



# COP 2017 Approval Meeting Outbrief Burundi

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Burundi Team

April 29, 2017

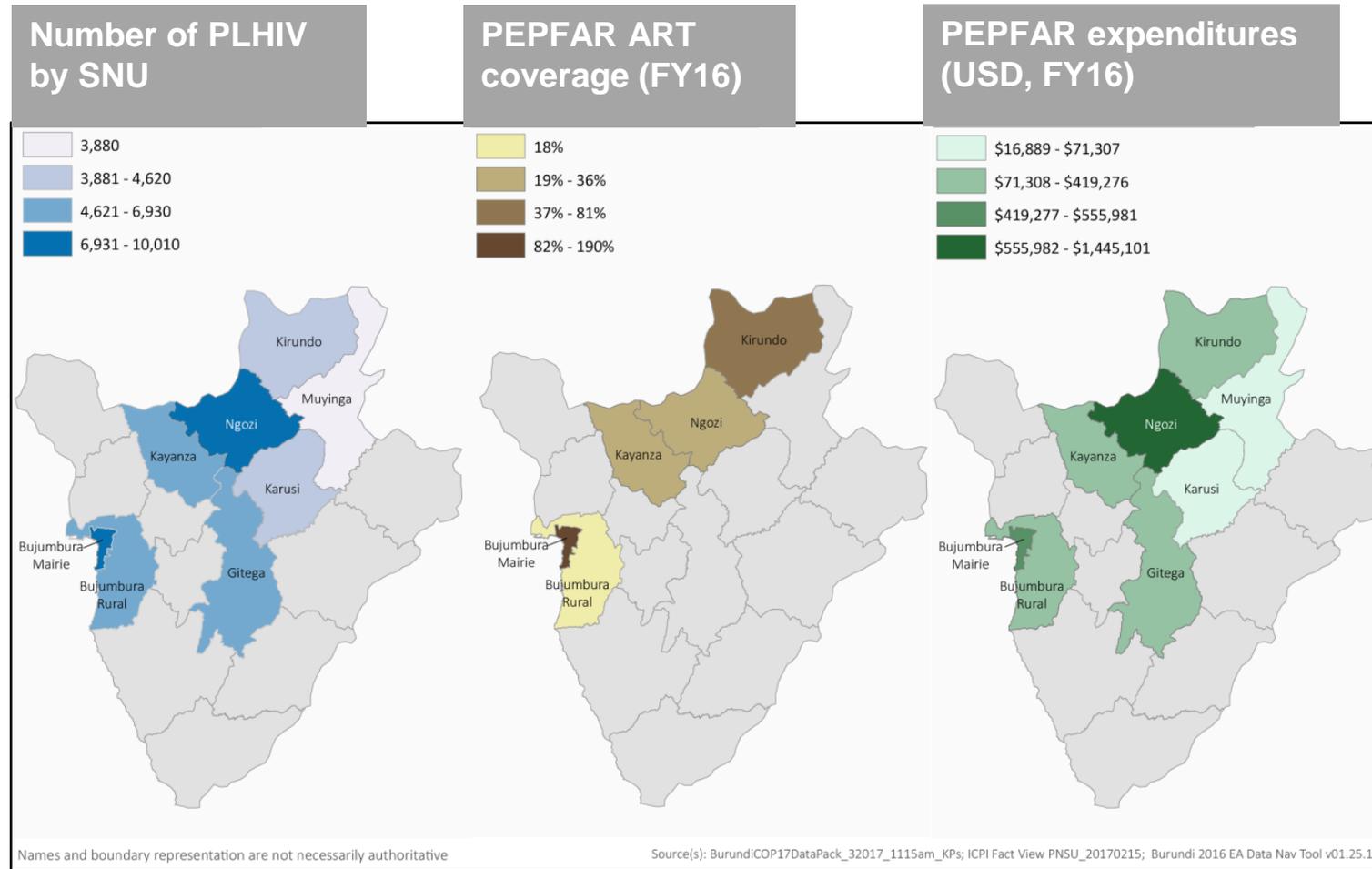
### **PLEASE NOTE**

All PEPFAR FY 2017 Q2 program results and achievements included within this presentation were based upon preliminary reporting and may differ from the final submission results. Final FY 2017 Q2 results, as well as past and future quarterly and annual PEPFAR program results, can be accessed on the PEPFAR Dashboard at <http://data.pepfar.net>.



# Status Overview: COP 2016 Implementation and Country Context

# Alignment of Investments to HIV Burden



# Policy Overview

## **Test and START**

- Policy adopted in September 2016
- Implementation plan finalized December 2016
- Implementation started Q1 2017 in PEPFAR-supported provinces including same day start

## **Multi-Month Scripting**

- Plan completed; HCW training underway
- Launch anticipated Q3 2017

## **International NGO Law**

Operational and registration procedures that place restrictions; potential limitations on the ability of NGOs to function

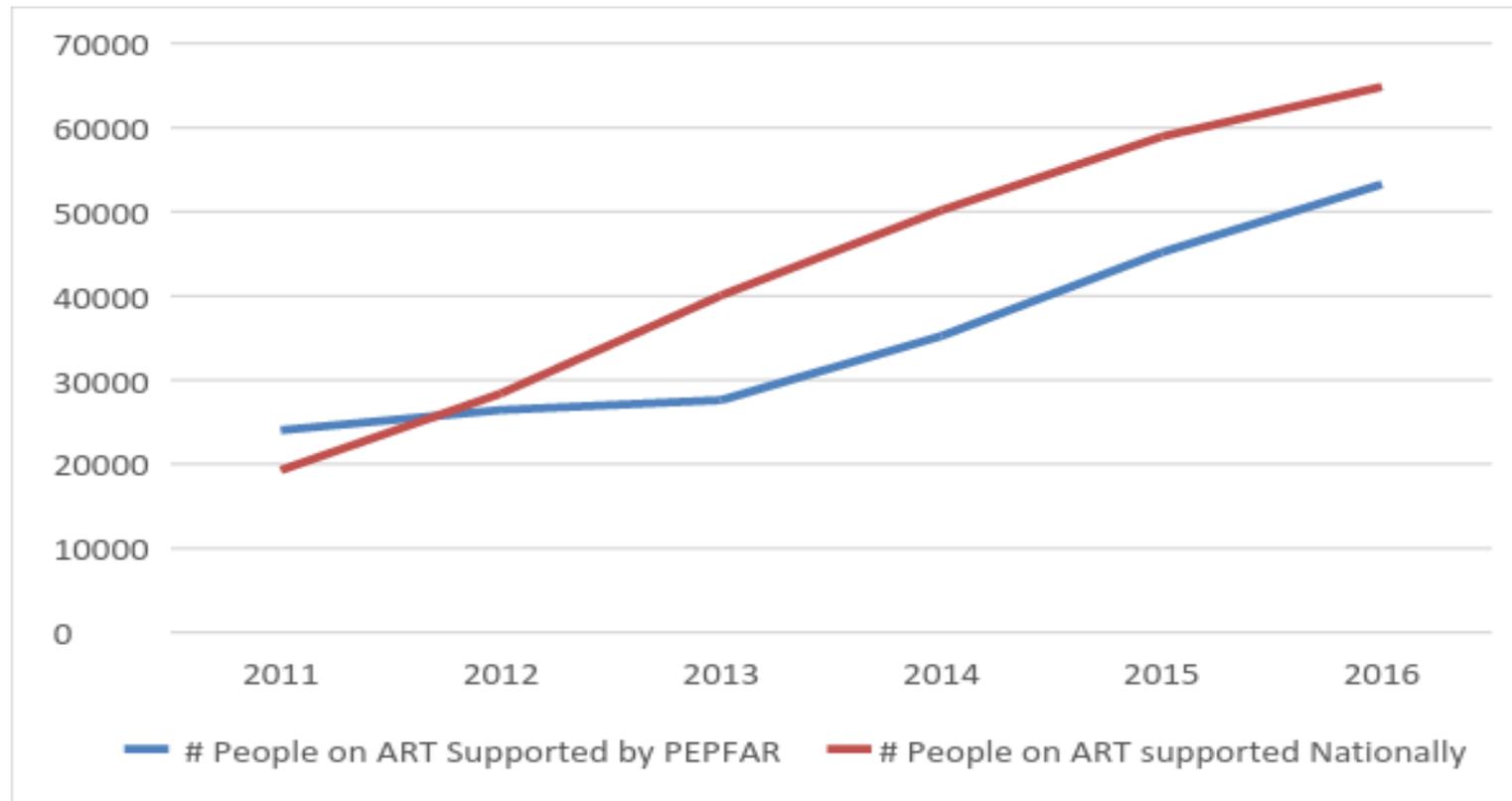
## **Viral Load**

Policy adopted to replace CD4 with VL for routine monitoring; implementation scale up plan still required

## **Self Testing**

Part of national testing guidelines

# National And PEPFAR Trend For Individuals Currently On Treatment



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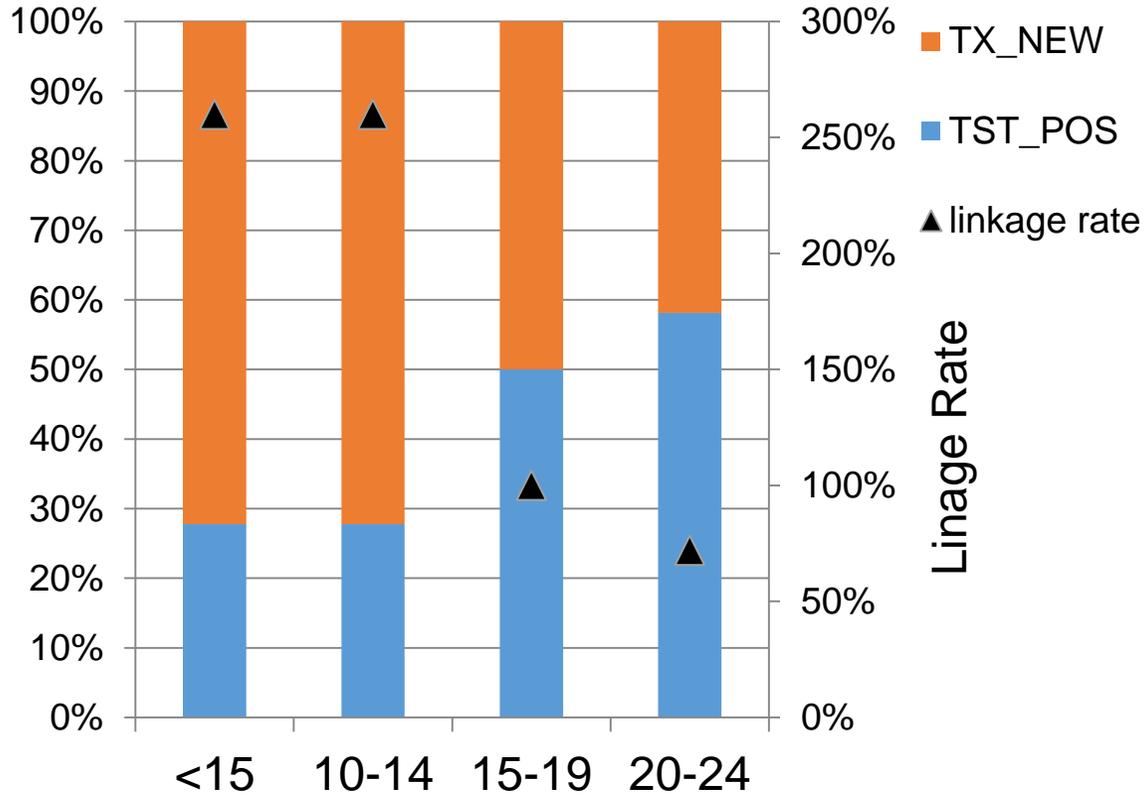
# COP17 Investments by Program Area

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

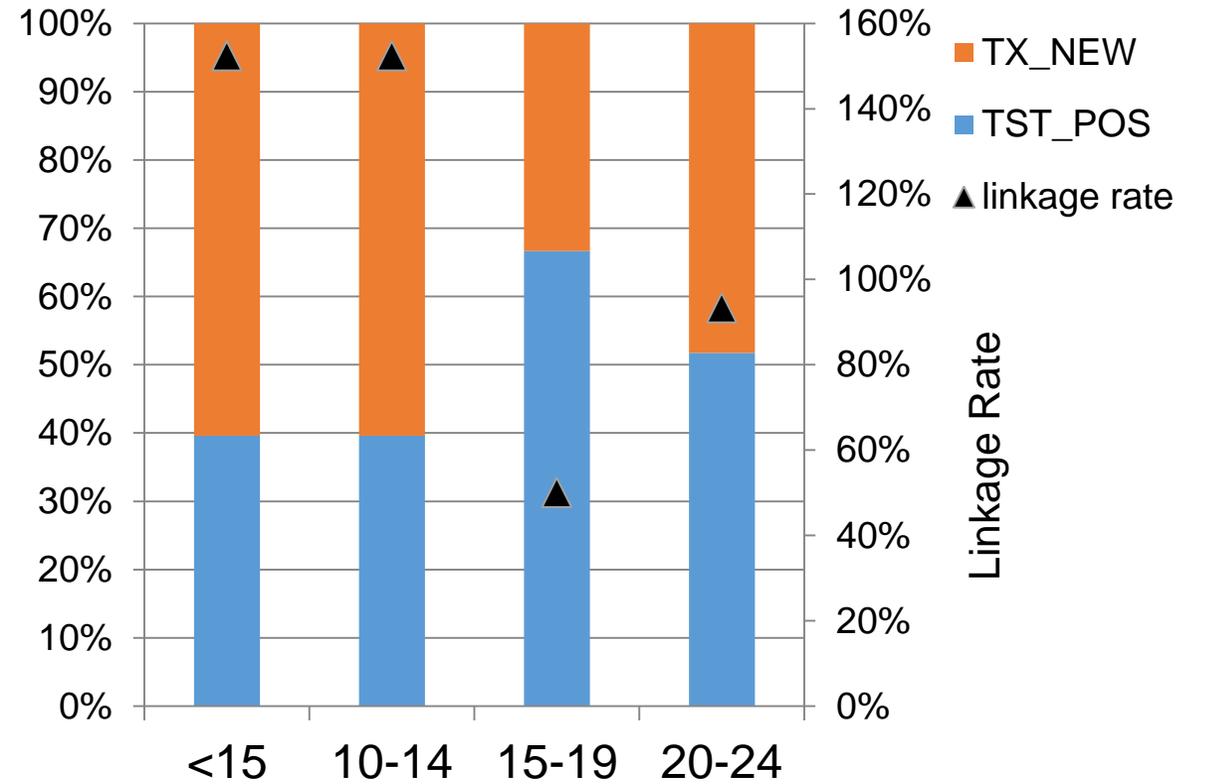
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# Clinical Cascade by Sex and Age Bands - FY17 Q1

