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INFORMATION MEMO FOR AMBASSADOR HIGGINS, BURUNDI

FROM: S/GAC – Acting U.S. Global AIDS Coordinator, Principal Deputy Assistant Secretary, Dr. Angeli Achrekar, DrPH, MPH

THROUGH: Ms. Pooja Vinayak (PEPFAR Program Manager) and Dr. Rachel Golin (Chair)

SUBJECT: Fiscal Year (FY) 2023 PEPFAR Planned Allocation and Strategic Direction

Dear Ambassador Higgins,

First and foremost, I sincerely hope that you and your team are safe and healthy. I am extremely grateful for your leadership of the PEPFAR program and additional COVID-19 response efforts during this difficult year.

While countries around the world continue to manage the effects of the COVID-19 pandemic, and the U.S. government acts on its commitment of support, it is encouraging to see vaccines making their way around the globe. The COVID response efforts – and continued use of the PEPFAR platform to support testing and vaccine delivery and uptake at point of care settings - are essential to our ability to provide ongoing care and life saving support for people living with HIV. The PEPFAR program has faced many challenges as a program during this period. Nevertheless, the PEPFAR family and partners have carried the mission forward while enduring significant personal impacts of COVID-19. Despite these challenges, what remains true is the strength and resilience of PEPFAR in partnership with countries and communities – through our teams, and our programs in the midst of dueling pandemics.

Tremendous effort has been made by PEPFAR over the year to protect and accelerate the HIV gains, while leveraging the platform to respond to COVID-19 as well.

PEPFAR Country/Regional Operational Plan (COP/ROP 2022) (for implementation in FY2023) represents a pivotal year in PEPFAR, as several countries are reaching or approaching the agreed upon UNAIDS 95/95/95 benchmarks for attaining epidemic control. As countries approach these benchmarks, while pivoting from "scaling to close gaps" to "sustaining" epidemic control, we must ensure HIV program and population equity, address outstanding barriers that threaten to derail progress made in reducing new HIV infections and associated mortality, and tailor our programs to serve all populations.

This year it is particularly important to plan COP/ROP22 together with the country government, civil society, and multilateral partners. Across PEPFAR, the focus on equity requires vigilant attention to program data demonstrating results and gaps. A focus on equity also means a focus on population groups where our efforts to date have not closed gaps, and specific planning, resource allocation, and program tailoring are needed – depending on what the data reveal for each country – focusing on: children, adolescent girls and young women, and key populations.

While implementation continues, or in many cases, has started to scale up, most PEPFAR countries are on a path to achieving program coverage goals. With that in mind, PEPFAR programs should focus on four key themes as we approach COP/ROP 22 planning and implementation:

1. Achieve and sustain epidemic control using evidence-based, equitable, people-centered HIV prevention and treatment services.
2. Support resilient and capacitated country health systems, communities, enabling environments, and local partners to build enduring capabilities.
3. Strengthen cooperation and coordination for greater impact, burden sharing, and sustainability.
4. Employ an equity lens with a persistent focus on reducing persistent inequalities experienced by children, key populations, and adolescent girls and young women.

I want to applaud the PEPFAR team for:

- Demonstrating year-on-year increased programming through local implementing partners. PEPFAR Burundi's OVC and GBV programs have successfully transitioned to local partners, and both programs exceeded annual targets in FY21.

- Continuing to implement targeted case-finding strategies to identify undiagnosed PLHIV and link them to treatment. Despite the challenges of COVID-19, PEPFAR Burundi exceeded the annual case finding target, with safe and ethical index testing largely contributing to this achievement.

- Making strong progress towards viral load suppression in FY21. Viral load suppression has improved between FY19 and FY21 for adult women, adult men, young adolescents, and children. Success can be attributed to improvements in continuity of treatment services, including transition to optimal treatment regimens and differentiated service delivery.

Together with the Government of Burundi and civil society leadership we have made tremendous progress together. Burundi should be proud of the progress made over the past 18 years of PEPFAR implementation and we are deeply grateful for the ongoing deep coordination with the Global Fund and UNAIDS.

As you will see in COP guidance this year, changes in program direction will vary depending on where countries are in reaching epidemic control and the continued COVID-19 mitigations efforts each team is facing. While assessing possible shortfalls in programming arising from COVID-19, overarching challenges still exist.

Specifically, more focus and attention should be given to the following key challenges in PEPFAR Burundi:

- Laboratory- and commodity-related constraints were a key challenge in FY21, especially in the context of COVID-19. Laboratory reagents were used for both HIV and COVID-19 testing. Additionally, laboratories faced malfunctions among already limited equipment, resulting in reduced testing coverage and prolonged turn-around-times for viral load monitoring and early infant diagnosis services.

- Burundi continues to have notable gaps along the pediatric HIV cascade. Nationally, the percentage of estimated CLHIV who have been diagnosed with HIV remains low, at 31%. Testing as part of early infant diagnosis services, especially for infants younger than two months of age, is markedly low, and this low coverage is driven by low demand creation, commodities stockouts, and breakdown of the GeneXpert machines required for testing.

- Limited interoperability between data systems and delays in data availability, including IBBS, recency surveillance, and implementation of unique identifiers, have resulted in programmatic challenges to providing optimal person-centered prevention, testing, and treatment services.

A fuller set of details, including funding earmarks and specific program direction are included in the accompanying COP/ROP 22 PEPFAR Planned Allocation and Strategic Direction Summary.

