 and Q4 for FY22 and scale up with COP22/FY23.

COP22 will prioritize capacity-building in utilizing data systems that communicate with eac.h 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 as well as continue to support the spectrum estimates that provide the data used for the COP planning process. In COP21, the SIDAInfo web-based platform, with integrated UID, was implemented and COP22 will contribute to its scale up, coordinated by the MoH through the SIDA-Info TWG.

COP22 will contribute to institutionalizing 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, including:

- 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

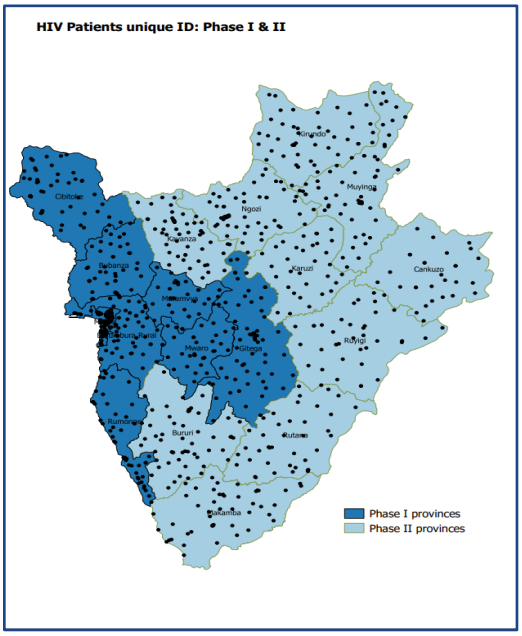
COP22 will also prioritize HMIS data governance and coordination, including:

- 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;

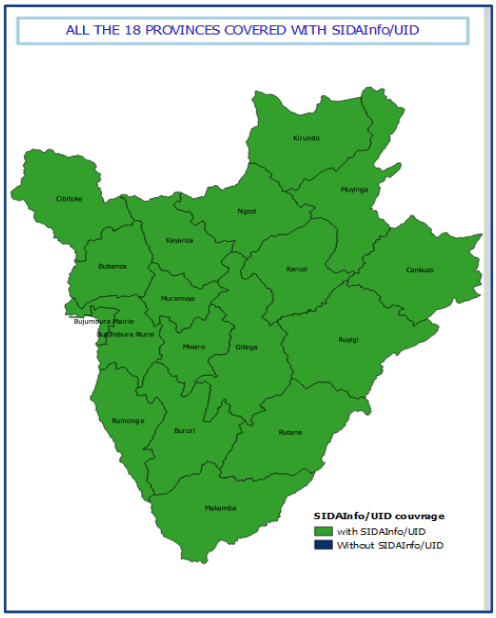
In addition, SIDAInfo Lab module, a VL and EID tracking app, with laboratory and healthcare provider dashboard access and patient-notification capacity via SMS, will be integrated with SIDA-Info and be implemented in COP22. PEPFAR will also work with the NACP to integrate the HAFI application in the SIDAInfo database as a DDD module, and scale up its use.

With COP21, all provinces started to implement the UID and 36% of patients are enrolled in the UID system as of Q2FY22. In COP22, PEPFAR Burundi will continue to scale up the implementation of UID and achieve 90% of patients with UID in sites with PEPFAR direct support.

Figure 5.2.1: Unique Identifier expansion



Source: Data.FI Report - Q2FY21



Source: Data.FI Report - Q2FY22

As of March 2022, SIDAInfo UID is available in 18 provinces. Expansion will be continued during COP21 implementation, and the following activities will be prioritized in COP22:

- Enhancing SIDAInfo capabilities for country priorities like OVC, support clinical partners to help/improve PMTCT/EID coverage and uptake of MMD6
- Interoperability with DDD (Decentralized Drug Distribution) application
- Enhancing SIDAInfo to support case-based surveillance (longitudinal follow up of each PLHIV through their sentinel events) to monitor the epidemic at district, provincial and national levels.
- Continue to conduct DQA after UID Implementation
- Harmonize data collection tools with new strategies and guidelines
- Provide technical support to district to analyze Spectrum, SIDAInfo and DHIS2 data and assess how they are reaching epidemic control and how to use data for decision making with the district approach
- Continue to reinforce data collection system at community, facility level, district and national levels

5.2 Case-based Surveillance

HIV case surveillance (CS) involves the routine and systematic reporting of diagnosed HIV cases in a population to a public health authority and subsequent reporting of their sentinel events throughout the course of infection. The primary objectives are to (1) establish a routine

surveillance system of secured patient-level deduplicated information on a national cohort of diagnosed PLHIV throughout the course of infection; and (2) use its data to routinely monitor epidemic trends and maximize programmatic impact to target HIV resources. A successful CS system provides information on the burden of disease as well as the gaps along the HIV care and treatment cascade (e.g., newly diagnosed cases, linkage to care, and ART continuity and viral suppression) to guide public health action in both civilian and military health systems adhering to utmost Data Security & Confidentiality guidelines according to international standards. As countries reach epidemic control, national HIV CS data has become essential to sustain epidemic control by monitoring population-level trends in new diagnoses, different modes of transmission (risk behaviors), geographic location, and demographics and prompting further investigation to rapidly identify and respond to potential gaps in HIV services--- such as interruptions in treatment including categories of attrition and challenges in access to or uptake of prevention interventions --- that may be contributing to transmission in the population, as a part of a comprehensive and sustainable Public Health Response to HIV. The establishment of HIV CS and use of its data remain a key priority for all PEPFAR programs in COP22.

The stages of CS implementation in a country include a pre-planning phase where stakeholders are introduced to CS and its value as a public health tool; a planning phase where CS infrastructure is established (development of a HIV case reporting policy, client unique identification information, standards based surveillance information system, and standard operating procedures); a small-scale implementation and evaluation phase; and a full-scale implementation phase where the system is nationally scaled and data are used routinely to guide effective and timely public health and programmatic response. To achieve this, it is imperative to have buy-in and commitment from the MOH and local stakeholders to ensure long-term sustainability of CS activities. PEPFAR Burundi plans to establish CS and scale its use by the end of COP22.

5.3 Policy, Governance, Technical Guidance and Support

From a policy perspective, PEPFAR Burundi, along with the World Health Organization (WHO) and other partners, will continue to support the NACP to adapt and implement national guidelines based on the best available evidence in compliance with WHO guidance and PEPFAR standards. PEPFAR will continue to support the ongoing strategic planning of the HIV programming in Burundi for the next five years to provide support evidence-based strategies including: PrEP for different population sub-groups, laboratory network optimization, community led monitoring and adaptation of the the national strategies based on results from the IBBS. PEPFAR will work with other relevant stakeholders including WHO, Global Fund and UNICEF to update policies to account for new evidence based interventions. In COP22, PEPFAR will support strategies that aim at improving the supply chain and reducing stockout while shaping MMD (six) scale up and TLD transition. In addition, PEPFAR will help address NACP concerns regarding MMP scale up and PrEP for adolescents and young women to improve their confidence in adopting those new strategies that have proven effectiveness.