## Female

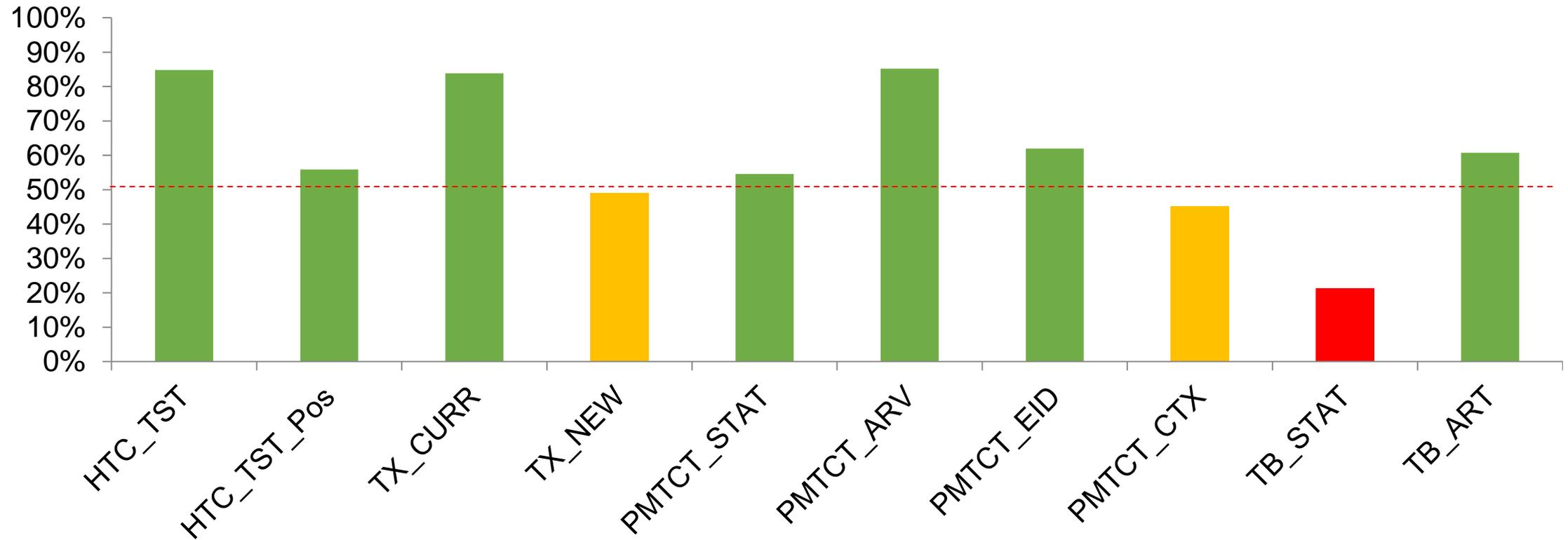


## Male



# Q1+Q2 Progress To FY17 Targets\*

% Achievement (Annual Target)



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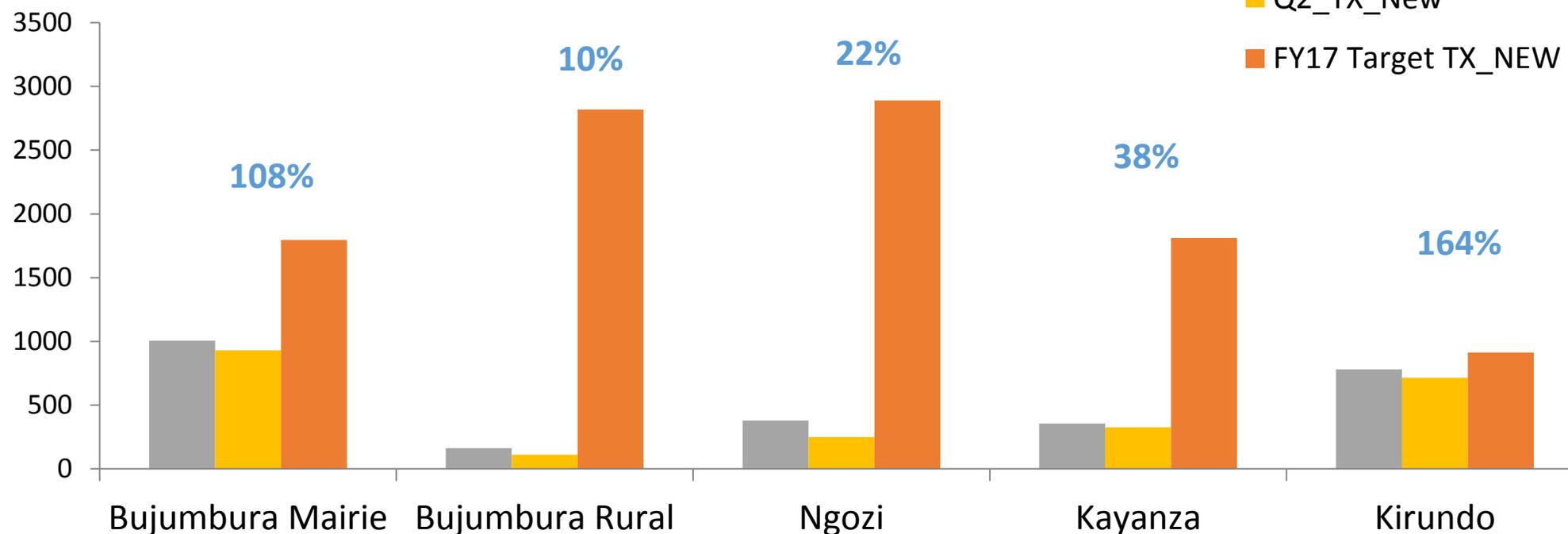
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# Q1/Q2: Treatment by SNU\*

Overall progress at SAPR = 49%

% progress at SAPR

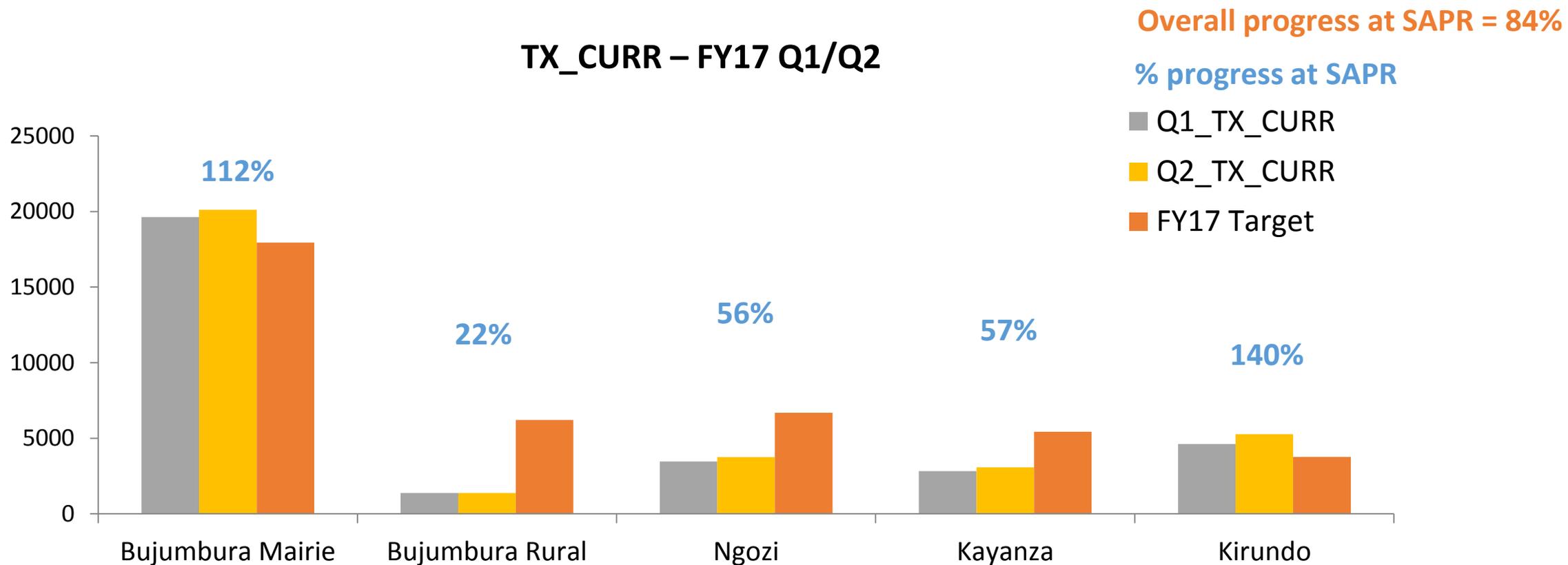
TX\_NEW - FY17 Q1/Q2



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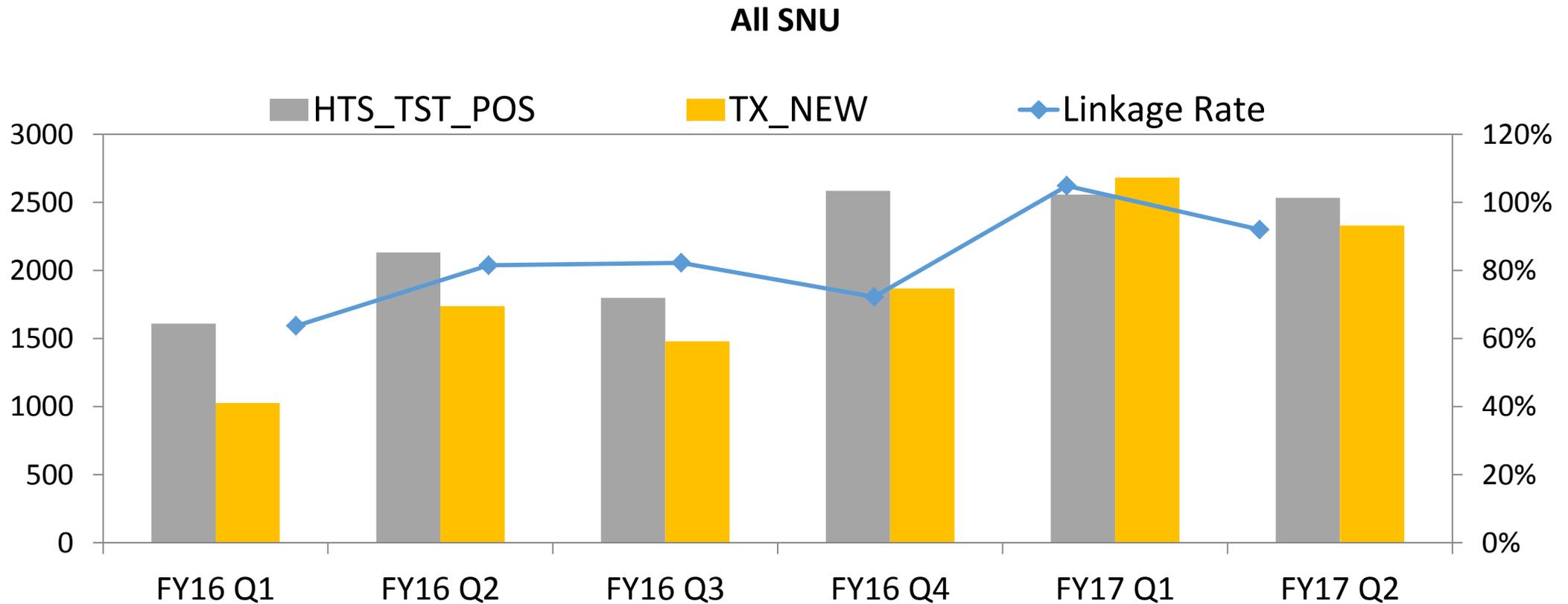
# Q1/Q2: Treatment by SNU\*