Consistent with the approach from years past, PEPFAR teams will once again be responsible for setting their own targets across PEPFAR program areas (with the treatment current target no less than the result that was to be achieved in COP 2021) in consultation with stakeholders. Teams should bear in mind that PEPFAR targets are not PEPFAR's but flow directly from the partner country government's commitment to the UNAIDS and SDG 3 goals.

The PEPFAR COP/ROP 22 notional budget for Burundi is **$25,400,000** inclusive of all new funding accounts and applied pipeline. All earmarks and program directives provided below must be met. Targets and the subsequent approved budget should reflect the level of ambition the PEPFAR team, in collaboration with the Government of Burundi and civil society of Burundi, believes is critical for the country's progress towards controlling the pandemic and maintaining control.

Finally, in alignment with efforts by the U.S. government to support diversity, equity, inclusion, and accessibility as well as to advance equity for underserved communities and prevent and combat discrimination or exploitation on the basis of race, religion, gender identity or sexual orientation, PEPFAR will work to ensure that these principles are upheld, promoted, and advanced in all PEPFAR programs and in how we do business.

Please note that within the next few days our PEPFAR Chairs and PEPFAR Program Managers (PPMs), working closely with our CAST teams, will review this planning letter and details contained, herein, with your wider PEPFAR country team. Stakeholder engagement is essential for a productive and impactful planning process, and civil society engagement will continue to be an integral part of this planning process. Included in this planning letter is an outline of the expectations for engaging key stakeholders and civil society, as we continue to finalize our approach to hosting a virtual COP/ROP22 planning and approval process.

Once again, thank you for your continued leadership and engagement during the COP/ROP22 process.

Sincerely,

Angeli Achrekar

Attachment: **COP/ROP 2022 PEPFAR Planned Allocation and Strategic Direction Summary.**
CC: **S/GAC – Ms. Pooja Vinayak (PPM) and Dr. Rachel Golin (Chair), Mr. Apollinaire Kavungerwa (USAID, Acting PEPFAR Coordinator), Ms. Marion McGowan (USAID, Senior Health Team Lead)**

Overview: COP/ROP 2022 PEPFAR Planned Allocation and Strategic Direction

With input from the field teams through the quarterly monitoring POARTs, as well as Headquarters Country Accountability and Support Teams (CAST) input, a thorough program review of your country over time has been conducted. This includes the end of year results of the Country Operational Plan (COP) 2020 and current COP 2021 implementation as we plan for COP 2022. We have noted the following key successes and challenges:

Successes

1. PEPFAR Burundi's OVC program has successfully transitioned to local partner Wiyizire. In FY21, Wiyizire exceed targeted enrollment of OVCs <18 years of age, ensured 100% of OVCs had a known HIV status, ensured 100% ART coverage of OVCLHIV, and achieved higher viral load coverage and suppression among OVCs compared to the general C/ALHIV population.

2. The COVID-19 pandemic has resulted in higher rates of gender-based violence globally, and there has been an increase in sexual violence against older adolescents in Burundi. PEPFAR Burundi has responded to this increased need by achieving strong results in post-GBV clinical care. The GBV program has successfully transferred to local partner Gir'iteka, which exceeded FY21 targets and provided post-GBV clinical care to over 4,000 individuals.

3. Despite the challenges of COVID-19, the PEPFAR Burundi program has continued to implement targeted case-finding strategies to identify undiagnosed PLHIV and link them to treatment. PEPFAR Burundi exceeded the annual case finding target, with safe and ethical index testing largely contributing to this achievement.

4. PEPFAR Burundi has made strong progress towards viral load suppression in FY21. In FY19-20, viral load suppression varied between 91-93% for adult women, 87-91% for adult males, and 70-83% for children and young adolescents. In FY 21, viral suppression improved from 94% in Q1 to 97% in Q4 for adult women, from 91% in Q1 to 96% in Q4 for adult men and from 85% in Q1 to 91% in Q4 for children and young adolescents. Success can be attributed to improvements in continuity of treatment services, including transition to optimal treatment regimens and differentiated service delivery.

Challenges

1. Laboratory and commodities were a key challenge in FY21, especially in the context of COVID-19 where laboratory reagents are used for both HIV and COVID-19 testing. Laboratories faced commodity stock-outs and malfunctions among already limited equipment, resulting in reduced testing coverage and prolonged turn-around-times for viral load monitoring and early infant diagnosis services.

2. Due to insufficient ARV stock levels, <1% of the treatment cohort were reported to receive 6MMD at the end of FY21. Recent efforts have been made to improve coordination of ARV orders across funders.

3. Burundi continues to have notable gaps along the pediatric HIV cascade. Nationally, the percentage of estimated CLHIV that know their status remains low, at 31%. Testing as part of early infant diagnosis services, especially within the first two months, is markedly low, and this low coverage is driven by low demand creation, commodities stockouts, and breakdown of the GeneXpert machines required for testing. Additionally, pediatric viral load coverage, viral load suppression and TPT completion rates are lower than achievements among adults.

4. Limited interoperability between data systems and delays in data availability, including IBBS, recency surveillance, and implementation of unique identifiers, have resulted in programmatic challenges to providing optimal person-centered prevention, testing, and treatment services.

Given Burundi's status of achieved or are near achieving epidemic control, the following priority strategic and integrated changes are recommended:

1. Implement best practices from the OVC program within the general pediatric and adolescent HIV program to improve pediatric and adolescent HIV clinical outcomes. Continue to press forward with offering OVC enrollment to at least 90% of children and adolescents < 18 years of age in PEPFAR-supported treatment sites in high volume clinics within high burden SNUs with an OVC program. Continue to transition children and adolescents living with HIV to optimal treatment regimens (e.g., DTG-based therapy).

