Burundi:

Key Populations' Strategic Priorities

Introduction

Key population (KP) programming in Burundi has been a joint initiative between the leadership of the Programme Nationale de Lutte contre le Sida et Infections Sexuellement Transmissibles [PNLS/IST], with investments from the Ministry of Public Health and Fight Against AIDS (MSPLS), the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), the United States President's Emergency Plan for AIDS Relief (PEPFAR) and community stakeholders.

Through differentiated service delivery, the country offered HIV prevention, testing, treatment, viral load monitoring and retention services, among others, to gay, bisexual and other men who have sex with men (GBMSM), sex workers (SW), people who use drugs (PWUD) and transgender people (TG) in 13 provinces (Bujumbura, Bujumbura-Rural, Bubanza, Cibitoke, Kayanza, Ngozi, Kirundo, Muyinga, Karusi, Gitega, Rutana, Makamba, Rumonge).

The PEPFAR KP programme had fully transitioned to KP-competent local partners: Association Nationale de Soutien aux Séropositifs et malades du SIDA (ANSS) who offered clinical services and the Society of Women Against AIDS (SWAA)/Burundi and PWUDs that had sub-contracted community organisations (HUMURE, MOLI, BAWA, BAPUD) for prevention related activities.

Burundi has consistently improved its HIV response making significant progress in controlling HIV, tuberculosis and malaria, with high ART coverage and declining AIDS mortality achieving 93-99-93 in the HIV cascade and was on track to become the first African francophone country to achieve the 95-95-95 UNAIDS targets[1].

What does the data say about HIV prevalence among KPs in Burundi?

31% among female sex workers (FSWs) and 6% among men who have sex with other men (MSM). There was no information on transgender people (TG) and people who inject drugs (PWUD).[2]

While there has been progress, KPs continued to experience disproportionately high rates of HIV infection, and challenges in the socio-political environment that increased the barriers that KP community members faced while seeking services. Communities experienced KP and HIV related stigma, discrimination, violence and structural barriers.

Burundi's KP response had greatly relied on external support to sustain the progress that it had made. The gains that have been made are now at risk of getting lost and reversing the overall successes of the HIV programme should they remain unaddressed.Over the past six months (January to June 2025), Burundi has experienced significant reversals in KP programming due to abrupt funding reductions, donor reprioritisation, and systemic integration without adequate safeguards. The US funding cuts have greatly stalled progress in the country especially for KP programmes that were largely PEFPAR-supported. More than 80% of KP services were lost following the cut at the beginning of 2025. Prevention, including pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP), structured psychosocial support, and sexual and reproductive health services tailored to KPs were suspended, community centres and focal points were either temporarily or permanently closed, peer educators/navigators lost their employment and income and those remaining are currently working only on a voluntary basis. The KP Integrated Bio-behavioural Survey (IBBS) that had just launched to gather data on MSM, FSW and transgender women had to be halted mid-way due to the cuts – leaving critical evidence gaps. Community engagement and capacity has been weakened with the loss of funding leading to a reduction in strategic meetings, irregular data collection, and limited participation in planning bodies.

In addition, funding to support structural interventions, such as the US government funded Burundi Economic Empowerment Program (BEEP), focused on job creation, employment and entrepreneurial skills for KPs was also cancelled.

[1,2] Burundi Country Operational Plan (COP) 2023 Strategic Direction Summary

The Humure consortium host to 7 organisations operating in rural areas and supporting 100 peer educators and MOLI have identified priorities for sustaining effective programming in the context of severely constrained resources and a costed strategy for essential elements designed to prevent further collapse and restore critical services, as detailed below.

KP Community Core Priorities

1. Antiretroviral Therapy (ART) and Service Continuity

The Burundi KP HIV programme used recent infection surveillance data to monitor epidemic trends, characterise recent HIV infections and monitor priority populations and had made efforts to sustain gains in same day linkage to ARV treatment for PLHIV.

The community ART distribution points (PODI) model was adopted into its national guidelines in 2016, PODI distribution of antiretrovirals (ARVs) was approved in 2020 and through partners, the programme provided person-centred differentiated services, such as decentralised drug distribution (DDD), including multi-month dispensing (MMD), to maintain PLHIV in care, and to provide support for timely and quality viral load services. In Quarter 1 FY 2024-2025, while the MSM programme had a case finding & linkage result of 126% (298/236) of the target for new positives met, ART coverage of 98% (649/663) and a high viral suppression of 97% (505/518), the programme demand far outweighed the targets. Among TG communities, 94% (31/32) of clients on ART had very good viral suppression, however, only there was low case finding (56% of target met; 15/27), and low ART coverage (67%; 35/52) showing significant gaps due to treatment interruption, poor linkage, stigma, or service inaccessibility.