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# Linkages Over Time\*

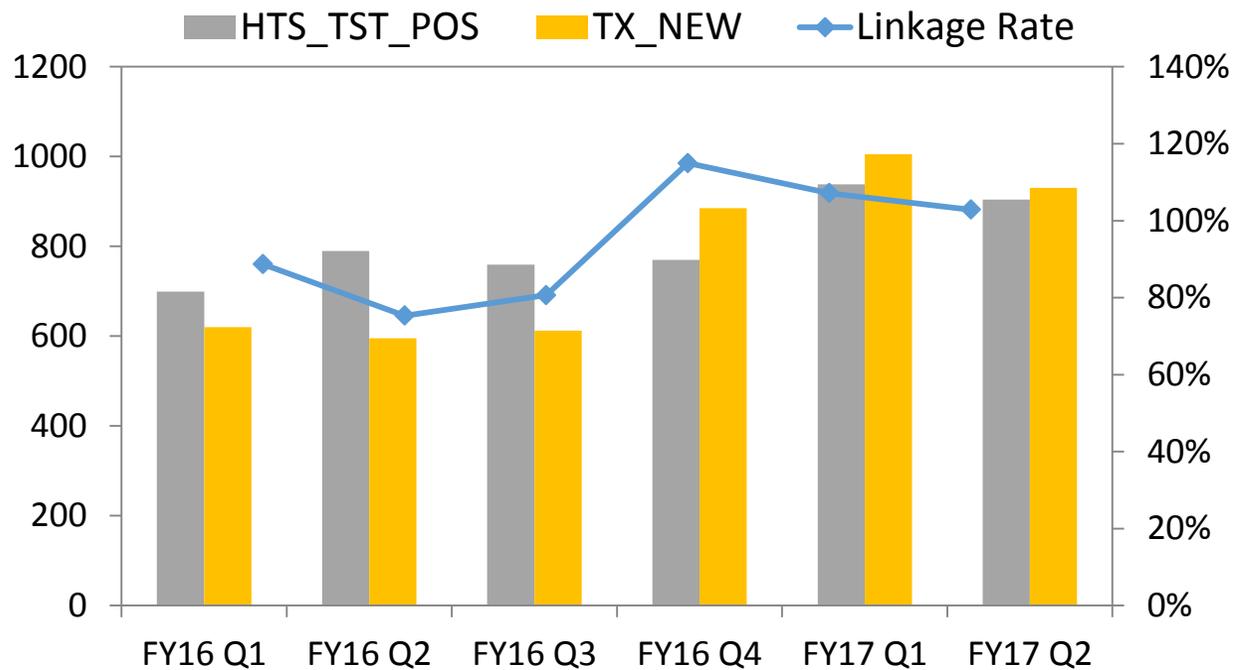


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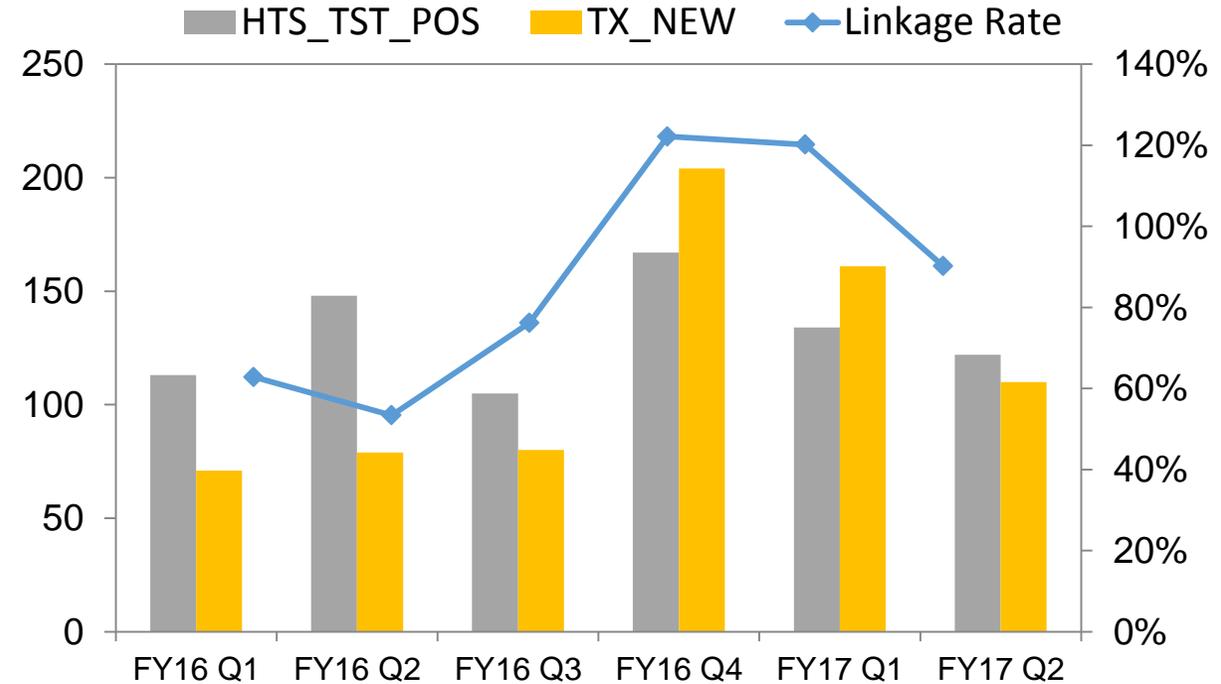
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# Q1/Q2: Test and Start Impact on Linkages: Example of Two SNU\*

### Bujumbura Mairie



### Bujumbura Rural



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# Path to Saturation: Progress

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



# COP 2017 Strategy

# Stakeholder Review and Comments

CSOs highly involved in PEPFAR/Burundi planning and implementation for many years

Programmatic success is attributed to high capacity/strong CSO engagement (ANSS, SWAA, RBP+, etc.)

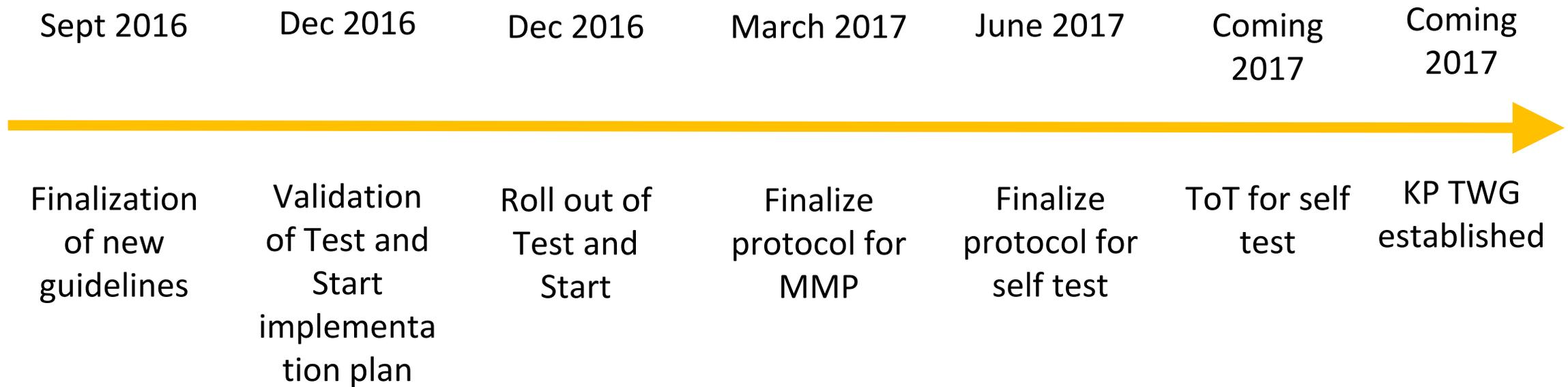
COP17 planning—CSO consultation Feb 9<sup>th</sup>

CSO response highlights/needs:

- Capacity building for peer navigators & educators
- Focus on adolescents in and out of school
- Utilize social networks to access key populations
- Promotion of self testing for MSM



# Key Dates And Timeline Of Stakeholder Engagement During The COP 2017 Process



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# Stakeholder Recommendations

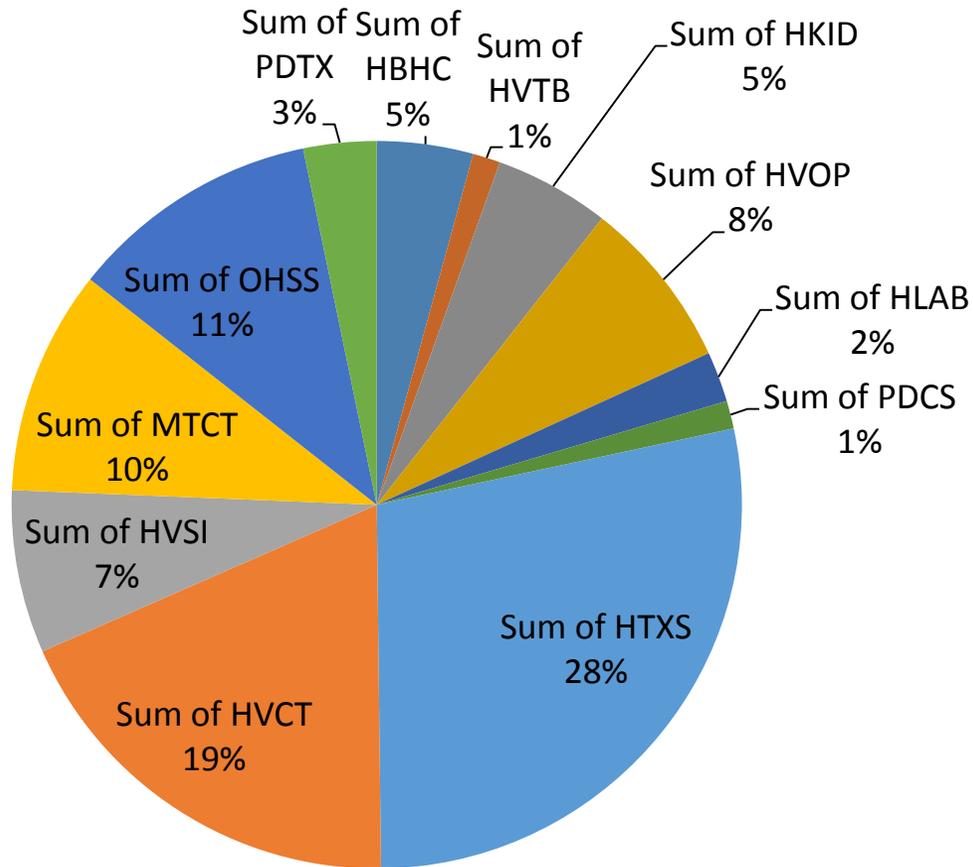
## Incorporated in COP 17

## Requiring Further Discussion

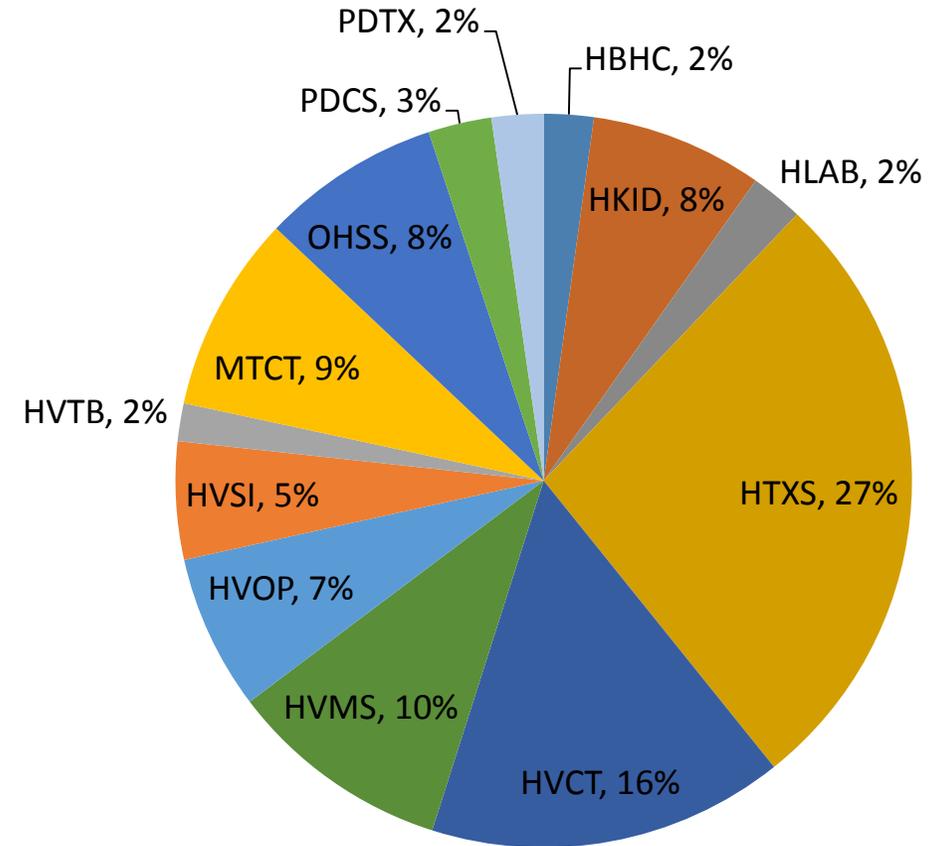
Promotion of self testing for MSM	Extend target populations to people leaving with disability, prisoners and fishermen. Not included in COP 17 because some are out of PEPFAR supported provinces (fishermen), others are already supported by other partners (prisoners) whereas people living with disability can be found among the priority or key populations already considered by the PEPFAR and other partners programming.
Greater focus on adolescents in and out of school	
Sensitization of communities on the availability of clinical services at sites (GBV, HIV testing, and other services)	To offer comprehensive and quality services in non PEPFAR supported provinces in order to bring people seek services near their homeland. Not considered in COP17 because the recommendation should be directed to the Government of Burundi.
Support capacity building for peer navigators and educators to reach youth	
Consider conducting annual mappings to identify new hotspots and populations at high risk	Consider PWID as a new target for KP program
Strengthening of CSOs institutional capacity and their promotion to prime implementing partners	
Support legal interventions for people living with HIV and key populations	

# COP 2016 vs COP 2017 by Budget Code

## COP 16 Budget Code Distribution



## COP17 Budget Code Distribution



# COP 2017 Agency Allocations and Pipeline

	New FY 2017 Funding (all accounts)	Applied Pipeline	Total Planning Level
USAID	11,051,700	4,950,640	16,002,340
DoD	47,763	1,309,897	1,357,660
<b>Total</b>	<b>11,099,463</b>	<b>6,260,537</b>	<b>17,360,000</b>

# Earmark Allocations

New FY 2017 funds allocated to care and treatment:

- COP17 requirement: \$1,649,200
- COP17 planned: \$4,534,395

New FY 2017 funds allocated to OVC:

- COP17 requirement: \$799,517
- COP17 planned: \$829,307

# Summary of COP 2017 Targets by Prioritization

COP17 Priority	COP17 Target (APR18) HTC_Test	COP17 Target (APR18) HTC_Pos	COP17 Target (APR18) Tx_New	COP17 Target (APR18) Tx_CURR	COP17 Target (APR18) OVC_Serv	COP17 Target (APR18) KP_Prev	COP17 Target (APR18) PP_Prev	COP17 Target (APR18) VMMC
<b>TOTAL</b>	<b>200,886</b>	<b>5,355</b>	<b>8,719</b>	<b>45,545</b>	<b>8,000</b>	<b>31,800</b>	<b>20,000</b>	
Saturation	83,311	3,476	5,256	31,714		<b>13,096</b>		
Aggressive	117,576	1,879	3,463	13,831	8,000	18,704		
Military	19,326	534					20,000	

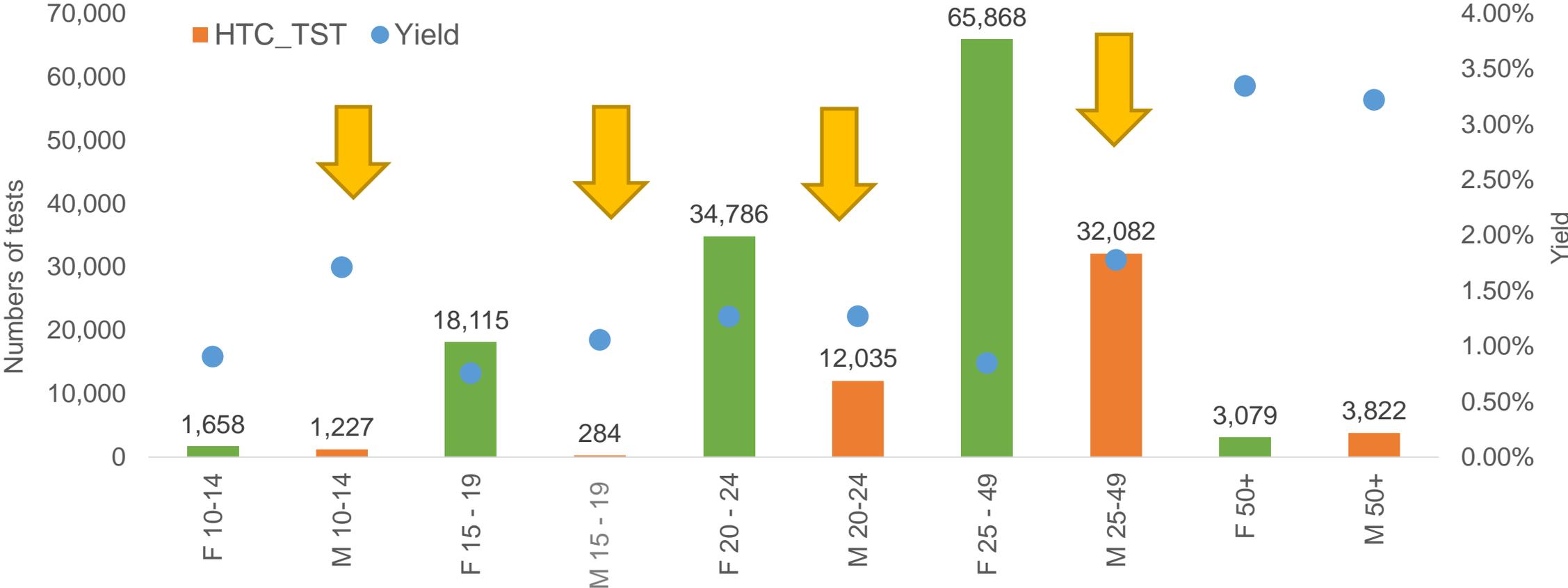
# Impact over time: Tx\_New and Tx\_CURR Details

COP 17 Priority	COP 16 # of SNU	TX_New: APR 2016 Achievement	TX_CURR: APR16 Achievement	TX_New: FY 2017 Target / FY 2017 Results to-date	TX_CURR: FY 2017 Target / FY 2017 Results to-date	COP 17 # of SNU	TX_New: COP 2017 Target (APR 2018)	TX_CURR: COP 2017 Target (APR 2018)	Net New: COP 2017
<b>TOTAL</b>	<b>6</b>	<b>6327</b>	<b>30,614</b>	<b>5,192</b>	<b>34,763</b>	<b>6</b>	<b>8,123</b>	<b>44,223</b>	<b>3,591</b>
Saturation	1	2726	18,983	1935	20114	2	3,145	22,422	886
Aggressive	4	3331	10,511	3,078	13,456	3	4,469	20,062	2,356
Other (Military)	1	270	1,120	179	1193	1	509	1,739	349

# 1st 90: COP 17 Testing Strategy

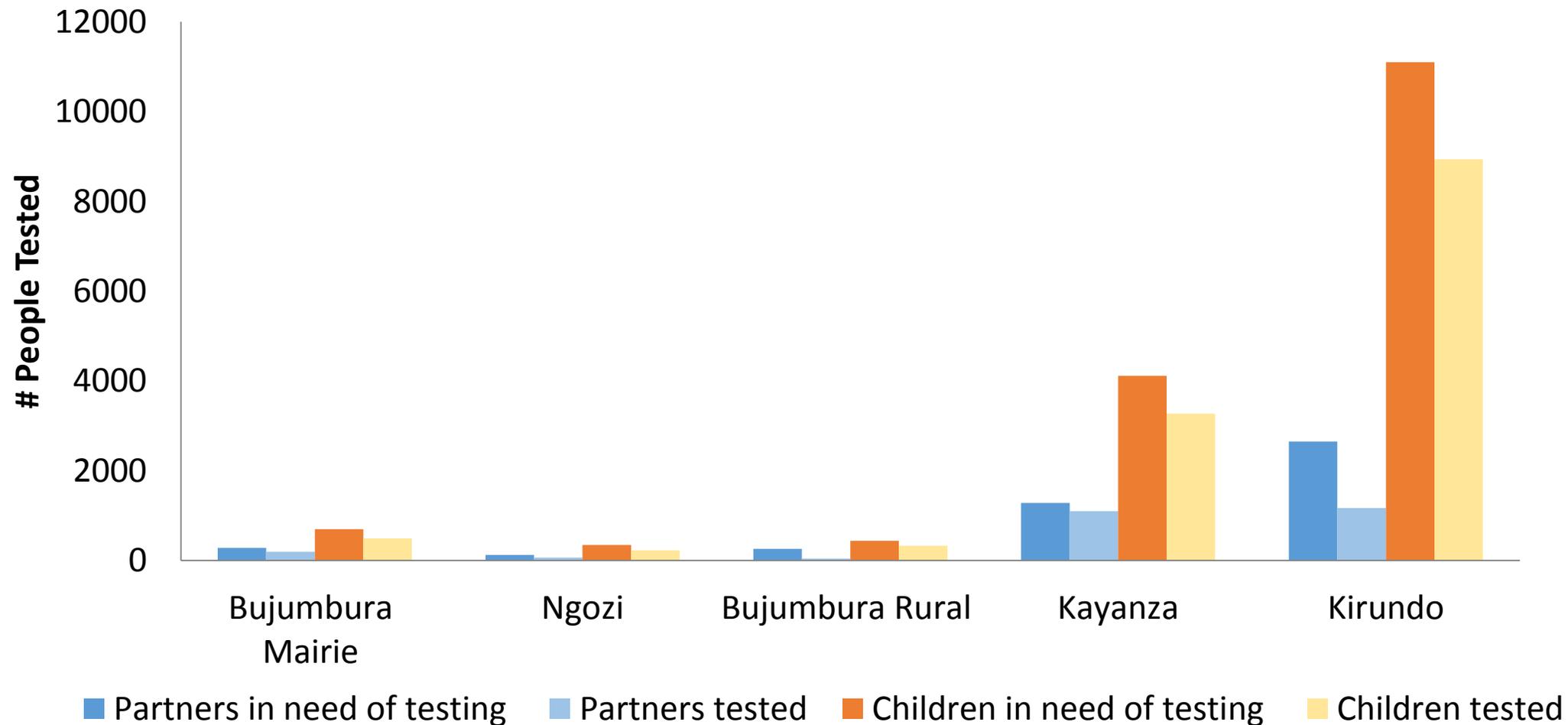
Challenges Identified	Approaches in COP17
Over-testing	<ul style="list-style-type: none"> <li>• Eliminate low volume sites &lt;5 positive tests in FY16 (N = 29, representing 98,000 tests performed in FY17 Q1)</li> <li>• Reduce co-located testing in sites with &gt;5,000 tests performed per quarter</li> </ul>
Limited targeted testing	<ul style="list-style-type: none"> <li>• Expand index patient testing to all provinces (Screen 100% of new clients and 50% of existing clients)</li> <li>• Increase in-patient and out-patient testing in Ngozi and Kayanza</li> <li>• Reduce in-patient and out-patient testing in Bujumbura Mairie and Kirundo – use screening tool to focus testing</li> <li>• Increase testing in TB clinics</li> </ul>
Key Populations not being tested	<ul style="list-style-type: none"> <li>• Use of HIV self-testing with KPs and youth &lt;30yo in all provinces (hotspots)</li> <li>• Scale up index case testing</li> </ul>
Limited pediatric case-finding	<ul style="list-style-type: none"> <li>• Strengthened Pediatric case finding through innovations including reaching children of female sex workers (FSW)</li> <li>• Strengthen EID uptake at 6 weeks</li> </ul>

# Reaching the First 90: FY17 Q1 by Sex and Age



- Success with reaching men >24

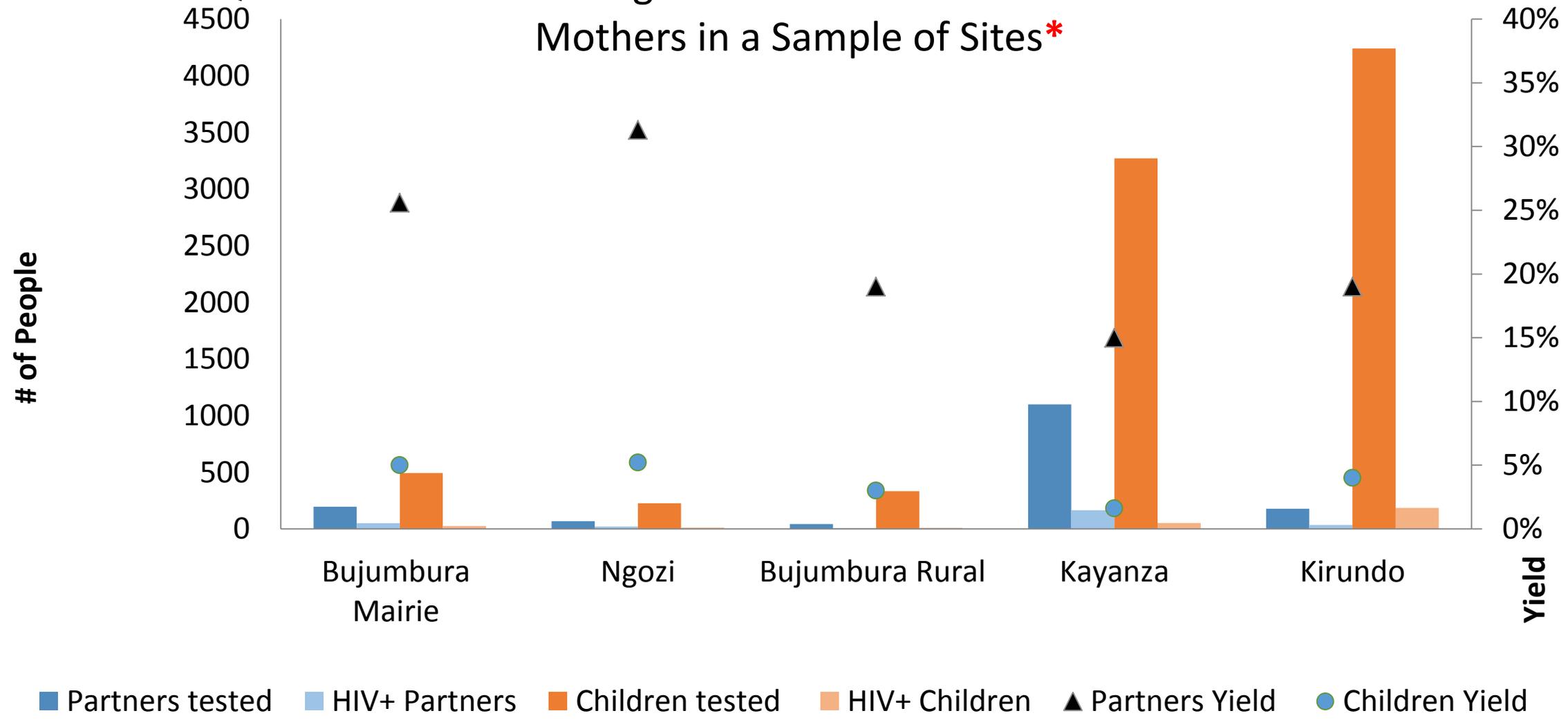
## Q2 FY17 Results: Index Testing of Partners and Children of Positive Mothers in a Sample of Sites\*