2. Continue to expand to 6-month MMD and person-centered differentiated service delivery for all eligible patients across geographies.

3. Continue to collaborate with the Global Fund and PNLS to optimize current lab investments to benefit individuals (e.g., EID and VL monitoring) and the program writ large (e.g., PMTCT, 3rd 95, recency surveillance). Implement an all-inclusive cartridge markup on Cephid GeneXpert machines that includes service and maintenance and key performance indicator (KPI) monitoring. Implement the recommendations from the Diagnostic Network Optimization (DNO) which will be completed in COP21/FY22.

4. Continue to develop interoperable data systems to facilitate triangulation of existing data, including: MER/HFR, SIMS, IBBS, UID, recency, eLMIS, Spectrum, etc. Utilize data to ensure high quality of services, successful site transition of mobile ART clients, and to address service provision gaps by population and geography. Establish a broader data management strategy that leverages existing data platforms (IBIPIMO, Abbot mView, GeneXpert data connectivity, and DHIS2) and provides greater visibility across all operational levels to inform program improvements across the VL/EID cascade.

SECTION 1: COP/ROP 2022 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2021 (EOFY) tool, and performance data, the total COP/ROP 2022 planning level is comprised as follows: Note – all pipeline numbers were provided and confirmed by your agency.

TABLE 1: All COP 2022 Funding by Appropriation Year

	Bilateral				Central				Total
	FY22	FY21	FY20	Unspecified	FY22	FY21	FY20	Unspecified	TOTAL
Total New Funding	$ 23,666,661	$ -	$ -	$ -	$ 400,000	$ -	$ -	$ -	$ 24,066,661
GHP-State	$ 23,666,661	$ -	$ -		$ -	$ -	$ -		$ 23,666,661
GHP-USAID	$ -				$ 400,000				$ 400,000
GAP	$ -				$ -				$ -
Total Applied Pipeline	$ -	$ -	$ -	$ 1,333,339	$ -	$ -	$ -	$ -	$ 1,333,339
DOD				$ -				$ -	$ -
HHS/CDC				$ -				$ -	$ -
USAID				$ -				$ -	$ -
USAID/WCF				$ 1,333,339				$ -	$ 1,333,339
TOTAL FUNDING	$ 23,666,661	$ -	$ -	$ 1,333,339	$ 400,000	$ -	$ -	$ -	$ 25,400,000

SECTION 2: COP 2022 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS**

Countries should plan for the full Care and Treatment (C&T) level of $13,813,200 and the full Orphans and Vulnerable Children (OVC) level of $1,664,400 of the PLL across all funding sources. These earmark levels on new funding are subsets of those amounts that must be programmed with specific types of funding due to Congressional requirements. The full amount programmed across all sources will be visible in the FAST.

TABLE 2: COP 2022 Earmarks by Appropriation Year*

	Appropriation Year			
	FY22	FY21	FY20	TOTAL
C&T	$ 13,813,200	$ -	$ -	$ 13,813,200
OVC	$ 1,664,400	$ -	$ -	$ 1,664,400
GBV	$ 675,500	$ -	$ -	$ 675,500

**Only GHP-State and GHP-USAID will count towards the earmarks (Care and Treatment, OVC, GBV, and Water).*

***Only GHP-State will count towards the GBV and Water earmarks*

TABLE 3: COP 2022 Initiative Controls: Each dollar planned in COP can belong to only one initiative. Most COP funding will be budgeted as Core Program. In general, initiatives other than Core Program are used to track activities/programs that cannot be tracked by the combination of program area and beneficiary alone. See Appendix 1 for more detailed information on initiatives.

	Bilateral	Central	TOTAL
Total Funding	$ 25,000,000	$ 400,000	$ 25,400,000
Core Program	$ 23,644,600	$ -	$ 23,644,600
Condoms (GHP-USAID Central Funding)	$ -	$ 400,000	$ 400,000
OVC (Non-DREAMS)	$ 1,355,400	$ -	$ 1,355,400

TABLE 4: Programmatic Controls: Programmatic controls are used to track programmatic directives that can be tracked by a combination of program area and/or beneficiary. Programmatic controls may overlap with Initiatives, for example PrEP for Adolescent Girls and Young Women may count towards both the DREAMS Initiative and the PrEP (AGYW) programmatic control. See Appendix 1 for more detailed information on programmatic controls.

	Bilateral	Central	TOTAL
Total Funding	**$ 685,000**	**$ -**	**$ 685,000**
PrEP (AGYW)	$ 342,500	$ -	**$ 342,500**
PrEP (KPs)	$ 342,500	$ -	**$ 342,500**

TABLE 5: State ICASS Funding

	Appropriation Year
	FY22
ICASS	$ -

(There are no approved State ICASS for this OU)

See Appendix 1 for detailed budgetary requirements and other budgetary considerations.