PEPFAR will also initiate and build the capacity of 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.

In COP22, PEPFAR will provide targeted technical assistance to the NACP and CNLS to improve their governance and institutional capacity to better manage and coordinate HIV programming in Burundi.

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

The PEPFAR team includes the USAID HIV team, acquisition and assistance staff, financial staff, and the U.S. Department of Defense (DoD) program manager and HIV/AIDS Clinical Services Specialist. The USAID Health Team Lead 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 COP22, the USAID PEPFAR Team will add two local employee staff positions: 1) a Deputy Health Team Lead to support the Health Team Lead in overall management of the team and to provide a path for career progression for local employees, 2) an AOR/COR Program Management position to augment the Health Team's capacity to manage local partner awards as direct funding to local partners increases.

Additionally in COP21, an AOR/COR Program Management position is being recruited to support the C&T Advisor and case surveillance coordination. The goal is to have the position filled by August 2022.

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.

APPENDIX A – Prioritization

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

SNU	COP	RIORITISATIO	Result reported	Atteined 90-90-90 (88%) by each Age Sex Band to Reach 95-95-95 overoll																										Overoll TX
				Treatment coverage at APR by Age and Sex																										
				<01		01-04		05-09		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+				
				F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M			
Bubanza	COP 20	Optimization	APR21	72%	0%	13%	11%	36%	31%	26%	23%	153%	169%	139%	78%	89%	50%	74%	52%	62%	40%	46%	39%	54%	38%	32%	41%	57%		
	COP 21	Optimization	APR22	23%	25%	12%	18%	28%	28%	46%	17%	134%	56%	130%	37%	91%	41%	70%	51%	46%	50%	41%	26%	54%	41%	21%	38%	47%		
	COP 22	Scale-up Aggres	APR23	100%	0%	40%	29%	67%	43%	30%	52%	83%	35%	173%	45%	176%	87%	123%	79%	149%	106%	111%	77%	101%	121%	83%	111%	101%		
Bujumbura	COP 20	Optimization	APR21	0%	30%	27%	26%	37%	52%	51%	47%	115%	140%	111%	76%	99%	56%	105%	69%	88%	67%	55%	51%	137%	80%	51%	64%	68%		
	COP 21	Optimization	APR22	21%	24%	13%	15%	16%	22%	34%	45%	56%	118%	53%	14%	61%	35%	63%	41%	68%	41%	20%	7%	30%	14%	23%	47%	37%		
	COP 22	Scale-up Aggres	APR23	0%	67%	30%	46%	58%	52%	67%	52%	78%	50%	104%	55%	123%	49%	116%	72%	145%	113%	120%	114%	112%	117%	80%	88%	94%		
Bujumbura Mairie	COP 20	Sustained	APR21	44%	32%	14%	25%	87%	65%	192%	133%	431%	343%	309%	116%	222%	68%	166%	53%	174%	64%	212%	81%	262%	143%	192%	179%	150%		
	COP 21	Sustained	APR22	31%	35%	73%	89%	136%	122%	146%	196%	281%	367%	293%	518%	51%	113%	226%	106%	118%	131%	113%	92%	167%	180%	101%	122%	159%		
	COP 22	Sustained	APR23	0%	14%	13%	13%	42%	47%	75%	66%	100%	77%	102%	53%	97%	41%	83%	34%	97%	59%	107%	82%	136%	121%	137%	156%	97%		
Bururi	COP 20	Sustained	APR21	111%	137%	44%	28%	130%	98%	114%	120%	230%	348%	253%	109%	148%	96%	129%	81%	142%	78%	124%	61%	209%	130%	127%	132%	132%		
	COP 21	Sustained	APR22	117%	52%	67%	61%	114%	134%	134%	115%	372%	441%	198%	199%	115%	83%	110%	60%	108%	63%	137%	92%	226%	180%	85%	109%	140%		
	COP 22	Sustained	APR23	100%	100%	64%	46%	71%	67%	115%	88%	85%	118%	95%	57%	124%	79%	98%	72%	153%	75%	110%	128%	197%	132%	186%	171%	131%		
Cankuzo	COP 20	Sustained	APR21	63%	56%	30%	39%	63%	68%	63%	107%	137%	275%	202%	161%	169%	72%	108%	87%	107%	95%	94%	81%	101%	88%	51%	69%	99%		
	COP 21	Optimization	APR22	70%	91%	13%	19%	78%	58%	49%	67%	116%	303%	110%	147%	102%	59%	60%	54%	86%	61%	116%	84%	66%	77%	32%	45%	82%		
	COP 22	Sustained	APR23	0%	0%	23%	43%	58%	53%	60%	70%	55%	66%	138%	51%	136%	71%	128%	68%	137%	94%	112%	124%	102%	133%	72%	86%	94%		
Cibitoke	COP 20	Optimization	APR21	22%	41%	27%	21%	58%	35%	28%	27%	81%	77%	102%	46%	85%	49%	64%	44%	60%	61%	43%	36%	43%	51%	37%	39%	49%		
	COP 21	Optimization	APR22	20%	61%	29%	18%	48%	33%	24%	23%	85%	72%	86%	44%	53%	53%	41%	39%	35%	60%	37%	47%	37%	53%	25%	26%	44%		
	COP 22	Scale-up Aggres	APR23	100%	233%	22%	13%	58%	34%	37%	38%	77%	35%	140%	56%	134%	86%	127%	74%	120%	94%	81%	115%	82%	78%	76%	80%	87%		
Gitega	COP 20	Optimization	APR21	20%	30%	9%	17%	44%	61%	81%	74%	152%	157%	126%	82%	92%	56%	95%	56%	89%	61%	96%	68%	104%	93%	59%	71%	75%		
	COP 21	Sustained	APR22	88%	93%	90%	99%	127%	123%	71%	78%	158%	177%	166%	124%	145%	152%	107%	125%	86%	111%	72%	88%	76%	97%	40%	58%	106%		
	COP 22	Scale-up Aggres	APR23	25%	25%	35%	26%	54%	50%	64%	69%	70%	52%	86%	36%	95%	46%	89%	59%	122%	89%	121%	99%	127%	124%	92%	100%	92%		