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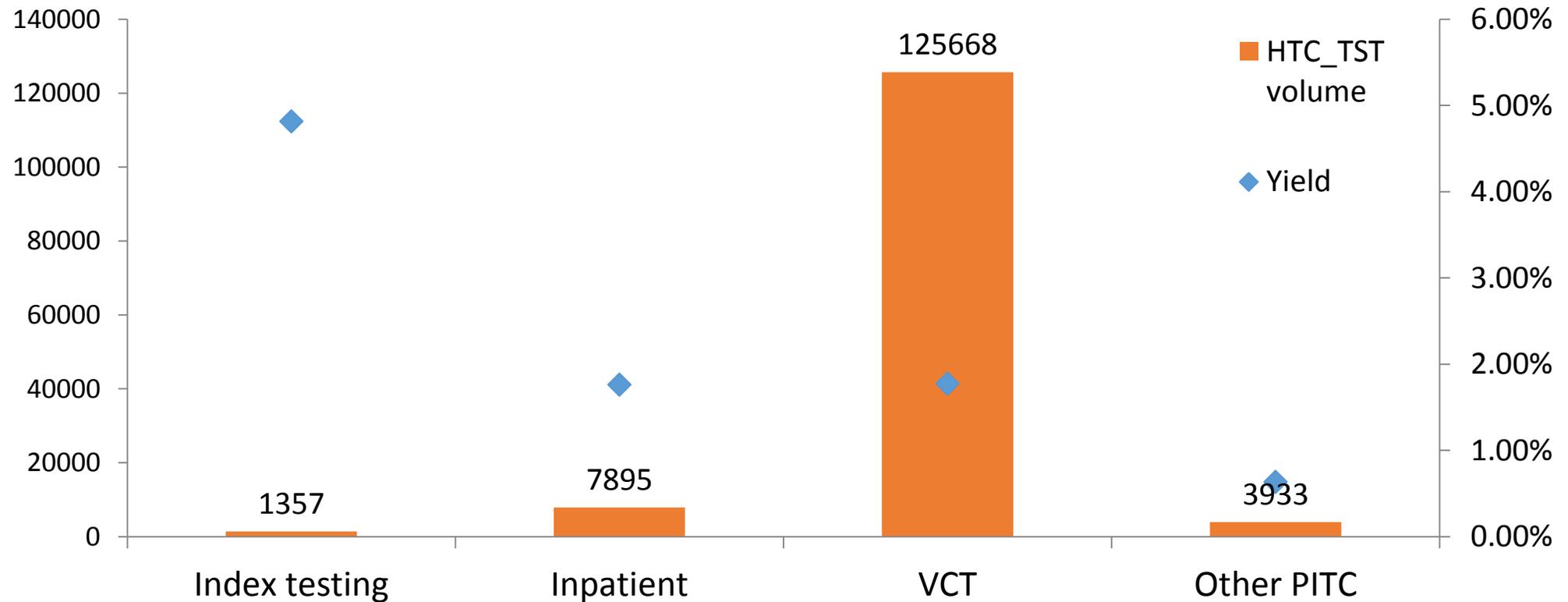
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## Q2 FY17 Results: Testing Yield of Partners and Children of Positive Mothers in a Sample of Sites\*

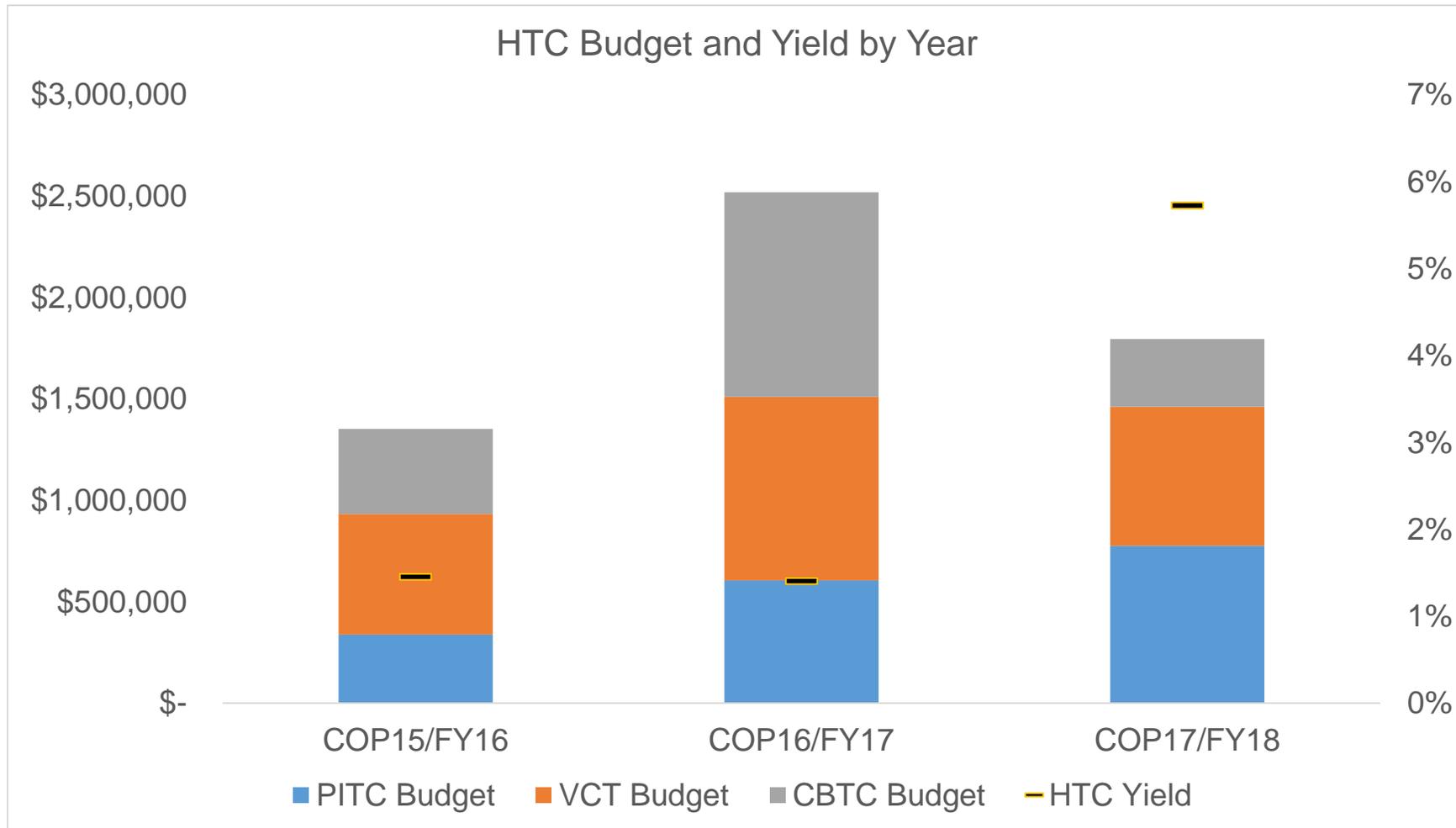


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# FY17 Q1: Volume and Yield by Modality

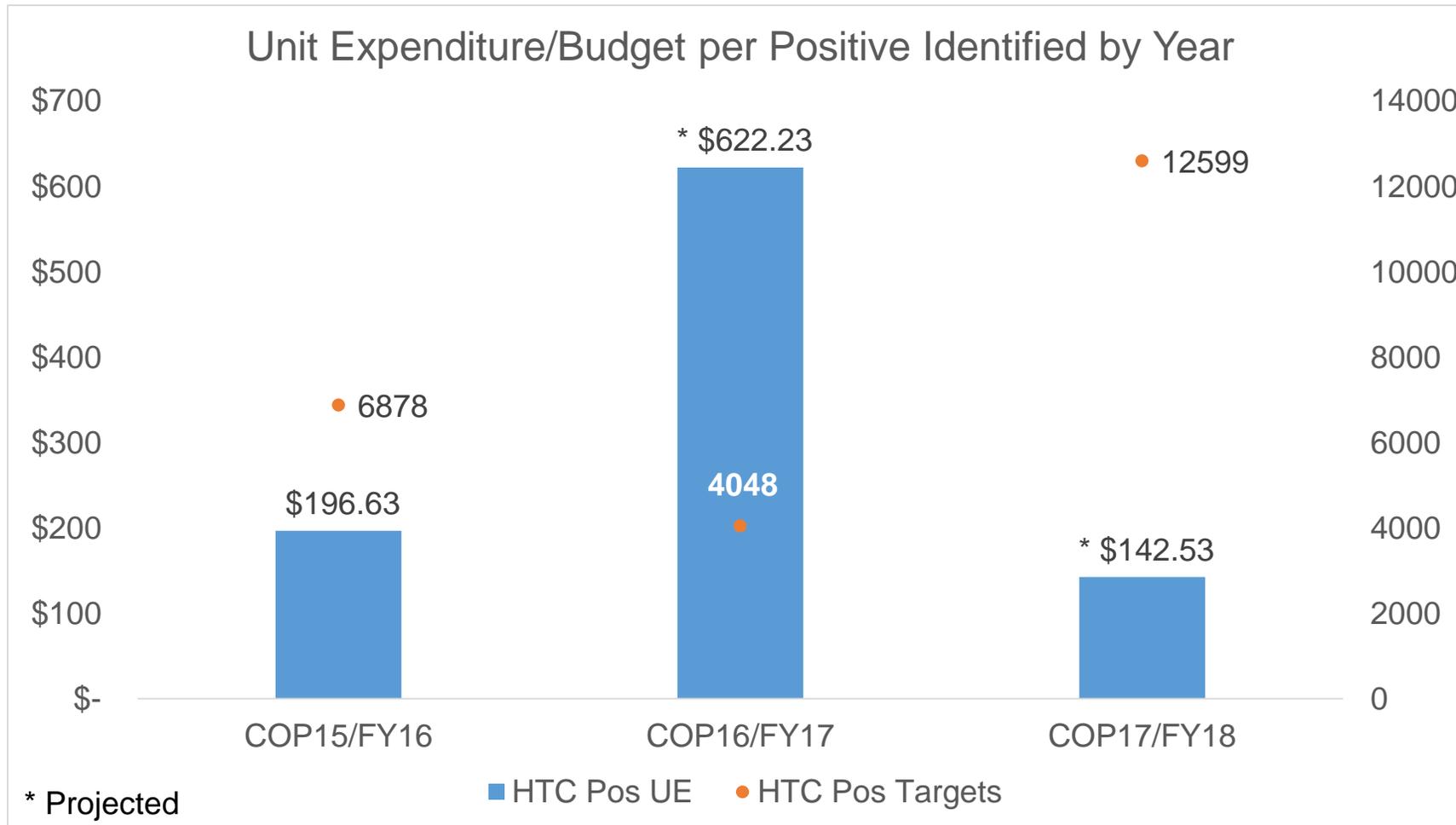


# Testing Investments Focused for Greater Effectiveness and Efficiency



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# Testing Investments Focused for Greater Effectiveness and Efficiency



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# 2<sup>nd</sup> 90: COP17 Linkage and Treatment Strategy

Support full implementation of Test and Start

- Including same-day ART initiation and differentiated models of care

Support strategies aiming at reaching a 90% linkage rate

- Targeted TA to facilities with <75% linkage rate (Ngozi, Kayanza)

Clinical service quality improvement in high volume facilities

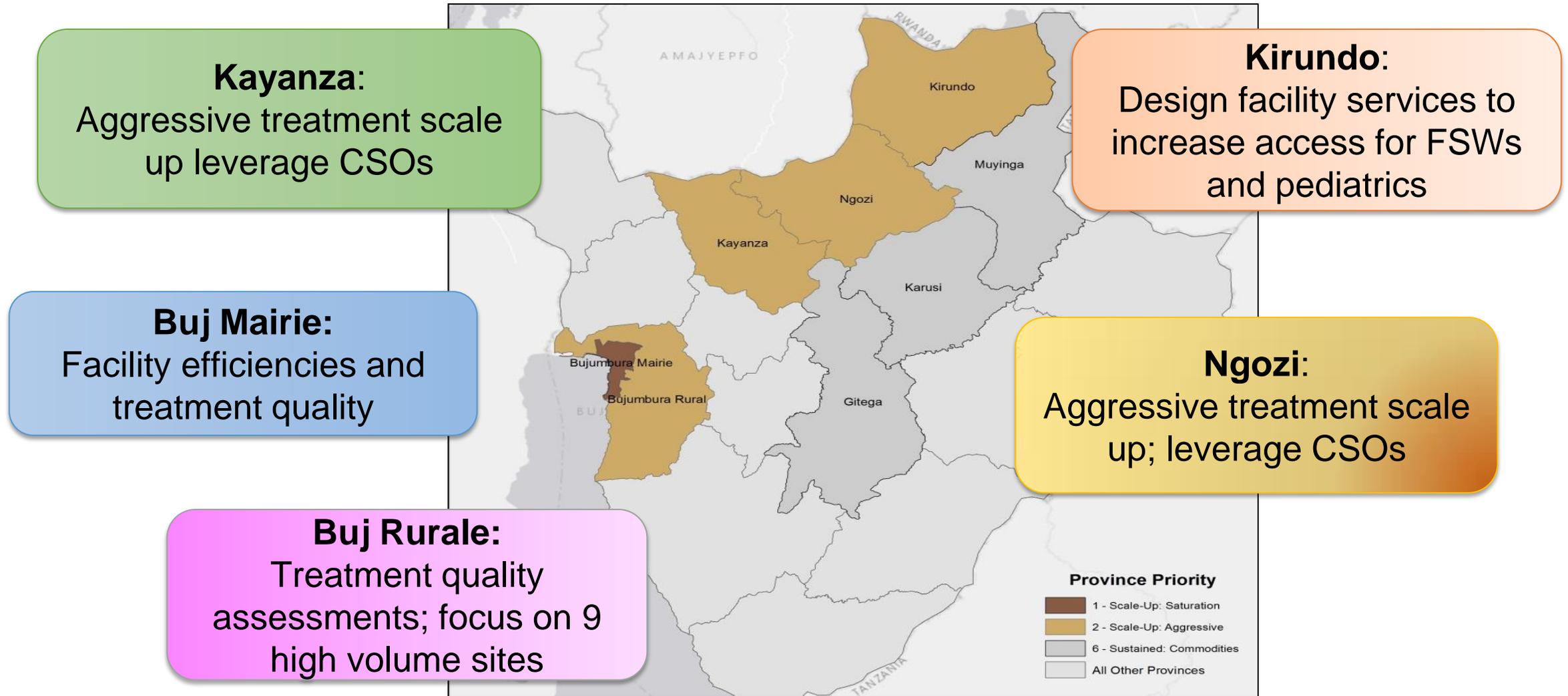
- Bujumbura Mairie – efficiency in service delivery models
- Bujumbura Rural – 9 facility strategy to improvement of services offered
- TB/HIV – IPT roll-out; 100% reach of TB identified or suspect cases

Maintain or increase the high 12 month retention rate (87%)

- Leverage national network of PLHIV(RBP+) and community adherence groups (CAGs)

Build capacity in KP treatment and pediatric treatment (Kirundo)

# COP17 Geographic Strategies



# Mobility for Services to Bujumbura Mairie

- Bujumbura Mairie is already over ART saturation but poor ART coverage in Rural – why?
- Many PLHIV travel to Mairie for work, school and to access services
- Rural border is 4 miles from “centre ville” of Buj Mairie
- 11% of PLHIV on ART in Mairie are from Rural



# Service Utilization Assessment in B. Rurale

Assessment reason for clients from Bujumbura Rurale choosing to obtain HIV care and treatment in Bujumbura Mairie.