SECTION 3: PAST PERFORMANCE – COP/ROP 2020 Review

TABLE 6. COP/ROP OU Level FY21 Program Results (COP20) against FY22 Targets (COP21)

Indicator	FY21 result (COP20)	FY22 target (COP21)
TX Current < 15 years of age	**2,505**	**7,502**
TX Current ≥ 15 years of age	**64,734**	**69,466**
VMMC ≥ 15 years of age	(Not applicable)	(Not applicable)
DREAMS (AGYW PREV)	(Not applicable)	(Not applicable)
Cervical Cancer Screening	(Not applicable)	(Not applicable)
TB Preventive Therapy	**14,146**	**20,061**

TABLE 7. COP/ROP 2020 | FY 2021 Agency-level Outlays versus Approved Budget

OU/Agency	Approved COP/ROP 2020 Planning Level	Total FY 2021 Outlays	Over/Under Outlays
Burundi	**$24,411,205**	**$21,783,205**	**$2,628,000**
DOD	$2,042,205	$1,248,824	$793,381
HHS/CDC	$700,000	$518,789	$181,211
USAID	$14,126,747	$15,557,765	($1,431,018)
USAID/WCF	$7,542,253	$4,457,827	$3,084,426
Grand Total	**$24,411,205**	**$21,783,205**	**$2,628,000**

TABLE 8. COP/ROP 2020 | FY 2021 Results & Expenditures

Agency	Indicator	FY21 Target	FY21 Result	% Achievement	Program Classification	FY21 Expenditure	% Service Delivery
HHS/ CDC	**HTS_TST**				HTS Program Area	$433,242	0%
DOD	**HTS_TST**	4,921	10,600	215.40%	HTS Program Area	$530,833	90%
	HTS_TST_POS	380	891	234.47%			
	TX_NEW	360	891	247.50%	C&T Program Area	$424,015	66%
	TX_CURR	3,332	3,339	100.21%			
USAID	**HTS_TST**	322,048	467,312	145.11%	HTS Program Area	$3,361,683	69%
	HTS_TST_POS	5,648	7,726	136.79%			
	TX_NEW	5,502	7,634	138.75%	C&T Program Area	$9,191,324	54%
	TX_CURR	72,573	63,900	88.05%			
	OVC_SERV	8,999	12,176	135.30%	OVC Beneficiary	$2,088,177	38%
				Above Site Programs		$2,195,992	
				Program Management		$3,101,580	

SECTION 4: COP/ROP 2022 DIRECTIVES

The following section has specific directives for COP 2022 based on program performance noted above. Please review each section carefully including the minimum program requirements.

Minimum Program Requirements (MPR)
All PEPFAR programs – bilateral and regional– must ensure the following minimum program requirements are in place. Adherence to these policies and practices is essential to the success of all PEPFAR programs at the national, subnational, and service delivery levels (e.g., facility, school, community). Evidence demonstrates that lack of any one of these policies/practices significantly undermines HIV impact and results in inefficient and ineffective programs.

All PEPFAR programs are expected to meet all of the requirements below, and the COP22 Planning Meeting will include a review of the status of each requirement, including assessment of implementation (including barriers) at the point of client services. To the extent that any requirement(s) have not been met by the time of the COP22 Planning Meeting, the PEPFAR Burundi team will need to present a detailed description of existing barriers and the remediation plans proposed that will allow them to meet the requirement(s) prior to the beginning of FY2023. The list will be included in the Strategic Direction Summary (SDS), as well.

Failure to meet any of these requirements by the beginning of FY2023 may affect the PEPFAR Burundi budget. The minimum requirements for continued PEPFAR support include the table below.

TABLE 9. COP/ROP 2022 (FY 2023) Minimum Program Requirements

Care and Treatment	
1.	Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups. Status: Completed
2.	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. Status: In-process (Target date: FY22) Issues or Barriers: The scale up of TLD continues and pediatric DTG has recently been introduced.
3.	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. Status: In-process (Target date: FY22) Issues or Barriers: FY21 commodity shortages have precluded a timely and full scale up of 6MMD.
4.	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. Status: In-process (Target date: Early FY23) Issues or Barriers: Timely and full uptake of TPT by eligible persons living with HIV is partially limited by commodity challenges with the 3HP regimen. Additionally, sample transport network challenges have resulted in longer times to initiation of TPT for those determined to not have TB disease.
5.	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. Status: In-process (Target date: FY22) Issues or Barriers: None; the DNO scope of work has been approved and data collection is in process and anticipated to be completed in FY22.
Case Finding	
6.	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.

	Status: In-process (Target date: FY22) Issues or Barriers: Additional technical support needs for pediatric index testing have been identified and are being addressed in COP21/FY22.
Prevention and OVC	
7.	Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices) Status: In-process (Target date: FY22) Issues or Barriers: Full implementation has been precluded by limited acceptance of the MOH to implement demand creation activities across every focus subpopulation.
8.	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 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV. Status: Completed
Policy & Public Health Systems Support	
9.	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. Status: In-process (Target date: FY22) Issues or Barriers: PrEP services for KPs have been delayed due to narrow eligibility requirements.
10.	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. Status: Completed
11.	OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy. Status: Completed; PEPFAR Burundi continues to implement QA through SIMS.
12.	Evidence of treatment literacy and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other partner 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. Status: In-process (Target date: Early FY22) Issues or Barriers: Additional MOH support is needed to promote U=U messaging.
13.	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. Status: In-process Issues or Barriers: No barriers; clear evidence has been demonstrated and the OU is to be commended for continued efforts to increase local partner direct funding.

14. Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended. Status: In-process (Target date: Early FY23) Issues or Barriers: Competing health and economic priorities may limit resource mobilization.
15. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity. Status: In-process (Target date: Early FY23) Issues or Barriers: Additional development of vital registries is needed to document morbidity and mortality.
16. Scale-up of case surveillance and unique identifiers for patients across all sites. Status: In-process (Target date: Early FY23) Issues or Barriers: Recency testing implementation was stalled due to COVID-19 and approval delays, but restarted in late FY21. Biometric UID implementation is also in progress.