Karusi	COP 20	Optimization	APR21	30%	69%	30%	20%	62%	49%	85%	85%	102%	130%	125%	62%	99%	62%	92%	59%	85%	61%	78%	56%	73%	89%	29%	57%	70%		
	COP 21	Optimization	APR22	51%	34%	18%	11%	52%	42%	80%	69%	97%	133%	90%	69%	83%	57%	70%	60%	58%	58%	63%	43%	49%	73%	22%	49%	60%		
	COP 22	Scale-up Aggres	APR23	100%	67%	61%	40%	70%	46%	73%	76%	74%	54%	115%	38%	122%	64%	102%	70%	140%	99%	120%	97%	97%	110%	65%	90%	90%		
Kayanza	COP 20	Optimization	APR21	16%	34%	16%	18%	53%	45%	82%	92%	196%	192%	141%	78%	116%	68%	93%	66%	91%	79%	71%	60%	91%	98%	39%	73%	80%		
	COP 21	Sustained	APR22	50%	63%	46%	51%	101%	112%	140%	131%	242%	284%	133%	138%	100%	67%	95%	66%	110%	79%	125%	87%	112%	104%	56%	98%	108%		
	COP 22	Scale-up Aggres	APR23	25%	0%	23%	19%	48%	45%	73%	68%	73%	78%	104%	47%	117%	56%	108%	59%	142%	113%	120%	92%	119%	118%	86%	101%	95%		
Kirundo	COP 20	Sustained	APR21	43%	13%	18%	20%	45%	52%	80%	51%	282%	180%	308%	208%	204%	181%	140%	153%	120%	134%	87%	94%	93%	129%	39%	76%	115%		
	COP 21	Optimization	APR22	49%	60%	36%	38%	75%	59%	84%	84%	153%	202%	95%	121%	70%	76%	69%	77%	72%	79%	77%	85%	74%	81%	36%	53%	79%		
	COP 22	Sustained	APR23	11%	44%	21%	21%	35%	39%	32%	30%	58%	35%	150%	50%	151%	76%	144%	101%	144%	116%	107%	103%	99%	107%	66%	87%	93%		
Makamba	COP 20	Sustained	APR21	127%	74%	32%	33%	61%	41%	98%	89%	248%	155%	223%	105%	178%	90%	155%	112%	119%	79%	116%	84%	141%	154%	75%	93%	112%		
	COP 21	Optimization	APR22	52%	35%	23%	21%	34%	50%	56%	48%	152%	120%	126%	59%	89%	59%	79%	61%	71%	51%	78%	59%	91%	80%	45%	67%	67%		
	COP 22	Sustained	APR23	75%	75%	19%	22%	39%	38%	47%	34%	52%	34%	125%	34%	124%	52%	111%	57%	121%	111%	103%	106%	106%	133%	76%	94%	88%		
Muramvya	COP 20	Optimization	APR21	0%	83%	5%	14%	58%	75%	104%	69%	122%	195%	99%	119%	65%	25%	63%	40%	91%	55%	89%	62%	112%	81%	55%	80%	73%		
	COP 21	Sustained	APR22	70%	58%	50%	81%	81%	99%	108%	124%	167%	218%	122%	109%	60%	47%	73%	91%	98%	95%	120%	49%	123%	142%	53%	89%	97%		
	COP 22	Scale-up Aggres	APR23	100%	0%	23%	7%	41%	82%	87%	74%	66%	103%	78%	59%	49%	29%	74%	32%	93%	102%	104%	96%	117%	134%	82%	99%	83%		
Muyinga	COP 20	Optimization	APR21	18%	62%	19%	18%	34%	34%	59%	59%	142%	137%	217%	92%	159%	100%	119%	70%	115%	76%	94%	69%	89%	81%	37%	58%	82%		
	COP 21	Optimization	APR22	28%	44%	26%	35%	69%	43%	83%	75%	206%	234%	152%	124%	53%	41%	46%	53%	65%	38%	86%	46%	96%	70%	57%	78%	77%		
	COP 22	Scale-up Aggres	APR23	0%	0%	27%	18%	29%	40%	44%	41%	77%	49%	145%	42%	149%	93%	116%	85%	149%	108%	114%	114%	98%	101%	66%	83%	93%		
Mwaro	COP 20	Optimization	APR21	24%	38%	5%	3%	25%	15%	56%	47%	114%	119%	54%	36%	39%	26%	33%	26%	46%	23%	55%	30%	69%	46%	36%	42%	42%		
	COP 21	Optimization	APR22	43%	30%	11%	15%	34%	36%	59%	42%	72%	101%	38%	16%	24%	21%	29%	46%	37%	52%	40%	21%	47%	39%	26%	33%	38%		
	COP 22	Scale-up Aggres	APR23	100%	100%	20%	27%	54%	21%	48%	48%	79%	85%	73%	35%	83%	24%	58%	50%	116%	88%	117%	74%	126%	98%	102%	99%	87%		
Ngozi	COP 20	Sustained	APR21	35%	31%	19%	27%	72%	70%	84%	62%	251%	200%	279%	179%	192%	148%	146%	121%	142%	114%	115%	107%	118%	117%	51%	76%	115%		
	COP 21	Sustained	APR22	33%	37%	27%	35%	107%	103%	161%	148%	225%	286%	91%	112%	45%	37%	64%	32%	104%	53%	113%	82%	114%	102%	57%	96%	94%		
	COP 22	Sustained	APR23	17%	0%	15%	17%	45%	44%	38%	54%	73%	50%	125%	57%	132%	71%	113%	73%	119%	110%	106%	119%	104%	105%	62%	67%	86%		
Rumonge	COP 20	Optimization	APR21	28%	43%	13%	19%	37%	17%	38%	46%	105%	83%	116%	75%	72%	32%	59%	54%	57%	39%	48%	40%	43%	46%	31%	43%	49%		
	COP 21	Optimization	APR22	21%	23%	12%	12%	41%	32%	37%	32%	95%	102%	85%	61%	78%	46%	54%	52%	56%	48%	59%	45%	67%	51%	49%	50%	50%		
	COP 22	Scale-up Aggres	APR23	133%	75%	25%	36%	34%	19%	71%	57%	70%	48%	123%	37%	126%	44%	104%	57%	106%	86%	83%	68%	88%	114%	61%	85%	80%		
Rutana	COP 20	Sustained	APR21	134%	59%	26%	30%	48%	41%	113%	86%	209%	166%	197%	138%	112%	99%	115%	84%	95%	74%	110%	90%	138%	132%	58%	83%	102%		
	COP 21	Sustained	APR22	100%	83%	42%	38%	167%	108%	158%	156%	278%	355%	113%	167%	66%	66%	66%	44%	72%	52%	117%	71%	101%	109%	37%	71%	110%		
	COP 22	Sustained	APR23	200%	0%	47%	33%	32%	55%	73%	36%	70%	42%	141%	70%	129%	98%	113%	63%	158%	102%	132%	131%	118%	133%	99%	110%	105%		
Ruyigi	COP 20	Optimization	APR21	12%	95%	11%	6%	79%	56%	90%	45%	181%	159%	129%	134%	123%	62%	92%	79%	108%	72%	104%	78%	85%	74%	45%	76%	83%		
	COP 21	Optimization	APR22	26%	49%	24%	16%	40%	32%	87%	45%	166%	177%	75%	98%	29%	51%	24%	37%	42%	22%	70%	38%	55%	46%	25%	46%	55%		
	COP 22	Scale-up Aggres	APR23	33%	33%	30%	30%	38%	49%	59%	44%	54%	31%	103%	58%	109%	65%	94%	56%	114%	98%	102%	109%	83%	107%	68%	82%	98%		