- Surveys will be adapted from existing validated surveys on quality improvement, satisfaction with healthcare

Quality assurance and improvement activities

- Activities will include: continued SIMS visits, participative data quality assessments, expansion of civil society organizations to Bujumbura Rural, and provision of focused TA to improve the quality of services in Bujumbura Rural at nine high-volume sites with the highest yield and number of positive cases.

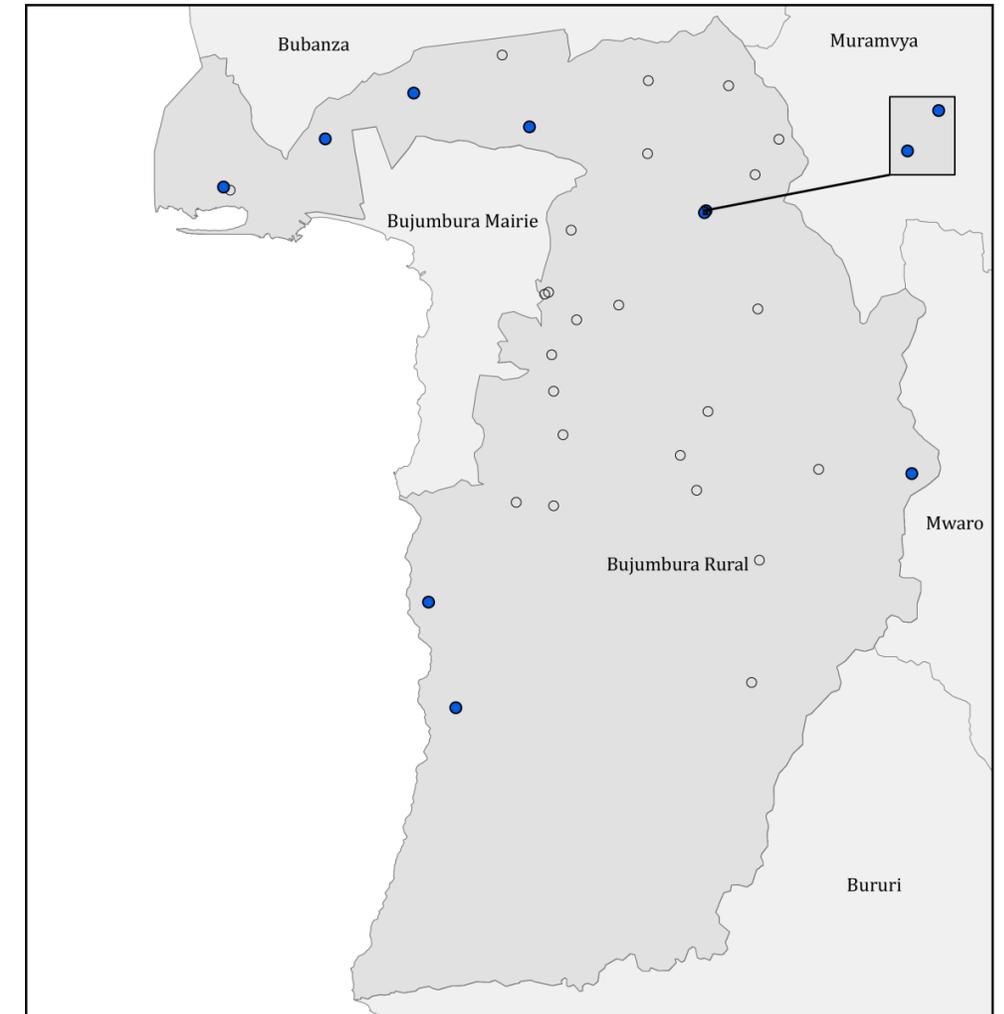
Capacity of Bujumbura Mairie sites to absorb new patients and provide high quality of HIV care and treatment.

- Several high volume sites in Bujumbura Mairie will be assessed to ascertain their capacity using existing tools, such as the Service Provision Assessment (SPA) or Service Availability Readiness Assessment (SARA).

# Identified 9 Buj Rurale sites to assess capacity and improve service quality

Facility	HTS_TST_T	HTS_TST_POS	TX_CURR	TX_NE_W	Linkage	Yield
CDS Mutumba	3589	18	41	17	94.44%	0.50%
Hôpital Rushubi	2059	20	94	50	250.00%	0.97%
CDS Kabezi	2437	22	7	10	45.45%	0.90%
CDS Rubirizi	2047	23	27	20	86.96%	1.12%
Hôpital Ijenda	2966	30	160	26	86.67%	1.01%
CDS Foundation Stam	1336	37	22	23	62.16%	2.77%
CDS Maramvya	5860	48	91	49	102.08%	0.82%
CDS Gatumba	5071	48	216	44	91.67%	0.95%
CDS Rukaramu	3740	62	63	35	56.45%	1.66%

Facilities with Highest Yield and Positives in Bujumbura Rural, Burundi, APR 2016



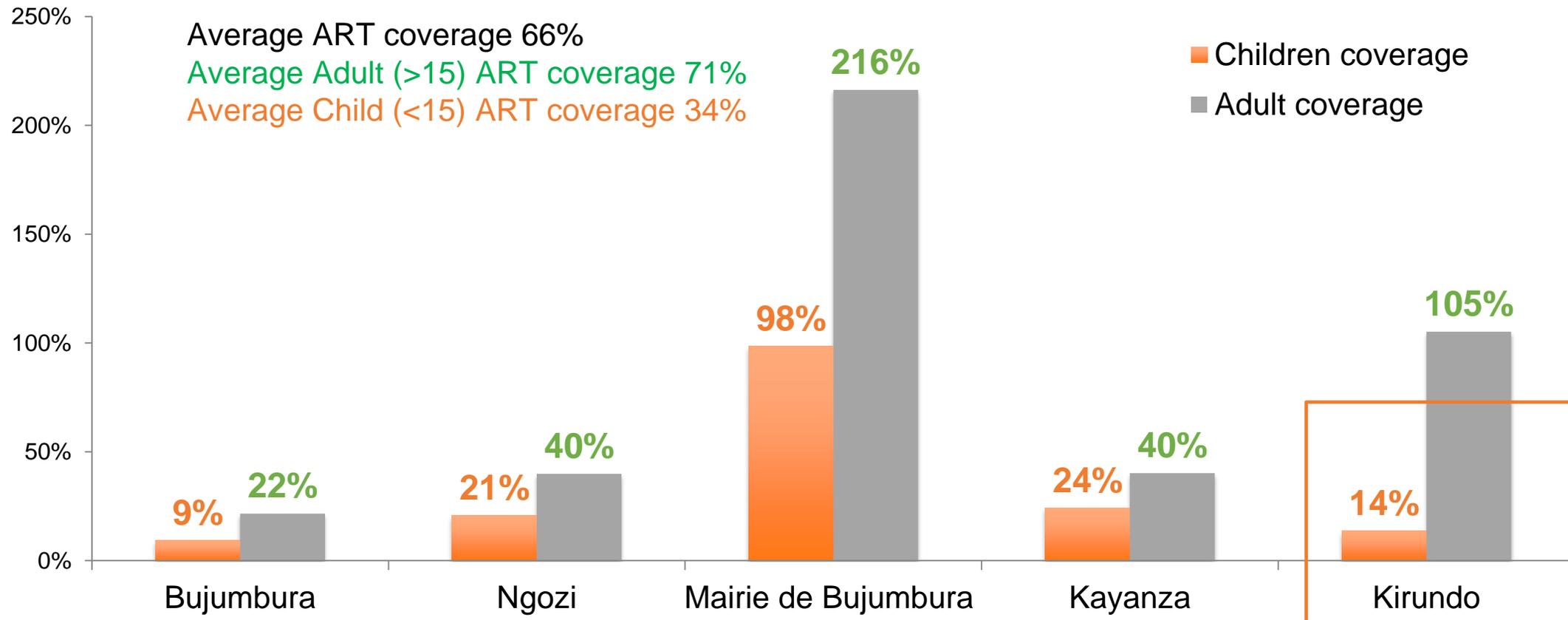
● Facilities with Highest Yield and Test Positives in Province

○ Other PEPFAR-Supported Facilities in Province

Yield defined as  $\frac{\text{HTS\_TST\_POS}}{\text{HTS\_TST}}$   
Positives defined as HTS\_TST\_POS

Made 4/27/2017  
Data provided by  
Burundi Mission

## *FY16: Treatment Coverage by SNU by Age*



# COP17 Pediatric Strategy

## **Identification:**

- Increase case finding in <2 year olds in all 5 provinces
- Scale up EID - improvement of sample transport system
- Utilization of SMS system for sample results reporting

## **Pediatric formulations:**

- Pediatric ART-LPV/r pellets for CLHIV

## **Pediatric treatment capacity in Kirundo (poorest coverage; minimal peds capacity):**

- Explore innovative strategy for improving ART coverage, including:
  - Mobile pediatrician outreach involving refresher trainings for nurses to support MOH task shifting for pediatric care and treatment, integration with KP programming to access children of KP through LINKAGES.

**Adolescents:** leverage existing mobile outreach strategy to reach school students during holidays to provide BCC and linkages to HTS.

# The 3<sup>rd</sup> 90: COP 17 Strategy

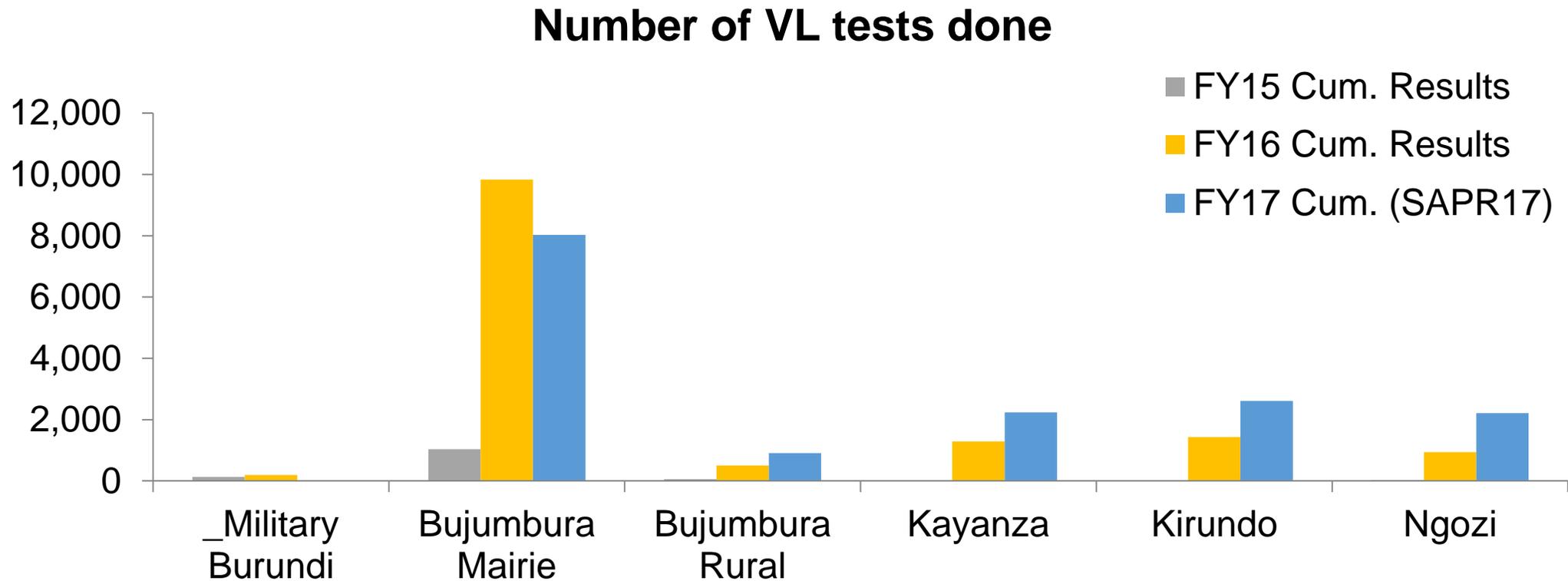
## **Continue strong VL monitoring scale up by:**

Target: 35,378 (80% of tx\_curr)

