

Decentralized Drug Distribution in Burundi: Final Report

Background

The Meeting Targets and Maintaining Epidemic Control (EpiC) project received Headquarters Bridge Funds (HBF) and Sustainable Financing Initiative (SFI) funds from the United States Agency for International Development (USAID) to support decentralized drug distribution (DDD) of antiretroviral therapy (ART) in Burundi. The EpiC DDD initiative was implemented in coordination with Burundi's National HIV/AIDS Control Program (Programme Nationale de Lutte contre le Sida et Infections Sexuellement Transmissibles [PNLS/IST]) and other programs in the country supported by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) (i.e., Reaching an AIDS-Free Generation [RAFG]; Reaching Impact, Saturation and Epidemic Control [RISE]; and Population Services International [PSI]/U.S. Department of Defense [DOD]) to help decongest health facilities and improve continuity of treatment for people living with HIV (PLHIV). DDD activities were designed to support PEPFAR programs to expand access to treatment through scale-up of the community ART distribution points (PODI) model.

Burundi adopted the PODI model into its national guidelines in 2016 and approved PODI distribution of antiretrovirals (ARVs) in 2020. In the context of COVID-19, the PNLS/IST also developed an emergency multimonth dispensing (MMD) scale-up plan in May 2020 to offer three-month MMD (3-MMD) for stable and unstable clients on ART, including children and pregnant and breastfeeding women. In collaboration with PEPFAR implementing partners (IPs), the EpiC team supported facilities to increase the number of PODIs and clients enrolled to receive MMD through this model. The initiative also supported the development of information systems to capture data to enhance client care and document processes, outputs, and lessons learned to inform national scale-up.

PODI Model

To form a PODI, health care providers schedule PLHIV who reside in the same area to convene at the facility to receive information about the PODI model. A PODI group can then be created among those who decide to enroll. Each PODI is led by a person living with HIV chosen by members of the group. The PODI leader's role is to coordinate the group, decide on the refill location, pick up the medications from the health facility on behalf of the group members,

EpiC is a global cooperative agreement dedicated to achieving and maintaining HIV epidemic control. It is led by FHI 360 with core partners Right to Care, Palladium International, Population Services International (PSI), and Gobe Group. For more information about EpiC, including the areas in which we offer technical assistance, click [here](#).

distribute the ARV package to each member at the specified meeting location, report back to the health facility on those who received their refills, and return all undistributed ARVs to the facilities within 48 hours. Health providers are responsible for packaging the necessary drugs for each PODI group, distributing them to the PODI leader, and making sure the PODI leader reports back on whether they were able to distribute all the ARVs and returns all undistributed ARVs. PODI members can also receive isoniazid and co-trimoxazole for tuberculosis preventive therapy in their medication package. During meetings, PODI leaders conduct adherence counseling sessions, provide reminders for viral load (VL) testing, and facilitate discussions on topics such as income-generating activities.

Key Achievements

From August 2020 to April 2021, the EpiC DDD initiative in Burundi implemented the activities listed in Table 1.

Table 1. Key activities implemented from August 2020–April 2021

Aug – Sep 2020	Oct 2020	Nov – Dec 2020	Jan – Mar 2021	Mar 2021	Apr 2021
<ul style="list-style-type: none"> Conducted the PODI baseline assessment Designed and developed the PODI tools and materials Selected two provinces and planned for a pilot 	<ul style="list-style-type: none"> Validated PODI tools Initiated implementation in Gitega and Bujumbura City 	<ul style="list-style-type: none"> Supported PODI implementation in the two provinces Distributed PODI tools and materials to PODI leaders (bag, umbrella, register, pen, soaps, masks) 	<ul style="list-style-type: none"> Rolled out PODI in eight additional provinces Supported IPs to implement PODI in their support zones 	<ul style="list-style-type: none"> Discussed potential use of the DDD app for PODIs Transitioned DDD activities into current clinical IPs 	<ul style="list-style-type: none"> Continued transitioning DDD activities to current clinical IPs Prepared the final DDD activities report

Under the leadership of PNLs and the health districts, the DDD initiative supported training sessions for 247 health providers and 826 PODI leaders. By the end of April 2021, 740 PODIs were created in 10 provinces, and 7,803 PLHIV had enrolled in the PODI model. DDD activities continued to be scaled up in other provinces and were available in 10 of the 18 provinces, including Bujumbura Mairie, Bujumbura Rural, Gitega, Kirundo, Mwaro, Bururi, Rutana, Rumonge, Muramuya, and Makamba (see Figure 1). In each province, orientation sessions were organized for key stakeholders, including the district health team, health providers, and PODI leaders. EpiC provided support for facilities to set up new PODIs in their catchment areas, increase the number of beneficiaries in each PODI, and distribute ART through the PODIs.