APPENDIX B – Budget Profile and Resource Projections

Table B.1.1 COP22 Budget by Program Area

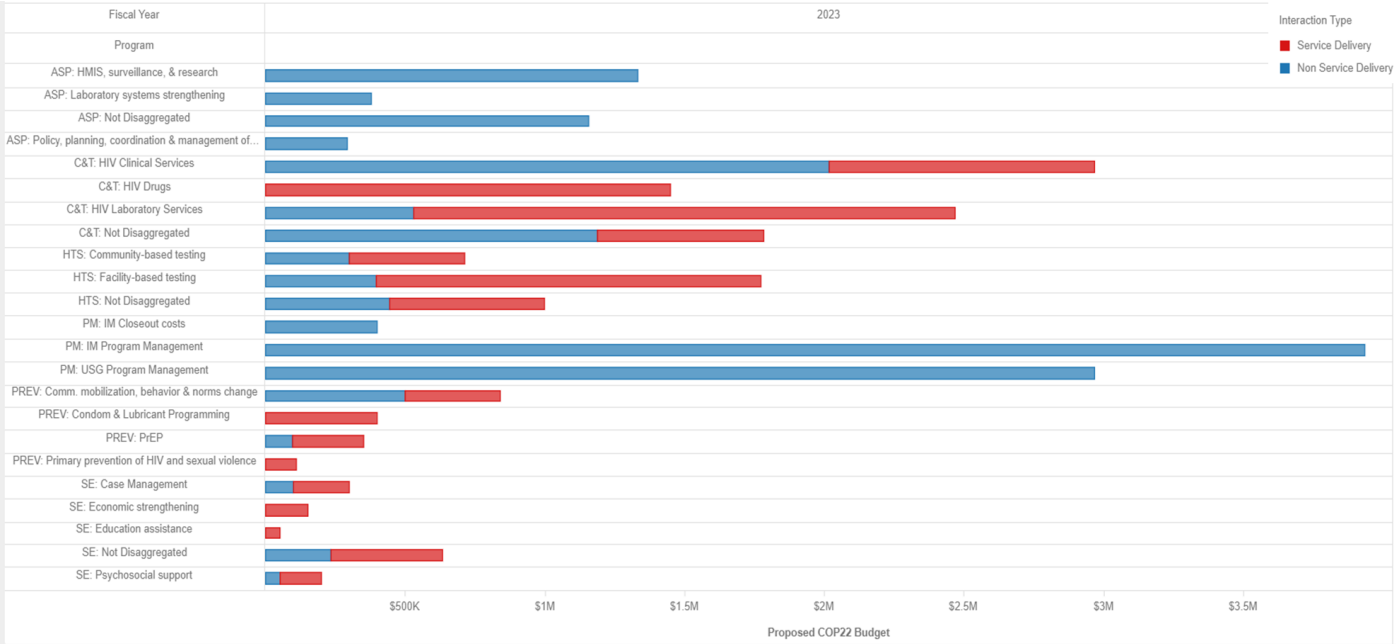


Table B.1.2 COP22 Total Planning Level

Applied Pipeline	New Funding	Total Spend
$1,333,339	$24,316,661	$25,650,000

Table B.1.3 COP22 Budget by Program Area

Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
	Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		**$16,319,458**	**$9,330,542**	**$25,650,000**	**64%**	**36%**	**100%**
C&T	**Total**	**$3,734,721**	**$4,932,276**	**$8,666,997**	**43%**	**57%**	**100%**
	HIV Clinical Services	$2,018,217	$948,441	**$2,966,658**	68%	32%	**100%**
	HIV Drugs		$1,448,087	**$1,448,087**		100%	**100%**
	HIV Laboratory Services	$530,000	$1,939,387	**$2,469,387**	21%	79%	**100%**
	Not Disaggregated	$1,186,504	$596,361	**$1,782,865**	67%	33%	**100%**
HTS	**Total**	**$1,142,285**	**$2,341,877**	**$3,484,162**	**33%**	**67%**	**100%**
	Community-based testing	$300,305	$413,883	**$714,188**	42%	58%	**100%**
	Facility-based testing	$396,980	$1,375,961	**$1,772,941**	22%	78%	**100%**
	Not Disaggregated	$445,000	$552,033	**$997,033**	45%	55%	**100%**
PREV	**Total**	**$594,538**	**$1,106,389**	**$1,700,927**	**35%**	**65%**	**100%**
	Comm. mobilization, behavior & norms change	$499,306	$339,121	**$838,427**	60%	40%	**100%**
	Condom & Lubricant Programming		$400,000	**$400,000**		100%	**100%**
	PrEP	$95,232	$257,268	**$352,500**	27%	73%	**100%**
	Primary prevention of HIV and sexual violence		$110,000	**$110,000**		100%	**100%**
SE	**Total**	**$384,474**	**$950,000**	**$1,334,474**	**29%**	**71%**	**100%**
	Case Management	$100,000	$200,000	**$300,000**	33%	67%	**100%**
	Economic strengthening		$150,000	**$150,000**		100%	**100%**
	Education assistance		$50,000	**$50,000**		100%	**100%**
	Not Disaggregated	$234,474	$400,000	**$634,474**	37%	63%	**100%**
	Psychosocial support	$50,000	$150,000	**$200,000**	25%	75%	**100%**
ASP	**Total**	**$3,161,548**		**$3,161,548**	**100%**		**100%**
	HMIS, surveillance, & research	$1,332,833		**$1,332,833**	100%		**100%**
	Laboratory systems strengthening	$378,980		**$378,980**	100%		**100%**
	Not Disaggregated	$1,158,000		**$1,158,000**	100%		**100%**
	Policy, planning, coordination & management of disease control programs	$291,735		**$291,735**	100%		**100%**
PM	**Total**	**$7,301,892**		**$7,301,892**	**100%**		**100%**
	IM Closeout costs	$400,000		**$400,000**	100%		**100%**
	IM Program Management	$3,935,716		**$3,935,716**	100%		**100%**
	USG Program Management	$2,966,176		**$2,966,176**	100%		**100%**

Table B.4 COP22 Resource Allocation by Program and Beneficiary

Operating Unit	Metrics	Proposed COP22 Budget							Percent to Total						
	Beneficiary	C&T	HTS	PREV	SE	ASP	PM	Total	C&T	HTS	PREV	SE	ASP	PM	Total
Burundi	**Total**	**$8,666,997**	**$3,484,162**	**$1,700,927**	**$1,334,474**	**$3,161,548**	**$7,301,892**	**$25,650,000**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
	Females	$88,247		$10,000				**$98,247**	1%		1%				**0%**
	Key Pops	$598,071	$1,037,604	$458,706				**$2,094,381**	7%	30%	27%				**8%**
	Males		$120,000					**$120,000**		3%					**0%**
	Non-Targeted Pop	$7,410,128	$1,084,338	$730,000	$150,000	$3,161,548	$7,036,892	**$19,572,906**	85%	31%	43%	11%	100%	96%	**76%**
	OVC			$340,000	$1,184,474			**$1,524,474**			20%	89%			**6%**
	Pregnant & Breastfeeding Women		$726,116					**$726,116**		21%					**3%**
	Priority Pops	$570,551	$516,104	$162,221			$265,000	**$1,513,876**	7%	15%	10%			4%	**6%**

B.2 Resource Projections

For COP22, the PEPFAR Burundi budget is projected to be $25,650,00. The COP22 Care & Treatment budget is $12,621,084, which represents approximately 49 percent of the OU's total budget. For COP22, Burundi has exceeded its OVC earmark, with $2,064,474 allocated for OVC programming. Burundi received $400,000 under USAID central funding for procurement of condoms. Of the total OU budget, 92 percent of the funding is allocated to USAID and eight percent to DoD.