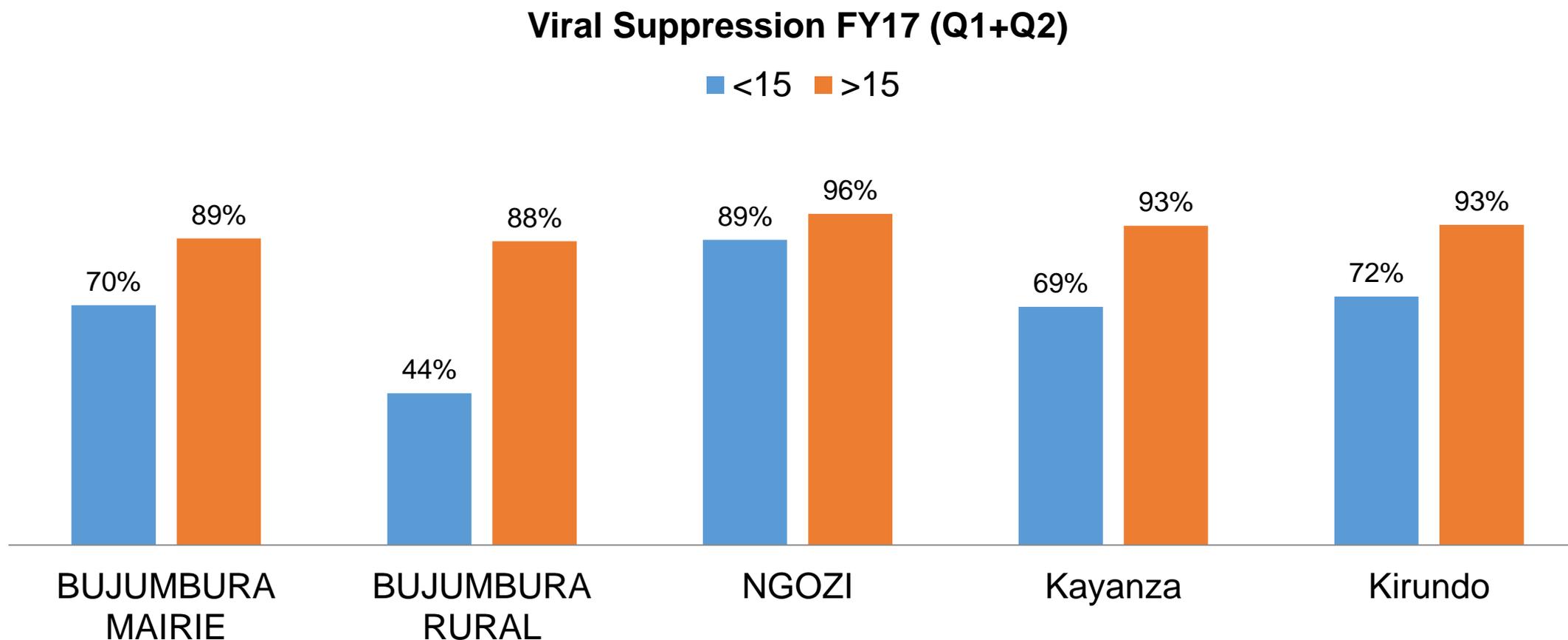
Support patient access to routine viral load monitoring to reach 70% test coverage and 90% viral load suppression in PEPFAR provinces by FY18.

TA for viral load testing, sample collection, results return , and clinical management through coordination across IPs

# Trend Over FY15-FY17 For # Of VL Tests Done



# Viral Load Suppression by SNU by Age (FY17)\*



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# Viral Load Monitoring

Viral load monitoring is routine in Burundi in alignment with new guidelines

Viral load coverage has been scaled up by **900%** in FY16 from FY15 although no targets were set

- Number of tests performed in 2016: 20,000 (of these 15,000 in PEPFAR supported provinces)

Access to viral load testing to **46%** of people on ART (TX\_VIRAL)

Suppression is **93%** for those accessing testing (TX\_UNDETECT) which is in line with **87%** retention on ART

*Lab network for VL testing needs additional support but there have been some improvements*



# Table 6: System Investments

## Table 6: Programmatic Gaps and Investments

**Budget:** 14% (\$2.47M) of the COP17 budget invested in systems to address bottlenecks and programmatic gaps that hamper efforts to achieve treatment saturation

Top three key programmatic gaps:

1. low adult ARV coverage
2. low pediatric ARV coverage
3. low number of key populations identified and linked to services

Strategic Information activities are seen as cross-cutting in order to improve the quality of available data and promote a culture of evidence-based decision making

*Note: In COP17, the team revalidated systems barriers and revisited activities developed in COP16 to assess areas of significant and limited progress. Feasibility of the benchmarks set for activities were assessed.*

# Summary of Table 6 (1/5)

Key Systems Barrier	Outcomes Expected after 3 years of Investment	Year One (COP 2016) Annual Benchmark	Year Two (COP 2017) Annual Benchmark	Budget
<b>6.1.1 Key Programmatic Gap #1: Low Adult ART coverage</b>				
1. Sub-optimal <b>HTC</b> strategy	The national HIV/AIDS program has the adequate capacity to collect and analyze data on testing yields to identify the highest yield entry points.	Testing yields at all sites are greater or equal to prevalence	Testing yields at all sites are greater or equal to prevalence	\$ 150,000.00
	Improve targeted testing to identify 90 % of PLHIV in PEPFAR-supported provinces	85% of PLHIV are identified in PEPFAR-supported provinces	90 % of PLHIV in PEPFAR-supported provinces	\$ 125,000.00
2. <b>Low SI capacity</b> at the National HIV program to monitor trends in the epidemic	Built capacity of national, provincial and district SI staff to produce annual national-level Epidemiological Report	An annual national-level Epi. report is produced (40 days after year)	Production of quarterly national-level report (40 days after year)	\$ 200,000.00
	National program making decisions based on Epi report	National program making decisions based on annual Epi report submitted 40 days after year end	National program making decisions based on quarterly Epi report	\$ 125,000.00
3. Lack of quality management (QM)/quality improvement ( <b>QI</b> ) system	A current QA/QI plan is developed	A functional QM/QI committee /team exist which regularly convenes (quarterly) and routinely reviews performance data and system- and patient-level outcomes, helping local facilities identify and address areas for improvement	Documentation of systematic monitoring of completed/ongoing QI projects with results across all health facilities	\$ 50,000.00
4. Low capacity for <b>viral load</b> monitoring.	90% of PLHIV on ART receive viral load test.	50% of PLHIV on ART receive viral load test.	70% of PLHIV on ART receive viral load test.	\$ 250,000.00
	VL testing turnaround time is reduced to less than 2 weeks	VL turnaround time is reduced to less than 4 weeks	VL turnaround time is reduced to less than 3 weeks	

# Summary of Table 6 (2/5)

Key Systems Barrier	Outcomes Expected after 3 years of Investment	Year One (COP 2016) Annual Benchmark	Year Two (COP 2017) Annual Benchmark	Budget
<b>6.1.2 Key Programmatic Gap #2: Low Pediatric ART coverage</b>				
1. Low rate of <b>pediatric case identification</b> and linkages to treatment	Children living with HIV are identified by index patient testing and through high yield entry points	50% of all children of PLHIV are tested	90% of all children of PLHIV are tested	\$ 150,000.00
2. <b>EID-lack of adequate and consistent capacity to perform timely DNA PCR Testing</b>	95 % of HIV exposed infants in PEPFAR-supported facilities are tested for HIV by 2 months of age	62 % of HIV exposed infants in PEPFAR-supported facilities are tested for HIV by 2 months of age	80 % of HIV exposed infants in PEPFAR-supported facilities are tested for HIV by 2 months of age	Included at Site Level
	EID test turnaround time (TAT) is reduced to < 2 weeks	EID test TAT is reduced to < 4 weeks	EID test TAT is reduced to < 3 weeks	Included at Site Level
<b>6.1.3 Key Programmatic Gap #3: Key Populations and GBV</b>				
1. Inadequate / weak political advocacy and <b>policies for GBV</b> Prevention and Key populations	Key Population TWG is formed at national level to provide guidance and advocacy on policies supporting KPs	The KP TWG is formed; the KP TWG meets on quarterly basis	The strategic guidance/propositions for KP access to services are decided/proposed in the KP TWG meetings	TA Only
	GBV TWG strengthened and supported to provide guidance and advocacy on policies preventing GBV	New activity for COP17. The national strategy on GBV is updated and the 2017-2021 implementation plan developed	The implementation of the 2017-2021 plan is evaluated and monitored ; a Gender data base including GBV data is developed	TA Only

# Summary of Table 6 (3/5)

Key Systems Barrier	Outcomes Expected after 3 years of Investment	Year One (COP 2016) Annual Benchmark	Year Two (COP 2017) Annual Benchmark	Budget
<b>6.2.1: Test and Start</b>				
1. Concerns about resource constraints including ARVs, commodities and human resources for Test and Start	Data is available for continuous planning and budgeting of resources for Test and Start policy	All data is available to forecast the number of new patients to start ART, according to new policy, for use in national annual quantification exercise.	All data is available to forecast the number of new patients to start ART, according to new policy, for use in national annual quantification exercise.	\$ 250,000.00
	National task-shifting policy is implemented in 100% of PEPFAR supported facilities	90% of PEPFAR supported facilities implement task-shifting	100% of PEPFAR supported facilities implement task-shifting	TA Only
<b>6.2.2: New and efficient service delivery models</b>				
1. Lack of MOH/PNLS capacity to design and implement new <b>service delivery models</b> to support the full implementation of Test and Start strategy	Community ARV dispensation model (CAG) is implemented	Sites are identified for community ARV dispensation model and policy is finalized	Community ARV dispensation model is implemented in 80% of identified sites	\$ 400,000.00
	Multi-month prescribing (MMP) policy is developed to decongest clinics and to increase retention on ART.	MMP policy is finalized; sites are identified for implementation; healthcare providers are trained on MMP.	MMP is implemented in 80% of identified sites.	

# Summary of Table 6 (4/5)

Key Systems Barrier	Outcomes Expected after 3 years of Investment	Year One (COP 2016) Annual Benchmark	Year Two (COP 2017) Annual Benchmark	Budget
<b>6.3: Other Proposed Systems Investments</b>				
<b>Laboratory</b>				
1. Support the Government of Burundi in the development and roll-out of the <b>national laboratory strategy</b> .	National laboratory strategy is implemented at district and facility levels.	None	<b>Quality assessment of key lab completed and priorities for improvement set; locus of leadership within the GoB established and functioning</b>	TA (CDC ATL)
2. Support the Burundi Ministry of Defense (MOD) in the <b>implementation of the national laboratory strategy at military health centers</b>	National Laboratory Strategy is implemented at military health centers by FY 17	None	<b>Two sites with functional equipment and SOPs in place.</b>	TA
<b>Strategic Information</b>				
3. Lack of current and reliable HIV <b>prevalence data among military</b>	Reliable survey based HIV prevalence data among military are available	Survey completed with MOD and MoH and results available at the national and sub-national levels by FY 17	Complete dissemination and publishing of survey results	\$ 150,000.00
4. Poor record keeping in <b>military settings and access to data systems</b>	EMR with quality data available	A military electronic health information network is in place and functional	Complete planning	\$ 150,000.00

# Summary of Table 6 (5/5)

Key Systems Barrier	Outcomes Expected after 3 years of Investment	Year One (COP 2016) Annual Benchmark	Year Two (COP 2017) Annual Benchmark	Budget
<b>6.3: Other Proposed Systems Investments</b>				
<b>Systems Development</b>				
Low capacity of the MOH to roll-out of the national <b>logistic management information</b> systems (LMIS).	100% health districts roll-out and implement LMIS	50% of health districts roll-out and implement LMIS.	100% of health districts roll-out and implement LMIS.	\$ 150,000.00
Low capacity of the MOH in strategy <b>planning and coordination for supply chain</b> related activities.	The National Supply Chain Master Plan is available and coordination meetings are organized.	70% of HIV commodities are distributed according to the National Supply Chain Master Plan; and 100% of coordination meetings are supported.	100% of HIV commodities are distributed according to the National Supply Chain Master Plan; and 100% of coordination meetings are supported.	\$ 250,000.00
<b>HRH - Systems/Institutional Investments</b>				
Insufficient <b>qualified human resources to provide HIV services in military settings</b>	100% military health centers have at least 3 personnel trained on HIV services delivery	New activity for COP17	31 student nurses at military school to be trained on HIV/AIDS service delivery	\$ 70,000.00

The background features a dark blue, semi-transparent world map. On the right side, there is a large, vibrant red graphic element consisting of two overlapping, curved bands that resemble a ribbon or a stylized 'X' shape.

# Prevention

# OVC

Strategic focus on vulnerable **adolescent girls and young women (AGYW)**

Approach focuses on four areas of intervention:

1. Education
2. Service Delivery
3. Household Economic Strengthening
4. Capacity Building

The target population 10 to 18 with a different package of activities for ages 10-14 and 15-18

Adolescent boys and young men included in testing strategies with education and sensitization activities

# Adolescent Girls and Young Women Activity: *MWIGEME KEREBUKA URASHOBOYE*



- **TARGETS:**            5,500 in FY17  
                                     8,000 in FY18
- More than 4,000 households and 5,000 AGYW in target province pre-identified in 65 *collines* using seven vulnerability factors
- Grant process on-going, pre-bidders meeting with 16 potential grantees
- Data collection for Rapid Assessment on-going

# Military Prevention

Targets: 20,000  
Budget: \$329,442

The Military are at higher risk for HIV as most are highly mobile within and outside of the country. Burundi has approximately 25,000 military personnel, comprised of mostly males between 25-34 years of age.

These military personnel, their dependents and proximate communities represent a total target population of 100,000 persons who are spread across the country in five military regions.

PEPFAR Burundi will target military personnel, their dependents, and neighboring communities through focused interventions - targeted HTC, and condom promotion and distribution.