In addition to meeting the minimum requirements outlined above, it is expected that PEPFAR Burundi will consider all the following technical directives and priorities. A full list of COP/ROP 2022 Technical Priorities and Considerations are listed in COP guidance and can be referenced in Section 6.

Table 10. COP/ROP 2022 (FY 2023) Technical Directives

Burundi–Specific Directives
HIV Clinical Services
1. Continue to ensure that safe and ethical index testing services are offered to all individuals living with HIV.
2. Carefully review, and modify as necessary, HTS screening tools to ensure alignment with PEPFAR program standards as defined in COP22 guidance.
3. Thoughtfully consider broadening the provision of HIV self-testing especially if facility-based HTS are difficult to access.
4. Demonstrate quarter-on-quarter improvements in <2m and < 12m EID coverage until PEPFAR global benchmarks are met and maintained. All infants who are diagnosed with HIV should initiate ART within seven days of diagnosis. Consider implementation of community-based support (e.g., mentor mothers) to improve health literacy and demand creation.
5. Building upon prior and current surge efforts, demonstrate quarter-on-quarter improvements across the pediatric and adolescent clinical cascades until PEPFAR program standards are met and maintained. Foster proactive and close collaboration between clinical, OVC, and KP IPs. Scale best practices from the OVC program to improve testing coverage, treatment coverage, viral load coverage, and viral load suppression for the general pediatric and adolescent HIV populations. Continue to prioritize enrollment of C/ALHIV into the OVC program, especially C/ALHIV who are newly diagnosed, newly initiating ART, are at risk for experiencing an interruption in treatment, and/or have an unsuppressed viral load. Mitigate any disruptions in the OVC program during forthcoming IP transitions.
6. Expand person-centered differentiated service delivery models to all eligible populations, including children and pregnant and breastfeeding women
7. Demonstrate quarter-on-quarter improvement in 6MMD until full implementation across all eligible subpopulations has been achieved.
8. Continue to strengthen continuity of treatment for all subpopulations by building upon best practices and lessons learned through root cause analyses. Strengthen provision of person-centered counseling and support to individuals newly initiating ART. Strongly consider performing a loss analysis across all age bands.

9. Improve viral load and EID coverage by addressing issues including, but not limited to: demand creation, reagent & instrument availability, turn-around-time of results.
10. Improve quality of TB screening, as current screening positivity is lower than expected. Additionally, improve TB specimen collection among all individuals with a positive TB screen, with a goal of achieving 100% specimen collection.
HIV Prevention Services
1. Continue advocating with PNLS to ensure national PrEP guidelines are firmly aligned with current WHO guidelines and PEPFAR technical guidance, including expanding eligibility beyond serodifferent couples.
2. Increase PrEP uptake among AGYW, KP, and other priority populations.
3. Collaborate with PNLS to implement person-centered PrEP delivery (e.g., community-based PrEP initiation, MMD of PrEP, etc.).
4. Continue advancing in treatment literacy, including U=U messaging.
5. Utilize recency surveillance data to inform prevention programming.
Infection Prevention and Control (IPC)
1. All clinical implementing partners (IP) are expected to ensure that all PEPFAR-supported sites are implementing IPC interventions in order to ensure that the services offered are safe to those receiving and delivering healthcare services.
2. All IPs should have a dedicated IPC person to coordinate and monitor IPC activities across sites supported by the partner.
3. Facility-based IPs should ensure that there is a site level IPC focal person identified who ensures compliance of IPC implementation at the facilities.
4. All implementing partners are strongly encouraged to use the PEPFAR personal protective equipment (PPE) planning tool to ensure availability of sufficient quantities of PPE as a critical component of IPC interventions.
5. PEPFAR Burundi is strongly encouraged to use the newly designed IPC SIMS CEEs to monitor compliance of IPC implementation at the supported facilities.
6. PEPFAR Burundi is strongly encouraged to proactively coordinate IPC activities with relevant national stakeholders and donor agencies (e.g., GFATM) working on IPC. PEPFAR-supported IPC activities are expected to be consistent with national IPC standards or WHO standards in the absence of national IPC standards.
Laboratory
1. Coordinate with GFTAM and PNLS to implement all-inclusive cartridge markup on Cephid GeneXpert machines that includes service and maintenance and KPI monitoring in order to address high instrument failures and to improve service delivery.
2. Operationalize the DNO, which is to be completed during COP21/FY22, and implement DNO recommendations defined in the operation plan. National Sample Transport Documentation must be updated to include an optimized sample transport strategy with standardized oversight and management (including KPIs). Strongly consider, and implement as feasible, leveraging the private sector 3PLS for sample transport and result return to improve turnaround time.
3. Establish a broader data management strategy to provide greater visibility across all operational levels, including end-to-end visibility of the VL/EID cascade. Leverage IBIPIMO, Abbot mView, GeneXpert data connectivity, and DHIS2 to improve program performance through greater visibility.
4. Increase use of molecular WHO-recommended diagnostic tests for TB (e.g., GeneXpert, TrueNat).
5. Collaborate with PNLS to prioritize EID and VL samples.
Sustainability

1. The two lowest scoring elements in this 2021 Sustainability Index and Dashboard (SID) were Data for Decision-Making Ecosystem and Private Sector Engagement. Additionally, Commodity Security and Supply Chain and Epi and Health Data domain elements are almost all scoring with weak or emerging sustainability that require more investment. Civil Society Engagement and Private Sector Engagement have consistently needed additional investment and in this SID have shown a decrease in scores. These are all critical elements to strengthen to ensure sustained systems to deliver the HIV programs. Please conduct an analysis to determine if the current portfolio of activities is appropriate and ensure sufficient COP22 investments in these elements to result in increases in the 2023 SID scores.
2. Conduct a public finance management assessment in FY22.
Other Government Policy, Systems, or Programming Changes Needed
1. Address the structural barriers that impede scale up of KP-led and KP-competent differentiated HIV services, as well as the lack of robust data to guide key populations programming.
2. Increase data visibility at all levels of the supply chain from central warehouse(s) level to facilities. This may be accomplished through supporting the Government of Burundi to implement an eLMIS award, strengthening PEPFAR MER supply chain reporting through implementing partners, and extending the commodities reporting currently done at district level to the facility level.