Each mechanism was costed in the FAST by reviewing mechanism-level PEPFAR interventions, deliverables, and budgets. Given the resource envelope for COP22, budgets were carried forward

by using COP21 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 COP22.

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

Key Systems Barriers-E (Entry of Objectives, Related SID Elements, Barriers to Local Responsibility)

Step 1: Select SID element	Step 2 - What is the outcome expected from investing in this element? (may duplicate outcome to more than one row to allow capture of all barriers)	Step 3: What are the barriers to local responsibility for this outcome?	Step 4: Describe the barrier	Step 5: Timeline to Barrier Addressed
1. Planning and Coordination	The Government of Burundi increases their investment into the HIV response.	Lack of Financial Resources	Weak financial commitment from the Government of Burundi to the HIV response.	10+ years
17. Data for Decision-Making Ecosystem	SIDAInfo is continuously updated and provides required support to sites for data management and reporting. SIDAInfo is utilized for clinical decision making.	Lack of technical capacity	Medical providers lack the knowledge to utilize data from SIDAInfo for decision making. SIDAInfo is not optimally used.	4-5 years
17. Data for Decision-Making Ecosystem	SIDAInfo is continuously updated and provides required support to sites for data management and reporting. SIDAInfo is utilized for clinical decision making.	Physical infrastructure not complete/further investment needed by donors	Lack of functional and enough computers at most facilities	2-3 years
16. Performance Data	There is interoperability between different data sources (DHIS2, SIDAInfo, etc.) in order to promote uniqueness of reporting.	Lack of technical capacity	Multiple systems are not linked, lack of planning and long-term vision/strategy. Lack of ownership	4-5 years
2. Policies and Governance	PrEP services are expanded to eligible AGYW outside of serodiscordant couples	Legal, policy or regulatory constraint	AGYW outside of serodiscordant couples not eligible under National PrEP Guidelines	4-5 years
6. Service Delivery	Scale-up in the number of MSM and TG enrolled in PrEP services.	Other	Lack of support from the Government of Burundi for key populations such as MSM and TG. Demand creation material/activities are not accepted by the MOH.	2-3 years
8. Commodity Security and Supply Chain	National commodity forecasts and supply plan tools are developed in accordance with new national guidelines; forecasting matches consumption to avoid any stock outs or expiries.	Lack of technical capacity	Delays in shipment delivery and poor data visibility	2-3 years

8. Commodity Security and Supply Chain	**A commodity and data visibility approach are established at site-level to ensure that commodities are distributed per site-specific needs and performance, not past requests.**	**Lack of technical capacity**	**Commodity security and end-to-end LMIS**	**2-3 years**
10. Laboratory	**High quality and patient centered laboratory services are provided with new integrated platforms, the leverage of POC platforms (GenXpert machines) and no reagent stockouts.**	**Other**	**Upscale of laboratory diagnostic access, capacity and data visibility**	**1 year**
10. Laboratory	**Establishment of a complete end-to-end VL service delivery visibility via IBIPIMO VL dashboard (inclusive of patient eligibility, samples collected, result return, TAT, supply chain, instrument performance, backlogs)**	**Other**	**Upscale of laboratory diagnostic access, capacity and data visibility**	**1 year**
14. Epidemiological and Health Data	**The web-based version of SIDA Info, with an integrated Unique ID System, is available nationally in all sites with at least 100 PLHIV on ART, to improve patient monitoring and experience, particularly for A/CLHIV (screening and subcategorization of patients, differentiated approach for each category of patient)**	**Other**	**Weak HMIS - Limited access to the updated version of SIDA Info (HIV EMR), with an integrated Unique ID system, at site level. Issues with electricity at facilities.**	**2-3 years**
17. Data for Decision-Making Ecosystem	**There is real-time data to inform HIV estimates and monitor the trajectory of the epidemic, with demographic and geographic data to guide prevention interventions**	**Other**	**Quality national data is not available through DHIS2 (not regularly updated) and DHS/IBBS (delayed implementation) to inform HIV estimates, to monitor the trajectory of the epidemic and to guide decision making.**	**2-3 years**

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.[15]	Completed. In fact, 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. As of FY22 Q1 the overall linkage rate is 99%, and the linkage rate in KP Program is linkage rate at 100%. In COP22, Burundi will continue to focus on direct and immediate (>95%) linkage from testing to treatment across all age, sex, and risk groups.
	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.	During COP20, Burundi completed a full phase out of EFV. Eligible PLHIV weighing >30 kg, including children and adolescents and women of childbearing potential are being transitioned to TLD. The full transition to CLHIV is limited by a remaining stock of LPV/r. An advocacy for its phase out is ongoing to complete the transition to DTG 10mg. Quantification and procurement of DTG 10mg was completed, and SOPs for pediatric ART are developed. In COP22, Burundi will continue to ensure all eligible clients are on DTG based regimens.
	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.	During COP18, Burundi adopted 6-month multi-month scripting (MMS) and 3-month multi-month dispensing (MMD), consistent with WHO and PEPFAR guidance. During COP19, significant progress was made in the implementation of 3–5 month MMD, from 0% to 75% , however there was limited implementation of 6-month MMD in all districts. During COP20, Burundi focused on the scale-up of CAGs as DSD models for ARV distribution. In COP21, efforts were made to increase procurement of ARVs for 6-month MMD, to expand MMD and DSD eligibility to 2+ years of age and to pregnant and breastfeeding women; and a national DSD policy is under drafting. In COP22, Burundi will continue to promote the rapid roll-out of 6-month MMD and to expand the adopted DSD models.
	All eligible PLHIV, including children and adolescents, should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	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 COP21, 99.6% of PLHIV were screened for TB with a 0.4% positivity rate, and the TPT completion rate is 79.9% both for adults and children in all provinces and districts. As TB diagnosis is challenging, use of GeneXpert, operational plan and sample transport scale-up plan are under development. In COP21, efforts were made to procure 1HP to emphasize high TPT completion. In COP22, Burundi plans to complete full-scale TPT coverage for adults and children.
	Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	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. In COP21, PEPFAR Burundi initiated a DNO process to revise the placement of VL/EID platforms and improve sample transport networks. In addition, 2 additional VL machines were procured to replace the aging machines. In COP22, PEPFAR Burundi will use the results of the DNO 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 an HIV positive biological parent should be offered testing for HIV.	The last update of the national HTS policy and strategy (including index testing and HIVST) was approved in2020. Since COP20, Burundi is focusing on ongoing rapid scale-up of index testing across all districts, 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 texting services, including consent and reporting of adverse events, and strengthening the monitoring and reporting systems at the community level. In COP22, 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). The SIMS tool will be used to evaluate the compliance with PEPFAR Guidance.
	Direct and immediate assessment for and offer of prevention services, including pre-exposure	PrEP is offered according to National Guidelines to KPs and serodiscordant couples if the partner is virally unsuppressed. PEPFAR Burundi will continue to support the