After the funding cuts, the KP programme was weakened by the loss of more than 80% of the services; only a few urban sites are currently providing minimal service and only clinical structures continue ART service provision[3].

No KP community sites remain operational. In December 2024, there were 6 KPs PEPFAR-supported sites all of which have since been terminated. Peer educators who provided the link between the community and the health services have also been terminated reducing retention of community members. Of those on treatment who are now required to seek services in the general facilities, treatment interruptions are being reported. However, KP data is now being integrated together with those of the general population reducing the programme's ability to track KP data. Key activities to improve retention such as multi-month dispensing that were vital are now limited in frequency.

Non-negotiable Priorities:

- **Restore continuous access community-based ART,** including logistical support for KPs in rural areas.
- **Reactivate and fund the network of 100 peer educators** and focal points for national coverage and regular support.
- **Strengthen and sustain safe spaces and community centres** offering clinical services and psychosocial support.
- **Integrate artificial intelligence tools** for service delivery, as well as mobile services in hard-to-reach areas.

[3] a rapid national survey conducted in early 2025 by HUMURE with 7 KP-led community organizations part of the consortium across 14 provinces

Strategic Element	Current Status (June 2025)	Annual Funding Required (USD)	Notes
ART Commodities	A lack of community based ART including logistical support	$20,653	Restore access and logistical support
Peer Navigation Support	100% reduction in peer support services	$200,000	Critical for addressing access barriers in general facilities
KP-Competent Service Training	Stigma and discrimination reported in general facilities	$120,000	Essential for safe access in integrated settings
KP-Specific ART Sites	100% of KVP organisations ceased operation after the funding cuts	$61,861	Bridge between general services and KP needs

ART Funding Gap: Approximately **$402,514** annually to restore comprehensive, peer-supported ART services for KVPs.

The cost of inaction? Limited facility-based ART services, weakened community components of treatment support, termination of peer workers who find, link and retain those on treatment, no data tracking of KPs all point to a grim HIV programme outcome. The successes of the KP programme will not be sustainable without a robust and well implemented KP programme.

2. Primary Prevention

Prior to the funding cuts, PEPFAR and the GFATM complemented each other in the provision of prevention services. The programme relied on differentiated testing strategies such as index testing and HIV self-testing (HIVST) modalities both at facility and community levels and provider-initiated testing and counselling (PITC) in high-yield service delivery points such as inpatient and sexually transmitted infection (STI) clinics and social network services (SNS) in KP networks to expand high quality testing service as one of the entry point for prevention services.

HIV negative clients were offered prevention options such as condoms, lubricants, PEP and PrEP. These services relied heavily on community and peer outreach services and other social network strategies.The programme also focused on reducing stigma, discrimination and violence in health services and society in general for key and priority populations, addressing policy challenges and capaciting health systems staff around inclusiveness.

Since the funding cuts, there is limited access to PrEP. Distribution of condoms, lubricants, and HIV tests has become sporadic and depend on donations that are limited. The estimated number of KPs who have accessed PrEP reduced by approximately 150 (350 to 200) people from December 2025 to June 2025 and the estimated number of people who initiated on to PrEP reduced from 120 to 50 from December 2025 to June 2025[4].

[4] HUMURE consortium programmatic monitoring and the rapid survey with 8 KP organizations (Dec 2024–June 2025)

Burundi was later in the order of countries to introduce oral PrEP, but there is an opportunity now to accelerate and expand impact with the addition of long-acting PrEP. While access to two-monthly injectable CAB-LA may continue to be somewhat limited, there is commitment from manufacturers to make six-monthly injectable lenacapavir more available. Long-acting injectable PrEP represents a powerful HIV prevention option that has the potential to dramatically decrease new infections, but only if accessible to those who need it. At a minimum, Burundi should amend national guidance in line with WHO and develop an investment plan to include long-acting injectable PrEP.