Figure 1. Map of provinces in which EpiC implemented the PODI model



STAKEHOLDER ENGAGEMENT

The EpiC team engaged key stakeholders at all stages of the DDD activities. Prior to initiation of activities, USAID/Burundi approved the scope of work, which was presented to the PNLS/IST. With technical assistance (TA) from EpiC, the PNLS/IST led the DDD activities, including the baseline assessment, design of the DDD tools, implementation of the PODI model, and scale-up of activities to other provinces. The PEPFAR IPs were also engaged and have been involved in PODI implementation in the provinces they support. Each IP has collaborated with respective health district teams, health facilities, and community leaders during implementation.

The leaders of networks of PLHIV were sensitized to DDD, and specifically the PODI model, and were involved in further sensitization and mobilization of their members for enrollment in PODIs. Biweekly meetings with USAID/Burundi, RAFG, and RISE were conducted to monitor and coordinate ongoing implementation. In addition, under the coordination of PNLS, meetings were organized with other stakeholders, including the World Health Organization, Global Fund, and the Red Cross, to share lessons learned and promising practices and discuss challenges and improvements to implementation approaches. During these meetings, the EpiC DDD team advocated for diversifying DDD models to offer additional options to clients, especially those in urban areas where PODIs were not as popular or practical.

BASELINE ASSESSMENT

Gitega and Bujumbura City, two provinces with 48 percent of PLHIV in Burundi, were selected for the rapid landscape assessment to understand how the PODI model was being implemented. Twenty-one high-volume sites were selected, consisting of sites with 300 or more clients in Bujumbura City and 200 or more clients in Gitega.

The rapid assessment was conducted in August 2020 and aimed to assess the implementation status of the PODI model, acceptance/adherence to the PODI approach among beneficiaries, engagement of health facilities and health providers in the process, service provision within PODIs, and existing national differentiated service delivery (DSD) tools and materials that could be adapted for PODIs.

Findings

In the 14 sites assessed, only 766 clients (8% of the 15,016 on treatment) were enrolled in the existing 82 PODIs. PODI enrollment was higher in Gitega, a rural area (15% overall but higher in some facilities, including Kibimba [31%], Mutaho [55%], and Mutoyi [60%]), compared to Bujumbura City (5%), an urban area. In the rural areas, the main barrier reported for accessing treatment was the long travel distance to the facility, which the PODI model addresses. In the urban areas, transportation is readily available for PLHIV to reach the health facilities, and distance is not a major challenge. Participants also expressed concern about stigma from pick-up of drugs in the community.

PODI meetings and ART pick-up took place at the home of the PODI leader or another PODI member, churches, or nearby schools. During the meetings, the PODI leader distributed ARVs to each member of the group and reported back to the facility. At 11 of the 14 sites (78%) assessed, the PODIs also conducted Village Saving and Loan Association (VSLA) activities.

Other key findings included:

- Some high-volume facilities (CPAMP/HPRC, Centre SOS, and CDS Mushasha) did not have PODIs.
- Four out of six facilities that served key populations (KPs) enrolled KP individuals in PODIs.
- In sites with functional PODIs, clients requested some additional services, including therapeutic education sessions (66%) and VL testing services (54%) in which blood samples were taken and results returned during PODI meetings.
- A need was expressed for standardization of the PODI model to guide all partners during implementation, including the development of standardized PODI tools and materials.

TECHNICAL ASSISTANCE AND DEMAND CREATION

TA was provided to harmonize and standardize the PODI implementation steps and data reporting system. Trainings, orientations, and sensitization sessions were organized for stakeholders involved in the PODI model, including district health teams, health care providers, and community PODI leaders. The sessions were focused on the eligibility criteria for PODI enrollment, advantages of the model, how the PODI functions, the roles and responsibilities of the PODI leaders, and how to use tools for data collection and monitoring. A standard operating procedure (SOP) implementation guide was developed, and DSD reporting tools were adapted for the PODI model.

Networks of PLHIV and community health workers were mobilized to create demand, communicate the benefits of the PODI model to their peers, and encourage their participation in the model. Health providers were engaged to help identify eligible participants, provide counseling on the advantages of the PODI model, enroll stable clients, and set up PODI groups.

Key Results

Four DDD custom indicators and targets were set for Burundi, all of which were achieved (Table 2).