In COP 2022, PrEP should continue to be scaled up with a focus on ensuring policy and programmatic access to PrEP for higher incidence populations. Populations prioritized for PrEP should be tailored to the OU's epidemic context with a focus on Key Populations (including sex workers, men who have sex with men, transgender people, people in prisons and other closed settings, people who inject drugs), adolescent girls and young women including pregnant and breastfeeding AGYW, and other identified higher-incidence populations.

COP/ROP 2022 plans should prioritize and take specific steps to address the structural barriers that impede scale up of KP-led and KP-competent differentiated HIV services, as well as the lack of robust data to guide key populations programming. To strengthen strategic information to guide KP responses, plans may include efforts to strengthen individual level data systems and analyses and address gaps in subnational data. Addressing structural barriers should entail improving the enabling environment for HIV service delivery; mitigating harmful policy and social norms that fuel stigma, discrimination and violence faced by key populations; strengthening the capacity of key populations organizations; and strengthening the KP competency of HIV service providers. PEPFAR teams should ensure they are coordinating strategically with relevant State and U.S. government units (e.g., DRL), partner government, multilateral, and other donor funding streams and institutions. As part of the new COP 22 MPR, PEPFAR teams will be expected to describe and present their approach to improving KP data and addressing barriers to accelerated KP-centered HIV services during COP/ROP 22 planning meetings.

COP/ROP 2022 Active Engagement with Community and Civil Society (see section 2.5.3 of COP Guidance)

The full participation of community stakeholders and civil society in every stage of PEPFAR programming, planning, and monitoring, as appropriate and consistent with applicable law, regulations and policy, from advocacy to service delivery, is critical to the success and sustainability of PEPFAR and the global effort to combat HIV. Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional, and international civil society and community stakeholders, multilateral partners and the partner country government.

Civil society organizations are essential and to be invited to participate in the virtual COP22 strategic retreats, planning meetings, as well as approval meetings. In particular, engagement with local CSOs at the country-level is required and should begin early and continue during the entirety of the COP planning, monitoring, and implementation process.

This engagement of civil society, including faith-based organizations/faith communities, specifically includes the sharing of FY 2021 Q4 and FY 2021 Annual Program Results (APR), analyses, and the convening of an in-country planning retreat with local stakeholders, no later than the week of February 7, 2022, in order to introduce and discuss all COP/ROP 2022 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP/ROP 2022. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund, with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In March 2022, PEPFAR will convene virtual meetings where outstanding decisions will be discussed and finalized. In addition to partner country representatives, the meetings will also include representatives from local and international civil society and community organizations, faith-based organizations/faith communities, private sector, and multilateral partners. Specific guidance for the 2022 virtual meeting delegations will be provided separately.

Engagement with all stakeholders is required beyond the meetings and throughout COP/ROP 2022 development, finalization, and implementation. As in COP/ROP 2021, the draft Strategic Direction Summary (SDS) is required to be shared with both CSO and FBO stakeholders for their input and comments at least 7 days prior to submission to S/GAC. Please refer to the COP/ROP 2022 Guidance for a full list of requirements and engagement timelines. In addition, a more detailed timeline for sharing key data visualizations and other information with stakeholders is forthcoming.

Community-led Monitoring (CLM)

In addition to prescribed and routine engagement during PEPFAR's annual business cycle, including around COP/ROP planning and quarterly POART processes, all PEPFAR programs are required to develop, support, and fund community-led monitoring (CLM) in close collaboration with independent, local civil society organizations and host country governments. Community-led monitoring in COP22 should build on prior activities in COP21 and be designed to help PEPFAR programs and health institutions pinpoint persistent problems, challenges, barriers, and enablers to effective client outcomes at the site level. In addition to being data-driven and action-oriented, CLM should continue to ensure indicators are defined by communities and health service users, and data should be additive and not a duplicate collection of routine data already available to PEPFAR through MER or SIMS. New in COP22, PEPFAR-supported community-led monitoring programs must include an explicit focus on key populations. CLM should be utilized to advance equity and to support improvement in programs, especially for populations who have not yet fully experienced the benefits of HIV epidemic control. For example, OUs with pediatric care and treatment programs should consider utilizing CLM to track and ensure accountability for child, adolescent, and family-centered care.