Non-negotiable Priorities:

- **Restore PrEP access:** Re-establish oral PrEP access points within community-led DICs to reverse coverage declines and meet current demand among KPs.
- **Reinstate KP-led prevention sites:** Prioritise operational support for KP-led prevention service delivery sites to increase PrEP initiation and retention.
- **Train health providers on KP-competent prevention:** Strengthen capacity of public and private sector providers to deliver non-judgmental, evidence-based prevention services tailored to KP needs.
- **Expand condom and lubricant distribution:** Restore and scale up peer-led outreach programmes to ensure consistent availability of condoms and lubricants to all KP communities.

Strategic Element	Current Status (June 2025)	Annual Funding Required (USD)	Notes
PrEP Commodities (Oral)	Only being provided in general facilities	$1,366,963	Restore PrEP access for all KP communities
PrEP Sites (Free-standing) including preparations for LA-PrEP roll out		$484,757	Restore and scale up drop-in centres, and other community pick-up points. Preparations for LA-PrEP Rollout
KP-Competent Public PrEP Sites including preparations for LA-PrEP roll out	Available but unfriendly	$484,757	Train health workers in KP friendly sites to provide quality safe and respectful services for KPs
Condoms & Lubricants	Limited	$5,000	Restore commodities and community distribution
HIV test kits	Sporadic	$6,300	Restore full access to HIV test kits

PEP (Post-Exposure Prophylaxis)		$10,000	Available nationwide to all at risk persons within the 72 hours
Demand creation for new PrEP products and broader prevention awareness	Unavailable	$150,000	Create demand for new PrEP products
Support for policy amendments to include new PrEP products	Needs update to include new PrEP products	$50,000	Update policy and SOPs to include new PrEP options

Primary Prevention Funding Gap: Approximately **$2,557,777** annually to restore comprehensive prevention services with peer support networks.

What is the cost of inaction? Prevention is key for KPs especially in settings where the political environment is more challenging. Burundi's KPs have been stripped off of key prevention infrastructure and access. This is the gateway to other critical services and determines the success of the KP programme.

3. Community Infrastructure

Prior to the cuts, the KP programme was improving community engagement. KPs were involved in planning, increasing KP community empowerment, community community-directed activities such as peer educators, treatment buddies and navigators. The KP programme had fully transitioned to, KP-competent local partners: Association Nationale de Soutien aux Séropositifs et malades du SIDA (ANSS) and Society of Women Against AIDS (SWAA)/Burundi to increase friendly access to services for KPs and intended to continue working with local partners to maintain the KP programme focus on person-centred services, ensuring KPs have access to comprehensive services where they are (at facility sites, community, CSO sites and virtually). ANSS worked in a consortia approach, funding MSM, TG and PWUD-led organisations to assist in delivering services via drop-in centres, hotspot mapping and outreach and virtual means. SWAA, capacitated FSW-led associations to take a greater management role in DICs.

To ensure the safety and the continuity of KP programmes, PEPFAR Burundi also invested in working with NACP and National AIDS Council (CNLS) to educate parliamentarians and other national/local political decision makers on the importance of KP programming; the right to care for all KP populations in both public and community service sites; the importance of mitigating KP-related stigma, discrimination and violence, and the scaling of other evidence-based strategies, including U=U and PrEP.

After the funding cuts, KP-led organisations were shut down as they relied greatly on PEPFAR support. Many NGOs are also now forced to reduce or suspend their advocacy efforts due to a lack of operational budget. The closure of the KP led organisations cut vital access for KPs who were forced to return to unfriendly general facilities. The community centres and safe spaces that remain open are few and have very limited activities/services. Community awareness efforts are now provided on a voluntary basis and without sufficient logistical support. The critical empowerment programmes have also been interrupted.

Key Estimates of Reductions (January-June 2025):

Area of Impact	By December 2024	By June 2025	Estimated Reduction	Narrative Explanation
Peer navigators/ Outreach workers	100 peer educators and focal points for national coverage and regular support.	0 peer educators and focal points for national coverage and regular support.	100% reduction	Peer navigation networks fully cut due to funding cuts
Drop-in centres	6 PEPFAR-supported dedicated sites	0 PEPFAR-supported dedicated sites	1000% reduction	All PEPFAR-supported DICs closed due to funding cuts
KP organisations conducting advocacy	~10–12 active organisations (Bujumbura, Ngozi, Gitega, Rumonge)	~to 5–6 active ones, some reduced to a minimum (only Bujumbura + Ngozi)	50% reduction	From 10 to 6 active organisations.
KP-led organisations providing social and material support	~7–8 initiatives (surtout à Bujumbura, Ngozi, Gitega)	to 2–3 local initiatives, mostly volunteer	~75% reduction	Almost total loss of material support (emergency housing, safe spaces). Only voluntary psychosocial support remains.