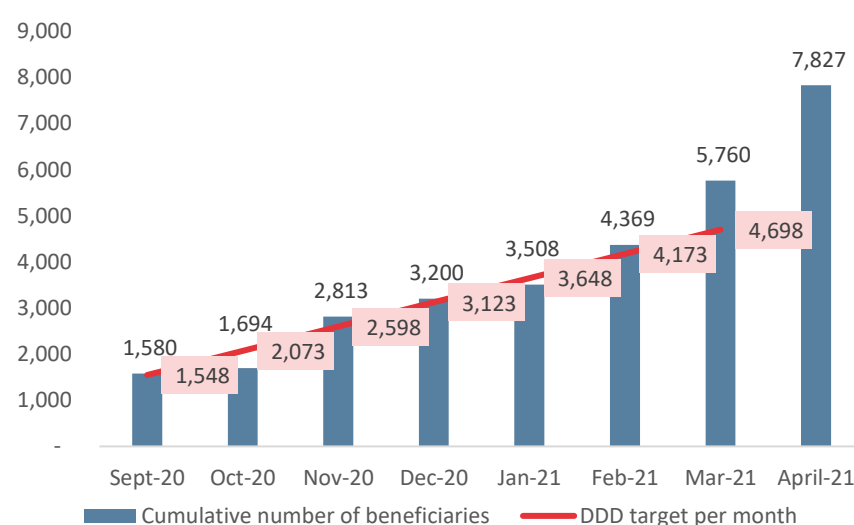
Table 2. Targets and achievements in March and April 2021

Indicators		Targets for March 2021	Achievement through March 2021	Achievement through March 2021 (%)	Achievement to date (April 2021) (%)
DDD_HF: Number of health facilities/stand-alone sites from which clients are devolved to DDD pick-up points (PuPs) or other DDD modalities for ARVs for treatment and/or PrEP		50	54	108%	128%
Number of DDD PuPs and other DDD modalities providing ARVs and PrEP to clients devolved from health facilities		469	541	115%	139%
TX_CURR_DDD: Number of adults and children currently accessing ARVs through DDD PuPs or other DDD modalities		4698	5760	123%	167%
Number of people trained/retrained in DDD	Health care workers	100	247	247%	247%
	PODI leaders	900	826	92%	92%

Indicators were regularly monitored while activities were implemented. The targets were achieved through close collaboration with existing PEPFAR IPs in each province and the leadership of the PNLS.

The number of PLHIV enrolled in the PODI model steadily increased from September 2020 through April 2021 (Figure 2), along

Figure 2. Cumulative number of PODI beneficiaries by month



with the number of PODIs established (Figure 3). At the close of the EpiC DDD initiative, the PODI model was implemented in high-volume facilities (those with more than 100 ART clients) in 10 of the 18 provinces.

The target number of beneficiaries to enroll by March 2021 was 4,698 PLHIV, whereas the project enrolled 5,760 PLHIV (123% of the target) by that date (Figure 2).

The target number of PODIs to establish by March 2021 was 469, and the project established 541 (139% of the target) (Figure 3). PODI setup and enrollment continued to increase through April 2021 (Table 3).

Figure 3. Cumulative number of PODIs established by month

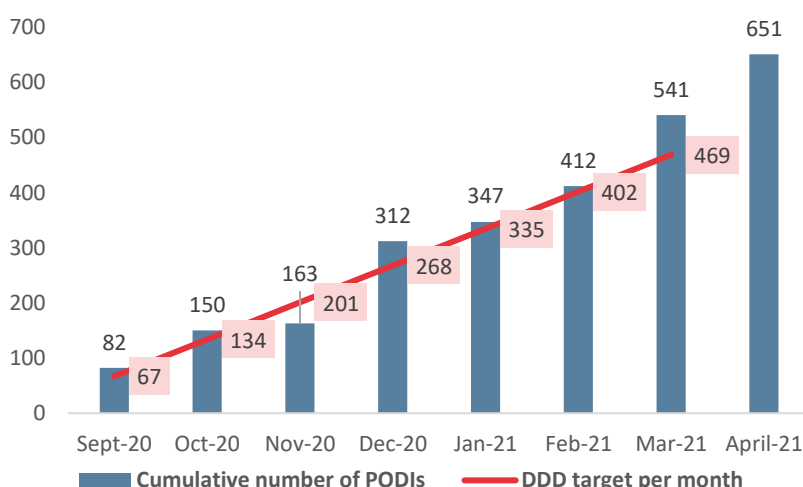


Table 3. Scale-up of PODIs by province from October 2020 through April 2021

Province	TX_CURR as of Feb 2021	Stable PLHIV	Number of Established PODIs	Number of PODI Beneficiaries	% of Stable PLHIV Clients Enrolled in PODIs
Bujumbura	1,878	1,329	28	461	35%
Bujumbura Mairie	21,040	14,010	132	2,164	15%
Bururi	1,710	1,110	22	150	14%
Muramvya	1,098	958	26	223	23%
Makamba	2,171	1,444	11	290	20%
Gitega	6,484	5,211	240	2,468	47%
Kirundo	6,354	4,042	98	1246	31%
Mwaro	967	739	17	141	19%
Rumonge	1,566	961	37	255	27%
Rutana	1,106	815	40	429	53%
Total	44,374	30,619	651	7,827	26%

Lessons Learned and Recommendations

Implementation experiences and lessons learned were continuously documented throughout the initiative and were shared with all facilities involved in the DDD scale-up through regular TA visits and meetings. Challenges encountered and strategies suggested for resolving challenges are summarized in Table 4.