APPENDIX 1: Detailed Budgetary Requirements

Care and Treatment: Each OU's COP/ROP 2022 minimum requirement for the care and treatment earmark is reflected in Table 2. If there is no adjustment to the COP/ROP 2022 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment earmark amount across new FY 2022 GHP-State and GHP-USAID funding. The Care and Treatment earmark will be calculated as the sum of the following:

- 100% Care and Treatment (C&T) Program Areas
- 50% Testing (HTS) Program Areas
- 100% Above Site Program: Laboratory System Strengthening
- 70% Pregnant and Breastfeeding Women Beneficiary Group
- Proportional % Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the C&T earmark)

Orphans and Vulnerable Children (OVC): Each OU's COP/ROP 2022 minimum requirement for the OVC earmark is reflected in Table 2. Countries must program to the full OVC earmark amount across new FY 2022 GHP-State and GHP-USAID funding. The OVC earmark will be calculated as the sum of the following:

- 85% (DREAMS initiative funding — commodities planned under DREAMS initiative — Any HTS interventions planned under DREAMS initiative — Any C&T intervention planned under DREAMS initiative)
- 100% (OVC Beneficiary group funding — commodities planned under any intervention with OVC beneficiaries — Any HTS planned under interventions with OVC beneficiaries
- Proportional Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the OVC earmark)

Abstinence, Be Faithful/Youth (AB/Y) Reporting Requirement: If AB/Y-programmed activities do not reach a 50 percent threshold of all sexual prevention funding, as calculated by the formula below, in any country with a generalized epidemic, S/GAC is required to report to the appropriate Congressional committees on the justification for the decision. Generalized epidemic countries which do not meet the 50 percent threshold must provide a brief written justification in FACTS Info, explaining the rationale for prevention programming decisions given the epidemiologic context, contributions of other donors, and other relevant factors.

Abstinence, Be Faithful/Youth (AB/Y) programming, formerly captured in the HVAB budget code, will now be captured by using a combination of prevention program areas and beneficiaries, which are identified in the formula below. The numerator captures those interventions that are Abstinence, Be Faithful/Youth (AB/Y) programming, and the denominator approximates all sexual prevention activities. The proportion of Abstinence, Be Faithful/Youth (AB/Y) programming as a proportion of all sexual prevention activities is calculated by dividing the numerator by the denominator:

Numerator

Prevention: primary prevention of HIV and sexual violence

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, and boys)

+

Prevention: community mobilization, behavior, and norms change

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, boys, adults, not disaggregated)

Denominator

Prevention: primary prevention of HIV and sexual violence (all populations)

+

Prevention: community mobilization, behavior, and norms change (all populations)

+

50 % Prevention: Not disaggregated (all populations)

Gender Based Violence (GBV): Each OU's COP/ROP 2021 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total **new FY 2022** funding programmed to the GBV cross-cutting code. Your COP/ROP 2022 earmark is derived by using the final COP/ROP 2021 GBV earmark allocation as a baseline. The COP/ROP 2022 planned level of new FY 2022 funds for GBV can be above this amount; however, it cannot fall below it.

Water: Each OU's COP/ROP 2021 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total **new FY 2022 funding** programmed to the water cross-cutting code. Your COP/ROP 2021 earmark is derived by using the final COP/ROP 2021 water earmark allocation as a baseline. The COP/ROP 2022 planned level of new FY 2022 funds for water can be above this amount; however, it cannot fall below it.

Initiative Controls: Table 3 shows initiative controls where S/GAC has directed funding for a set of activities that cannot be accounted for through program areas and/or beneficiaries alone. These controls can be exceeded without a control change, but a control change would be required before a lower level for these activities can be planned.

The four initiative controls below (**Cervical Cancer**, **DREAMS**, **OVC (non-DREAMS)**, and **VMMC**) have been assigned to the appropriate OUs. For OUs where these controls are designated in the PLL, the amounts reflect the minimum required. These initiative controls can be exceeded without a control change, but a control change request would be required before a lower level for these activities can be planned.

Cervical Cancer - This initiative provides funding for all activities related to cervical cancer screening and diagnosis and treatment of precancerous cervical lesions for women living with HIV as outlined in the COP Guidance.

DREAMS - The DREAMS initiative should capture all funding specifically allocated as DREAMS in the OU's planning level and must be used for the goal of HIV and sexual violence prevention among adolescent girls and young women (AGYW) ages 10-24 years (unless otherwise approved) in approved DREAMS SNUs in accordance with the DREAMS and COP Guidance. The DREAMS initiative can also include prevention interventions in DREAMS geographic areas for girls and boys aged 10-14 which may be cost shared with the OVC (non-DREAMS) initiative as noted in the COP guidance.

OVC (non-DREAMS) - OVC (non-DREAMS) is a new initiative in COP/ROP 2022. OUs should use the initiative to budget for OVC (non-DREAMS) programming, including all OVC comprehensive activities as outlined in the COP Guidance. The OVC (non-DREAMS) initiative should include ASP, SE, and PREV costs (except PrEP and VMMC) linked to any OVC beneficiary (including sub-beneficiaries such as OVC caregivers). As the initiative is new for COP/ROP 2022, OUs should pay particular attention to funds programmed under OVC (non-DREAMS) to ensure that the current cohort of children enrolled in the comprehensive program receive continuity of care for FY 2023. The OVC (non-DREAMS) initiative can also include prevention interventions for girls and boys aged 10-14 which may be cost-shared with the DREAMS initiative as noted in the COP guidance. The OVC (non-DREAMS) initiative cannot be met with any HTS, C&T, PM or commodities costs.

VMMC - All services and equipment related to providing surgical and ShangRing VMMC for boys/men ages 15 and above, and ShangRing circumcision only for boys age 13 and 14 years, should be budgeted using the VMMC initiative.

While the CLM initiative does not appear in PLL budget tables, as CLM remains a requirement in COP/ROP 2022 for all OUs, each OU is responsible for programming a portion of funds under the **Community-Led Monitoring** initiative.