Community-led monitoring (CLM) programmes	4 structured programmes (RNJ+, HUMURE, Sex Workers Network, LGBTIQ+ Youth NGO)	1 active programme , others suspended	75% reduction	Data collection has been halted due to lack of funding. Only a community-based informal monitoring initiative remains.
Legal and rights protection services supporting KP	5 partner structures (Bujumbura, Ngozi, Gitega, Muyinga, Rumonge	at 1–2 accessible services in Bujumbura)	~75% reduction	
violence prevention and response services.	6 active services (including through NGOs and community	2 informal services left	66% reduction	

Non-negotiable Priorities:

- **Reactivate and fund the network** of 100 peer educators and focal points for national coverage and regular support.
- **Reopen the DICs** as they are vital to KP service delivery and a critical link to KP communities.
- **Fund advocacy rights and violence protection and safe spaces** to empower KPs to advocate for better services and innovate by digitizing support hotlines for violence reporting.
- **Restore KP led CLM.** CLM is vital especially now to ensure that the quality of KP service delivery is maintained.
- **Maintenance of income-generating activities** (IGAs, VSLAs) to support the resilience of community workers (peer educators, focal points, and LBQ single mothers)

Strategic Element	Current Status	Annual Funding Required	Key notes
National KP Coalition/Network	In need of funding	$100,000	Merge small NGOs into regional platforms
KP Advocacy Organisations	None	$1,100,000	Support advocacy to better service delivery
Legal & Rights Protection	Greatly reduced	$150,000	Provide training to KPs to become qualified paralegals and Aim for quality rather than quantity, partially digitise (hotlines)
Violence Prevention Services	Greatly reduced	$150,000	Key to reducing violence against KPs especially TG women
Community-led monitoring	Drastically reduced	$500,000	Key to ensure that quality service for KPs are maintained
Income generating activities	Limited as other were terminated	$800,000	Critical to ensuring self reliance

Community Infrastructure Funding Gap: $2,800,000 to rebuild essential community systems and protective mechanisms.

What is the cost of inaction? Ensuring a successful KP programme requires investing in community infrastructure. Ensuring competency in KP service delivery, including ensuring confidential services to mitigate harm, as well as offering differentiated service delivery models via KP-specific drop-in centres, offering comprehensive health services, DICs support HIV testing and treatment with complementary services, such as family planning, mental health, and/or violence mitigation services increase the programme's ability to find, test, and retain KPs living with HIV. The current cuts create a substantial access barrier for KP and persistence in returning KP to mainstream facilities will result in a poor outcomes for KPs.

4. Data and Monitoring Systems

The success of the HIV programme relies on quality KP data to support decision making for the overall programme. Data on KPs in Burundi has been lost as KP members are being transferred to the general facilities for health service and where identifying oneself as a KP community member is not possible for most KPs. The closure of KP DICs has also led to the loss of the vital data as the community led sites are no longer able to keep track of KPs as they did before.

Non-negotiable Priorities:

- **Restore high-quality, disaggregated data for an effective prevention and treatment programme for KPs.**

Strategic Element	Current Status	Annual Funding Required	Key notes
Disaggregated data	Not collected	$731,319	Restore high-quality, disaggregated data and institutionalise a data collection data base

Data and Monitoring Systems Gap: $731,319 annually to rebuild data and monitoring

What is the cost of inaction? The closure of KP specific service delivery sites is a great loss for KP data. A lack of KP specific data collection will hinder the country's ability to programme for KPs and eventually affect the country's success at achieving the 95-95-95 UNAIDS targets.

Summary of proposed cost of the Burundi Key Population Plan

Targeting and Costing Methodology

In Burundi, the methodology used the National population size estimates from PEPFAR and UNAIDS KP Atlas. Where lacking an estimate for TG, a standard percentage from the region is used. We considered the percentage of KPs that need prevention services (set initially at 90%). We further estimated KP living with HIV using HIV prevalence from PEPFAR or the KP Atlas. Where lacking prevalence data, a standard percentage from the region is used. We had considered % of KPLHIV in need of treatment services (set initially at 100%). To meet the Burundi budget, Burundi will focus on 70% of treatment and 50% as indicated below. Prisoners and clients of FSW are not included in the costing exercise.