Key lessons learned and recommendations emerging from the EpiC DDD initiative in Burundi include:

- Engaging and coordinating with stakeholders under the leadership of the PNLS early in the process ensured greater buy-in from all stakeholders throughout implementation.
- In the context of the COVID-19 pandemic, DSD approaches, particularly DDD through PODIs, offered added value by limiting contact between PLHIV and health providers and facilitated the decongestion of high-volume sites, potentially reducing the risk of COVID-19 transmission at the facilities.
- Incorporating testimonies from PODI beneficiaries helped create demand for PODI enrollment in other provinces.
- Having PODI leaders take the lead in sensitizing and encouraging peers in the community enhanced beneficiary enrollment in the PODIs.
- Involvement of health care workers throughout the process of establishing PODIs—including in scheduling refill appointments, use of existing DDD tools, and mentoring the existing PODIs in the community—was instrumental for the success of the model. Health facilities with less provider engagement or more provider reluctance saw lower rates of enrollment.
- Once the PODI functions well, it could be leveraged for VL sample collection and return of results.

Table 4. PODI model challenges and solutions

	Individual Level	Community Level	Health System Level
Challenges	<ul style="list-style-type: none"> Stigma and fear of being identified as a person living with HIV if distribution is done in the community Low rates of PODI model enrollment among adolescents Low rates of PODI model enrollment in urban settings Among PLHIV, fear of being disconnected from the facility 	<ul style="list-style-type: none"> Community workers were not sufficiently involved by health workers, but community workers were a necessary force for reaching PLHIV in the community 	<ul style="list-style-type: none"> Only one DSD model is approved by current national guidelines. Some sites/health workers were reluctant, as they felt disconnected from their clients. Monitoring tools and SOPs were being developed as implementation started, and finalization took time, which had an impact on the rollout of PODIs. National platform tools (DHIS2 and SIDA Info) did not yet include the DSD component.
Strategies to address	<ul style="list-style-type: none"> Continue to sensitize PLHIV to adhere to PODIs by highlighting their advantages and added value. Propose other types of DSD models: weekend clinics for adolescents, private pharmacy model for urban settings, and facility-based ART groups. 	<ul style="list-style-type: none"> Train community workers, and involve them in sensitizing and further engaging PLHIV. 	<ul style="list-style-type: none"> Sensitize and train health workers on the DDD approach. Diversify DSD models. Standardize DSD tools, and adopt them as national tools (DHIS2, national EMR [SIDA Info software]).

Transition Plan

Before EpiC support for DDD activities ended in March 2021, a transition plan with key activities, timeline for completion, and the projects/IPs responsible for each activity was developed to maintain DDD activities through the current PEPFAR programs in Burundi (Table 5).

Table 5. Transition plan for continuing DDD implementation in Burundi beyond the EpiC Burundi period of support

Activities	Expected Result	Responsible
Organize a workshop with PNLS/IST and IPs to share progress and results of the DDD model	Commitment and engagement of all stakeholders to continue scaling up the DDD model in the remaining provinces	FHI 360
Disseminate the SOP implementation guide and standard tools developed and validated by PNLS/IST and IPs to the new sites engaged for DDD	Dissemination of DDD tools and materials in the new sites involved in DDD	PNLS, EpiC, RISE, PSI, RAFG
Scale up the PODI model to other high-volume sites in provinces supported by RAFG, RISE, PSI, and EpiC Burundi	Establishment of PODIs in facilities with a high volume of PLHIV in additional sites and provinces	RAFG, RISE, PSI
Continue supporting health facilities to implement the PODI model (e.g., site visits, supervision)	Ongoing implementation of the PODI model in sites where PODIs have been established	RAFG, RISE, PSI
Continue providing TA, mentorship, and monitoring to existing PODI groups	Existing PODI groups remaining functional and well supported	RAFG, RISE, PSI
Extend the PODI model to KPs	All existing DICs (drop-in centers) to become points of ART distribution for KPs	EpiC
Assess DDD clinical outcomes (continuity on treatment and VL suppression)	Assessment and dissemination of DDD clinical outcomes for sites implementing the PODI model for 12 months or more	RAFG, RISE, EpiC, PSI

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