[15] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, Sept 2015

	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)	NACP, together with the World Health Organization (WHO), to update national guidelines based on the best available evidence and in compliance with WHO and PEPFAR guidance. In addition, PEPFAR Burundi with other stakeholders will continue to advocate so that other populations may benefit from PrEP such as high-risk pregnant and lactating women and AGYW.
	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.	Completed. 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, PMTCT surge and targeting adolescents for differentiated services. As of FY22 Q2, 92% of CLHIV were offered enrollment among which 93% of them completed their enrollment into the OVC program. In COP22, PEPFAR will maintain gains and expand into a new province (Ngozi). In FY23, PEPFAR will leverage other funding sources at the Mission and to extend the OVC package to offer nutrition services to the OVC and enhance GBV prevention and mitigation as well as expanding support to the youth friendly services. In COP22, PEPFAR will offer HIV testing to all OVCs with an unknown HIV status and continue to offer differentiated services to CLHIV with an unsuppressed viral load and provide them psychosocial support to improve adherence to treatment.
	In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.	PEPFAR Burundi completed a stigma intex assessment in 2022. PEPFAR will use the data to inform COP22 implementation to address stigma at all levels including service-provider level stigma toward HIV patients, especially key populations.
	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.[16]	Completed. No fees charged in Burundi for HIV related services.
	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.	Completed. PEPFAR Burundi continues to implement QA through SIMS. SIMS visits are now activated through a third-party contractor, who also provide evidence of measurement against site standards. In addition, quality improvement activities are implemented in order to track the continuity of treatment through RCA, DQM and robust evidence-based CQI practices. In COP22, Burundi will continue district-level and clinical mentoring in all provinces, focusing on priority indicators.
	Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	Health facilities display and utilize educational visuals and messaging related to U=U. Starting in 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 COP22, 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.

[16] The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care. Geneva: World Health Organization, December 2005

	Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses.	Agency progress is seen. In COP19, PEPFAR Burundi awarded two local partners, one for GBV and one for OVC. In COP21, the KP program is transitioning to two local partners receiving direct awards - ANSS and SWAA.
	Evidence of partner government assuming greater responsibility of the HIV response including	The GOB has increased its commitment year to year from 2018 to 2020. In COP22, PEPFAR Burundi will continue to advocate for increased government resource commitment.
	Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	PEPFAR tracked mortality and interruption in treatment data through the MER indicator TX_ML and triangulated it with MSPLS mortality data. In COP22, mortality and morbidity will be integrated within SIDAInfo and reported on a frequent basis.
	Scale-up of case-based surveillance and unique identifiers for patients across all sites.	COP20 plans focused on the active development of a web-based version of SIDAInfo, with fingerprint integrated, to establish a national unique identifier system. By March 11, 2022, SIDAInfo was installed in all 18 provinces (133 sites) and 36% of the PEPFAR Cohort (24508) have an UID. During COP21, key activities will be conducted such as the alignment with robust security and confidentiality guidelines. In COP22, PEPFAR Burundi will continue to expand SIDAInfo and add the systems interoperability and quality data for decision making in order to improve the person-centered care.

APPENDIX E – Assessing Progress towards Sustainable Control of the HIV/AIDS Epidemic

1. Misalignments between Investments and Outcomes

PEPFAR Burundi supports high volume sites in all the provinces covering more than 80% of the cohort, which are mostly district hospitals, yet most ANC and PMTCT services are provided at lower volume sites. The focus of PEPFAR's support therefore limits the capacity to reach children and pregnant women and represents an essential gap in case finding and viral load access. To address this issue, PEPFAR will continue to enhance the district approach and leverage the "centers of excellence" to support the low volume sites, where ANC and PMTCT services are typically provided, to fill those gaps.

The Stigma Index results have shown that HIV stigma still persists in Burundi even among service providers. PEPFAR will work with the Ministry of Health, CSOs and other donors to address stigma at all levels of HIV programming in Burundi.

The logistic management information system is weak, and unable to provide accurate data, affecting accurate and timely forecasting and quantification. Support to introduce an electronic logistic management system (eLIMS) in COP22 will help address that gap to improve the use of supply chain data for decision making.