The itemised costing of each intervention is found on this link: Burundi Targeting and Costing.

Burundi Priorites	Costs	Total	Cost per target	General costs	GBV	Testing	TX	Biomedical Prev	STI
Priorites	Costs	$6,335,309	$185	$462,983	$20,457	$280,018	$402,514	$4,695,994	$473,345
	Percent of total			7.31%	0.32%	4.42%	6.35%	74.12%	7.47%
		National Targets							
Targets	KP Treatment	2,700							
	KP Primary Prevention	31,500							
	Total	34,200							

What should a good core package for quality key population service delivery include?

- Outreach services
- Lubricant
- Male condoms
- KP friendly HIV testing and counselling, including HIV self testing
- KP friendly HIV care and treatment
- HIV and PrEP support groups to improve continuity in care
- Psycho-social support
- Pre-Exposure Prophylaxis (PrEP)
- Post-Exposure Prophylaxis (PEP)
- Mental health services
- Linkage to justice services
- Pmtct
- Information package for sexual health services
- KP friendly STI prevention, testing & treatment services
- Gender-based violence services on-site or by referral
- Peer educators/navigators at the facility
- Vaccination, diagnosis, and treatment of viral hepatitis (including HBV, HCV)
- Prevention, diagnosis, and treatment of tuberculosis
- Counselling and risk reduction information
- Anal health services
- Voluntary Medical Male Circumcision (VMMC)
- Prostate cancer screening
- Cervical cancer screening
- Screening and treatment for ano-genital warts
- On-site and referral for other SRHR services

PWUD specific:

- On-site and referral drug dependence initiation and treatment (e.g. methadone)
- On-site and referral drug-dependence counselling and support
- Resources to take up referred services (e.g. taxi fare)
- Wound and abscess care
- Unused needles, syringes, or other injecting equipment
- Overdose management and treatment (e.g. naloxone)
- Drug dependence support group

TG specific:

- Hormone Replacement Therapy (HRT)

Methodology

This rapid strategy and budgeting exercise was designed as a structured assessment process to capture country-level impacts of foreign aid transitions and identify essential services requiring continued investment for KPs. The methodology began with orientation to a standardised Excel worksheet framework designed to systematically capture country coalitions' assessments across three critical domains: ART service delivery, HIV prevention programming, and community infrastructure (including civil society engagement, community-led monitoring, community mobilisation, and advocacy capacity).

The assessment process examined three distinct time periods: baseline status at the end of 2024, immediate impacts following foreign aid transitions that began in January/February 2025, and current conditions as of June 2025. Country coalitions collected quantitative and qualitative data through surveys, key informant interviews, organisational assessments, and coalition consultations to document service disruptions, funding gaps, and programmatic changes across these timeframes.

Following data collection, coalitions engaged in facilitated consensus-building processes to analyze findings, identify priority concerns, and develop collective views on current programming status. Through these discussions, coalitions articulated their "essentials"—critical activities, services, and investments necessary to maintain effective HIV responses for KPs in their contexts. This worksheet was used as the basis for a strategy narrative, developed by the GBGMC support team, that included a summary table of priority interventions requiring funding and attention.

Burundi's Methodological Guide:

The Burundi Key Populations' Strategic Priorities were developed through a rapid, participatory process involving 8 KP organizations, including 7 members of the HUMURE consortium and 1 sex worker-led organization. This process was guided by a structured assessment of service delivery, prevention, and community systems.

Data collection and analysis drew on multiple sources, including the Ngirankabandi report, which documented triennial data from 2022–2025. HUMURE led the community KP component, while ANSS managed the clinical service component, ensuring a comprehensive view of KP service delivery.

The methodology combined:

- Desk review of routine programmatic and surveillance data.
- Community networks to capture service disruptions and priorities.
- Organisational assessments to measure the impact of funding cuts on both community and clinical services.

The Team

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List of Burundi organisations that participated

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TUREMESHANYE

Association TWIYUNGE

TURIHAMWE, TUMENYANE

Association des Jeunes Unis pour l'Avenir (AJUPA)

Association pour la Solidarité au Travail (AST)

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