Community-Led Monitoring - During COP/ROP 2020, PEPFAR invested in expansion of community-led monitoring, making it a requirement of all OUs, as a critical way to listen to community voices in assessment of program quality and design of client-centered services. Community-led monitoring remains a requirement in FY 2023.

In addition to the five initiatives above, S/GAC may also allocate funding to OUs under two additional initiative controls: **Condoms (GHP-USAID Central Funding)** and **One-Time Conditional Funding**. If the OU was designated to receive funding under either one or both these initiatives in COP/ROP 2022, Table 3 will reflect these amounts. Unless otherwise noted, country teams should meet these funding controls when programming in their FAST.

Condoms (GHP-USAID Central Funding) - This initiative control denotes the amount of GHP-USAID central funding the country team may use to procure male and female condoms, lubricants, and to ship these commodities to the OU. Any additional condoms and lubricants to be procured with PEPFAR funding should be budgeted in the FAST with bilateral funding.

USAID Southern Africa Regional Platform - This initiative is for the country's share of the costs to operate the USAID Southern Africa Regional Platform, which provides administrative and technical support for Angola, Botswana, Eswatini, Lesotho, and Namibia. These funds were previously planned as part of the bilateral COP funding, but are now budgeted and notified centrally, with country amounts included as central funding in the overall COP levels for Angola, Botswana, Eswatini, Lesotho, and Namibia. Only these 5 countries may use this initiative, and this initiative can only be used with central funding specifically provided as part of the PLL controls.

One-Time Conditional Funding - The release of any funding made available under this initiative is contingent upon the OU's ability to meet all requirements outlined in their final COP/ROP approval memo. OUs that fail to meet these minimum standards may be ineligible to receive these funds for programmatic implementation in FY 2023.

No control is set in the PLL for the **HBCU Tx** and **Surveillance and Public Health Response** initiatives, but OUs may include relevant funds under these initiatives instead of Core Program as appropriate.

All funding not attributed to one of the nine COP/ROP 2022 initiatives above should be attributed to the **Core Program** initiative.

For additional details on initiatives, see the PEPFAR Financial Classifications Reference Guide.
Programmatic Controls: Table 4 shows programmatic controls where S/GAC has directed funding for certain programmatic activities. These controls can be exceeded without a control change, but a control change would be required before a lower level for these activities can be planned. Since every dollar programmed in COP must belong to one initiative, programmatic controls will be a subset of one or more initiative controls, even if the standard Core Program initiative.

PrEP (AGYW) – The PrEP (AGYW) programmatic control tracks all funding budgeted under the Prevention – PrEP program area and sub-program area for the Females – Adolescent Girls and Young Women sub-beneficiary. The control encompasses both service delivery (SD) and non-service delivery (NSD) activities, inclusive of any commodities costs. OUs should tailor the distribution of funds to SD and NSD based on the country context prioritizing the provision of PrEP services and increasing the number of AGYW on PrEP wherever possible. Countries with a PrEP (AGYW) control should expect to program no more than 10 to 30 percent of their control as non-service delivery.

PrEP (KPs) – The PrEP (KPs) programmatic control tracks all funding budgeted under the Prevention – PrEP program area and sub-program area for all sub-beneficiaries under the KP beneficiary. The control encompasses both service delivery (SD) and non-service delivery (NSD) activities, inclusive of any commodities costs. OUs should tailor the distribution of funds to SD and NSD based on the country context prioritizing the provision of PrEP services and increasing the number of KPs on PrEP wherever possible. Countries with a PrEP (KPs) control should expect to program no more than 10 to 30 percent of their control as non-service delivery.

State ICASS: Table 5 shows the amount that the OU must program under State for ICASS Costs.

Funds Programmed under State/SGAC (S/GAC TBDs)
No funding may be programmed under State/SGAC without prior approval from S/GAC M&B. In general State/SGAC TBDs are only used in extraordinary and or unusual circumstances. To the degree that funding is approved, the rationale and any conditions attached to the funding will be documented by M&B. Any S/GAC TBDs approved during COP/ROP 2022 planning will require supplemental language in the OU's COP/ROP 2022 approval memo, clearly outlining the process for how these funds can be accessed. Any funds that have not been distributed to agencies before the end of FY 2023 may be subject to reprogramming in future planning cycles towards the same OU or another OU.

COP/ROP 2022 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)
Whenever possible, all agencies within an OU should hold several months of pipeline at the end of COP/ROP 2022 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. If an agency/OU combination has a history of over-outlays, or in cases where an agency/OU COP envelope has increased in recent years, there may not be sufficient funding to maintain this buffer. With the exception of Dominican Republic, Ethiopia, Haiti, South Sudan, Zimbabwe, Asia Regional Program, and Western Hemisphere Regional Program, which should hold up to four months of pipeline, all other OUs are permitted to hold no more than three months of buffer pipeline.

Any agency that anticipates ending COP/ROP 2021 implementation (end of FY 2022) with a pipeline in excess of three or four months is required to apply this excessive pipeline to COP/ROP 2022, decreasing the new funding amount to stay within the planning level.

Transitioning HIV Services to Local Partners

To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs. In COP19 Guidance, PEPFAR set a goal that 40% of partners must be local by the end of FY19, and 70% by the end of FY20.While considerable progress was made in this effort, the 70% mark was not achieved by all agencies in all OUs, and thus in FY22 and FY23, teams must continue to prioritize this so that the 70% goal can be realized. Each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services. Therefore, each OU agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY23 as appropriate through their COP/ROP 2022 submission.