Figure E.1.1 Percent Primary Responsibility Ratings from Responsibility Matrix

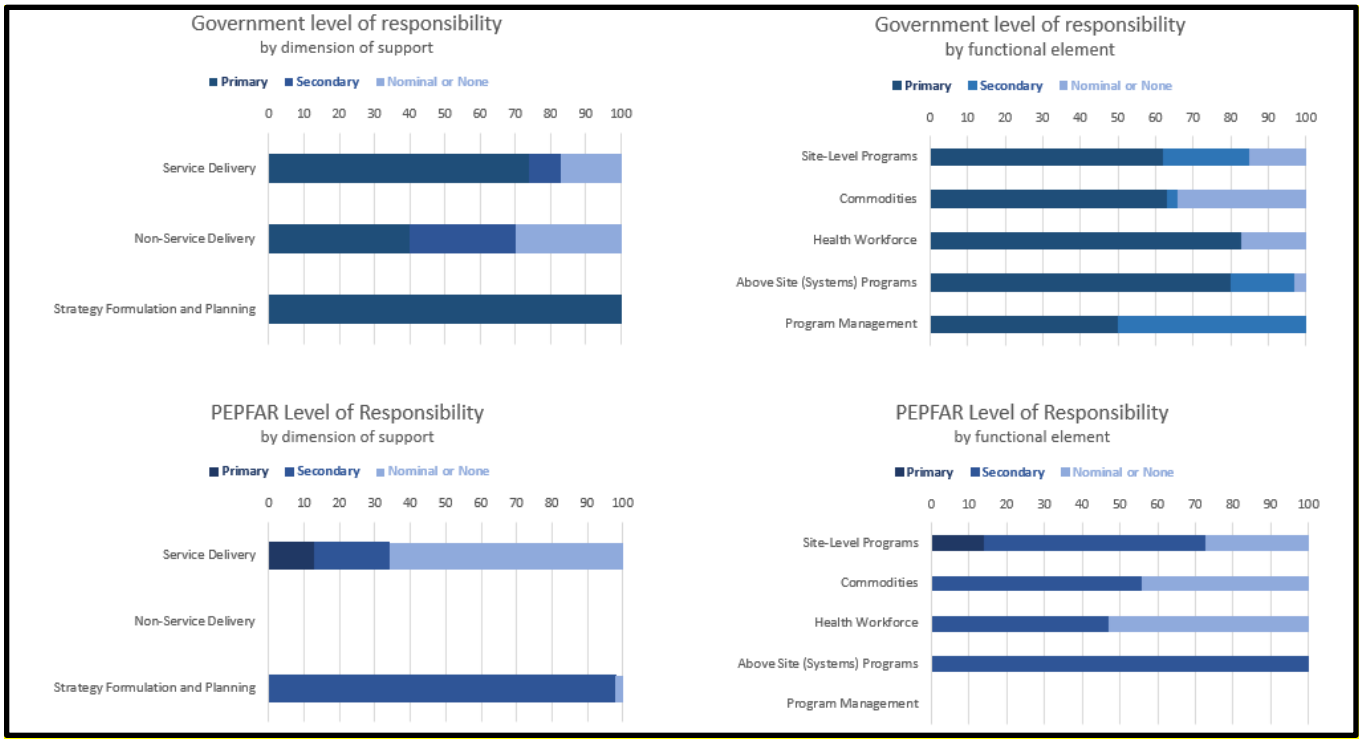


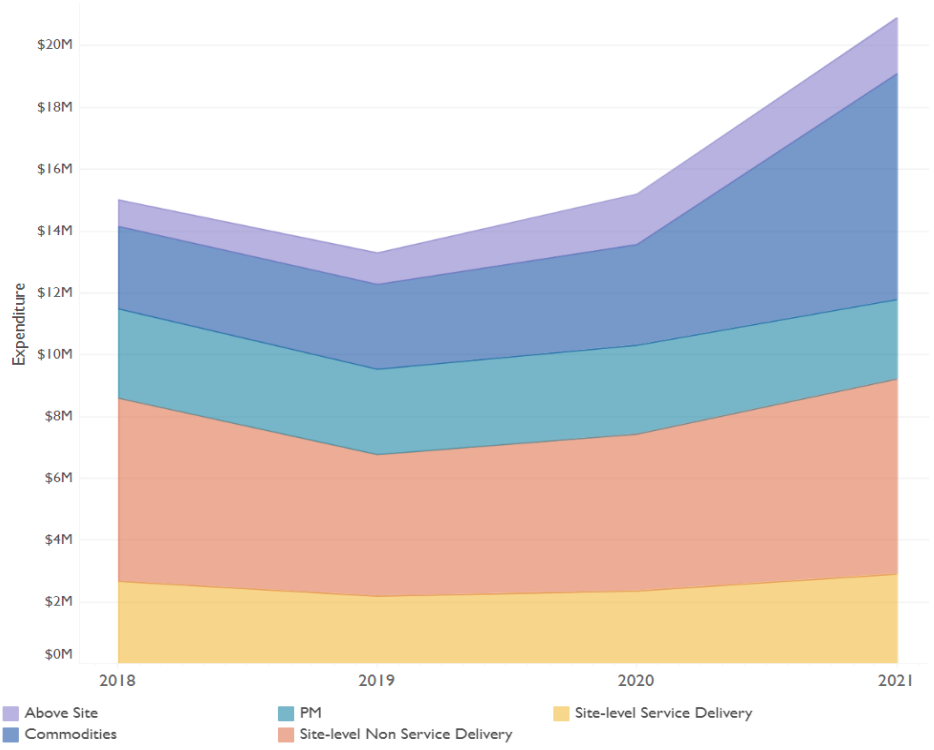
Figure E.1.2 Trends in SID Scores for System-Related Elements

SID

Domain	Sum of SIDweighted_answer SID Element	FY2017	FY2019	FY2021
Governance, Leadership & Accountability	1. Planning and Coordination Score:	9.00	9.29	8.17
	2. Policies and Governance Score:	6.51	6.34	6.45
	3. Civil Society Engagement Score:	6.96	7.17	5.50
	4. Private Sector Engagement Score:	4.51	6.29	4.11
	5. Public Access to Information Score:	7.00	10.00	8.00
National Health System & Service Delivery	6. Service Delivery Score:	5.46	6.55	6.17
	7. Health Workforce Score:	5.76	6.53	6.37
	8. Commodity Security and Supply Chain Score:	2.79	4.57	4.78
	9. Quality Management Score:	5.00	7.00	6.33
	10. Laboratory Score:	4.75	6.72	6.19
Strategic Financing & Market Openness	11. Domestic Resource Mobilization Score:	6.94	8.21	8.73
	12. Technical and Allocative Efficiencies Score:	7.06	8.28	7.80
	13. Market Openness Score:		10.00	10.00
Strategic Information	14. Epidemiological and Health data Score:	6.04	5.97	5.26
	15. Financial/Expenditure data Score:	5.00	5.00	6.67
	16. Performance Data Score:	7.52	7.12	7.28
	17. Data for Decision-Making Ecosystem Score:		5.00	4.00

Source: SID 2021

Figure E.1.3 PEPFAR Expenditure Trends by Interaction Type and Epidemic Control Status



2. Areas for Transition

The Government of Burundi is currently developing a National HIV/AIDS 5-year Strategic Plan to reach and sustain HIV epidemic control. In line with the goals proposed in this plan, some areas of transition include improving data for decision-making, strengthening the community health worker (CHW) system, and adapting "centers of excellence" at the district hospital level.

Improving Data for Decision-Making

As noted above, in COP22, PEPFAR will continue to scale up the deployment of government-owned systems such as SidaInfo and UID and eLMIS to improve quality and availability of data for decision making. There will be continued focus on building the national and district capacity to analyze data and use it for decision making with the lead of the NACP.

Strengthening the community health worker (CHW) system

As proposed in the National HIV/AIDS Strategic Plan, the MoH is committed to improving community engagement in helping to reach and sustain HIV epidemic control. This is evident through the inclusion of Mentor Mothers, KP Ambassadors and Peer Navigators as part of the CHW system.

During COP22, PEPFAR Burundi will continue to advocate with the MoH for a more effective ratio of CHWs to colline ("hill", a sub-district administrative entity) to strengthen the CHW system.

Creation of "centers of excellence " at district level hospitals

In an effort to strengthen case finding, especially among PBFW and children, PEPFAR Burundi is proposing the introduction of "centers of excellence" at the district level. PEPFAR Burundi will provide technical assistance to ensure increased capacity of the DHTs and centers of excellence to support sites in delivering quality person-centered HIV services and help scale-up new HIV strategies in low volume sites that are not directly supported by the PEPFAR program.

Support to the DHTs will focus on improving the continuum of care system by improving the last mile supply chain, data collection, processing, analysis and quality as well as strengthening laboratory capacity for viral load and EID testing. Key activities/outputs to improve DHTs capacity for systemic functions are described in the table below. While all provinces will receive this support, each district may receive tailored assistance to meet its needs and goals.

Preliminary discussions with members of the MoH indicate a keen willingness to try this approach. A plan of implementation will be developed in COP21 with the intent to start executing in COP22.

3. Sustainability

To ensure sustainability of the HIV response, PEPFAR continues to improve the country's ownership through improved policies and plans, enhancing technical and governance capacity to improve coordination, planning and monitoring and evaluation. Additionally, PEPFAR will support the establishment of the effective technical working groups to support the country's coordination and planning in different areas of HIV programming in Burundi including PMTCT, Lab and supply chain among others. Further, PEPFAR is building the capacity of local NGOs to improve their organizational

and technical capacity to manage grants, to implement effective HIV programs. To that end PEPFAR will continue to transition to local partners reaching up to 42% in COP22.