# PMTCT

The package of service will remain unchanged from COP16 based on strong performance:

- Systematic HIV testing of all pregnant women who present at ANC
- Immediate enrollment on ART of all HIV-positive pregnant women
- Promotion of systematic testing of male partners and children born prior to PMTCT enrollment
- Resolution of challenges to EID sample transport network

# GBV Prevention Activities

- Comprehensive package of services to include post violence care.
- Strengthened health sector response (i.e. training of providers to meet minimum criteria of SGBV service provision)
- Increase awareness of available services through community informational tours of facilities, facilitate referrals and strengthen referral networks through CDFCs and TWG coordination
- Promotion of equitable community norms and survivor support (MAP trainings) to shift harmful attitudes and behaviors

CONCERNS: Need for psychosocial support to strengthen GBV response

CHANGE: Implementing partners to sub-partner with CBOs to integrate psychosocial support into GBV response

## COP 2017 Direction for PrEP

- PrEP is part of the new WHO inspired national guidelines
- Consist in prescribing 3TC-TDF to seronegative people at a higher risk of contracting HIV
- Targets for serodiscordant couples, and key populations
- Will first be implemented on a pilot basis and will be progressively extended



# Key Populations

# Key Populations

## **Epidemiology:**

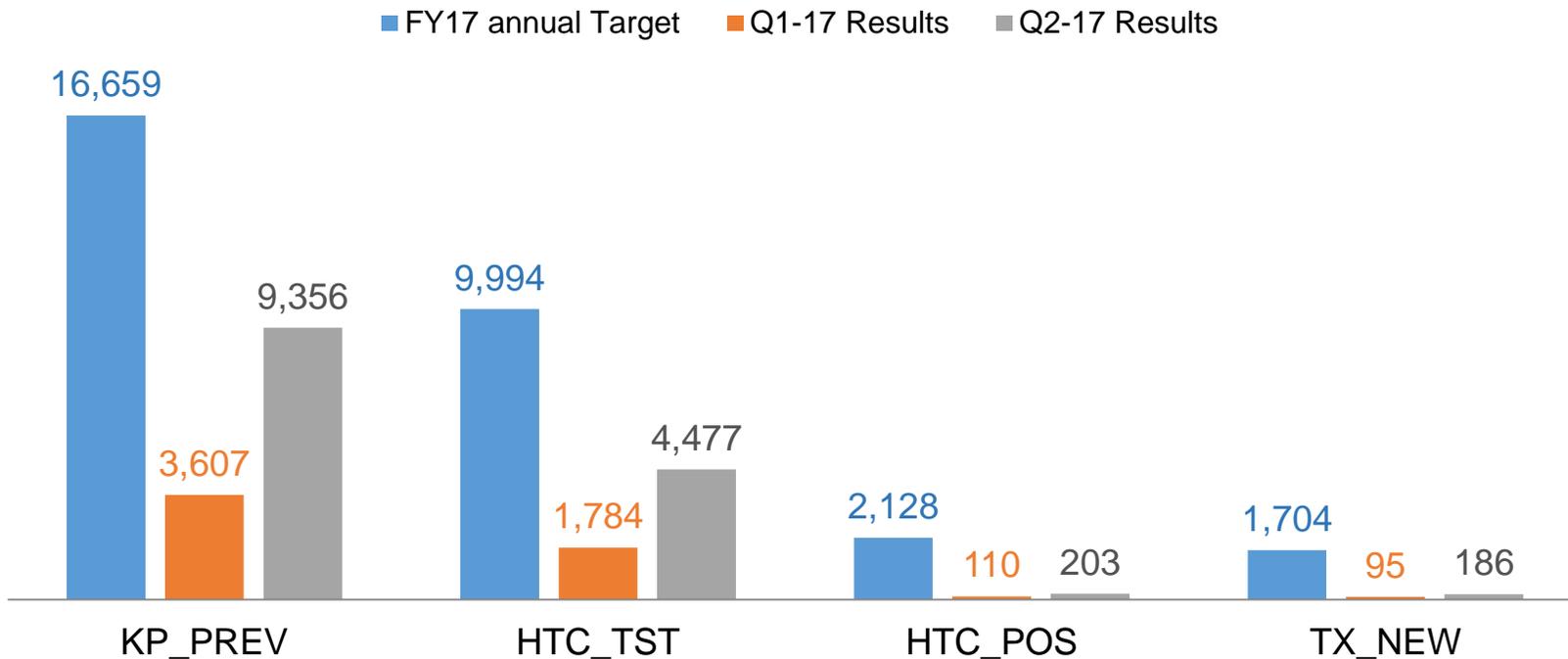
- HIV Prevalence: 21.3% FSW and 4.6 % MSM
- National Size Estimates: 59,225 FSW and 12,716 MSM (PLACE, 2014)
  - Micro-mapping exercise for estimates recently completed in PEPFAR SNU

## **Policy/Systems Barriers:**

- Low access to HIV prevention, care, treatment services
- Sex work and homosexuality is criminalized
- Stigma and discrimination exist
- HIV National Strategic Plan 2014-2017 promotes comprehensive prevention, care, treatment and support for key populations

# FSW: Q1/Q2 FY17\*

## LINKAGES program - FSW FY17



FSW	Q4	Q1	Q2
% test of reached	71%	49%	48%
Yield	7%	6%	5%
Linkage rate	25%	86%	92%

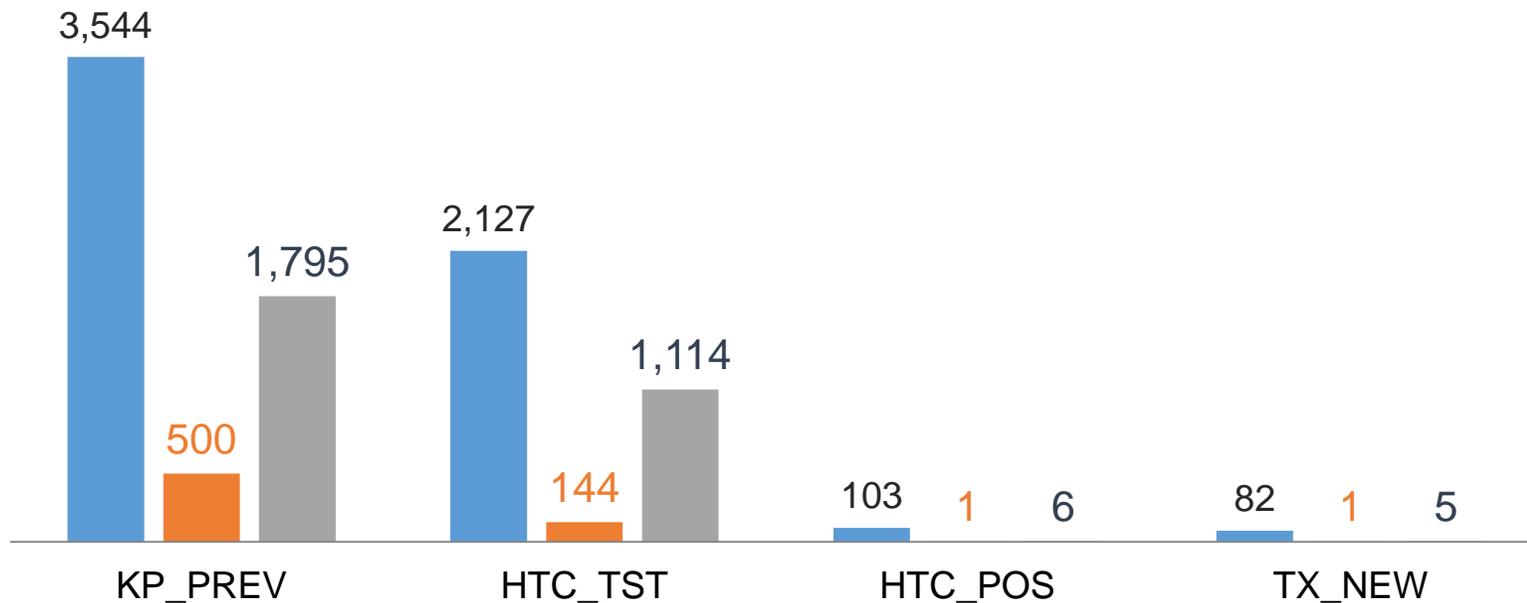
Better testing rates and outreach to children needed  
 → **Children of FSW approach**

\* Please note that all PEPFAR FY 2017 Q2 program results and achievements in presentation are based on preliminary reporting and may differ from final submission results. Final results can be accessed via PEPFAR Dashboard at <http://data.pepfar.net>.

# MSM: Q1/Q2 FY17\*

## LINKAGES program - MSM FY17

■ FY17 annual Target ■ Q1-17 Results ■ Q2-17 Results



MSM	Q4	Q1	Q2
% test of reached	16%	29%	62%
Yield	0.00%	0.70%	0.50%
Linkage rate	0.00%	100%	83%

Intensive focus needed to test and link MSM  
 → **Self test pilot, social media approaches**

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# COP17: Key Population Strategies

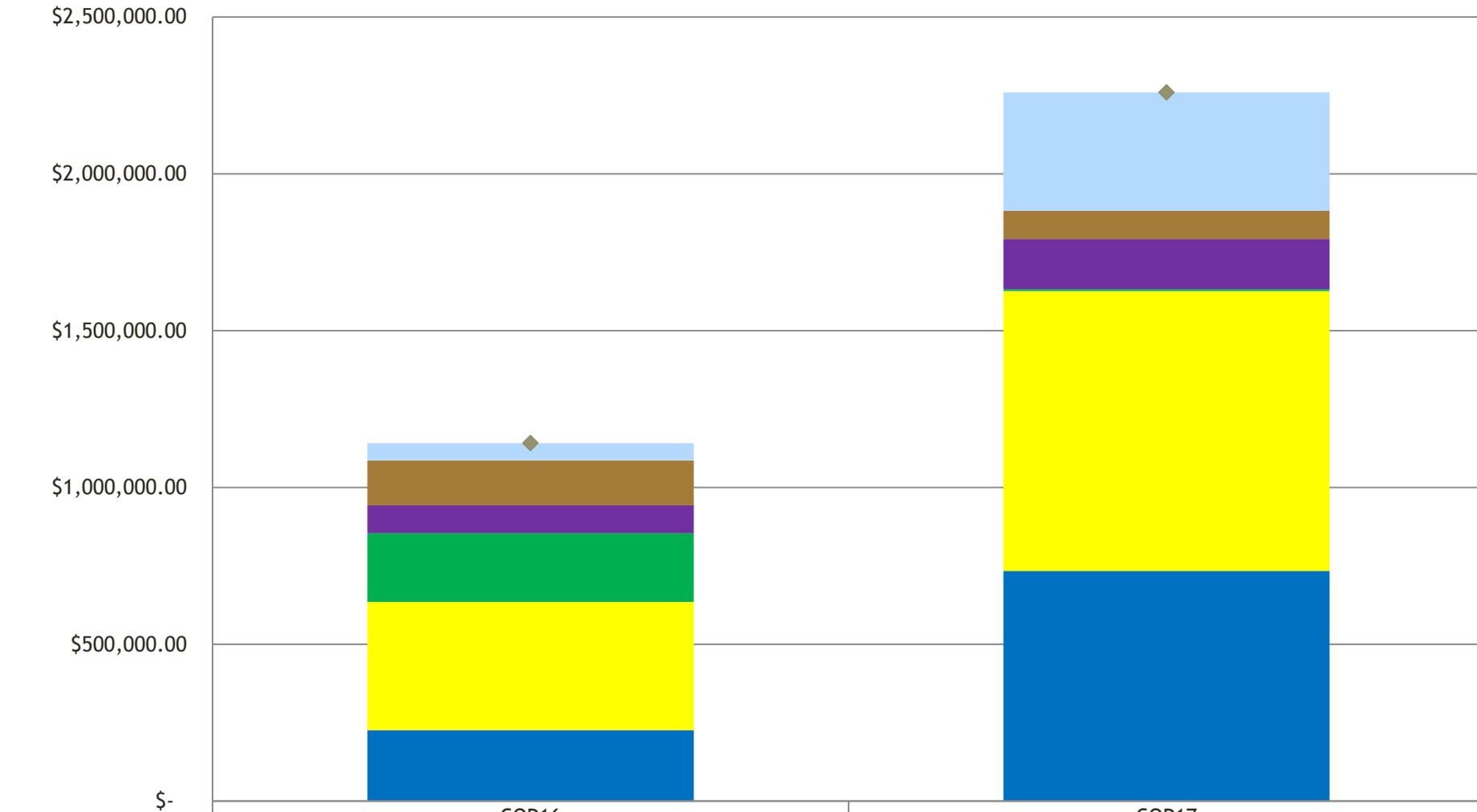
All strategies will engage KP CSOs in development

- **PrEP provision for HIV-negative KPs:** Supported through new HIV guidelines
- **HIV self-testing pilot:** A pilot program to assess the feasibility and efficacy of reaching MSM will guided self-testing will be implemented, where peer educator/navigators assist a peer in conducting their own self-test
- **Reaching children of FSW:** Reach the children of FSW, testing and linking them to prevention, care and treatment as needed
- **Capacitation of public sector clinics to be “KP Friendly”:** Stigma and discrimination trainings for healthcare providers
- **Key Population TWG:** PEPFAR will facilitate the formation of TWG at national level to provide guidance and advocacy on KP-friendly policies

The background features a dark blue world map with a prominent red ribbon graphic on the right side. The ribbon is thick and glossy, curving from the top right towards the bottom right, crossing itself. The map shows the continents in a lighter shade of blue against a darker background.

# Commodities

## Comparison of COP16 and COP17 Commodity Budgets



	COP16	COP17
Warehousing Costs	\$54,335.00	\$376,582.58
Essential Meds	\$143,366.00	\$90,852.25
Lab Test	\$88,793.00	\$160,077.71
DBS Kit	\$218,798.00	\$5,724.24
RTK	\$409,409.00	\$892,724.80
ARV	\$226,330.00	\$733,533.90
◆ Total Budget	\$1,141,031.00	\$2,259,495.48

### **PLEASE NOTE**

All PEPFAR FY 2017 Q2 program results and achievements included within this presentation were based upon preliminary reporting and may differ from the final submission results. Final FY 2017 Q2 results, as well as past and future quarterly and annual PEPFAR program results, can be accessed on the PEPFAR Dashboard at <http://data.pepfar.net>.



Thank You!