Currently the GoB is in the process of developing a 5-year National HIV/AIDS Strategic Plan to ensure that Burundi will reach and sustain HIV epidemic control. Like COP22, the development of the strategic plan has been a collaborative process, taking into account the recommendations of various stakeholders including CSOs, development partners and implementing partners. As a result, there is clear alignment of the proposed National HIV/AIDS Strategic Plan with COP22, including focus on improving community engagement, increasing prevention interventions like PrEP, and intensifying case findings for PBFW and children.

Other key initiatives for COP22 include strengthening technical working groups to help facilitate sharing of lessons learned and providing data-driven recommendations to the MoH. Regular meetings and robust discussions will also ensure that there is no duplication of effort by the various stakeholders.

Finally, transitioning programming to local partners is central to ensuring sustainability. PEPFAR Burundi continues to support developing local capacity to receive direct funding. In COP22, two new local partners will be receiving direct funding. Further, with the advent of community led monitoring (CLM), the community will have a stronger voice in ensuring that HIV services are meeting the needs of PLHIV.

While there is still a long road to complete sustainability, concrete strides are being made. In COP22 and beyond, programs are being designed in collaboration with stakeholders to advance towards sustainability.

From an analysis of the Sustainability Index Dashboard (SID) aligning with PEPFAR expenditure reporting (ER) data, PEPFAR has increased expenditures over time to support areas with highest vulnerabilities, including quality data for decision-making, private sector engagement, commodity security and supply chain management, epidemiological and health data, civil society engagement, quality service delivery, laboratory systems, quality management, human resources for health, policies and governance, financial and expenditure data.

COP22 will focus on the following sustainability vulnerabilities:

- **Data for Decision-Making Ecosystem**
  In COP22, PEPFAR will continue to scale up the deployment of systems such as SidaInfo and UID and eLMIS to improve quality and availability of data for decision making and programming for effective care and treatment services, laboratories data management information system for a quick viral load results turn around and improve logistic management information. Focus will be on building the national and district capacity to analyze data and use it for decision making.

- **Private sector engagement**
  The Ministry of Health is developing a five-year National HIV/AIDS Strategic Plan to reach epidemic control that aims at improving domestic resources including the contribution of the private sector to the HIV response. PEPFAR will support the Ministry of Health in that journey to improve sustainability of HIV programming in Burundi.

- **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. The strong collaboration of PEPFAR and Global Fund continues to secure the availability of HIV commodities and to improve the supply chain system. PEPFAR will continue to build the drug regulatory agency and the national medical store capacity to manage the supply chain to reduce stock out and improve efficiencies. PEPFAR will continue to advocate for more Government contribution to financing the epidemic response and support the Ministry of Health in mobilizing more domestic resources including the private sector's social responsibility (CRS) to finance the procurement of commodities and support the program management.

- **Epidemiological and Health data**
  PEPFAR will continue to support the country's capacity to analyze program and epidemiological data and evidence-based decision making. PEPFAR will support the expansion of SIDAInfo to integrate surveillance data as the country continues to implement recency and use of unique identifiers to track individuals through the clinical cascade. PEPFAR will build NACP capacity to perform data quality assessments to improve data quality and alignment.

- **Civil Society Engagement**
  In Burundi, there is active civil society engagement in HIV/AIDS advocacy, decision-making processes and service delivery in the national HIV/AIDS response. However, there is a need to continue supporting the CSOs for capacity building in project development (setting targets and measurable indicators), fundraising, and management. PEPFAR will continue to build the capacity of civil society organizations to take more responsibilities in supporting the epidemic response and improve Government accountability as a response to the community led monitoring to be implemented through the civil society organizations.

- **Service Delivery**
  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 patients experiencing an interruption in treatment. Service delivery is the responsibility of Burundi's decentralized district health system. District Health Teams (DHTs) need to play a more central role in providing technical oversight for HIV services through the improvement of their supervisory and support functions to health facilities. PEPFAR will continue to build the health district teams' capacity to oversee the quality of services in their area of responsibility while the building the capacity of communities to lead the monitoring of the quality of services with aim to work with health managers at all levels to make the necessary change as a response to the recommendation of the community led monitoring.

- **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. Burundi needs support for the implementation of the National Viral Load Scale-up plan under the umbrella leadership of the MSPLS. PEPFAR will continue to support Burundi in its journey towards the effective implementation of diagnostic network optimization. Further, PEPFAR has introduced the service rental agreement with the Abott platform and will continue to advocate for extending it with the Opera and GeneXpert machines to optimize their utilization and overcome the challenges related to machine breakdown and maintenance.

- **Quality management**
  The GOB has a current QM/QI plan for HIV care and treatment, but there is need for improvement of data collection and use. The introduction and scale up of the community led monitoring and the new district approach that aims to improve systems at the district level will contribute to improving quality management and quality insurance.

- **Human resources for health**
  The GOB does not have sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services and other key health services in health facilities and in the community. However, all the staff of the public health facilities are recruited and paid by the GOB as well as some of the staff of the faith based and private for profit organizations. PEPFAR support will be provided to continue to build the capacity of available staff at the facility as well as available community health workers supporting the community programming in Burundi.

- **Policies and governance**
  The country has policies in place that support the collection and appropriate use of patient-level data for health, including PEPFAR will continue to support the implementation of existing policies and the introduction of new policies to meet WHO and international standards in health care to improve the quality of services and improve coordination and accountability in the HIV response.

- **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. PEPFAR in collaboration with the Global Fund will support the introduction of the activity based costing approach to improve visibility on health expenditure. The Government of Burundi is working on completing the 2020 health expenditure analysis that will inform financial data programming. PEPFAR will leverage the work bank effort improving transparency and accountability in health expenditure data availability and data use for decision making.

4. Data Use and Sharing and Quality Control

In COP22, PEPFAR Burundi will depend upon the strong and long-standing partnership between the stakeholders who invest in epidemic and health data in the country. In COP22, PEPFAR Burundi and MoH will routinely share their respective results from DATIM and HMIS. Periodic data exercises are

underway currently, and will be enhanced in COP22, especially as more systems come on line. A dashboard for HIV recent infection surveillance program data was recently released and shared with stakeholders. Similarly, PEPFAR Burundi conducts a monthly commodity dashboard update which is shared with stakeholders. Routine data reviews with stakeholders provide avenues to discuss progress and program improvement. This transparency and collaboration continues to strengthen the PEPFAR program.

Data quality continues to be a high priority for PEPFAR Burundi and the MoH. PEPFAR Burundi conducts an annual DQA for program data. Further investments in data quality activities, including strengthening SIDAInfo and routine reporting systems and expanding the UID system will continue to improve data quality in COP22. PEPFAR IPs are expected to conduct routine data quality improvement activities, and USG staff are routinely reviewing results to strengthen data quality.